

**Reflection in Home Visiting: The What, Why, and a Beginning Step Toward How**

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### **Abstract**

The work of home visitors in early childhood fields may include addressing many challenges to achieving curricular outcomes, including issues such as maintaining boundaries and managing one's own reactions to children, parents, and overall family situations. Increasingly, reflective supervision and consultation are recognized as a way for workers in home visiting early intervention and early care fields to address these personal and professional challenges and build competence (Watson, Gatti, Cox, Harrison, & Hennes, 2014). The features of home visiting that make reflective supervision/consultation essential are discussed. Next, results of a pilot project in which a sample of Part C early intervention providers respond to a vignette portraying a challenging parent-child interaction are briefly presented and discussed. Despite often stating the importance of relationships, participants did not identify concrete methods of supporting relationship or demonstrate recognition of parallel process. In addition, providers seldom endorsed the use of reflective skills, such as observing, listening, wondering, or reflecting (Weatherston, 2013) and no providers discussed a need for reflective supervision/consultation. We suggest that these findings illustrate some of the areas in which early intervention home visitors could benefit from participation in reflective supervision/consultation to move from identifying reflective skills as important to actually being able to use such skills in their work with families.

**Keywords:** Reflective practice, reflective supervision/consultation; home visiting

## Introduction

In programs for at-risk families, supportive parent-professional relationships are understood as a major force for change and a way to prevent possible future problems within the parent-child relationship. In many early childhood systems and programs, the support that workers provide to parents is an explicit component of the work. What underlying skills and capacities must home visitors demonstrate to be able to function in this sensitive way with parents? How are these skills developed? Although the work and skills needed for home visitation are broad, the ability to use reflection in practice and to make best use of supervision/consultation may be the answer to both questions.

In any discipline, workers seek to gain skills and improve their practices, often by use of some form of reflection. These activities can occur independently, in groups, or as part of one on one learning relationship. For this paper, we adopt Brandt's (2014) terminology to define *reflective activities*, *reflective process*, and *reflective practice*. Reflective activities are described as a continual process of actively considering beliefs and knowledge. Reflective process is defined as combining one's own internal experiences (i.e., ideas, thoughts, instincts) with external knowledge that might include research, best practice guidelines, or input from others. Finally, with more experience, the worker is now able to use reflective activities and engage in reflective process during encounters with families, referred to as engaging in reflective practice (Brandt, 2014). When a provider seeks the support of another more experienced worker to regularly and collaboratively engage in reflection about work with families, the terms reflective supervision or consultation are used. Reflective supervision often has a legal connotation in which the supervisor shares some formal responsibility for the work, whereas consultation, can be used for other supportive relationships that seek to support professional development outside of this level of responsibility. For this paper we will use the term *reflective supervision/consultation*. All of these methods may support professional development and enhance outcomes for families.

The ability to use reflection to consider one's own inner experience and that of others is thought to be a uniquely human one (Slade, 2005; Fonagy, Gergely, Jurist, & Target, 2002). In addition to their role in forming relationships, reflective skills are highly valued as an avenue for learning, especially when

they occur within a supportive relationship (Shahmoon-Shanok, 2009; 2010). For very young children, parental reflective functioning is thought to underpin this process of relationship formation and development. When parents are able to consider and attend to their young child's experience, a secure attachment is more likely to form and learning is facilitated; the process can also serve to repair relationships when needed (Fonagy & Target, 2005; Sadler, Slade & Mayes, 2006).

This ability to grow and learn through a relationship that supports reflection continues past childhood. As a result, the formation of a positive relationships between parents and providers is frequently cited as a key component of many home visiting programs (Roggman, Cook, Innocenti, Jump Norman, Boyce, & Christiansen, 2016). Supportive relationships in adulthood, including relationships between parents and home visitors, can result in enhanced outcomes for families (Schaefer, 2016; Zapart, Knight & Kemp, 2016). Just as parents' reflective functioning is thought to be a primary vehicle through which the parent-child relationship is strengthened, so too may provider reflective skills work in service of the parent-provider relationship.

When parents have not experienced healthy relationships in the past, a positive relationship experienced as an adult may be so powerful that it has been termed a *corrective attachment relationship* (Lieberman, Silverman, & Pawl, 2000). Support for this concept comes from a recent survey of mothers who received home visits through a program in New Zealand. Participants reported that a positive relationship with the home visitor characterized by *availability* and *responsiveness* was key to the long term impact of the program (Zapart, et al., 2016). In thinking about how parent-professional relationships may come to affect parent-child relationships, the concept of *parallel process* (Heffron & Murch, 2010; Parlakian, 2002) is frequently invoked. Briefly, it is thought that "when parents receive support, they are fueled to be better parents" (Tomlin, Sturm, & Koch, 2009, p. 636). As providers perform actions that parallel those needed for the formation of a secure infant attachment, the relationship between parent and provider is strengthened, such that the parent's sensitivity and responsiveness to his or her children can also be improved.

Thus, it is increasingly clear that just as young children benefit from supportive relationships with parents, and parents benefit from supportive relationships with interventionists, so professionals may benefit from a supportive supervisory relationship when building their reflective practice. As a result, engaging in reflective process and reflective practice, once considered primarily for mental health professionals, is now considered essential to the work of a full range of early care and education professions across practice settings and is understood to be a foundation for lifelong professional development (Brandt, 2014). Furthermore, many writers contend that engaging in reflective activities and process within the context of a reflective supervision/consultation relationship is a highly effective form of professional development that leads to reflective practice (Heffron & Murch, 2010; Watson, Gatti, Cox Harrison, & Hennes, 2014; Weatherston, Weigand & Wiegand, 2010).

Although work with young children and families in any setting may be complex, work that occurs in the home setting can be challenging due to issues associated with the setting, the population served, worker preparation and training, and responses that workers may have to the work with the families and children they serve (Peterson, Roggman, Green, Chazan-Cohen, Korfmacher, McKelvey, Zhang, et al., 2013). The target families of many home visiting programs are involved in the program due to significant stressors that carry high levels of risk, such as poverty, domestic violence, or parental mental illness (Ammerman, Putnam, Chard, Stevens, & Van Ginkel, 2016; Forstadt, 2012; Peterson, et al., 2013; Teeters, Ammerman, Shenk, Goyal, Folger, Putnam, & Van Ginkel, 2016). These stressors can interfere both with the formation of positive relationships between providers and parents and with the degree of engagement that is needed to work collaboratively. In addition, as attention is placed on these psychosocial concerns, providers may struggle to attend to their assigned role and tasks with a family, expected outcomes related to curricula may not be attained, and boundaries may be blurred (Bernstein & Edwards, 2012; Tandon, Mercer, Saylor, & Duggan, 2008).

Over time, workers may acutely feel the weight of supporting families in such difficult circumstances, leading to experiences that have been termed “burnout” and “compassion fatigue” (Maslach, Schaufeli, & Leiter, 2001). Reflective supervision/consultation may be most useful in these

situations when home visitors or other early childhood professionals are faced with events or situations for which they lack formal preparation; especially when it provides a sense of empowerment and the supervision is provided by someone with direct knowledge of the work (Lee, Esaki, Jeehoon, Greene, Kirkland, & Mitchell-Herzfeld, 2013; Jones Harden, Denmark, & Saul, 2010). In the next sections we will briefly consider each of these challenges, then discuss how reflective supervision/consultation serves as a supportive learning environment that builds the reflective skills of home visitors needed to address these concerns.

### **Setting Issues**

A concrete aspect of home visiting that must be addressed is worker safety. Because many of the families who receive home visiting services are eligible for programs based on some type of psychosocial risk, providers may feel uncomfortable or even physically unsafe in some homes. These feelings may stem from concerns about the safety of the neighborhood, the condition of the home itself, and safety issues connected to domestic violence.

A second aspect of the environment that can affect home visiting work is the level of intimacy that is part of working with families with very young children (Tomlin & Viehweg, 2003). Home visiting in particular, with its emphasis on relationship and because it occurs on the family's "turf", may bring increased closeness. What this closeness means to parents may be different from the perspective of the home visitor. In fact, approximately three quarters of participants in home visiting programs report viewing the visitors as a friend in contrast to the view of home visitors, who described their role as a resource for information, a person who cares or helps, or a friend with boundaries (Riley, Brady, Goldberg, Jacobs, & Easterbrooks, 2008; Mills, Schmied, Taylor, Dahlen, Schuiringa, & Hudson, 2012). Setting and abiding by relationship boundaries is necessary, but can be difficult for both the provider and the family (Jones Harden, Denmark, & Saul, 2010). Reflective supervision/consultation can provide a safe place for home visitors to become more aware of their own reactions to family situations and increase their ability to resist crossing boundaries of practice.

### **Family and Parent Characteristics**

The parent-provider relationship is at the center of successful intervention as it may serve as a vehicle for sharing knowledge, skills and resources (Lee, Esaki, Kim, Greene, Kirkland, & Mitchell-Herzfeld, 2013; Schaefer, 2016). A common core value to the many existing home visiting models, is the importance of the parent-provider relationship (Forstadt, 2012; Roggman, et al., 2016). At times, a parent's personal relationship history may get in the way of the formation of this relationship. For example, negative experiences with other providers or personal relationships, or histories that include trauma exposure can interfere with one's ability to form new relationships. In addition, many parents who participate in home visiting programs have personal characteristics such as mental health problems, addictions, or developmental disorders that can be barriers to engaging with professionals (Ammerman, et al., 2016; Osofsky, 2009; Tandon, et al., 2008; Teeters, et al., 2016). Home visitors report that when parents have these challenges, it can be hard to complete their work. For example, nurses in a Nurse Family Partnership program reported that families in which parents have mental health issues need more time and that it was harder to stay on the schedule as planned (Zeanah, Larrieu & Boris, 2006). Engaging in reflective supervision/consultation can help the provider recognize patterns of interaction within the relationship, be more cognizant of the parent's perspective, adjust responses and expectations to match the parent's challenges, and maintain professional boundaries that may be tempting to cross when family needs are high.

### **Worker Training and Preparation**

Although home visiting as a profession has a long history and there is current consensus about its utility, preparation for the work can be variable. Some home visitors may have come from professional programs (e.g., occupational or physical therapy) that were historically focused on work with individual adult clients (Romano, 2006). Other workers may have entered the field with an interest in working with children and have had relatively little preparation for working with parents or parent-child dyads (Heffron & Murch, 2010). In some cases, the worker's experience and training has been primarily with young children, leaving them with limited skills needed to address adult learning or coaching parents to work

with their own children. There also may be misperceptions of parents who may understand the home visitor's role as one of "doing work" directly with the child. The combination of the provider's professional preparation and parent expectations may result in the primary method of delivering service being the home visitor interacting with the child while the parent watches and is seldom acknowledged, leaving little to no chance to practice the strategies being demonstrated (Jones Harden, Denmark, & Saul, 2010; Kashinath, Coston, & Woods, 2015). Reflective supervision/consultation can assist workers to maintain a balance between the needs of the parent and those of the child. It may also help participants to identify their own training needs related to working more effectively with parents.

### **Worker Responses to the Work**

Overall, home visitors report that they would like more supervision provided by a mentor who can give emotional support and who has the ability to understand the "boots on the ground" work (Jones Harden et al, 2010). Younger or newer and less experienced home visitors may be most likely to benefit from reflective supervision/consultation as they are also more likely to report burn out symptoms (Lee et al., 2013). Less burnout is reported when workers are more satisfied with supervision and feel empowered in their work (Lee et al., 2013). Use of reflection in supervision or consultation has been reported to build new skills, improve current skills, and increase competence (Eggbeer, Shahmoon-Shanok, & Clark, 2010; Watson et al., 2014).

As we have discussed so far, many aspects of the work of home visitors make these jobs difficult. Furthermore, providers themselves typically have many responses, feelings, and thoughts related to their work with children and families, that at times can interfere with the work (Bernstein & Edwards, 2012). In addition, the worker's own history may play a role in how she sees or understands a family and their child. Time, space and support for reflection is needed for providers to be able to accurately recognize, organize and make meaning of these reactions so they can form appropriate and helpful responses to the needs of families and children. It is thought that these skills develop best through a reflective supervision/consultation process. This means that providers need regular opportunities to receive support for reflection from a more experienced provider (Osofsky, 2009; Parlarkian, 2002; Weatherston &



Barron, 2009). Without these types of supports home visitors can feel “isolated and overwhelmed” and as a result, the work does not move forward (Yoches, Summers, Beeber, Jones Harden, & Malik, 2012, p. 95). Unfortunately, although home visitors would like reflective supervision/consultation and the benefits are known, provision of reflective supervision or training in reflective activities, process or practice remains rare among home visitors (Forstadt, 2012).

Although there is likely variability in individuals’ tendencies to engage in reflective activities and process, it is also thought of as a set of skills that may be taught and developed. Efforts to improve reflective functioning of parents through home visiting are well documented (see for example, Sadler et al., 2006; Slade, 2005). Although just as important, historically there has been less information available regarding reflective functioning of practitioners. However, researchers have begun to consider the reflective process and practices of early care and intervention providers as a step toward examining which aspects of the parent-professional relationship are most beneficial in effecting change in the parent-child relationship.

A simple but powerful model of the reflective skills that are needed in early childhood work has been provided by Weatherston (2013). Reflective skills highlighted in this model include *observing*, *listening*, *wondering*, and *responding*. Across these four components, attention must be paid to the baby, parent, and the worker’s own responses. Consistent with Selma Fraiberg’s approach (1980), the provider’s intentional use of these strategies is understood to invite parents to develop similar skills needed to get to know their babies and to understand how healthy past and present relationships create “development, growth, and change” (Weatherston, 2013, p. 62).

In a previous study, early intervention professionals were asked to rate the importance of reflective skills to their work using the observe, listen, wonder, and respond model. Overall, participants highly endorsed this set of reflective skills as important in their work and differentiated these skills from other more direct service skills, such as completing paperwork (Tomlin, Sturm, & Koch, 2009). Both providers who had more education and those from a program that placed a high value on reflective practices (i.e., Healthy Families Indiana) were most likely to say that these reflective skills were

important in their work. However, there was no relationship observed between the respondents' endorsement of reflective skills and their report of the most likely action they would take in a hypothetical challenging clinical situation (Tomlin, Sturm, & Koch, 2009). Intrigued by these findings, we conducted a follow up pilot study intended to collect more detailed information about how providers think about their moment-by-moment interactions with parents and children.

### **Current Pilot Study**

#### **Methods and Participants**

Due to the interest in learning more about reflective skills in home visitors without mental health backgrounds, a recruitment plan was designed to identify a small group of participants with the following characteristics: 1) Scope of work includes home visiting with families with children birth to three years; and 2) a member of any non-mental health discipline. Because in Indiana the majority of Part C work occurs in the home setting, we collaborated with the Indiana First Steps Early Intervention System to obtain a pool of potential participants. An email inviting participation was sent to all Indiana First Steps providers who self-identified with a discipline other than mental health (e.g., social work and psychology providers were excluded). Interested invitees were asked to contact the co-investigators to arrange a face to face meeting at a convenient location. The study was approved by the Indiana University institutional review board and written consent was obtained from each participant.

Nine female providers, all Caucasian, agreed to participate and were able to attend scheduled interviews. Professional affiliations included speech-language pathology (n=3), occupational therapy (n=2), developmental therapy (n=2) physical therapy (n=1) and audiology (n=1). (In Indiana, a developmental therapist is a professional who specializes in broad-based early intervention with young children.) Nearly all providers (8 of 9) reported Masters degrees in their field; one had a Bachelors degree. Nearly all providers had more than 8 years of experience working with infants (8 of 9); one reported 3 to 5 years.

## **Procedures and Materials**

Individual interviews were conducted with a co-investigator, each of whom is a clinical psychologist and experienced with semi-structured interview methods (A.T. or L.S.). After completing written informed consent, participants completed a brief survey about their educational and training background and work experience. They then read a vignette which portrayed a prototypical situation in home visiting early intervention work and were asked a series of questions about how they would initially respond to the situation. All interviews were audiotaped and subsequently transcribed by the co-investigators.

The authors used their clinical and supervisory experience to develop the vignette, which involved a baby spitting up on a mother's clothing (see Addendum A for vignette). Interview questions began with: "If you observed this parent child interaction, what might you say or do next?" A series of four questions followed, each incorporating the participant's response and probing the intended goal or purpose of the intervention: "What would you hope to accomplish with your actions or statements (respondent's initial response repeated back to them) with respect to:

- the parent;
- the child;
- the parent-child relationship;
- your relationship with the parent;

Interviewees were then asked to imagine having a strong reaction in response to the parent-child interaction described in the vignette and to explain what they might say or do in the moment as well as what they would do later related to their reaction. Interviewees were also asked how they would know if they had accomplished their stated goal—specifically, what would they see, hear or feel internally—and what steps they would take if they felt they had not met their initial goal (e.g., what would you say or do next).

**Qualitative Analyses:** Qualitative content analysis of the data was performed by a postdoctoral fellow in clinical psychology (E.H.). Themes concerning anticipated intervention and goals were developed with input from one of the co-investigators (L.S.) using an iterative analysis and discussion. Given the lack of prior research in this area and the study's goal of mapping the range of intended interventions and associated goals, particularly those related to reflective skills or process, themes needed only be stated by one participant in order to be included in the coding scheme for a given question. After the fellow coded responses, a second coder (a co-investigator) independently coded the data and percent agreement was calculated. Percent agreement were: say or do next (84%); goals with parent (70.8%); goals with child (90%); goals with parent child relationship (100%); goals with parent-provider relationship (89%); say or do after strong reaction (83%); do later related to reaction (89%). Coding disagreements were resolved through discussion.

## **Results**

Participants described a wide variety of interventions and intended goals related to the parent, child, parent-child relationship, and parent-provider relationship. Participants' responses varied in length and the number of themes identified. In general, the participants were more likely to describe goals related to parent education and coping skills than goals related to increasing parents' awareness of their babies' experiences. For example, when asked what they might say or do next if they observed the parent-child interaction in the vignette, most participants (7 out of 9) indicated that they would provide parent education on typical child development and/or reflux (e.g., "I would talk to her about how babies do spit up"). Nearly as many (6 of 9) reported they would take direct action by holding or caring for the baby (e.g., so the mother could change her clothing). One-third of participants would refer the mother to the child's pediatrician.

When asked what they would hope to accomplish with their actions or statements, participants most commonly indicated that they hoped to provide parent education and reduce the mother's frustration (e.g., "I want her to feel calm and not so upset"), including one third who would try to normalize the

baby's behavior (e.g., "Help her understand that it's not just her; it's very common for babies to spit up"). The most common theme related to their goals for the child revolved around keeping the child safe in the moment (e.g., "To get him away from mom in case she is angry").

In terms of goals related to the parent-child relationship, the majority of statements globally referenced promoting the parent-child relationship (e.g., "You definitely want them to keep a good relationship"; "Help keep that bond"). When asked about goals related to their own relationship with the parent, most participants (8 out of 9) discussed the desire to build a strong, collaborative relationship with the parent (e.g., "To have them involved in the process and interacting with you throughout it"). Several participants wanted the parent to view them as a fellow mother or friend (e.g., "I would hope that she could see me as another mom") or as a competent, knowledgeable provider.

Participants were asked to imagine what they would do or say in the moment if they had a strong reaction to the interaction between the parent and child in the vignette. The most common themes involved being aware of the mother's circumstances or actions (e.g., "I need to remind myself they may be inexperienced") and managing emotions in the moment (e.g., "I would try to stay calm"). One-third of participants indicated that they would be mindful of their reaction in order to protect the parent-provider relationship (e.g., "There's no reason to have a huge reaction and it would damage the future relationship"). When asked what they might do later related to their reaction, the most common theme involved contacting other professionals (e.g., service coordinator, child protection, or the child's pediatrician). Please see Table 1 for details about the themes identified and examples of participant responses.

## **Discussion**

Past work has indicated that early intervention home visitors are aware of and value reflective skills including observing, listening, wondering, and reflecting; however the ability to implement these behaviors in practice may lag (Tomlin, Sturm, & Koch, 2009). The current pilot study provides additional support for the idea that early intervention home visitors are holding a number of concepts and perspectives in mind and are intentional about their interactions with parents and their children. However,

some aspects of reflective practice were not apparent or less evident in the responses of this group of providers to hypothetical interactions with families.

In a recent survey study, parents identified that both parenting advice and emotional support were important parts of their relationship with a home visitors (Zapart, et al., 2016). In this study, the majority of the participant responses across all questions can be thought of as action oriented rather than reflective. This finding is consistent with previous work that suggests that early intervention providers may tend toward active responding in their work with parents rather than engaging in reflective activities or process (Bernstein & Edwards, 2012; Wesley & Buysse, 2001). In this sample, when asked what they would say or do after witnessing a mother react with frustration after her baby spit up, participants most often reported that they would take direct action to support the parent, physically protect the baby, or would teach, educate, or model to parents in ways that were intended to increase parent knowledge or change parent behavior. Although prompted in later questions to think about what they might say or do with regard to a specific relationship, providers often continued to respond with comments that often had an educational basis. Overall, responses that involved addressing emotions of the parent or the experience of the baby were much less frequent than the action oriented responses. Those who reported a strategy that made mention of the mother's emotions often utilized education rather than simply addressing the emotion itself. These types of action-oriented responses may represent a reaction to internal "presses" to family needs as discussed by Heffron, Ivins, and Weston (2005). In contrast, very few responses indicated the reflective activity of wondering, with only a few providers stating that they would ask a question to gather more information.

When asked directly to talk about what they might do or say relative to the parent-child relationship, about half of the respondents addressed the importance of relationship or bonding, and others again mentioned a teaching approach. When directly prompted to talk about what they may say or do in regard to their own relationship with the parent, almost all respondents discussed the importance of the relationship. In follow up questioning, many comments related to the importance of the parent seeing the provider as knowledgeable or competent. This type of response is in direct contrast to the non-expert

stance that is often suggested for those who are utilizing a reflective or relationship-based approach (Weatherston, 2000). In contrast, relatively fewer comments demonstrated consideration of the parent's experience (e.g., parent feeling successful, not feeling judged). Interestingly, even some of the responses that addressed empowering the parent also included a kernel of the notion that the parent should do what the provider had taught (i.e., "Making sure that they're going to be able to follow through with it").

Participants were asked to imagine having a strong response to the experience in the vignette and to talk about what they might say and do right away and later about their own reactions. The two most frequent response categories included attending to parents' experience and managing one's own responses; however, each of these categories occurred in less than a quarter of the responses gathered. Interestingly, some participants did not appear to understand that they were being asked about their own experiences as they spoke instead about the child or the parent. Those who did comment on their own hypothetical responses reported they might make contact with a service coordinator or even child protective services to address what they had seen, but did not refer to how they personally felt about what they had seen. No participants spoke about participation in reflective consultation or supervision.

As a pilot effort the study has some limitations that should be considered when interpreting the results and in planning future related research. With regard to the sample, the number of participants is small compared to the total recruitment group. In addition, all were volunteers, which may reflect a self-selection bias that limits the generalizability of the results to a subset of home visitors in general. In future studies, larger samples should be used and comparisons made between types of providers may be of interest. A larger sample size would also allow for random assignment to groups that do and do not receive reflective supervision/consultation. Pre- and post-comparisons of a variety of interventions intended to enhance reflection, including individual and group reflective supervision/consultation, use of reflective activities and process without reflective supervision/consultation, and direct coaching in specific reflective skills could be possible. It is worth noting, however, that despite the small sample size, the results are in line with previous work that identified a gap between "knowing and doing" (Schaefer, 2016; Tomlin, Sturm, & Koch, 2009). For example, providers talk about the importance of relationships

but do not describe use of reflective skills, process or practice that are needed to achieve a solid working relationship. It is recognized that reflective supervision/consultation and other apprenticeship models in which skill building occurs through a supportive relationship with a more experienced provider are a way to bridge this gap (Heffron & Murch, 2010; Weatherston, Weigand & Wiegand, 2010).

A second possible limitation is the study method that included narrative reports that were analyzed qualitatively. However, a recent study that sought to identify changes in practice and reflective skills of family child care providers following participation in a reflective and attachment-oriented professional development intervention reported that narrative coding measures best captured reflective processes compared to self-reports using Likert-type scales (Gray, 2015). In another recent study, lack of concordance between narrative data and an objective measure was found (Schaefer, 2016). In this small sample of home visitors considered to be “effective”, a measure of empathy did not result in high levels for all participants as expected (Schaefer, 2016). In future studies it is possible that multi-method (both qualitative and quantitative approaches) should continue to be explored. For example, combining measures of other traits that may relate to reflection and to other personal characteristics identified as important in home visiting with qualitative analyses of interviewee responses to vignettes such as the one piloted here, may prove fruitful. Additionally, in future research more than one vignette should be examined to ensure that responses are more general and not related to the specific content of the vignette. Furthermore, exploration of participant generated versus standard vignettes may be interesting (Schaefer, 2016).

In summary, the home visitors in this pilot sample demonstrated knowledge about child development, had an understanding that parents can gain skills through a positive relationship with a provider, and appeared aware of some aspects of adult learning, such as taking a strength-based approach, partnering, and use of modeling. Furthermore, the participants did recognize and speak about the importance of forming good relationships between parents and children and between parents and providers. However, they neither provided many detailed comments about how their specific behaviors could support the various relationships nor demonstrated recognition or curiosity about how these



“parallel relationships” (e.g., parent-baby, parent-provider) might be connected. Overall, participant responses seemed to indicate that their preferred role in this hypothetical situation was directly instructing parents regarding child development and appropriate parenting. Little to no attention was placed on use of reflective activities, such as asking questions or collecting more information from the parent, wondering about the internal experience of the parent or baby, or linking behaviors or experiences across relationships. Participants for the most part also omitted discussion of their own responses and did not acknowledge a need for consultation around any of these issues. We suggest that these findings support the proposal that early intervention home visitors may tend toward action over engagement in reflective activities, process or practice, and would likely benefit from participation in reflective supervision/consultation in order to move from identifying reflective skills as merely important in theory to actually being able to use reflective skills functionally in practice.

### **Summary**

Interest in early intervention and recognition that young children are best served in programs that are family-focused have yielded an expansion of home visiting programs across the country to all 50 states (Stoltzfus & Lynch, 2009). For most families an identified risk factor (e.g., having a child with a disability or delay, being a young or vulnerable parent, or experience or risk for child welfare involvement) leads to their eligibility for services (Forstadt, 2012); in turn, these risk factors for family eligibility are also indicators that home visitors may need their own supports to provide a high level of service and to learn to manage their own responses (Bernstein & Edwards, 2012; Osofsky, 2009). As a result we have also seen an acceleration of interest in reflective practice, consultation, and supervision as a source of professional development and support for many kinds of providers whose work involves the well-being of families and their very young children (Tomlin, Weatherston & Pavkov, 2014; Watson, Gatti, Henderson & Hennes, 2014). This interest cuts across clinical practice and policy development at the personnel preparation and program-development levels (e.g., providing training in relationship-based and reflective practices, provision of reflective supervision/consultation within programs). Other examples of this interest include the availability of formal curricula and other professional literature

aimed at increasing the reflective skills and practice of home visitors (Tomlin & Viehweg, 2016; Weatherston & Tableman, 2015). Importantly, interest is also reflected in the emerging research aimed at examining the process and effectiveness of reflection, reflective practice, and reflective supervision/consultation (Eggbeer, et al., 2010; Forstadt, 2012; Watson, et al., 2014; Weatherston, et al., 2009; 2010).

Although research about reflective supervision/consultation is relatively new, progress is being made toward understanding its effectiveness. Reported benefits of reflective supervision /consultation are many and include those that are specific to the provider personally (increased feelings of support and recognition; better ability to identify one's own strengths and needs) (Watson & Gatti, 2012) and professionally (e.g., less burnout) (Mena & Bailey, 2007), to the agency (lower turnover) (McGuigan, Katzev & Pratt, 2003), and to families and children (increased skill and ability to form relationships) (Heffron & Murch, 2010; Norman-Murch, 2005; Tomlin, Weatherston & Pavkov, 2014; Watson, et al., 2014; Weatherston, et al., 2009).

In this article we have considered the role of reflective skills, process and practice (Brandt, 2014) in the work of home visitors and have argued that reflective supervision/consultation may offer one of many avenues for professional development in these areas. As the work is rich and complicated, so must our efforts to understand the work be similarly complex. More information is needed about how participation in reflective skill building activities such as reflective supervision/consultation can support changes in the ways that participants approach their work with families-including what they think and do, what they intend for those actions to accomplish, how they notice and manage their own responses, and how they understand the connections among their own, the parent, and the child experiences. Skilled supervisors often speak about feeling a “shift” that occurs when participants experience the “ah ha” moment that signals new knowledge or connections. Identifying ways to capture how reflective supervision/consultation and other intentional practice and training allows for these moments of learning and how this new knowledge is transferred to practices that support families and children remain critical goals for the field.

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TABLE 1. Question 7: “Imagine you had a strong reaction to seeing this interaction between the parent and child. In that circumstance, what might you do later related to your reaction?”

Theme	Number of Participants	Example Quotations
Contact additional professionals	3	“I’d call the service coordinator and give a verbal report about what went on and comment on the episode.”
Vent/seek advice from other therapists	2	“Venting is good, talking to a fellow therapist and getting advice.”
Contact mother following the appointment to check in	2	“Make a phone call and follow up and ask her how it’s been going.”
Reflect on own emotional reaction or situation	2	“I would probably do a self-check again to make sure that I did react appropriately.”
Deal with reaction immediately and do nothing later	1	“I would try to deal with it right away. I don’t think there’s much to do later on.”
Use coping skills to manage emotional reaction	1	“I’ll go home and beat a pillow.”
Contact mother following the appointment to assess how she processed the session	1	“I may call the mom later before the next visit...that sometimes would give me some information about how mom took what I said, whether it helped, whether it didn’t help.”



ADDENDUM A. Vignette of prototypical situation in home visiting early intervention work used in study

*You have been working with first time mother Brittanie for about 8 months, beginning with her pregnancy. Her son was born about 4 weeks early but is doing well developmentally. During a recent visit, Brittanie is feeding her 3 month old son formula from a bottle. You notice that she does a nice job holding the baby while feeding and feel pleased with their mutual gaze and apparent enjoyment. While being burped, the baby suddenly spits up on Brittanie's shirt. Brittanie expresses disgust and reports that he "always" spits up. She says, "This is what I have been telling you about. Sometimes he is just bad. He does this stuff on purpose because he knows it makes me mad." She roughly holds the baby out to you, saying, "Here. Just take him. I have to change."*