THE SIGNIFICANCE OF REFLECTIVE SUPERVISION FOR INFANT MENTAL HEALTH WORK

PATRICIA O’ROURKE
Women’s and Children’s Hospital, North Adelaide, Australia

ABSTRACT: Parent–infant work is inherently relational and occurs in the intersubjective space between parent, infant, and worker. This space can be charged with primitive, unmet needs of both parent and infant, and this in turn can trigger these same states in the worker. The challenge for workers is to remain open to being affected by and responsive to these feeling states when their own early and possibly preconscious responses and coping strategies are being stirred. If these remain out of awareness, they can manifest as avoidance and denial, and this can be reflected in the system and result in limited service delivery. This article emphasizes the significance of reflective supervision for parent–infant work and suggests that it needs to be an integral part of the system of service delivery. I am grateful to the infant mental health workers who allowed me to use examples of their work in this article, and thank Dr Jon Jureidini for his encouragement and support.

Abstracts translated in Spanish, French, German, and Japanese can be found on the abstract page of each article on Wiley Online Library at http://wileyonlinelibrary.com/journal/imhj.

* * *

. . . she was a baby once and she has in her the memories of being a baby; she also has memories of being cared for, and these memories either help or hinder her in her own experience as a mother.

D.W. Winnicott (1987)

I give reflective supervision to members of an early intervention team who work in a community-based, primary healthcare setting. In the past, they have used this discipline-specific knowledge—speech and language, occupational therapy, and psychology—in taking referrals for developmental delay. Five years ago, they shifted their focus to work primarily with the parent–infant relationship, viewing this as the cornerstone for healthy development. The relationships they form with parents and coworkers are crucial to this work. I have provided monthly reflective group supervision to support this transition and help develop and sustain their capacity to work relationally in group programs and with individual dyads.

Direct correspondence to: Patricia O’Rourke, Department of Psychological Medicine, Women’s and Children’s Hospital, 72 King William Road, North Adelaide, SA 5006 Australia; e-mail: Patricia.O’Rourke@health.sa.gov.au.
Members of the team meet with very distressed families with infants and toddlers. The mothers—and sometimes fathers—with whom they work are always isolated, often have significant trauma histories (e.g., domestic violence, childhood sexual abuse, attachment trauma), and are struggling to parent two and sometimes three children under 5 years of age. The team has worked together for some years and share a deep trust. The workers often arrive at supervision looking exhausted and, at times, dissociated—like people in a war zone.

At a recent session, I notice that J gives L a concerned look. I then see that L is laughing but has no expression behind her eyes. I comment on J’s glance and she suggests we start with L’s client as she is worried about the effect the recent session had on L.

As we turn our attention to L, she briefly begins to tell the story of the mother and infant she has just seen but when asked what it is about this particular dyad she wants to focus on she looks vaguely around, takes a deep breath, bends forward, covers her face with her hands and begins to sob. . . .

It is the isolation of this young mother that has got to L. L’s own mother struggled with three small children and a husband broken by war and while L knows the effect of this and other difficulties on her upbringing, today she feels it again. She has re-experienced that feeling and has fallen back on the well-worn coping strategy she initially developed to survive the experience. At some point with her own internal conflict overwhelming her, she has dissociated from the intensity of the feeling that the client brought—her overwhelmed hopelessness. The closeness of her relationships with the group allows her to re-experience, contain and make sense of her level of distress.

One reason why workers shrink from parent–infant work or rationalize their way out of it is that it feels so difficult (Gilkerson, 2004). To be effective in bringing about change, the worker needs to be able to be affected by and responsive to the feeling states in the room. These feeling states often trigger early, preconscious memories in the worker. Sometimes it is possible to recognize at the time what feeling is being activated, but sometimes—and this is often the case with the neediest families—these preconscious, nonverbal, implicit knowings are out of awareness, and they throw us around like an earthquake that wakes us from sleep.

In this article, I use the term parent–infant work for work that involves the infant and their primary caregiver. I use the terms mother and parent interchangeably when discussing infants’ early development. I outline early developmental processes in the infant, the mother, and their relationship and how this can affect the worker. Using examples from reflective group supervision, I explore how the mother–infant relationship is replicated within the worker’s relationship with the client and again in the supervisory relationship. I show how relational processes inherent in reflective supervision build and support the worker’s capacity to be in relationship, a core ingredient in producing therapeutic change.

THE PRIMACY OF RELATIONSHIP IN EARLY DEVELOPMENT

Infants are born relational with minds that are attuned to other minds (Trevarthen, 2001; Tronick, 1989). As Stern (2008) eloquently stated, babies’ minds grow in the “traffic with other minds” and within “these interactions, their minds will be formed and maintained” (p. 183). Infants, lacking symbolic thought, lay down early experience in feeling states (Gaensbauer, 2004) and relational procedures (Stern, 2004), and in this way, construct the foundations of their relational life.
The role that emotion plays is crucial in the development of infants’ sense of self and in their relational capacity. Trevarthen (2001) wrote that “human emotions are both relational or interpersonal and referential from the beginning of experience” (p. 116) and that throughout all the developments in cognitive systems and language, “emotions hold the self together” (p. 114). However while infants feel a lot, they cannot fully process these feelings until they have developed the capacity for symbolic thought.

Infants are highly dependent on using another’s mind to make sense of their experience and to be able to use that experience to further their development (Stern, 1985). It is the attentional mind of another—their mother/primary caregiver—who provides the environment within which infants can begin to make sense of that experience. This capacity for reflective functioning (Slade, 2005, p. 269) is central to the infant’s healthy development (Fonagy & Target, 2005).

Mothers of infants also are in a state of flux (Stern, 1998) as their own early needs and dependencies are awakened. When mothers experience difficulty either internally or externally, their capacity to provide a containing mind for their infant diminishes. While this occurs on and off in small ways in every dyad in everyday life, if it becomes the predominant way the mother functions, her ability to tune into the baby is impaired. She is unable to allow the baby the opportunity to resonate with her and make sense of what is happening in the baby’s world.

The baby is then left to experience distress alone and manages this by separating these unbearable feelings from his or her relational experience (Bion, 1959, 1962). There are many ways babies do this: They cry inconsolably, they feign disinterest, and very small babies’ bodies may go rigid and may distort their faces. When they are most in need of help to manage these feelings, they have disengaged from them. Parents are overwhelmed not only by their distress for their baby but also by their own infantile distress that has been triggered. They too project their distress and need containment of that (Bion, 1962).

The felt experience is transmitted nonverbally and deeply affects everyone—the worker, the parent, and the infant—often in ways of which they are unaware. Parent–infant work, however, requires the worker to be in a relationship—with the parent, the baby, and/or the parent–infant relationship. It is the presence and nature of this intersubjective experience which creates both the possibility and the challenge for parent–infant work.

THE CHALLENGE FOR PARENT–INFANT WORKERS

Seeing young children and babies with their parents is always both exciting and challenging, and differs from interventions with older children and adults in a number of ways. There is a sense of getting in early, of building strong foundations. On the downside, parents of young children are often exhausted and overwhelmed, which creates practical difficulties around setting, timing, and access. The infant’s total dependency on the parent has a profound effect on us as workers as well as on the parent. Such dependency can scare us, and it is hard to tolerate. And always, there is the developmental timeframe for the infant, creating a time imperative within which we must work.

While workers may be aware of these challenges and able to meet them, they are often unaware of the impact that the nature of parent–infant work is having on their own functioning and experience. When they fail to identify, acknowledge, and work with this profound area of experience, they inevitably move into avoidance and denial.
It is another day. Therapist D arrives at the supervision session holding himself as if braced against a gale. He is smiling and chatting but looks pale and tense. When he brings forward the situation he is interested in, he appears to become short of breath. He gulps air and describes a feeling in his chest as if he is “breaking.” D talks of his work with a small boy and his mother who finds it hard to see her child. She is always full of her own story which she launches into each session. D says it feels as if she vomits it over him in her haste to be rid of it. The child unseen is so distressed he smears faeces at times and, as is common in this patient group, has a speech delay.

I notice D starts to hold his breath as he begins to feel a deep pain “like a weight” in his chest while telling us the situation—he needs to be encouraged to keep breathing. He breathes in racking gulps of air with almost soundless out breaths. When he was a baby his mother was told he “had a condition” that meant his skin hurt when he was touched. His mother, unable to comfort him, was often beside herself. He has no conscious memory of this pain. As a child he grew to be quiet and good, taking care of his overwhelmed isolated mother. While this worker knows the story of his infancy the pain of the felt experience threatens again to burst through and overwhelm him. He holds himself tightly—even breathing causes him pain.

This is not an unusual occurrence. There is always a risk that early somatic unprocessed material will be activated in a worker when he or she meets with a distressed infant and an overwhelmed parent. The younger the child and the more distressed the dyad, the more likely it is that a worker’s early experience stored in the body as unprocessed threat (Van der Kolk, 1994) will be evoked. Note that this primitive way of relating occurs not only in the parent–infant relationship but also in the parent’s and/or the dyad’s relationship with the worker.

The challenge for the worker is to be open to these stirrings and to be available to create something new and containing for both mother and infant. In order to receive, contain, and process these split-off early experiences and assist the client to redigest them, the worker needs to some degree to experience these fragmented feeling states. This is the core of the meeting in the intersubjective space.

**MEETING IN THE INTERSUBJECTIVE SPACE: THE CORE INGREDIENT OF CHANGE**

Change occurs in therapy in moments when the worker and client meet in the intersubjective space—when they more or less share for a brief time the same mental landscape (Stern, 2004. p. 151), and the experience rearranges the landscape. These are the “I and Thou” moments described by Martin Buber (1923/2004), and “the encounter” (Moreno, 1969, pp. 11–23). These change moments, when one feels seen, experienced, and met by another, impact on the internal experience of both, changing the relational field between them.

This type of interaction occurs in the area of “implicit relational knowing” (Stern et al., 1998, p. 905), and Hobson (as cited in Lyons Ruth, 2006, p. 598) argued that infants have the capacity for this emotional relatedness from birth. It is intersubjective in nature and becomes increasingly complex, integrating affect, cognition, and behavior through interactional experiences. Implicit relational knowing is what we just know—“the unthought known” (Bollas, 1987)—and forms the basis for much of what may later become symbolically represented. It is, by definition, out of awareness and fleeting.

---

1It is these intersubjective experiences that create the conditions that allow attachment relationships to develop. The opportunity for a relationship with an attachment figure provides the closeness needed for the infant’s capacity for intersubjective experience to develop and deepen.

*Infant Mental Health Journal* DOI 10.1002/imhj. Published on behalf of the Michigan Association for Infant Mental Health.
Because this “moment of meeting” (Stern, 2004) is one of the key elements needed to bring about change, it is important that workers go into that space without preconceived ideas and ready to work with what is encountered.

How does a worker “meet” a parent who is feeling overwhelmed by the needs of his or her dependent infant, and whose own experience as a baby and of being mothered is being powerfully triggered? How does the worker continue to work if his or her own early experience, with representations of him- or herself as both a helpless distressed infant and an overwhelmed, bewildered mother, is activated? This experience is “felt” or just “known” by the worker.

How much more forbidding is the work of “being with” a dyad in which the mother has experienced early trauma or unresolved loss and has been unavailable to hold or contain her infant possibly physically and almost always emotionally, and where the infant has repeatedly experienced terror and longing in their relationship with the mother and the intersubjective space is littered with powerful preverbal projections, sensations, and feelings?

In the face of such primitive feelings and stirrings between mother and baby, the worker may unwittingly resist fully engaging and become avoidant. The worker may experience irritation, anger, negative fantasies, a sense of fear, dread, or anxiety and often an urgency to come up with “solutions.” The solution may take the form of a too-quick or too-sure diagnosis. Premature formulation of pathology risks binding up the worker’s feelings and distancing him or her from the parent or the infant.

Workers need to resist this temptation because quick solutions are likely to be restrictive and avoid the crucial meeting in the intersubjective space. They miss the opportunity to co-create the “now” (Stern, 2004): to be with and coregulate the other. This requires moving beyond technique to create a truly authentic moment of meeting.

**THE ROLE OF SUPERVISION**

This meeting is more difficult in practice than it sounds. It requires workers to get under their client’s and their own defensiveness and be authentic in the moment. Workers need to attune to their clients, match their affective tone, and provide an experience of coregulation to achieve this meeting in the intersubjective space.

To do this, workers themselves need to have had this kind of experience, especially if they are to continue to repeatedly provide this to their clients over time. Reflective supervision (Gilkerson, 2004; Heffron, 2005) has the potential to provide workers this opportunity.

G arrives later for supervision. She has been on a home visit to a severely depressed, agoraphobic woman referred with her baby on discharge from an inpatient unit. G looks unusually drawn—even uncoordinated—greeting us with an overbright smile as she enters declaring that she can’t face going there again. I ask her to say more because she looks ungrounded and is disconnected from the group.

She describes a zombie-like mum with a small baby and her husband who G laughingly says “looks like a monster.” She then recalls in detail that this father has no teeth and has food remains stuck around his mouth. His left eye she says looks sideways and is in the wrong place on his face. As she talks she swings between grimacing and laughing. She looks revolted, shocked and slightly panicked.

The group meets her with empathy and someone mirrors her profound horror. Her actual visual perception of this man seems distorted. As she begins to express her feelings she remembers a recent conversation where an elderly relative described seeing her father’s emaciated and wild appearance on release from a concentration camp. Everyone in the group is moved and feeling with her. Not much needs to be said as she comes to feel herself here and now and to take in the experience of others seeing and hearing her and being with her now in this moment.
At the next session, she reports returning to the family and her immense satisfaction in being able to meet this couple again and be fully herself in that interaction. The man’s eyes do wander but she is relieved to report they both face forward. She is excited about the relationship she has established with this family, and how fully present and real she is able to be with them.

She identifies that her experience in the group supervision enabled her to return and have an authentic experience with this family. She says “I wasn’t frightened this time” and describes her feeling of being able to connect with their humanness and how deeply satisfying and rewarding this experience was. She described going under the defensiveness, theirs and hers, being real and “getting to the honey” inside them.

In the end, it is the joy of being with a mother falling in love with her baby and seeing herself and her child anew—often for the first time—and the “aliveness” the worker can feel being able to tolerate the pain and joy of it all that enables mother–infant work to proceed. It is this immense satisfaction that assists workers to return again and again to these families, providing them with a crucial experience of relationship and trust, lessening the isolation that cripples our communities.

THE SUPERVISORY PROCESS

The success of reflective supervision, like that of the work with a parent and an infant, depends primarily on the quality of the relationship that is developed between the supervisor and the supervisee.

The supervisory relationship is the container within which the worker can identify, explore, and reflect on their own as well as their client’s functioning. Like a “good-enough” mother with her new baby and workers with their clients, the supervisor provides an attentional mind, sensitively attuning to the workers’ affective state and resonating in the moment with their present experience. As workers present their cases and concerns, they have their own experience of being safely held in the mind of another.

This experience of reflective functioning assists workers to more deeply appreciate what they did and why they did it. It stimulates an appreciation of the internal and external forces impacting on them and their client. It can help them to make sense of the intense, unprocessed material that is often present in a parent–infant session and to identify splitting processes that have occurred—sometimes at multiple levels of the system. Sometimes, a parallel process can be identified where the supervisory relationship mirrors what has occurred in the worker’s relationship with a client.

Supervisees need to experience themselves in an authentic, empathic relationship which allows them to be vulnerable and feel safely held. As with the mother–infant relationship and their relationship with the client, it is the encounter, the moments of meeting in relationship, which restore the worker’s sense of competency and agency.

Group Supervision

Group supervision provides a setting for workers to have an even more powerful relational experience. Working with the group process as well as supervisees’ content maximizes the potential for relational experience. Additional benefits are that anxieties and feelings of inadequacy are
Significance of Reflective Supervision

•

normalized and universalized. Workers are exposed to the wide range of personal responses from other group members.

The supervision needs to encourage a culture that invites curiosity and values “not knowing.” It needs to attend to the development and deepening of the relationships among group members as well as with the supervisor (White, 1995).

The present-moment experiences of intersubjectivity that occur in these sessions are perhaps the most important feature of reflective group supervision because they expand workers’ capacity to work relationally. In addition, where group supervision is provided to a team of workers, the development and deepening that occur in their relationships can carry over into their everyday team functioning. This increases the development of relational capacity, mutual support, and resilience within the team.

Recognition of the value of regular reflective supervision for infant mental health workers is already emerging. The Child Trauma Research Project at San Francisco General Hospital has an open-door policy around urgent supervision needs and provides workers with one hour of supervision for every three patients seen. This commitment to supervision acknowledges the intensity of mother–infant work and its effect on workers attempting to ensure that no worker “goes to sleep with terror in their heart” (A. Lieberman, personal communication, July 8, 2008).

DISCUSSION

Currently, our systems are not set up to cater to workers who experience powerful sensations and feelings that have been long buried and emerge inexplicably with no sense-making words or narrative.

At a management level, these responses can be interpreted as not coping, and so create additional pressure for the worker who denies or dismisses them. Furthermore, where supervision is linked to line management and performance-appraisal requirements, it can be more difficult for a worker to show vulnerability.

At a systems level, there is frequently an urgency to seek quick solutions, replicating and reinforcing the corresponding temptation experienced by workers. While there is an increasing awareness of the importance the relationship plays in healthy development, there needs to be a deeper grasp of the pervasive role of the relationship throughout systemic processes.

When these responses resonate throughout our services and institutions, they infect the entire system. Staff retention is impacted, which in turn leads to a loss of experience and a corresponding loss in relational capacity and understanding of the dynamics involved. Mother–infant work is given a lower priority, its effectiveness is limited, and the known benefits of such early intervention fail to be realized.

The very nature of parent–infant work demands recognition of the requirement for a relational approach at the level of the individual worker, at the management level, and throughout the system.

CLINICAL IMPLICATIONS

Reflective supervision needs to be an integral part of any parent–infant service delivery. This supervision needs to regularly provide the worker with a relational experience that is authentic, reflective, and restorative.
Reflective supervision must be valued and be seen to be valued within workplaces. Management needs to provide active support for the provision of this form of supervision, allocating more time and money to this critical element of parent–infant work.

Our deeper knowledge of early relationship and its importance over a life’s trajectory needs to be translated beyond parent–infant or family functioning into broader systems of team, management, and organizational development. When workplaces provide and value reflective, relationship-based supervision, then meaningful authentic relationships can be realized throughout the system. Relational work is required at every level of the system.

REFERENCES


