Getting Started – Introduction and Background

Who are you?

How did we meet and where?

The Institute for Infants, Children & Families

The Mission

Infant - Parent Study Center

35% of U.S. children are estimated by teachers to reach kindergarten with challenges sufficient that they interfere with learning* ....

THE MISSION OF THE INSTITUTE FOR INFANTS, CHILDREN & FAMILIES IS TO CREATE A SAFETY NET FOR THE VULNERABLE 35% TO CATCH, HOLD AND HELP THEM SO THEY FLOURISH, RATHER THAN FAIL.
The Infant-Parent Study Center

Year One

First Semester (14 weeks)
- Development of Infants and Young Children (80 minutes)
- Adult/Parent Development, Assessment, and Intervention (80 minutes)
- Observation and Assessment of Infants and Young Children (80 minutes)
- Group Supervision (90 minutes)
- Individual Supervision (50-60 minutes)

Second Semester (14 weeks)
- Development of Infants and Young Children (80 minutes)
- Adult/Parent Development, Assessment, and Intervention (80 minutes)
- Leadership: Social Policy and Systemic Issues (80 minutes)
- Current Developments in Infant/Parent Psychotherapy: Applying Psychoanalytic Concepts in Diverse Settings (90 minutes for 8-10 weeks)
- Group Supervision (90 minutes)
- Individual Supervision (50-60 minutes)

Integrative Project

Began in Spring of Year One, completed by May of Year Two

The Infant-Parent Study Center

Year Two

Third Semester (14 weeks)
- Infant/Young Child Psychopathology and Diagnostic Approaches (80 minutes)
- Observation and Assessment of Relationships (60 minutes)
- Community Seminar: Observing, Assessing, and Intervening Across Cultures (90 minutes)
- Group Supervision (90 minutes)
- Individual Supervision (50-60 minutes)

Fourth Semester (14 weeks)
- Infant/Young Child Psychopathology and Intervention/Classification (80 minutes)
- Relationship Development, Assessment, and Intervention (80 minutes)
- Leadership Seminar: Uncover Your Voice (80 minutes)
- Group Supervision (90 minutes)
- Individual Supervision (50-60 minutes)

Integrative Project

Begun in Spring of Year One, completed by May of Year Two

Integrating Concepts Across Disciplines

Zero to Five *

*Multi-disciplinary, cross-disciplinary, interdisciplinary and transdisciplinary
Why Train Across Allied Health Disciplines?

- The younger or more vulnerable the child, the less differentiated s/he is … (Shahmoon-Shanok, Henderson, Grellong & Foley, 2006, p. 384).

- Minshew and her colleagues believe that the #1 challenge of children with developmental disorders is “connectivity” (ICDL Annual Conf, 11/09).

- None of us know enough!

OBJECTIVES – Participants will

- Think across disciplinary bounds

- Understand how shifts in clinical practice occur by integrating relational and reflective supervision into the practice of allied health professionals

- Appreciate the importance of post-degree training in making significant changes across allied health disciplines

- Hear how reflective practice and relationship-centered learning augments the practice of allied health practitioners

OBJECTIVES – Participants will

- Learn how specific mental health constructs were integrated into one specific allied discipline, namely, speech-language pathology

- Recognize the benefits, challenges and possibilities in the reflective supervision of allied health providers

- Recognize that it is possible to fully integrate reflective practice into graduate education in the allied disciplines
Reflective Supervision

- The process of examining with someone else, the thoughts, feelings, actions and reactions evoked in the course of working closely with infants, young children and their families.
- The essential features of this supervisory relationship are reflection, collaboration, and regularity of occurrence.

(Eggbeer, Mann & Seibel, 2007, pp. 5 - 6).

Overview: The Process of Change

- Reflective Supervision as a Change Agent
  - In the beginning …
    - The Clinical Case
    - The Supervision
- Our Collaboration
  - Appendix A
- Outcomes – EG and Long Island University
  - Clinical Supervisors
  - Graduate Students

Why Do Our Fields Need to Change?

“ All practitioners influence the mental health of those they serve.”

“ Those helpers who have the most impact on supporting capacities and reducing risks in families . . . . are often not mental health practitioners.”

Social-Emotional Principles to be Integrated Across Allied Health Disciplines

- RELATIONSHIP, RELATIONSHIP, RELATIONSHIP!
  - Nurture therapeutic alliances
  - Pay attention to the latent dynamics of relationships
    - Use self- and other-awareness
  - Support strengths and capacities of each parent-child (or practitioner-parent-child) relationship
  - Engage in developmental parental guidance

MINDSIGHT!

Practicing Mindsight

The ability to perceive the internal experience of another person and make sense of that imagined experience. This involves:

- Affective or emotional attunement - Aligning one's internal feeling state to the internal state(s) of another person.
- Contingent responding
  - Responding to the actual message of the other person without predetermined, rote, or rigid models of what is expected.
- Repairing (naturally occurring) communication breakdowns.

(Siegel & Hartzell, 2003)
Figure 2. The Modalities of Mother-Infant Bidirectional Exchange. From Trevarthen (1989). Reproduced by permission.


TWO INTERTWINING STORIES

Elaine’s Clinical Case

and

Her Reflective Supervision

ONCE UPON A TIME…

The Clinical Case

- Engaging in dyadic work
  - Who is the agent of change for the child?
- Integrating speech-language goals with relationship-based constructs
- The language of intervention
Parents – Muslimah and Saleh
Child – Nafi
Boundaries, Gender and Cultural Issues

The Process of Change: The Story
- The Child and Family
- The SLP and the Clinic
- The Intervention
- The Supervision Process
- Graduate Education
  - Clinical Supervisors
  - Graduate Students

Appendix A
- The following 7 slides offer a few of the highlights to intrigue you!
- Please see Shahmoon-Shanok & Geller (November/December, 2009), Infant Mental Health Journal, 30 (6), 591 – 620.
## Forming the Therapeutic Alliance

### TRADITIONAL CLINICAL PRACTICE
- Treats client and family with positive regard;
- Establishes the goal of transforming or modifying the behaviors of the client;
- Respects knowledge of parent(s);

### RELATIONAL AND REFLECTIVE CLINICAL PRACTICE
- THE SLP:
  - Starts to develop a working alliance;
  - Encourages parent to become an active participant in asking questions and finding possible solutions;
  - Explains constructs of working relationally and dyadically;
  - Focuses on parent’s intention and motivation for changing the relationship;
  - Is attuned to the affective displays of the dyad;
  - Respects knowledge of parent(s);

## Working with Parent(s)

### TRADITIONAL CLINICAL PRACTICE
- Usually works with client in isolation from family or parent(s);
- Also may work with family parent(s) in isolation from client (e.g., giving information, discussing how to stimulate language, sharing insights, etc.);
- Typically works from the outside in - doing something to the child (or parent) to change or transform behaviors;

### RELATIONAL AND REFLECTIVE CLINICAL PRACTICE
- THE SLP:
  - Works with dyad and views the dyad as the client;
  - Acknowledges the parent’s anxiety and supports his/her effort in working with and being with the child;
  - Encourages each parent to see the child’s strengths and capacities;
  - Focuses on helping the parent learn how to meet the child at his/her developmental level;
  - Incorporates working from the outside in with working from the inside out;

## Working with Parent(s)

### TRADITIONAL CLINICAL PRACTICE
- Is usually directive and didactic in telling and explaining to the parent how to better engage the child; or,
- Explains how to wait the child out in order to get particular language forms or communicative acts from the child;
- Often addresses behavioral problems and other parental concerns;

### RELATIONAL AND REFLECTIVE CLINICAL PRACTICE
- THE SLP:
  - Follows the parent’s lead in learning how to better read/interpret the child’s non-verbal signals and intentions;
  - Focuses on helping each parent respond to the child in a contingent and affective manner;
  - Focuses on each parent’s strengths and capacities with their child;
<table>
<thead>
<tr>
<th>Transference and Countertransference</th>
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<tbody>
<tr>
<td><strong>TRADITIONAL CLINICAL PRACTICE</strong></td>
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<tr>
<td>THE SLP:</td>
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<tr>
<td>- Does not address these areas since they are not part of academic or clinical education;</td>
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<td>- Adopts a warm, pleasant and friendly attitude towards client and family;</td>
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<td>- Establishes rapport;</td>
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<tr>
<td><strong>RELATIONAL AND REFLECTIVE CLINICAL PRACTICE</strong></td>
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<td>THE SLP:</td>
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<tr>
<td>- Learns how to use these principles as insights with which to understand parents, child and self;</td>
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<td>- Addresses ongoing countertransferential reactions to each parent and the child;</td>
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<td>- Tries to understand each parent’s view of the child as a transference object;</td>
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<td>- Does not share reflections;</td>
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<td>- Mirrors the affect, intentions and internal states of parent and child during interactions;</td>
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<tr>
<th>Boundaries: Gender and Cultural Issues</th>
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<tr>
<td><strong>TRADITIONAL CLINICAL PRACTICE</strong></td>
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<tr>
<td>THE SLP:</td>
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<tr>
<td>- Cultural beliefs, practices and variations are addressed in courses, readings and within traditional clinical approaches;</td>
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<td>- Boundaries are not addressed in graduate education;</td>
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<tr>
<td><strong>RELATIONAL AND REFLECTIVE CLINICAL PRACTICE</strong></td>
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<td>THE SLP:</td>
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<td>- Often looks at the optimal boundaries between self and each family member in an attempt to figure out a position that is not too close or too distant;</td>
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<td>- With parents, creates a safe, trusting and secure space for an alliance;</td>
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<td>- Encourages and supports each parent in discussing their past histories and how their cultural values and beliefs impact on their current relationship with their child;</td>
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<th>Representations</th>
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<td>THE SLP:</td>
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<tr>
<td>- Tries to gain some sense of each parent’s internal representations of their child;</td>
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<td>- Empathizes with each parent about their concerns and frustrations about their child;</td>
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<td>- Recognizes potential guilt, sadness, grief and other struggles;</td>
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<td>- Tries to empathize and appreciate the parent’s particular behaviors in light of each parent’s representations and culturally determined commitments to their child;</td>
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### Generating Language and Communication Goals

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<th>Relational and Reflective Clinical Practice</th>
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<tr>
<td><strong>The SLP:</strong></td>
<td><strong>The SLP:</strong></td>
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<tr>
<td>Generates language and</td>
<td>Guides the parents in arriving at goals for the child that are appropriate to the child's developmental level;</td>
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<tr>
<td>communication goals based on</td>
<td>Tries to engage in ongoing dialogues regarding potential differences in viewpoints about early goals of intervention;</td>
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<td>various theoretical learning</td>
<td>Empathizes with parents' anxiety that the child learning words immediately;</td>
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<tr>
<td>theories;</td>
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<td>May integrate language,</td>
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<td>cognitive, and social-emotional goals or may work on language domains in isolation from other areas;</td>
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### Reflective Practice

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<tr>
<td><strong>The SLP:</strong></td>
<td><strong>The SLP:</strong></td>
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<tr>
<td>Engages in task analysis;</td>
<td>Creates an environment that slows down the clinical process and allows time for observation and reflection;</td>
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<td>Is aware of the client's</td>
<td>Describes observable behaviors of dyad;</td>
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<td>developmental level;</td>
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<td>Pays attention to goals and</td>
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<td>demands placed on the client;</td>
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<td>Focuses on changing client's</td>
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<td>language, communication or</td>
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<td>behavioral functioning;</td>
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<td>May engage in coaching;</td>
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<td>Reflects on developmental</td>
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<td>changes;</td>
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**The LIU Supervision Group**

**Videotape Clip**
“I find it hard to hold and contain the supervisee’s (anxieties); I want to take away the anxiety.”

“My press is that we need to get everything done in forty-five minutes, that is, to decide on the goals, procedures, theory, etc.”

“Sometimes when there is silence in supervision, I have to fill it and keep it going.”

“I am good at giving advice, giving direction and being direct – I am trying to turn things around and get more from the supervisee.”

“Just observing myself is so powerful.”

“We need some tools – a reflective package!”

“Coming from a medical model everything was right or wrong and I had to fix things (in the client or the supervisee) – and then I got my first set of (negative) evaluations.”

“I feel like a graduate student – it is so developmental!”
LIU Supervisors Over Time …

Using a Relational and Reflective Model

“I have become more willing to partner with them (supervisees) to say – What should you do? And to ask – What do you think?”

“I learned that there is another way to do supervision; that is, we can re-visit something and we don’t have to solve everything in any given moment in time.”

“At times, I see a countertransference or a delayed countertransference – I often react later. Then I see how I could have done something differently.”

“There is an unconditional atmosphere in here (the supervision group); that is, I can say anything and I won’t be judged.”

Selected References


Carnegie Corporation of New York (1994). Starting points: Meeting the needs of our youngest children, p.5


Selected References


