Reflective Consultation With Groups via Virtual Technology

What Is Best Practice?

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Abstract
As the field of infant and early childhood mental health (IECMH) continues to grow and professionals realize the value of reflective supervision/consultation (RS/C), the need for equitable access to quality RS/C expands. One way that providers of RS/C have increased access to RS/C is through virtual technology. The growth of virtual RS/C requires professionals to define best practice for this new medium. Through the use of the Best Practice Guidelines for Reflective Supervision/Consultation (Guidelines; Michigan Association for Infant Mental Health, 2004), we offer three case studies in which the Guidelines serve as the foundation for providing virtual RS/C to distinctly different groups.

The use and understanding of reflective supervision/consultation (RS/C) is critical to strengthening infant and early childhood mental health–informed (IECMH-informed) practice. IECMH-informed professionals include those who work in behavioral health, child welfare, early care and education, early intervention, health, home visiting, and mental health consultation. In 2004, the Michigan Association for Infant Mental Health (MI-AIMH) created the first edition of the Best Practice Guidelines for Reflective Supervision/Consultation (Guidelines). Infant mental health (IMH) professionals from Michigan, across multiple service sectors, created these guidelines to familiarize professionals with RS/C, to emphasize the importance of RS/C for best practice, and to better ensure that those providing RS/C were appropriately trained. MI-AIMH's long commitment to the use of a multidisciplinary approach made it increasingly important to be able to refer to a clear set of guidelines describing the organization's collective understanding of RS/C across disciplines and service sectors. In 2005, MI-AIMH expanded the Guidelines with input from the Texas Association for Infant Mental Health, now known as First3Years. Both groups offered this document as an open source to all their members.

RS/C is a key component of Endorsement® for Culturally Sensitive, Relationship-Focused Practice Promoting Infant and Early Childhood Mental Health (Endorsement®). Beginning in 2002, MI-AIMH started a national effort to raise the professional standards for the IECMH field by licensing the *Competency Guidelines*® and Endorsement to associations for infant mental health (AIMHs; Funk et al., 2017; Weatherston, Kaplan-Estrin, & Goldberg, 2009; Weatherston, Dowler Moss, & Harris, 2006). As the effort grew, the Alliance for the Advancement of Infant Mental Health (The Alliance) was created to provide the leadership and support needed for a growing organization (Funk et al., 2017). To date, 30 AIMHs and 2 international AIMHs participate.

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The Guidelines have evolved over time to reflect changes in the IECMH field and to include new voices and new knowledge of RS/C practice. In this sense, it is a "living document" with each version representing a collective set of recommendations at the time. The most recent revision in 2018 was led by The Alliance to provide clarity around the following:

- best practice for IECMH policy leaders, faculty, and researchers
- best practice for consultants and consultees
- reference to the Diversity-Informed Tenets for Work With Infants, Children and Families (Irving Harris Foundation, 2018)
- differentiation between types of RS/C, including program supervisor as provider, group, and individual
- exploration of the provision of virtual RS/C
- more thorough definitions of the RS/C that is required for Endorsement

The Guidelines capture best practice at this moment in time. Members of The Alliance will respond as the IECMH field grows and changes, and while the core Guidelines provide a framework, this living document will continue to be revisited to reflect evolving knowledge from the field. The Guidelines remain an open source document for the field.

Virtual RS/C

As the field of IECMH and the practice of RS/C have grown, technology has made it possible for an increasing number of professionals to work together in reflective relationships, often spanning vast distances. Professionals around the world are now able to engage in RS/C via various forms of technology (e.g., video conference, conference calls). As is stated in the Guidelines,

> *With the emphasis on relationship as the instrument for growth and change for families and for service providers, a significant factor to consider when using virtual technology is how to build a relationship that will fuel development as well as reflective capacity.* (Alliance for the Advancement of Infant Mental Health, 2016, p. 11–12)

As reflective supervisors and consultants contemplate whether providing RS/C via a virtual platform is a good fit, they will consider many more details than when doing RS/C in person. These details may be relatively straightforward (see Box 1). Some level of comfort with technology will be required of the provider, and it will be important to establish a back-up plan if the virtual platform fails. For groups, the provider will want to determine the ideal size for virtual RS/C. The Guidelines suggest that a virtual RS/C group be no more than 6–8 people. Taking it one step further, if providing RS/C to a group, the provider will inquire whether the group participants are in the same physical space or each in different places. Finally, and of the highest importance, the provider will contemplate the relationship-based components of RS/C.

Box 1. Considerations for Virtual Reflective Supervision/Consultation

Important questions for providers of virtual reflective supervision/consultation (RS/C) to consider:

Technical Components

What technology platform will be used?

Is the virtual platform accessible to all?

Is there a cost to use the virtual platform?

Is the virtual platform compliant with all privacy regulations?

Relationship-Based Components

How will the provider establish a sense of "being with" without being in the same room with the supervisee or consultees?

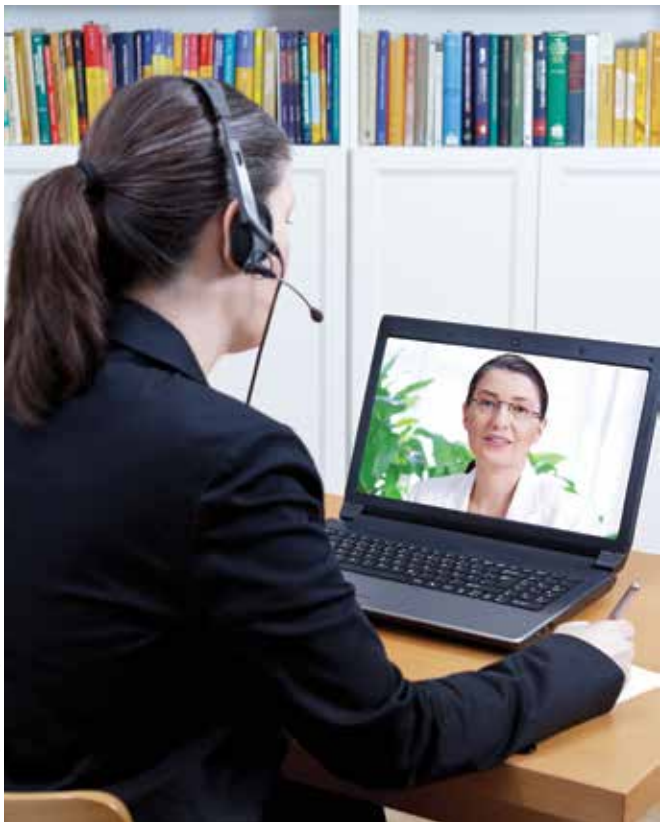
How will the provider navigate additional variables of importance?
- environment
- presence
- culture

What parameters will the provider set up for the time to be most effective?
- structure
- timing
- breaks

How will the provider set up appropriate expectations before the first session?
- need to have WIFI access
- computer with video option
- being in a private and quiet space

How will silence be navigated?

As outlined in the Guidelines, while the provider of virtual RS/C is encouraged to incorporate all best practice strategies, successful virtual RS/C requires the provider to put extra care and focused attention on specific best practices. We are continuously learning what works best for the infant, young child, and family field to promote and sustain relationships when using virtual technology for RS/C, and this discussion reflects some lessons learned. First, it is important to discuss special issues of privacy and confidentiality specific to the use of virtual technology. In addition, what is the "etiquette" for this way of being together? What "ground rules" can be put in place to assist this? It may be harder to ensure quiet, uninterrupted space. How do we know that the presenter and members of the group are getting and giving undivided attention (Heller & Gilkerson, 2009)? These special circumstances offer both barriers and opportunities for deeper reflection. As the group develops its own rhythm and pace, particularly around turn-taking, there will be moments of miscues and misinterpretation. It is within these moments of disconnect and reconnecting that strong relationships can be built. As is true in infant–parent relationships, the process of "rupture and repair" is expected and essential to the development of secure group relationships in the practice of RS/C (Keyes, Cavanaugh, & Scott-Heller, 2009).



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There are various ways that RS/C providers can mitigate the challenges of virtual RS/C. The provider of RS/C can create ongoing opportunities for the group to name what might be hard about meeting in this unique way and invite group participants to create solutions. The provider should consider having a conversation after the first 2–3 sessions to discuss how the communication is flowing, make appropriate adjustments, and continue the feedback process on a regular basis. It can also be helpful to begin each session with a quiet period or a transitional relaxation or mindfulness activity, inviting participants to let go of distractions and direct their focus into the group reflective process. Lastly, many experts suggest that virtual meetings be supplemented with opportunities for face-to-face meetings when possible (Mulcahy, 2018).

The following case studies explore the provision of virtual RS/C to three distinctly different groups, using the Guidelines as the underpinning for best practice. Each case study is written by one of the authors of this article. They offer rich examples of how different providers facilitate RS/C virtually using recommendations from the Guidelines. It is important to note that the reader will notice commonalities across the three stories: commitment to regular meetings, protection against interruptions, co-construction of the agenda and routine, and attention paid to both content and process. While the Guidelines are the foundation on which each provider grounded themselves, the provider in each case also used their unique personal style and professional training experience, their understanding of the group make-up (including experience in the field, experience with RS/C, discipline, and type of direct service work), and assessment and use of the virtual environment to inform their reflective approach.

Establishing Trust and Safety: Case Study #1

I (Ashley McCormick) was asked to provide reflective consultation (RC) to seven individuals whose primary role was to supervise IECMH consultants. Infant and early childhood mental health consultation (IECMHC) is a prevention-based service that teams a mental health consultant with early care and education staff, programs, and families of young children (Johnston & Brinamen, 2006). More recently, IECMHC has also been used in home visiting and pediatric settings. The Substance Abuse and Mental Health Services Administration (SAMHSA) Center of Excellence describes IECMHC as a mental health specialization and emphasizes the importance of understanding the impact of trauma (SAMHSA, 2019). IECMH consultants may experience vicarious trauma in their work. In order to best support the program supervisors, consultants, and the families they serve, it is critical that they receive RC.

The supervisors were spread out geographically across the state, so we met via video conference, each in our own individual spaces. The group members were required to participate in RC. I was immediately aware that their required participation could be a potential barrier. Another possible obstacle was that the supervisors had never previously received RC and were new to reflective practice. Being mindful of the possible barriers in front of us, I went into the first group session very aware of the need to establish trust and safety.

Whenever I begin RC with a new group, I use the Guidelines as my guide to focus initially on the importance of reliability, predictability, and dependability. As I considered this specific group, I wondered: *How will I establish safety and consistency within these new relationships? How will the consultees come to know that they can depend on me? How will I provide them a space to show up as their authentic selves, free to make mistakes and show their vulnerabilities?*

With this group of supervisors, I considered ways that I could illustrate being dependable and predictable. My efforts included creating a consistent schedule for our sessions, by choosing the same day and time each month, showing up on time, and being fully present. On the first day I discussed the virtual platform and possible obstacles and troubleshooting that we may encounter through this format. We planned for situations like poor WIFI and sound or video not working. I made sure to exchange cell phone numbers and email addresses with the consultees. Just as important, we talked about things that the consultees and I had control over, such as limiting noise and distractions within our own spaces. I paused and allowed

the group to wonder aloud together: *How can our collective environments provide an optimal learning space for each of us? Can we establish a shared space that ensures that each of us has the opportunity to feel respected, heard, and held?*

We talked about building relationships virtually by video. We discussed what it is like to be seen and to see others. Alternatively, we wondered what it would be like if someone did not have their video camera on during our sessions. I asked the consultees to give a virtual tour of their space. Doing so allowed the group to begin to know one another specific to their physical spaces in addition to offering reassurance that the space was private. This discussion of privacy led us into a conversation about respect and confidentiality. Because the meetings took place virtually, it was important for each consultee to consider if and when someone else may be present in their space and how they would handle this during RC.

Finally, within the first meeting, I facilitated a discussion about how we envisioned our group functioning together. We discussed the importance of a predictable, yet flexible routine and co-created the structure and flow of our group. With virtual RS/C, I find myself relying more heavily on a schedule than I do with in-person RS/C. We agreed that having regular conversations about our routine would be helpful, and I assured them that I would provide opportunities for feedback.

I also know that there are other things that facilitate feelings of safety and trust that are less concrete. They are subtle things such as listening carefully, following the lead, illustrating self-control, observing thoughtfully, offering flexibility when needed, responding, paying attention, accepting the other, and caring for the other. In my RC groups work, I must consistently demonstrate these qualities so the consultees can begin to recognize them. Through my actions, I want the consultees to experience the message: "I welcome what you have to tell me."

I allowed the process of getting to know one another unfold slowly in the beginning; I did not want to rush building our relationship-focused foundation. I started by asking a broad question so everyone could answer within their own comfort level. For this particular group, I asked, "How did you get here?" I added the following prompts to consider: What led you to this group, on this day? What experiences with babies, young children, and families led you here? What previous supervision experiences do you have (or not) that contribute to your presence? I listened closely for themes across their stories as they spoke.

Knowing that this group was new to RC, defining RS/C and providing an opportunity to discuss it further was an integral part in establishing safety. The more one knows about something, the less anxious, fearful, or overwhelmed one is by it. I specifically emphasized that within RS/C we wait and listen and hold the urge to problem solve. I explained my role as a facilitator more than as the "expert," which required that the group wonder together for increased understanding.

Within that same conversation, we talked about the parallel process. Specifically, we discussed how "far away" the

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It can be helpful to begin each session with a quiet period or a transitional relaxation or mindfulness activity, inviting participants to let go of distractions and direct their focus into the group reflective process.

supervisors feel from the young child who is the target of IECMHC. The group became curious about how they would be able to keep the young child in mind while also holding the experience of the consultant, who is supporting the experience of the child care provider or program, who is embracing the experience of the young child.

Because this is a group of supervisors who have staff of their own, I asked them to muse on how they establish safety and trust with their own supervisees. A majority of them responded quickly, "It's the in-person meetings that allow us to build safety so that we can then do a majority of our work virtually." Although an in-person meeting is considered a best practice, I live many states away from these individuals and expressed my worry that we would not be able to have an in-person touch point. I acknowledged how crucial this was to the process of establishing trust and safety and wondered what it meant for our group. They were quick to discuss this and eagerly expressed their desire to find a way for this to occur. We realized that we would all be in relatively close proximity to one another in the coming months and made a plan to meet and connect over dinner. This decision felt affirming that we were on the right track to establishing a solid foundation.

One person added to the conversation, "I think a big part of trust is one's own approach to relationships. It seems that many people operate in two ways: They either trust until they have a reason not to, or they do not trust until they have a reason to trust." With her offering this observation, the group members became curious about what type of person they were. They each began to share their thoughts and reflections with one another. After many minutes of this, each person shared in their own way that they felt safe "here."

Deepening of Reflective Relationships: Case Study #2

The group I (Faith Eidson) came to work with was funded through a grant with a purpose to build IECMH knowledge and skills for professionals in a small, rural community. Due

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Providing virtual reflective supervision/consultation requires extra attention to forming safe and trusting relationships.

to a lack of options in their geographical area, I was asked to provide RS/C to this group via video technology, with an allowance for one in-person meeting at the end of the year-long contract. The group came together in one space in their community twice a month for 2 hours, and I joined them via video screen. During our first meeting, I was struck by the diverse experiences of the group members: clinicians, home visitors, mental health consultants, child welfare case managers, and midwives had come to reflect together.

I began my time with the group explicitly addressing the odd feeling of being in the room with them via a screen and discussing the unique barriers we might encounter due to the technology. We also discussed boundaries around safety, confidentiality, and how to protect our time from interruptions. In our second meeting, I offered a small amount of information about IMH and RS/C, and then asked the group to talk about how they saw it fitting into their work. As they did this, I began to see a common purpose forming around caring deeply about what happens for babies and families and with that, the group began to bond. In this meeting, I also shared a routine I tend to follow during my RS/C sessions and asked for feedback. My routine often looks like this: mindfulness moment/activity, check-ins, update from previous session's presenter, identified presenter shares their work while the group listens carefully, then time for reflection together. We all agreed on this format for our coming together, and we were on our way!

Over time, group members implicitly and explicitly sent messages that this coming together to slow down and think carefully about their work with vulnerable babies and families was an oasis for them. Our time together felt like a true partnership, a shared construction of our process. In this way, the power was shared among all of us. I had a sense of how the group was going, but sometimes left the virtual meeting wondering if my sense was accurate. I have found it can be hard to read a group's energy and strength of relationships when joining them via technology. In addition to not sharing the physical space during RS/C, I also am not always there for the beginning, as they welcome each other and reconnect, and I am absent for the little conversations that continue once the meeting has ended and I have left the computer screen. As I find the feeling of disconnection a bit unsettling, I began to make a point to join the meeting 10 minutes early so I could be present during the "hellos." Doing so allowed me moments of catching up individually with the group members who also came early, which happens naturally when I am physically in the room with groups, and it also gave me an opportunity to observe how they came together.

I have learned to offer more time and space than I generally would for in-person groups to invite members to talk about how the process has been going for them. This is a way for me to hear about how the sessions have felt for them and to recalibrate my own sense of the group based on their feedback. After six sessions, I invited this group to share their experiences so far: *What was working well? What might we shift?* Participants were able to share that they appreciated the format and reflection opportunities. They also expressed their frustration about group participants regularly missing or showing up late. I noticed they were practicing saying hard things in kind ways, trusting it would be good for the group. I made a point to say this out loud and to name what was happening. I watched as they collectively sat up straighter and began looking around at each other, offering eye contact, and smiles.

The deepening of the reflective process, even across such a long distance, became evident in small yet powerful ways. They began to share more of themselves in check-ins, offering insights into how they felt in the world around them. I noticed more quiet, as the group settled into deep listening and observation when one person spoke. Instead of offering solutions or things to do, I heard statements from group members like, "I notice that you mentioned you felt frustrated with this child. This reminds me of what you said when you checked in. I wonder if it is related?" Or, in response to a group member's assessment, "It could be that. There are so many reasons that could explain what is happening for this mom and baby. What else have you considered?" They were generously listening, setting aside their urges to share their own stories or solutions, and really showing up for one another. They also began to learn each other's strengths and seemed to never miss an opportunity to remind another of the gift they brought to the work. Over time, as I noticed these shifts, I made a point to step out of the process and summarize what I saw the group doing together. I put words not just to what they said or did, but also to how I saw them interacting, and how this interaction was linked to IMH and relationship-based practice. Sometimes, I also invited them to consider how this process would look in their direct work with young children and families. In some ways, the task of naming the process felt easier than when I am present in person. I already held an "outside" position in the group as the facilitator, and my literal distance from the group allowed me to observe what was happening in a unique way. I am certain there were times the group members forgot

I was there; they were so deep in their shared space. I had to be careful to balance the role of being with them and a part of their process, while also acknowledging the very real experience of being apart from them.

At the end of the year, we met together in person, in their community. I came prepared with prompt questions and activities to deepen our relationships with one another; they each brought food to share. We spent time describing what happened for us over the course of the year and how we planned to integrate what we learned together into our work. And, when given the opportunity to sign up for another year of RS/C, with me joining remotely, they all came back.

Balancing the Need to Foster Reflection With the Need to Learn: Case Study #3

I (Mary Harrison) provided virtual RC to groups of two to three child protection workers and others who worked with children in or at risk of out of home placement. They participated as part of a voluntary online/hybrid child welfare training program in IMH which also included 6 months of instructor-guided virtual learning and three in-person learning opportunities. Therefore, for these practitioners, I wore both a "teacher" hat and a "reflective consultant" hat. Because one of the best practices for RS/C as identified in the Guidelines is: *"Based on the Supervisees' training, experience, and emotional readiness... Apply specialized knowledge to expand the understanding of the case material and teach/guide supervisee as necessary"* (Alliance for the Advancement of Infant Mental Health, 2018, p. 6), I knew it was appropriate to include links to relevant theoretical concepts, but I was not sure exactly how I would do that.

I knew how to set up the group so that consistency, dependability, and confidentiality were established as cornerstones of the reflective process. It felt much trickier for me to learn to wear two hats; I often wondered when to provide teaching and guidance and when to stay with a reflective process. Providing virtual RS/C requires extra attention to forming safe and trusting relationships, and I was concerned that bouncing between two roles would get in the way of our relationships. When I began, I often felt like my attempts to link stories about babies and families to theoretical concepts were awkward and interrupted the flow of our reflective discussion. When I tried to make the links, I worried that I talked too much and was not allowing enough time for wondering together. After a few sessions, I decided to explicitly check out this concern with them. I explained my challenge and asked for feedback. We were, after all, piloting this program, and I wanted it to be a good fit for the child protection workers. To my surprise, group members reported really liking the explicit connections. Many said they had done readings and watched videos, but the concepts made much more sense when they could think about them in the context of a particular family. In retrospect, I am grateful that the RS/C model includes a sharing of power between the consultant and consultees; I was not under pressure to "do it right" because there are many "right" or "good enough" ways to provide RS/C. This notion is particularly useful to remember when providing virtual RS/C because there are more risks of being misunderstood when there are fewer opportunities for nonverbal cues. Instead, it felt natural to check out my own perceptions and wonderings with my group members as we were co-constructing our experience. Once I realized how much the child protection workers appreciated that "linking," I began to develop ways of doing it that felt more natural. I also developed phrases that helped me make the transition (see Box 2).

Three months later, one child protection case worker brought up a concern she had about a kinship placement for a young child. She wondered whether she should have considered a different placement for the child because, when she visited the aunt's apartment, it was in a low-income neighborhood and the aunt did not seem to have a lot of money or many toys. Trusting in the relationship that we had established, I wondered with the consultee about how familiar the aunt was to the child, about safety concerns, and about how it felt to observe the child and the aunt together. We reflected on topics we had covered in learning sessions about the power of supportive relationships and how much more important they are than access to toys or "nice" things at home. We considered ways that she could focus her next observation, looking for "serve and return-like" interactions, noticing if the child seemed to feel safe enough with the aunt, able to use

Box 2. Weaving Learning Opportunities Into Reflective Conversations

Examples of phrases linking reflection with learning include the following:

"*As we talked about at our last in-person discussion...* [even babies and young toddlers can be greatly impacted by witnessing domestic abuse]"

"*Do you remember...* [watching the video on the still face? What you're describing reminds me of the mother's 'still face' in that video. And do you remember how the baby reacted? I wonder what this baby has learned by not crying and not asking for help from her mom?"]

"*The good news is that now we know a lot more about what babies and young children need at times like this...*

- continuity of care, or
- a coherent story about what happened, or
- a transitional object

...and even though you can't erase what happened, you can...

- ask the child care center whether they could allow this girl to stay with her toddler group for longer because she really needs to be with teachers she feels safe with and knows well right now
- encourage the foster parents to write a short story with their new foster child—even with stick figures—about how he came to live with them and how he can ask for help from them when he needs it
- make sure that when you pick the kids up for their visits, they each have time to choose a special stuffed animal and blanket to bring."

her for comfort. In response, the child protection worker said she felt relieved. She said she had liked the aunt and thought this was best for the child, but she had been doubting herself and was concerned that her placement decision would be questioned. This led to a discussion about how we are all impacted by the parts of our culture that make it seem like children need to be in beautiful homes full of lots of toys. We considered whether this distracted us, at times, from what we have learned about the primary importance of secure relationships in early development. We ended thinking, together, about developing a practice habit of returning to knowledge about early development to help guide casework. It was interesting to note, too, the parallel process between our own self-doubt and vulnerability when trying to choose the best environment for a child and a parent's often similar feelings when making choices for their children. We could hold a compassionate space for parents and provide a parallel reflective, relational experience to wonder together when parents were faced with difficult choices.

As I continue to provide virtual RC to child protection workers, I feel increasingly comfortable weaving learning opportunities into reflective conversations about complex cases. Even though the virtual format and my dual role add additional challenges to our RC groups, the benefits of being able to provide RC to child protection workers in rural areas and those facing other barriers to joining in-person groups mean that more practitioners can benefit from this "relationship for learning" (Fenichel, 1992, p. 9).

Summary

The Guidelines provide a solid framework for anyone providing RS/C. Like all relationship-based processes, the decision about how and when to apply the different components of the Guidelines will vary. The recent growth of virtual RS/C has allowed us to explore and define the best practices for this unique format. The case studies in this article highlighted examples from different providers and groups practicing RS/C virtually. In all examples, the following best practices in providing virtual RS/C can be found: meet regularly, create a routine, set up expectations, establish shared language, share specialized knowledge (where appropriate for supervisee's needs), name the process (meta-conversation), and regularly offer opportunities for feedback. All three providers also explicitly identified for the groups a solid connection between relational safety within the group and relational safety for babies. There was an emphasis early in the conversations about parallel process and how what was happening in the room between the group members would no doubt affect the relationships between them and their supervisees and families they served. While there were differences in individual provider style and group composition in these case studies, it is clear that the Guidelines offer our field a strong foundation for shared best practices in providing RS/C virtually.

Learn More

Alliance for the Advancement of Infant Mental Health
www.allianceaimh.org

Center for Reflective Practice at the Center of Early Education & Development at the University of Minnesota
http://ceed.umn.edu/center-for-reflective-practice

Michigan Association for Infant Mental Health
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