

## ARTICLE

# Infant mental health home visiting therapists' reflective supervision self-efficacy in community practice settings

Sarah E. Shea<sup>1</sup> | Jennifer M. Jester<sup>2</sup> | Alissa C. Huth-Bocks<sup>3</sup> | Deborah J. Weatherston<sup>4</sup> | Maria Muzik<sup>2</sup> | Katherine L. Rosenblum<sup>2</sup> | The Michigan Collaborative for Infant Mental Health Research\*

<sup>1</sup>School of Social Work, Eastern Michigan University, Ypsilanti, Michigan

<sup>2</sup>University of Michigan/Michigan Medicine, Ann Arbor, Michigan

<sup>3</sup>University Hospitals Cleveland Medical Center, Case Western Reserve University, Cleveland, Ohio

<sup>4</sup>Alliance for the Advancement of Infant Mental Health, Southgate, Michigan

## Correspondence

Sarah Shea, Eastern Michigan University  
School of Social Work, Ypsilanti, MI 48197.  
Email: sshea1@emich.edu

\*The Michigan Collaborative for Infant Mental Health Research (MCIMHR) is comprised of researchers from eight universities and from the Alliance for the Advancement of Infant Mental Health, each of whom have collaborated in the design and implementation of the current study. MCIMHR members include (in alphabetical order): Holly Brophy-Herb, Hiram Fitzgerald, Alissa Huth-Bocks, Jennie Jester, Megan Julian, Jamie Lawler, Alyssa Meuwissen, Maria Muzik, Larissa Niec, Julie Ribaud, Katherine L. Rosenblum, Sarah Shea, Paul Spicer, Ann Stacks, Laurie Van Egeren, Christopher Watson, Deborah Weatherston.

## Funding information

Michigan Department of Health and Human Services; Michigan Department of Health and Human Services Children's Mental Health Block Grant; Eastern Michigan University's Office of Research Development and Administration; Ethel and James Flinn Foundation; University of Michigan's Women and Infants Mental Health Program; Community Foundation of Southeast Michigan; Gerstacker Foundation

## Abstract

In recent years, there has been an increase in the research on reflective supervision, including the development of tools designed to measure reflective practice in the context of reflective supervision. The Reflective Supervision Self-Efficacy Scale for Supervisees (RSSESS) is a self-report measure that has been used in previous evaluations and is designed to assess perceived reflective practice self-efficacy for Infant Mental Health-Home Visiting (IMH-HV) therapists. Properties of the RSSESS including factor structure and reliability are explored in a first study that lays the foundation for the use of the RSSESS in an IMH-HV evaluation in the State of Michigan. IMH-HV therapists completed the RSSESS at 4 time points over a 12-month period and also completed a Clinician Profile Form that included questions about their IMH background and their work experience, including job satisfaction and burnout. Results indicated that the RSSESS is a reliable tool to measure change in reflective practice skills. IMH-HV therapists demonstrated growth in their use of reflective practice skills with families and their observational skills over the 12-month period. In addition, results indicated correlations between reflective supervision self-efficacy and job satisfaction as well as burnout.

## KEYWORDS

home visiting, infant mental health, reflective practice, reflective supervision

## 1 | INTRODUCTION

Anecdotal and case study evidence about infant mental health (IMH) intervention supports the value of reflective supervision in IMH professional development and IMH home visitors' capacity for tolerating powerful emotional content in the context of IMH home-based practice with vulnerable infants, toddlers, and families (Eggbeer, Shahmoon-Shanok, & Clark, 2010; Gilkerson, 2004; Heffron & Murch, 2010; O'Rourke, 2011; Schafer, 2007; Shahmoon-Shanok, 2006; Weatherston & Barron, 2009; Weatherston, Kaplan-Estrin, & Goldberg, 2009). However, there has been minimal empirical evidence to demonstrate the growth of reflective practice skills and the impacts of reflective supervision on IMH home visitors' practice and issues related to IMH home visitor well-being, including burnout and job satisfaction, though there is a growing effort to develop this area of inquiry (Finello, Heffron, & Stroud, 2016; Gallen Ash, Smith, Franco, & Willford, 2016; Shea, Goldberg, & Weatherson, 2016; Tomlin & Heller, 2016; Watson, Gatti, Cox, Harrison, & Hennes, 2014; Watson, Harrison, Hennes, & Harris 2016). The Michigan Infant Mental Health-Home Visiting (IMH-HV) evaluation, a statewide effort to evaluate the IMH-HV psychotherapeutic service provided by Community Mental Health Services Programs (CMHSP) agencies, provides an opportunity to examine the relationships between reflective supervision and home visitor characteristics such as Infant Mental Health Endorsement (IMH-E), reflective supervision frequency and type, and job satisfaction and burnout. In addition, because this study includes data collection at multiple time points (3, 6, 9, and 12 months), the change in reflective practice skills over time can be tracked, contributing to the empirical foundation for understanding how reflective practice develops and is used in IMH home visiting programs.

## 2 | MEASURING REFLECTIVE SUPERVISION AND WHAT THE RESEARCH TELLS US

The relationship between reflective supervision, reflective practice with infants and families, and outcomes for infants and families has been documented in the theoretical literature and is embedded in the training competencies associated with endorsement of IMH professionals (Alliance for the Advancement of Infant Mental Health, 2018). However, the empirical support for these associations is minimal despite the fact that there is consensus that such research is necessary in order to ensure continued funding and administrative support for reflective supervision for infant and early childhood professionals (Frosch, Varwani, Mitchell, Carraccioli, & Willoughby, 2018; Tomlin & Heller, 2016). The

existing research does provide promising results that support the value of reflective supervision. For example, evidence suggests a relationship between provider insightfulness and reflective supervision (Virmani & Ontai, 2010) and an association between reflective supervision and increased reflective practice skills (Watson, Bailey, & Storm, 2016) and increased reflective practice self-efficacy and positive impacts on "professional functioning and well-being for early childhood interventionists receiving reflective supervision" (Frosch et al., 2018, p. 392).

One of the main reasons for the limited research on reflective supervision concerns the challenges inherent in measuring a relationship and reflective capacities (Shea et al., 2016; Tomlin & Heller, 2016). However, there is evidence to suggest that such research could yield promising results. For example, Cologon, Schweitzer, King, and Nolte (2017) demonstrated an association between a therapist's reflective functioning capacities and therapist efficacy as it relates to client outcomes. Such findings suggest that supporting the enhancement of therapists' reflective functioning in the context of treatment can lead to improved outcomes for clients. Reflective functioning, the ability to identify and recognize one's own affective state and that of another, is closely linked to reflective practice in that reflective practice requires that a therapist remain attuned to their own emotional resonance while also observing and attending to the emotional state of the infant and family. As Slade (2005) describes, the infant's capacity for reflective functioning is only developed in the context of experiencing the parent's reflective functioning in the context of the parent-infant relationship. In a parallel to that relationship dynamic, reflective supervision involves the use of reflective functioning by the supervisor in the context of the supervisory relationship to support the therapist's use of reflective functioning with the parent so that the parent can then utilize reflective functioning with the baby (Heffron, Reynolds, & Talbot, 2016; Harrison, 2016; Many, Kronenberg, & Dickson, 2016; Pawl & St. John, 1998; Schafer, 2007).

## 3 | SELF-EFFICACY AS A CONSTRUCT IN THE MEASUREMENT OF REFLECTIVE SUPERVISION

In response to the need for additional research regarding this central component of IMH practice, the effort to measure reflective supervision has grown significantly in the last decade with the emergence of several tools. Each tool serves a unique purpose and addresses different aspects of reflective supervision measurement (Gallen et al., 2016; Heller & Ash, 2016; Low et al., 2018; Shea et al., 2016; Tomlin & Heller, 2016; Watson et al., 2016). Examples of such

measures include the Provider Reflective Process Assessment Scales (Heller & Ash, 2016), which focuses on 5-minute transcribed description of an early childhood provider's experience working with a particularly challenging family. The transcript is coded and scored according to six subscales: "self-knowledge, self-regulation, collaboration, process, authentic attitude, and multiple perspectives" (Heller & Ash, 2016, p. 26). The Reflective Supervision Rating Scale (Gallen et al., 2016) provides another means of assessing reflective supervision by asking the supervisee to rate the frequency of their reflective supervisor's use or demonstration of specific reflective supervision elements; the factors identified in this scale were "reflective process and skills, mentoring, supervision structure, and mentalization" (Gallen et al., 2016, p. 33). A third example of a non-self-report reflective supervision measure is the Reflective Interaction Observation Scale (RIOS), which utilizes 15-minute videotaped reflective supervision segments that are then coded for the content to determine which of the following essential elements are being discussed: "understanding the family story, holding the baby in mind, professional use of self, parallel process, or reflective alliance" (Watson et al., 2016, p. 16). The segments are also coded for the demonstration of specific collaborative tasks, "describing, responding, exploring, linking, and integrating" (Watson et al., 2016, pp. 16–17). The RIOS is unique in that it assesses the actual reflective supervisory relationship as opposed to focusing on either the supervisee or supervisor's experience of or contribution to the reflective supervision experience (Watson et al., 2016).

In addition to the constructs used in these measures of reflective supervision, another means of assessing reflective practice is through the lens of self-efficacy. Self-efficacy is a construct that has relevance to the parent–infant relationship (Moran, Polanin, Evenson, Troutman, & Franklin 2016; Moran, Troutman, Franklin, & Evenson, 2012; Shea et al., 2016; Troutman, Moran, Arndt, Johnson, & Chmielewski, 2012) and aligns with the skills associated with reflective supervision (Frosch et al., 2018; Shea et al., 2016; Watkins, 2015). Increased self-efficacy in the context of reflective practice suggests that a respondent has greater confidence about their ability to engage in post hoc reflection or "reflection on action" (Schön, 1983), about their work with families and their use of and engagement with the reflective supervisory relationship. In related literature, increased self-efficacy has been identified as a desired outcome for therapists receiving clinical supervision that incorporates reflective practice (Curtis, Elkins, Duran, & Venta, 2016) and self-efficacy has been positively correlated with the supervisory alliance (Watkins, 2015). In addition, the literature regarding parenting self-efficacy (PSE) also offers support for the use of self-efficacy as a construct in measuring reflective practice (Frosch et al., 2018). PSE has been defined as "both level of perceived knowledge of appropriate child-rearing behaviors and degree

of confidence in one's ability to perform parenting tasks" (Troutman et al., 2012, p. 45). The reciprocal nature of the parent–child relationship thrives in the context of the infant's secure attachment with a caregiver and requires the invested commitment of both infant and parent to the existence of the relationship; when PSE is low, the parent–child relationship is at risk (Moran et al., 2016). Research has demonstrated that PSE is positively associated with more favorable parent–infant interactions (Troutman et al., 2012) and "low PSE is associated with parental anxiety, depression, stress, negative cognitions, learned helplessness, passive coping style, coercive discipline and demoralization" (as reported in Moran et al., 2012, p. 81). The associations between parental self-efficacy and the parent–infant relationship may provide a parallel for conceptualizing the therapist's experiences of their relationships with their reflective supervisors and the families they serve (Shea et al., 2016).

Recommendations for interventions designed to increase PSE mirror that which is recommended for the reflective supervisor in their efforts to support the reflective practice development of the supervisee. Specifically, such PSE interventions involve a nondirective, parent-driven approach whereby the therapist follows the parent's lead and employs a "be with; do less" approach to intervention (Moran et al., 2012). As previously described in Shea et al. (2016), Ainsworth and Bell (1974) described the infant's development of relational competence as a product of the consistent experience of having needs met by a primary caregiver. The consistency of this experience engenders a sense of efficacy, whereby the infant develops a repertoire of strategies for communicating such needs and a feedback loop is instituted between caregiver and infant; the more consistent the response the more effective the infant becomes in communicating their needs (Ainsworth & Bell, 1974). Similarly, the reflective supervisor is encouraged to remain "attentive, engaged, thoughtful" (Tomlin, Weatherston, & Pavkov, 2014, p. 74) and using "curiosity, thinking/feeling, compassion, and shared attention" (Weatherston & Barron, 2009, p. 67) to foster the supervisee's exploration that will lead to next steps. The value of increasing an IMH-HV therapist's reflective practice self-efficacy is multiplied when considering the parallel nature of relationships. As the supervisee experiences their needs being met by their reflective supervisor, they develop a greater sense of confidence regarding their capacity to impact their supervisor. Supervisees will then be able to communicate these needs more consistently with an assurance that the needs will be met most of the time (Shea et al., 2016). This sense of relational competence is also experienced by the parent who grows to trust in the IMH-HV therapist's ability to provide the emotional sustenance parents need through the therapist's use of consistency, attunement, and a willingness to repair ruptures. The parent's relational self-efficacy is strengthened through this relationship experience

with the IMH-HV therapist; self-efficacy then supports the parent's confidence to offer new relationship experiences to their infant. The construct of self-efficacy therefore captures the experiential learning that is essential to reflection. In order to develop these reflective practice skills, the IMH-HV therapist must experience them in relationship to another (Schafer, 2007), which is the essence of the reflective supervision experience.

### 3.1 | Reflective Supervision Self-Efficacy Scale for supervisees

The *Reflective Supervision Self-Efficacy Scale for Supervisees* (RSSESS; Shea, Goldberg, & Weatherston, 2012) is a 17-item self-report measure that assesses IMH home visitors' confidence about their reflective practice skills. The RSSESS was developed in 2012 for use in an evaluation of the Michigan Association for Infant Mental Health (MI-AIMH)'s unique reflective supervision training series (Shea et al., 2016). The 2012 pilot evaluation required a tool to assess changes in reflective practice skills, specifically with regard to reflective supervision; at the time, there were very few options that would fit the scope of an evaluation that required ease of administration and scoring as well as a differentiation between the skills specific to reflective supervisors and reflective supervisees (Shea et al., 2016). The RSSESS was developed utilizing the construct of self-efficacy. Bandura (1997) defined self-efficacy as, "beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments (p. 3)," a construct that is frequently used in self-assessment tools to measure level of confidence related to particular skills or tasks. Self-efficacy tools have been used in a variety of practice contexts (Berzoff, Dane, & Cait, 2005; Ellett, 2009; Frosch et al., 2018; Holden et al., 1997; Miller, 2011; Shea et al., 2016). In addition, self-efficacy is positively correlated with the supervisory alliance suggesting that it is a construct well suited to measuring skills associated with the relational skills of reflective practice (Watkins, 2015).

The RSSESS differs from the previously described measures in that it is a self-report tool. Furthermore, the RSSESS invites respondents to rate their level of confidence with regard to specific skills centered on reflective practice with the families they serve and their engagement in reflective supervision with a reflective supervisor. This self-report format complements reflective practice because it allows respondents to consider their own skills, areas of strength, and areas for growth. Accurate completion of the measure also requires self-awareness; respondents must be able to consider how they view themselves in relation to their reflective supervision experiences as well as to their work with infants, toddlers, and families. The self-awareness required for this kind of self-report measure aligns with the reflective super-

vision experience. Specifically, the reflective supervision is a relational endeavor in which the subjectivities of both the supervisor and supervisee are in effect in the supervisory experience; and the supervisee must use self-awareness to consider how they have contributed to and impacted the supervisory experience (Davys & Beddoe, 2009; Franklin, 2011; Miehl, 2010; Shea et al., 2016; Weatherston & Barron, 2009).

The RSSESS has shown promising results in previous evaluations (Frosch et al., 2018; Shea et al., 2016); however, the measure's properties have not yet been fully explored. This paper describes two studies: the first is an analysis of the properties of the RSSESS, which lays the foundation for the utility of the RSSESS as an effective tool to measure the self-confidence of IMH-HV therapists to engage in reflective practice, including their use of reflective supervision. The authors hypothesized that the RSSESS is a reliable measure based on previous smaller studies that showed promising reliability results. The second study involves the use of the RSSESS in the Michigan IMH-HV evaluation to measure the relationship between reflective practice self-efficacy and IMH-HV therapists' experience of their work. The authors hypothesized that there are associations between factors such as work experience, reflective supervision experience, endorsement category, and job burnout and satisfaction and reflective practice self-efficacy. Both of these studies contribute to the empirical support for the value of reflective supervision in IMH practice.

## 4 | STUDY 1: EVALUATING THE PROPERTIES OF THE RSSESS

The purpose of this study was to assess the properties of the RSSESS including the factor structure and scale reliability. The RSSESS has been used in previous evaluative efforts (Frosch et al., 2018; Shea et al., 2016); however, the sample sizes for these research studies have been small, limiting the scope of the findings. The combination of a variety of IMH-HV therapist samples provided an opportunity to conduct a first time factor analysis. The literature suggests that more information is needed to demonstrate the utility of the RSSESS to assess for reflective supervision self-efficacy among IMH-HV therapists (Frosch et al., 2018; Shea et al., 2016). This study lays the foundation for the utilization of the measure in the Michigan IMH-HV evaluation.

### 4.1 | Study 1 method

#### 4.1.1 | Study 1 participants

To assess the properties of the RSSESS, five samples of IMH-HV therapists employed in CMHSP IMH-HV programs were

combined ( $N = 116$ ). The samples included: IMH-HV therapists ( $n = 13$ ) who participated in a reflective supervision training series designed for supervisors and supervisees (Shea et al., 2016); IMH-HV therapists ( $n = 16$ ) who participated in a 2014 Advanced, Competency-Based IMH Training Series that focused on foundational theoretical and practice-based IMH content (Shea, 2014); attendees of the Michigan Association for Infant Mental Health's 2016–2017 ( $n = 8$ ) and 2017–2018 ( $n = 23$ ) IMH Core Curriculum training series, a practice-based IMH curriculum for early career infant-family professionals (Shea, 2017; Shea & McCormick, 2018); and participants ( $n = 56$ ) in the Michigan IMHHV evaluation (Lawler et al., 2017). All of the participants were IMH-HV therapists employed in CMHSP settings in Michigan and providing home-based IMH services to caregivers and their children ages birth-3. All of the therapists held a masters degree in social work, psychology, counseling, or a related field, and all of the participants were receiving reflective supervision, as is required by endorsement.

#### 4.1.2 | Study 1 procedures

The RSSESS was administered to participating IMH-HV therapists for the evaluations of the reflective supervision training series (Shea et al., 2016); the 2014 Advanced, Competency-Based IMH training series; the 2016–2017 Core Curriculum Training Series; and the 2017–2018 Core Curriculum training series. In addition, this study included the initial administration of the RSSESS for IMH-HV therapists in the Michigan IMH-HV evaluation. All participating IMH-HV therapists provided written consent. The five samples were reviewed to crosscheck for duplicate participants. Duplicates were removed, and in each case the first administration of the RSSESS for a participant was retained. Institutional review board (IRB) approval was obtained at both universities where the research studies took place.

#### 4.1.3 | Study 1 measures

##### *Reflective Supervision Self-Efficacy Scale*

The RSSESS uses a 5-point rating scale (1 = *no confidence*; 2 = *low confidence*; 3 = *average confidence*; 4 = *high confidence*; 5 = *very high confidence*), and the score is calculated by adding up the ratings for all 17 items with the highest possible total score of 85. The measure asks participants to rate their confidence, based on their reflective supervision experiences, with regard to specific reflective practice tasks, such as “build a trusting relationship with my supervisor” and “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.” The tasks and skills are rooted in the reflection competency as described in MI-AIMH’s *Endorsement for Culturally Sensi-*

*tive, Relationship-Focused Practice Promoting Infant Mental Health*<sup>®</sup> (MI-AIMH, 2002/2015). The measure was piloted in the evaluation of the reflective supervision training series as noted earlier (Shea et al., 2016) and has been used in subsequent evaluations and adapted for use with early childhood interventionists (Frosch et al., 2018).

#### 4.1.4 | Study 1 data analysis

To assess the properties of the RSSESS, a principal components factor analysis was conducted using an Oblimin rotation. A Cronbach’s alpha was calculated to assess the reliability of the overall scale and subscales. Bivariate correlations assessed the associations between subscales.

### 4.2 | Study 1 results

#### 4.2.1 | Properties of the RSSESS

The factor analysis indicated four components with eigenvalues exceeding 1, explaining 38.55%, 13.39%, 7.25%, and 6.45% of the variance. Only items with loadings above .40 were included on each factor (Stevens, 1992). Each factor included strong item loadings, and all items for each subscale had face validity with the subscale that it loaded on most heavily (see Table 1).

Subscale 1 ( $\alpha = .86$ ), “Use of Supervisory Relationship,” (“Supervisory Relationship”) includes skills that are specific to creating and engaging in an authentic relationship with a supervisor that provides opportunities for reflection. An example of an item in this subscale is “feel safe to discuss emotional responses to infants and families in the context of supervision.” Subscale 2 ( $\alpha = .75$ ), “Use of Reflective Practice Skills with Families,” (“Reflective Practice”) features skills that are specific to engaging in or understanding the work with infants and families; for example, “understand the reason(s) for service to the infant and family and put into words what is at the center of your work together.” Subscale 3 ( $\alpha = .79$ ), “Use of Observational Skills,” (“Observational Skills”) highlights skills that are specific to observation with curiosity and freedom from judgment; for example, “describe/discuss observation of parent(s), attentive to strengths and concerns/risks.” Finally, Subscale 4 ( $\alpha = .79$ ), “Use of Self-Awareness,” (“Self-Awareness”) includes skills that are specific to the clinician’s ability to remain attuned to their thoughts and feelings in relation to their work; for example, “identify the ways in which my emotional responses may have interfered with my ability to identify or meet the needs of infants and families.” The correlation matrix results (see Table 2) indicated significant moderate associations among all subscales. The Cronbach’s alpha for the RSSESS total scale score was .90 ( $n = 114$ ; due to listwise deletion).

**TABLE 1** Factor loadings for exploratory factor analysis with Oblimin rotation of RSSESS ( $N = 114$ )

Scale	“Use of Supervisory Relationship”	“Use of Reflective Practice Skills With Families”	“Use of Observational Skills”	“Use of Self-Awareness”
Subscale 1: “Use of Supervisory Relationship” (38.55%, $\alpha = .86$ )				
Build a trusting relationship with my supervisor?	.879	.007	.205	-.110
Feel safe to discuss emotional responses to infants and families in the context of supervision?	.773	-.249	.141	.241
Remain open to feedback from my supervisor about my work with infants and caregivers?	.747	.170	.006	-.037
Consult with my supervisor to understand my own capacities and needs?	.632	.229	-.095	.147
Discuss emotional responses regarding difficult or challenging experiences with infants and families in the context of supervision?	.579	-.016	-.034	.357
Subscale 2: “Use of Reflective Practice Skills with Families” (13.39%, $\alpha = .75$ )				
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?	-.109	.700	.296	.002
Understand the reason(s) for service to the infant and family and put into words what is at the center of your work together?	-.090	.748	.267	-.021
Discuss instances of not knowing what to do in work with infants and caregivers?	.230	.617	-.024	.039
Integrate supervisory discussions and details into the work with infants and families?	.243	.667	-.299	.182
Subscale 3: “Use of Observational Skills” (7.25%, $\alpha = .77$ )				
Describe/discuss observations of infant or toddler, attentive to health, social, emotional, and cognitive capacities and the stories parents share?	-.161	.304	.621	.170
Describe/discuss observations of parent(s), attentive to strengths and concerns/risks?	.215	-.061	.832	.047
Describe/discuss the interactions and developing relationship between parent and young child?	.277	.152	.690	.060
Subscale 4: “Use of Self-Awareness” (6.45%, $\alpha = .79$ )				
Regularly examine my thoughts, feelings, strengths, and growth areas?	.101	-.214	-.023	.691
Identify the parallels that may exist between my emotional responses and the experiences of the families and infants I serve?	-.211	.096	.262	.750
Identify ways in which my emotional responses may have interfered with my ability to identify or meet the needs of infants and families?	.034	.093	.010	.763
Address ruptures or misattunements that have occurred with my supervisor in the context of supervision?	.210	.247	-.135	.562
Address ruptures or misattunements that have occurred with infants and families in the context of supervision?	.201	.325	.097	.487

**TABLE 2** RSSESS subscale correlations

	“Use of Supervisory Relationship”	“Use of Reflective Practice Skills with Families”	“Use of Observational Skills”	“Use of Self-Awareness”
“Use of Supervisory Relationship”				
Pearson correlation	1	.413**	.361**	.631**
<i>N</i>	116	115	116	115
“Use of Reflective Practice Skills with Families”				
Pearson correlation	.413**	1	.535**	.519**
<i>N</i>	115	115	115	114
“Use of Observational Skills”				
Pearson correlation	.361**	.535**	1	.465**
<i>N</i>	116	115	116	115
“Use of Self-Awareness”				
Pearson correlation	.631**	.519**	.465**	1
<i>N</i>	115	114	115	115

\*\*Correlation is significant at the 0.01 level (two-tailed).

## 5 | STUDY 2: THE MICHIGAN IMH-HV EVALUATION’S ASSESSMENT OF RELATIONSHIPS BETWEEN IMH-HV THERAPIST CHARACTERISTICS AND REFLECTIVE SUPERVISION SELF-EFFICACY IN THE MICHIGAN IMH-HV EVALUATION

One purpose of the Michigan IMH-HV evaluation was to examine the associations between IMH-HV therapist perceived reflective practice self-efficacy, the self-reported sense of confidence an IMH home visitor experiences related to tasks specific to their engagement in reflective supervision, and use of reflective practice with infants, toddlers, and families.

### 5.1 | Study 2 method

#### 5.1.1 | Study 2 participants

Out of a total of 66 participating clinicians in the Michigan IMH-HV evaluation study, this particular study included 56 IMH-HV therapists who completed the RSSESS at least once during the study period of 12 months. All of the participants were working in 12 CMHSP Home-based Services programs in mid- and southeastern Michigan. All of the participants held a masters degree, with the majority having a masters in social work (67.9%); the remaining had a masters in counseling (21.4%) or psychology (10.7%). With regard to IMH-E, 41.1% had received a waiver from the state and were working toward earning endorsement, 28.6% held a Category II Infant Family Specialist Endorsement, 19.6% held a Category III Infant Mental Health Specialist Endorsement, and

10.7% held a Category I Infant Family Associate Endorsement and were working on earning a Category II or Category III Endorsement. The participants’ average number of months practicing IMH was 39.46 ( $SD = 43.06$ ). The participants reported receiving reflective supervision on average 1.57 times per week ( $SD = 0.83$ ). The vast majority of the sample (76.8%) reported receiving a combination of group and individual reflective supervision; 21.4 % were receiving only group reflective supervision, and only one participant was receiving only individual reflective supervision.

#### 5.1.2 | Study 2 procedures

Participating IMH-HV therapists provided written consent to participate in the Michigan IMH-HV evaluation. The Clinician Profile Form used in the analysis of IMH-HV therapist characteristics was administered to the participating IMH-HV therapists by the research team at the time of study entry. The RSSESS was administered to participating IMH-HV therapists by the research team 3, 6, 9, and 12 months after the study commencement. In addition, IRB approval was maintained at the university where the research took place.

#### 5.1.3 | Study 2 measures

##### *Reflective supervision Self-Efficacy scale*

See earlier description.

##### *Clinician profile form*

The Clinician Profile Form (Rosenblum & Muzik, 2016) assesses IMH-HV therapist characteristics for the Michigan IMH-HV evaluation. This self-report tool includes 15 items inquiring about IMH-HV therapists’ experience providing IMH services, educational background, IMH endorsement, and reflective supervision frequency and type. In addition,

the form asks respondents to specify their level of agreement using a rating scale of 1–5 (1 = *strongly disagree*; 2 = *disagree*; 3 = *neutral or not sure*; 4 = *agree*; 5 = *strongly agree* with the following statements: (a) I feel burnt out at my job; (b) I find meaning at my job; (c) I find my job satisfying; and (d) I have strategies for coping with the challenges in my work. Finally, participants identified the coping strategies they use to manage work challenges.

### 5.1.4 | Study 2 data analysis

Descriptive statistics were calculated for IMH-HV therapists' responses to the Clinician Profile Form. Correlational analyses were conducted to examine associations between the RSSESS overall score at 3-months and various clinician characteristics as well as the RSSESS subscale scores at 3-months and the clinician characteristics including (1) number of months working at current agency; (2) average number of IMH cases; (3) average number of total cases; (4) number of months practicing IMH; (5) number of months practicing other early childhood practice(s); (6) frequency of reflective supervision; (7) supervision format; (8) IMH-E; correlations were also used to examine associations between the RSSESS overall score and subscale scores at 3-months and therapist ratings about job satisfaction and coping strategies at work. Finally, latent growth models were estimated for each RSSESS subscale separately. Latent growth models were estimated with the value of each subscale at 3-, 6-, 9-, and 12-month study periods as indicators of latent growth structural equation models using MPlus 7.4. Linear growth was assumed, and full information maximum likelihood was used to account for any missing values.

## 5.2 | Study 2 results

### 5.2.1 | Assessment of relationships between IMH-HV therapist characteristics and reflective supervision self-efficacy in the Michigan IMH-HV evaluation

The average level of agreement reported by IMH-HV therapists with respect to the statement, "I feel burnt out at my job" was relatively low, with an average rating of 2.39 ( $SD = 0.80$ ), where 2 = "Disagree." On average, participants expressed agreement in response to the statement, "I find meaning at my job" ( $M = 4.61$ ;  $SD = 0.53$ ). This was also true for the statements, "I find my job satisfying" where the average score was 4.27 ( $SD = 0.62$ ); and "I have strategies for coping with the challenges in my work" ( $M = 4.09$ ,  $SD = 0.58$ ), where 4 = "Agree." Thus, overall participating therapists described fairly high levels of job satisfaction.

At the 3-month time period, the overall perceived reflective practice self-efficacy was significantly, positively associated with IMH home visitor job satisfaction and negatively asso-

ciated with job burnout, but unrelated to finding meaning and having coping strategies (see Table 3). There were no correlations found between the overall RSSESS score at 3-months and (1) number of months working at current agency; (2) average number of IMH cases; (3) average number of total cases; (4) number of months practicing IMH; (5) number of months practicing other early childhood practice(s); (6) frequency of reflective supervision; (7) supervision format; (8) IMH-E.

At the 3-month point, the "Use of Supervisory Relationship" and "Use of Self Awareness" subscales were each positively associated with IMH home visitor job satisfaction. "Use of Supervisory Relationship" had a negative association with self-reported burnout. The "Use of Observational Skills" subscale had a positive association with IMH home visitor's statement, "I find meaning in my job." The "Use of Supervisory Relationship" subscale was negatively associated with the number of months practicing infant mental health (see Table 3).

A one-way ANOVA ( $F(3, 192) = 3.436$ ,  $p = .018$ ) revealed differences in the mean scores of the subscales at 3 months with a Tukey post hoc test showing that the mean "Use of Self-Awareness" score ( $M = 3.77$ ,  $SD = 0.51$ ) was significantly lower than the "Use of Supervisory Relationship" mean score ( $M = 4.13$ ,  $SD = 0.63$ ), which was the highest mean for all subscales at 3 months. Latent growth models showed that there was significant growth from 3- to 12-months for "Use of Reflective Practice Skills" and "Use of Observational Skills," but not for the "Use of Supervisory Relationship" or "Use of Self-Awareness" (see Table 4). Job satisfaction, burnout, meaning, and coping strategies as rated at 3 months were tested as predictors of the intercept and slope of the growth models for RSSESS subscales. Results revealed that higher burnout at baseline predicted lower intercept (i.e., mean level) of two of the subscales, "Use of Supervisory Relationship" and "Use of Observational Skills," and a trend for lower intercept of "Use of Self-Awareness" at 3 months, but did not predict differences in growth over time for any of the subscales (see Table 5). Higher job satisfaction predicted higher intercept of each subscale at 3 months, but did not predict growth from 3 to 12 months (see Table 6). None of the other clinician characteristics were found to be predictors of the intercept or slope of the growth models.

## 6 | DISCUSSION

Results from these two studies utilizing different samples of IMH-HV therapists across the State of Michigan provide some evidence that the RSSESS is a valid and reliable tool that can measure changes in IMH home visitors' sense of confidence with regard to reflective supervision and reflective practice skills. The identification of four subscales creates new opportunities to better track and support IMH-HV

**TABLE 3** RSSESS Total score and subscale scores at 3-months and clinician characteristic correlations ( $N = 56$ )

Clinician characteristic	RSSESS total score	“Use of Supervisory Relationship”	“Use of Reflective Practice Skills with Families”	“Use of Observational Skills”	“Use of Self-Awareness”
“I find my job satisfying”					
Pearson correlation	.330*	.354**	.222	.200	.323*
“I feel burnt out at my job”					
Pearson correlation	-.375**	-.439**	-.145	-.259	-.229
“I find meaning in my job”					
Pearson correlation	.166	.184	.153	.269*	.215
Number of months of IMH practice					
Pearson correlation	-.205	-.339*	.053	-.098	-.076

\*Correlation is significant at the 0.05 level (two-tailed).

\*\*Correlation is significant at the 0.01 level (two-tailed).

**TABLE 4** Latent growth models for subscales ( $N = 56$ )

Subscale	Intercept mean (SE)	$p$ for intercept mean	Slope mean (SE)	$p$ for slope mean
“Use of Supervisory Relationship”	4.2 (0.08)	.000	0.015 (0.052)	.16
“Use of Reflective Practice Skills with Families”	4.0 (0.07)	.000	0.024 (0.010)	.011
“Use of Observational Skills”	4.0 (0.07)	.000	0.024 (0.010)	.011
“Use of Self-Awareness”	3.79 (0.07)	.000	0.015 (0.06)	.20

**TABLE 5** Job burnout predicting subscale intercept and slope ( $N = 56$ )

Subscale	Intercept mean (SE)	$p$ for intercept mean	Slope mean (SE)	$p$ for slope mean
“Use of Supervisory Relationship”	-1.6 (0.46)	.001	0.025 (0.072)	.73
“Use of Reflective Practice Skills with Families”	-0.48 (0.36)	.17	-0.006 (0.06)	.92
“Use of Observational Skills”	-0.55 (0.25)	.029	0.05 (0.04)	.23
“Use of Self-Awareness”	-0.76 (0.41)	.067	0.017 (0.078)	.83

**TABLE 6** Job satisfaction predicting subscale intercept and slope ( $N = 56$ )

Subscale	Intercept mean (SE)	$p$ for intercept mean	Slope mean (SE)	$p$ for slope mean
“Use of Supervisory Relationship”	2.05 (0.60)	.001	0.059 (0.10)	.55
“Use of Reflective Practice Skills with Families”	0.838 (0.41)	.039	0.094 (0.068)	.17
“Use of Observational Skills”	0.709 (0.33)	.032	-0.037 (0.051)	.47
“Use of Self-Awareness”	1.48 (0.52)	.004	-0.012 (0.102)	.90

therapists' confidence about their reflective practice skills specific to their work with families and IMH-HV therapists' confidence specific to their participation in the reflective supervision relationship.

The “Use of the Supervisory Relationship” subscale aligns with the literature's description of supervisees' tasks and behaviors in the reflective supervisory relationship, which is a partnership that requires that the supervisee be an active

participant in the relationship-based exploration of their work with infants and families (Weatherston & Barron, 2009). Tomlin et al. (2014) conducted a Delphi study, a qualitative method that invited expert reflective supervisors to participate in three phases of a survey, generating open-ended responses to questions regarding reflective supervision, with each phase including more structured questions based on the previous set of responses. The results included identification of the

essential elements of reflective supervision, including qualities that a supervisee should demonstrate in the context of reflective supervision and mutual behaviors and qualities important for both reflective supervisor and supervisee; these findings align with results using this subscale. For example, the supervisee's "ability to ask for help and to participate in collaboration" (Tomlin et al., 2014, p. 76) is closely aligned with this subscale's item, "consult with the supervisor to understand my own capacities and needs." Another example is found in Tomlin et al.'s (2014) identification of "a safe, confidential relationship is maintained between supervisor and supervisee" (p. 76) as one of the most important mutual behaviors and qualities, which closely aligns with the subscale item, "build a trusting relationship with my supervisor."

The tasks or skills captured in the subscale "Use of Reflective Practice Skills with Families," are representative of the unique IMH approach that privileges nondirective, relationship-based intervention that first seeks to understand the parent and infant and their attachment relationship so as to eventually be able to offer the parent a relationship experience that provides the safety and compassion that the parent can then offer their infant (Fraiberg, Adelson, & Shapiro, 1975; Pawl & St. John, 1998; Weatherston & Tableman, 2015).

The "Use of Observational Skills" features a key component of IMH practice. Observation is identified as an essential element of reflective practice by Shahmoon-Shanok (2009) who suggests that the expanded notion of observation essential to reflective supervision offers opportunities for providers to consider that which is not articulated or conscious in work with infants and toddlers, breeding curiosity, and openness. Engaging in observation requires a nondirective approach where the therapist remains present and attuned to the family's relational challenges and strengths (Fraiberg et al., 1975; Weatherston & Tableman, 2015). These skills can be fostered by a reflective supervisor who asks questions designed to heighten curiosity like, "What do you notice between the baby and mother during those moments?" Such questions have a dual purpose in that the therapist is then encouraged to articulate these observations as meaningful data about the family and the importance of attending to such observations in home visits is emphasized. In this way, the reflective supervisor is teaching about the use of observation in IMH work.

Finally, the "Use of Self-Awareness" subscale captures those tasks and skills that relate to identification and use of the parallel process to better understand the work with infants and families and the use of self in the reflective supervisory relationship and in the relationship with families (Tomlin et al., 2014). This subscale is indicative of some of the major points of differentiation between reflective supervision and other supervision approaches. Specifically, this subscale reflects the tasks of the supervisee who is engaged in a supervisory experience where the supervisory relationship itself is an interven-

tion, providing the supervisee with an opportunity to engage in the reflective practice skills they can then use with families (O'Rourke, 2011; Schafer, 2007; Shahmoon-Shanok, 2006, 2009; Weatherston & Barron, 2009; Weatherston et al., 2009).

Results from the Michigan IMH-HV evaluation demonstrated that growth in reflective practice skill confidence is possible for IMH-HV therapists during a 12-month period. In order to contextualize these findings, it is important to understand the IMH practice and reflective supervision experience of the sample. While data regarding the length of time the clinicians were receiving reflective supervision from their supervisors and the length of time the supervisees have been in a reflective supervisory relationship with their current reflective supervisor are not available, we can look at the length of time that the clinicians have been in IMH practice, which on average was a little more than 3 years ( $M = 39.46$ ,  $SD = 43.06$ ). Therefore, we can suggest that the clinician sample is on average in the early career stage of IMH practice and participation in reflective supervision.

If these subscales are understood as representative of the skill areas essential to reflective supervision, it can be reasoned that some skill areas might be further developed first in order to provide a foundation for the development of other reflective practice skills. While it might be hypothesized that reflective practice and observational skills would develop after increased capacity for therapist self-awareness, the findings suggest that the growth may first occur in the practice with children and families. Additionally, the findings suggest that use of the supervisory relationship may precede use of self-awareness. It is important to note that while there was no growth in the sample's "Use of Supervisory Relationship" subscale score, it was the highest mean subscale score at 3-months. Skills related to developing a safe and trusting relationship with a reflective supervisor may develop first in order to support the development of other reflective practice skills. The negative association at 3 months between the number of months in IMH practice and the "Use of the Supervisory Relationship" could indicate that less seasoned IMH-HV therapists may be making significant use of the supervisory relationship as they navigate the relationship challenges inherent in IMH work, and their growth in confidence about their capacity to use this supervisory relationship may be the first area of reflective practice skill to develop. Furthermore, this finding suggests a need to better understand changes in the reflective supervision experience for IMH-HV therapists as IMH practice experience increases. The ways in which the use of the supervisory relationship changes over time with greater IMH practice experience might help to explain the decrease in self-efficacy in this area for more experienced IMH-HV therapists.

The increased self-efficacy over the 12-month period was specific to reflective practice skills utilized with infants, toddlers, and families and observational skills, developed in

the context of reflective supervision, strengthening the argument that reflective supervision can in fact impact reflective practice skills with families, at least as reported by IMH-HV therapists. The “Use of Reflective Practice Skills with Families” and “Use of Observation Skills” subscales involve the application of reflective practice skills in home-based clinical work with infants, toddlers, and their families.

Weatherston and Barron (2009) describe the trajectory of the reflective supervisory relationship as first focusing on “building trust through observation,” whereby the reflective supervisor uses their own capacities for observation and focused attention to support the supervisee’s capacity to “[share] observations about the infant, the family, and when able, personal responses awakened with them” (p. 70). The next phase of this beginning relationship is centered on listening as the reflective supervisor pays close attention to the emotional content, seeking to understand the experience of the supervisee as well as the experiences of the parent and infant. The supervisee then engages in a greater capacity to “wonder about the experience” (p. 71). During the third phase of this beginning reflective supervisory relationship, “reflecting on shared vulnerability” (Weatherston & Barron, 2009, p. 71), the supervisee increases their use of the relationship to examine their personal responses to their work with infants and families, facilitated by the supervisor’s thoughtful use of self disclosure to share their own experiences of the work.

This description of the evolution of the reflective supervisory relationship aligns with the current study’s findings. The skills captured in “Use of Reflective Practice Skills” are also ones that can be supported in the early stages of reflective supervision as the reflective supervisor engages the therapist in discussions about assessment and next steps, for example, exploring with the therapist what the baby and family are communicating in their verbal and nonverbal interactions with the therapist during home visits. The therapist develops skills specific to understanding how IMH services might benefit infants, toddlers, and families and identifying when they are having difficulties identifying how to utilize such services effectively with families.

The growth in IMH-HV therapists’ reflective practice skills and observational skills recognizes the foundational nature of observation and relationship-based assessment in reflective practice. The “Use of Self-Awareness” subscale describes the therapist’s connection with the reflective supervisor and the unique use of that relationship to support self-exploration and personal and professional development. Such skills require that the therapist experience a sense of safety in order to engage in the vulnerability inherent in the introspection involved when considering the ways in which one contributes to and impacts the supervisory and clinical relationships. For example, to be able to acknowledge misattunements and foster repair with families and/or with the reflective supervisor necessitates that the therapist has established a strong capac-

ity for remaining present, using keen observational skills in assessment and intervention, and understanding the multiple relational forces that shape a IMH-HV therapist’s relationship with a family and/or a supervisor, skills represented in “Use of Reflective Practice Skills with Families” and “Use of Observational Skills” subscales. The skills captured in the “Use of Self-Awareness” subscale are developed over time, in the experience of reflective supervision where the therapist receives the consistency, predictability, and compassion from the reflective supervisor that they will then offer the family, a parallel to the way in which the baby will develop the capacity for reflective functioning and subsequent empathy only as a product of having received this very mindful attention from their caregiver.

The association between burnout and reflective supervision self-efficacy is significant for a variety of reasons. First, burnout among mental health professionals is widespread (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012), which is not surprising given the intense nature of mental health treatment and the exposure to the multiple stressors that impact clients living in poverty; further, burnout negatively impacts services (Morse et al, 2012). IMH practice is no exception; in fact, families utilizing IMH services typically experience cumulative trauma and adversity. For instance, the sample of caregivers participating in the Michigan IMH HV evaluation reported on average 4.5 Adverse Childhood Experiences ( $SD = 3$ ), suggesting that a significant proportion of the families served by an IMH-HV therapist have multiple stressful life events, heightening IMH-HV therapists’ risk of burnout (Cummings, Singer, Hisaka, & Benuto 2018; Osofsky, 2009). Second, burnout has been widely associated with job turnover in the helping professions (Morse et al., 2012), which negatively impacts the development of a therapeutic relationship, the central source of intervention in IMH practice. Therefore, it seems essential to identify strategies to reduce burnout among IMH-HV therapists. Reflective supervision has been identified as one such tool (Osofsky 2009), and the current study also suggests that IMH HV therapists’ increased self-report of “Use of Reflective Supervisory Relationship” is associated with decreased burnout. This provides some beginning empirical support for this assertion; however, caution should be utilized when exploring this finding because it is important to note that this sample’s report of burnout was relatively low and there was minimal variability in the results. Additionally, this study’s assessment of burnout was limited to one self-report question about clinician’s experience of burnout. In order to fully address the relationship between burnout and reflective supervision, future studies should utilize standard measures of burnout and compassion fatigue that would substantively measure these constructs. As Watkins (2015) argues, there is research that connects supervisees’ experiences of the supervisory alliance and job burnout, suggesting that reflective super-

vision that is centered around specific attention to the establishment and maintenance of a strong supervisor-supervisee relationship might be well designed to reduce or prevent burnout. The impact of job burnout on overall wellbeing and employee turnover rates highlights the importance of further exploring the relationship between burnout and reflective supervision.

Additionally, the finding regarding the association between job satisfaction and reflective supervision self-efficacy warrants careful attention because there is evidence that job satisfaction is associated with job performance, whereby both factors mutually influence each other (Alessandri, Borgoni, & Latham, 2016). In addition, the association between job satisfaction and overall reflective supervision self-efficacy, this study also highlights relationships between job satisfaction and the "Use of the Reflective Supervisory Relationship" and "Use of Self Awareness," suggesting that these elements of reflective practice could be further supported in IMH HV therapists so as to increase their positive relationship with their work. Furthermore, the positive association between IMH HV therapists' identification of meaning in their work and the "Use of Observational Skills" also provides preliminary evidence that attention to honing the capacity to remain curious about the parent(s), infants, and toddlers, and the parent-infant relationship can sustain IMH HV therapists' belief in the value of their IMH practice. These findings contribute to a growing body of research that connects reflective supervision with benefits for the early childhood professional workforce. Priddis and Rogers (2018) conducted exploratory research about reflective practice skills and a variety of professions including IMH, with preliminary results demonstrating that, "building reflective capacity might *indirectly* influence job satisfaction via fostering a greater desire for improvement" (p. 100), which supports findings from Study 2 in the present paper. In addition, Frosch et al. (2018) found that reflective supervision is linked to early childhood interventionists' "overall job satisfaction," among other related factors such as ability to "effectively cope with job stress" (p. 391).

It is important to address some of the study limitations relevant to these two research studies. First, there are some inherent risks when using self-report measures; specifically, the overestimation of skills is an important consideration when administering this kind of rating scale (Jaeken et al., 2017). For example, participants may interpret the tasks and skills featured in the measure to be more elementary or basic than they are in reality. This kind of misinterpretation can lead to inflated ratings that are sometimes followed by declines in ratings at a later administration after respondents have more experience with or training about engaging in the challenges associated with these tasks and skills (Jaeken et al., 2017; Shea et al., 2016). In addition, another risk of the self-report format is that respondents may also underestimate their skillset. The potential for "self-diminishment

bias" (Jaeken et al., 2017) can skew the results when respondents have received training that then raises doubts about their capacities as they may begin to more actively engage in self-appraisal. Future studies should incorporate observational measures such as the RIOS, secondary reports completed by the supervisor or supervisee to rate the reflective practice skills as a means of reducing the impacts of rating bias that may occur with self-reports. However, despite these risks, the use of a self-report tool provides opportunity for IMH-HV therapists and their supervisors to track growth in skills specific to reflective supervision.

With regard to the first study, while the sample size was larger than previous research efforts involving the RSSESS, a second factor analysis is warranted with a much larger sample size to confirm the factor structure. In addition, the combined nature of the sample prevented additional analyses regarding associations between IMH-HV therapist training, background, and demographics and the RSSESS factors given that each sample had been collected using different methodologies. In addition, Study 1 did not assess for construct validity by comparing the RSSESS self-report and one of the existing observational tools measuring similar constructs, which is an important goal for future research using the RSSESS. Additionally, future studies might include attention to supervisor-supervisee alliance, IMH-HV therapist and parent working alliance, and IMH-HV therapist's reflective functioning, and parental reflective functioning.

With regard to the Michigan IMH-HV evaluation (Study 2), one of the study limitations includes the small sample size of therapists, which limits the generalizability of the growth analyses. Additionally, while the IMH-HV evaluation provided for the assessment of reflective practice self-efficacy over a 12-month time period, it will be important to have more longitudinal data for the RSSESS in order to track growth in reflective supervision self-efficacy beyond 12 months. Related to this issue, the current study did not include data regarding the length of time the supervisee had been receiving reflective supervision or the length of time for the supervisee's reflective supervisory relationship with their supervisor. Given that the reflective supervisory relationship is one that can be deepened with time, safety, and consistency, future research must consider how the duration of the supervisee-supervisor relationship might impact supervisees' reflective practice self-efficacy. Use of this relationship by IMH-HV therapists could become increasingly more sophisticated when there is greater opportunity for a deeper relationship with the supervisor. Additionally, as previously mentioned, the lack of standardized measure of burnout, coping skills, and job satisfaction limits the findings' generalizability.

In conclusion, these two research studies provided evidence that the RSSESS can be a useful tool for assessing IMH-HV therapists' perceived reflective practice self-efficacy based

on the construct validity of self-efficacy and the preliminary establishment of outcome validity with associations between job satisfaction and burnout. Specifically, the RSESS can provide information about changes in IMH-HV therapists' self-efficacy with regard to their use of the supervisory relationship, use of reflective practice skills with families, use of observational skills, and self-awareness. This tool lends itself to be used both in research and clinical settings due to its relative brevity. Importantly, results from the Michigan IMH-HV evaluation provide additional empirical support for the value of reflective supervision in supporting IMH-HV therapists' job satisfaction and reducing burnout. Additionally, this study contributes to the reflective supervision literature by providing preliminary evidence of growth in reflective practice skills over a 12-month period, with specific growth areas in observational skills and use of reflective practice skills with families. Results suggest that further examination regarding changes in reflective supervision self-efficacy over longer time periods is warranted to explore how supervisees' growth in reflective practice skills evolves over time and can be supported by supervisors. Finally, the importance of connecting reflective supervision with outcomes for infants, toddlers, and families is of central importance to the IMH field. There is promising evidence to support such inquiry (Cologon et al., 2017); however, future studies should include attention to the association between constructs measured by the RSESS and parent-child outcomes including parenting self-efficacy, parental reflective functioning, and children's social-emotional functioning.

## ACKNOWLEDGMENTS

We gratefully acknowledge that this research was made possible through the financial support provided by the Michigan Department of Health and Human Services, the Ethel and James Flinn Foundation, the Gerstacker Foundation, the University of Michigan's Women and Infants Mental Health Program, and the Michigan Department of Health and Human Services Children's Mental Health Block Grant (K. Rosenblum and M. Muzik, PIs). We also acknowledge support from the Ethel and James Flinn Foundation (2013, C. Mills and S. Shea, PIs; 2014, S. Shea, PI) and the Gerstacker Foundation and Community Foundation of Southeast Michigan and Eastern Michigan University's Office of Research Development and Administration (2016–2017, S. Shea).

## REFERENCES

Ainsworth, M. S., & Bell, S. M. (1974). Mother-infant interaction and the development of competence. In K. J. Connelly & J. Bruner (Eds.), *The growth of competence* (pp. 97–118). London: Academic Press.

- Alessandri, G., Borgoni, L., & Latham, G. P. (2016). A dynamic model of the longitudinal relationship between job satisfaction and supervisor-rated job performance. *Applied Psychology, 66*(2), 207–232.
- Alliance for the Advancement of Infant Mental Health (2018). *Endorsement for culturally sensitive, relationship-focused practice promoting infant and early childhood mental health*. Retrieved from <https://www.allianceaimh.org/endorsement-licensing>
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York, NY: W. H. Freeman.
- Berzoff, J., Dane, B., & Cait, C. A. (2005). Innovative models for developing post-masters curriculum in end-of-life care. *Journal of Teaching in Social Work, 25*(3), 63–88.
- Cologon, J., Schweitzer, R. D., King, R., & Nolte, T. (2017). Therapist reflective functioning, therapist attachment style, and therapist effectiveness. *Administrative Policy in Mental Health and Mental Health Services Research, 44*, 614–625.
- Cummings, C., Singer, J., Hisaka, R., & Benuto, L. T. (2018). Compassion satisfaction to combat work-related burnout, vicarious trauma, and secondary traumatic stress. *Journal of Interpersonal Violence, https://doi.org/10.1177/0886260518799502*
- Curtis, D. F., Elkins, S. R., Duran, P., & Venta, A. C. (2016). Promoting a climate of reflective practice and clinician self-efficacy in vertical supervision. *Training and Education in Professional Psychology, 10*(3), 133–140.
- Davys, A., & Beddoe, L. (2009). The reflective learning model: Supervision of social work students. *Social Work Education: The International Journal, 28*(8), 919–933.
- Eggbeer, L., Shahmoon-Shanok, R., & Clark, R. (2010). Reaching toward an evidence base for reflective supervision. *Journal of Zero to Three, 3*(2), 39–45.
- Ellett, A. (2009). Intentions to remain employed in child welfare: The role of human caring, self-efficacy beliefs, and professional organizational culture. *Children and Youth Services Review, 31*, 78–88
- Finello, K. M., Heffron, M. C., & Stroud, B. (2016). Measuring process elements in reflective supervision: An instrument in the making. *Zero to Three, 37*(2), 39–45.
- Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry, 14*, 387–421.
- Franklin, L. D. (2011). Reflective supervision for the green social worker: Practical applications for supervisors. *The Clinical Supervisor, 30*(2), 204–214.
- Frosch, C. A., Varwani, Z., Mitchell, J., Carraccioli, 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.
- Gallen, R. T., Ash, J., Smith, C., Franco, A., & Willford, J. A. (2016). How do I know that my supervision is reflective? Identifying factors and validity of the Reflective Supervision Rating Scale. *Zero to Three, 37*(2), 30–38.
- Gilkerson, L. (2004). Reflective supervision in infant/family programs: Adding clinical process to non-clinical settings. *Infant Mental Health Journal, 25*(5), 424–439.
- 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. (2010). *Reflective supervision and leadership in early childhood programs*. Washington, DC: Zero to Three Press.

- Heffron, M. C., Reynolds, D., & Talbot, B. (2016). Reflecting together: Reflective Functioning as a focus for deepening group supervision. *Infant Mental Health Journal, 37*(6), 628–639.
- Heller, S. S. & Ash, J. (2016). The Provider Reflective Process Assessment Scales (PRPAS): Taking a deep look into growing reflective capacity in early childhood providers. *Zero to Three, 37*(2), 22–27.
- Holden, G., Cuzzi, L., Spitzer, W., Rutter, S., Chernack, P., & Rosenberg, G. (1997). The hospital social work self-efficacy: A partial replication and extension. *Health & Social Work, 22*(4), 256–263.
- Jaeken M., Zech E., Brison C., Verhofstadt, L. L., Van Broeck, N., & Mikolajczak, M. (2017). Helpers' self-assessment biases before and after helping skills training. *Frontiers in Psychology, 8*, 1377. <https://doi.org/10.3389/fpsyg.2017.01377>
- Lawler, J. M., Rosenblum, K. M., Muzik, M., Ludtke, M., Weatherston, D. J., & Tableman, B. (2017). A collaborative process for evaluating infant mental health home visiting in Michigan. *Psychiatric Services, 68*(6), 535–538.
- Low, C. M., Newland, R., Silver, R. B., Parade, S., Remington, S., Aguiar, S., & Campagna, K. (2018). Measuring reflective supervision within home visiting: Changes in supervisors' self-perception over time. *Infant Mental Health Journal, 39*(5), 608–617.
- Many, M. M., Kronenberg, M. E., & Dickson, A. B. (2016). Creating a "nest" of emotional safety: Reflective supervision in a child-parent psychotherapy case. *Infant Mental Health Journal, 37*(6), 717–727.
- Miehls, D. (2010). Contemporary trends in supervision theory: A shift from parallel process to relational and trauma theory. *Clinical Social Work Journal, 38*(4), 370–378.
- Miller, S. E. (2011). *Parallel experiences: Associations between providing attachment-based treatment to children in foster care and clinical social workers' sense of self-efficacy* (Unpublished doctoral dissertation). Smith College School for Social Work, Northampton, MA.
- Moran, T., Polanin, J. R., Evenson, A. L., Troutman, B. R., & Franklin, C. L. (2016). Initial validation of the assessment of parenting tool: A task-and domain-level measure of parenting self-efficacy for parents of infants from birth to 24 months. *Infant Mental Health Journal, 37*(3), 222–234.
- Moran, T., Troutman, B. R., Franklin, C., & Evenson, A. (2012). Creation of a developmentally sensitive measure of parenting self-efficacy. *Zero to Three, 33*(2), 80–82.
- Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health, 39*(5), 341–352.
- O'Rourke, P. (2011). The significance of reflective supervision for infant mental health work. *Infant Mental Health Journal, 32*(2), 165–173.
- Osofsky, J. (2009). Perspectives on helping traumatized infants, young children, and their families. *Infant Mental Health Journal, 30*(6), 673–677.
- Pawl, J. H. & St. John, M. (1998). *How you are is as important as what you do .. In making a positive difference for infants, toddlers, and their families*. Washington, DC: Zero to Three Press.
- Priddis, L. & Rogers, S. L. (2018). Development of the reflective practice questionnaire: Preliminary findings. *Reflective Practice: International and Multidisciplinary Perspectives, 19*(1), 89–104.
- Rosenblum, K. L. & Muzik, M. (2016). *Clinician Profile Form*. Unpublished measure. Ann Arbor, Michigan: University of Michigan.
- Schafer, W. M. (2007). Models and domains of supervision and their relationship to professional development. *Zero to Three, 28*(2), 10–16.
- Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. New York, NY: Basic Books.
- Shahmoon-Shanok, R. (2006). Reflective supervision for an integrated model: What, why, and how? In G. Foley & J. Hochman (Eds.), *Mental health in early intervention* (pp. 343–381). Baltimore, MD: Brookes.
- Shahmoon-Shanok, R. (2009). What is reflective supervision? In S. Heller & L. Gilkerson (Eds.), *A practical guide to reflective supervision* (pp. 7–23). Washington, DC: Zero to Three Press.
- Shea, S.E. (2014). *Expanding the availability of an advanced, competency-based, professional development training model for infant mental health clinicians: An Evaluation*. Unpublished report, Ypsilanti, Michigan: School of Social Work, Eastern Michigan University.
- Shea, S.E. (2017). *Evaluation of Michigan Association for Infant Mental Health's Core Curriculum Training Series: Summary Report*. Unpublished report, Ypsilanti, Michigan: School of Social Work, Eastern Michigan University.
- 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), 653–662.
- Shea, S.E. & McCormick, A. (2018). *Evaluation of the Michigan Association for Infant Mental Health's Detroit-Wayne Core Curriculum Training Series*. Unpublished report, Ypsilanti, Michigan: School of Social Work, Eastern Michigan University.
- Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment and Human Development, 7*(3), 269–281.
- Stevens, J. P. (1992). *Applied multivariate statistics for the social sciences* (2 ed.). Hillsdale, NJ: Erlbaum.
- Tomlin, A. M. & Heller, S. S. (2016). Measurement development in reflective supervision: History, methods, and next steps. *Zero to Three, 37*(2), 4–12.
- Tomlin, A. M., Weatherston, D. J., Pavkov, T. (2014). Critical components of reflective supervision: Responses from expert supervisors from the field. *Infant Mental Health Journal, 35*(1), 70–80.
- Troutman, B., Moran, T. E., Arndt, S., Johnson, R. F., & Chmielewski, M. (2012). Development of parenting self-efficacy in mothers of infants with high negative emotionality. *Infant Mental Health Journal, 33*(1), 45–54.
- 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.
- Watkins, C. E. (2015). The alliance in reflective supervision: A commentary on Tomlin, Weatherston, and Pavkov's critical components of reflective supervision. *Infant Mental Health Journal, 36*(2), 141–145.
- Watson, C., Bailey, A. E., & Storm, K. J. (2016). 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 Day Care*, Vol. 18 (pp 1–25). Bingley, UK: Emerald Publishing.
- Watson, C. L., Harrison, M. E., Hennes, J. E., & Harris, M. M. (2016). Revealing 'the space between': Creating an observation scale to understand infant mental health reflective supervision. *Zero to Three*, 37(2), 14–21.
- Weatherston, D. J., & Barron, C. (2009). What does a reflective supervisory relationship look like? In S. Heller & L. Gilkerson (Eds.), *A practical guide to reflective supervision* (pp. 61–80). Washington, DC: Zero to Three Press.
- Weatherston, D. J., Kaplan-Estrin, M., & Goldberg, S. (2009). Strengthening and recognizing knowledge, skills, and reflective practice: The Michigan Association for Infant Mental Health competency guidelines and endorsement process. *Infant Mental Health Journal*, 30(6), 648–663.
- Weatherston, D. J., & Tableman, B. (2015). *Infant mental health home visiting: Supporting competencies, reducing risks*. Southgate, MI: Michigan Association for Infant Mental Health.

**How to cite this article:** Shea SE, Jester JM, Huth-Bocks AC, et al. Infant mental health home visiting therapists' reflective supervision self-efficacy in community practice settings. *Infant Ment Health J*. 2020;41:191–205. <https://doi.org/10.1002/imhj.21834>