RELATIONSHIPS COUNT: A QUALITATIVE CASE STUDY OF A PROFESSIONAL LEARNING SERIES FOR EARLY INTERVENTIONISTS

A dissertation submitted to the Kent State University College of Education, Health, and Human Services in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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Early intervention practitioners need professional development opportunities to nurture and sustain strong relationships with the families they serve. Reflective consultation is a form of professional development that addresses a relationship-based approach to service delivery. However, there have been few published empirical studies about the construct of group reflective consultation. The purpose of the qualitative case study of the Relationships Count series was to examine core components and perceived benefits for early interventionists.

The series consisted of monthly group sessions that were facilitated by an infant mental health specialist. The participants included 10 early interventionists from a large Midwestern county. Data collection methods included interviewing four early interventionists and observing, recording, and participating in 10 monthly reflective consultation sessions during 2013-2014. Coding, concept mapping, and comparative analysis of data were used to examine what happened during the series as well as to identify and describe perceived benefits for early interventionists.

The findings indicate core components of facilitation and participation contributed to a relationship-based approach to supporting the professional development of early interventionists. Specifically, the findings indicate that discussion, observation, practice, and experience of a relationship-based approach were associated with perceived
development of competencies including gentle inquiry, reflecting on thoughts and feelings, active listening, supporting without problem-solving, and promoting competence. Early interventionists identified that participation strengthened feelings of competence and confidence in their ability to support children and families. The study contributes to the evidence base of group reflective consultation by linking core components with perceived benefits for early intervention practitioners.
ACKNOWLEDGEMENTS

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CHAPTER I
LITERATURE REVIEW

Early intervention practitioners need professional development opportunities to nurture and sustain strong relationships with the families they serve (Bailey, Raspa, & Fox, 2012; Bruder, 2000; Bruder, Dunst, & Mogro-Wilson, 2011). As early intervention services transition from being provided in clinic and center-based settings to home and community settings, early intervention practitioners feel challenged by their ability to address the complexities involved in family-centered practice (Bruder, Mogro-Wilson, Stayton, Smith, & Dietrich, 2009; Dunst, Bruder, & Espe-Sherwindt, 2014; Fleming, Sawyer, & Campbell, 2011; Salisbury, Woods, & Copeland, 2010). Early intervention practitioners report high levels of job stress and feeling a lack of competence and confidence in their ability to support families (Alexander, Gallen, Salazar, & Shahmoon-Shanok, 2012; Bruder et al., 2011; Tomlin & Hadadian, 2007). Reflective consultation has been recommended by the World Association for Infant Mental Health, Zero to Three®, and Head Start to strengthen competencies needed to build strong relationships with families (Eggbeer, Mann & Siebel, 2007; Michigan Association for Infant Mental Health, 2007; Watson & Neilsen Gatti, 2012; Watson, Gallen, Tomlin, & Strum, 2013). In a general sense, reflective consultation can involve regularly scheduled meetings that invite intentional exploration of what early intervention practitioners observe, experience, and feel during their work (D. Weatherston, personal communication, September 25, 2014). Reflective consultation has been reported to help early intervention practitioners feel better prepared and more confident in their ability to work effectively with families
(Summers, Funk, Twombly, Waddell, & Squires, 2007; Watson & Neilsen Gatti, 2012; Watson, Harrison, Neilsen Gatti, & Cox, 2013). However, there is a lack of published empirical evidence regarding the content and construct of reflective consultation sessions (Tomlin, Weatherston, & Pavkov, 2014; Watson, Gallen, et al., 2013). The lack of evidence creates a barrier for identifying core components of reflective consultation that are associated with strengthened feelings of competence and confidence in the ability to support families. The current study explores the link between what occurs during reflective consultation sessions and perceived benefits for early intervention practitioners.

One example of reflective consultation is Relationships Count, a professional learning series for early interventionists in Michigan. The Relationships Count series was modeled after a successful reflective consultation project conducted in Minnesota (Watson & Neilson Gatti, 2012). The series was first offered to early interventionists in Oakland County, MI during the 2012-2013 school year. I conducted an exploratory study of perceptions of the first year of the series, with the hypothesis that reflective consultation would be perceived as beneficial by the early interventionists. Findings from the exploratory study indicated that early interventionists believed it to be a valuable learning experience that supported positive relationships with children, families, and colleagues. The current study is based on my examination of what occurred during the second year of the Relationships Count series. Specifically, I describe how the series was facilitated and how early interventionists participated. Further, I describe changes in early interventionists’ perceptions related to the development of relationship-based competencies and strengthened feelings of competence and confidence.
Statement of Research Problem and Practice Problem

The purpose of the current study was to examine two problems: a research-based problem found within the literature about reflective consultation and a practice-based problem identified within a specific community of early intervention practitioners. I characterized the first problem as a research problem. The research problem involved the limited number of published empirical studies about reflective consultation and a corresponding lack of operational definitions for what occurs during group reflective consultation sessions. I characterized the second problem as a practice problem. The practice problem involved a community of early intervention practitioners who describe feeling ill-prepared to address challenges encountered during work with families. An elaboration of each problem is provided in the following sections.

The first aim of the study was to define what occurred during the Relationships Count series, an example of reflective consultation. A review of literature highlights the lack of empirical evidence to support the identification of core components of reflective consultation in a series such as Relationships Count. The absence of operational definitions has created a challenge for researchers interested in designing studies to measure the impact of reflective consultation. In addition, there are multiple terms used to identify the variety of facilitated reflective professional development learning experiences for early intervention practitioners. Specifically, “reflective supervision” “reflective consultation” and “reflective supervision/consultation” are terms used to describe similar experiences. Initially, “reflective supervision” was the term used to describe both group and dyadic experiences (Eggbeer, Shahmoon-Shanok, & Clark,
“Reflective consultation” is emerging as the term used to describe facilitated group reflective experiences for early intervention practitioners (Watson & Neilsen Gatti, 2012; Watson, Harrison, Neilsen Gatti, & Cox, 2013). The inconsistent use of terminology has contributed to the challenge of building a research-base to define and study the impact of reflective consultation. Several leaders in the field of infant mental health have stated a need for empirical research that can provide clear operational definitions of such facilitated reflective professional development experiences in order to better describe what occurs during both reflective supervision and reflective consultation sessions (Eggbeer et al., 2010; Watson, Gallen, et al., 2013; D. Davies, personal communication, 2014; Tomlin et al., 2014). To date, the literature on reflective consultation has indicated positive effects on the feelings and attitudes of practitioners; however, there is a need for research that can identify and define elements that lead to positive outcomes. Identifying and describing core components of facilitation and participation in the Relationships Count series contributes to the research aim of defining reflective consultation.

The second aim of this study was to address how attending the Relationships Count series supported the professional learning and development of early interventionists related to family-centered practices. According to Part C of the Individuals with Disabilities Education Act (IDEA), federally funded services for children birth to three who have identified delays or disabilities must be provided in natural environments such as home and community settings (34 CFR §303.12(b)).
comply with federal requirements, early intervention programs are shifting from clinic and center-based models of service delivery to the provision of home-based early intervention services. A national study of self-efficacy beliefs of early interventionists reported widespread feelings of lack of competence and confidence in the ability to deliver family-centered services (Bruder et al., 2011). Specifically, in Oakland County, Michigan, the coordinator for early intervention services noted that early interventionists reported feeling unprepared to address challenges encountered when providing intervention services in the home (D. Koger, personal communication, 2012). She determined that early interventionists needed professional development opportunities that supported a family-centered model of service delivery. The current study examined how early interventionists, who attended the Relationships Count series, perceived benefitting from the experience. Specifically, the study explored how early interventionists perceived skills were developed and what lead to increased feelings of competence and confidence in the ability to support families.

**Research Questions**

The identification of the research problem and the practice problem led to the selection of a qualitative case study of what happened across the second year of the Relationships Count series, as well as an examination of perceived impact on the development of relationship-based competencies. Data collection methods included interviewing four early interventionists and observing, recording, and participating in 10 reflective consultation sessions. The data were analyzed and interpreted to answer
questions related to the research problem and the practice problem. The questions that
guided the study included

- What happened during the Relationships Count series?
- What were perceived benefits for early interventionists?

**Organization of Literature Review**

The following sections include a critique of the literature related to reflective consultation and a description of the need for professional development that can strengthen family-centered practices in early intervention. The literature review begins with a brief history of reflective consultation, identification of key features, and an analysis of published and in-progress research. The literature surrounding reflective consultation is not limited to application in early intervention, but includes the broader field of early childhood practitioners who provide a range of services to young children and families. Next, the focus of the chapter shifts to exploring recommendations specific to a relationship-based approach to early intervention service delivery. This section of the literature review includes the identification of gaps between what is recommended and what is occurring in the delivery of early intervention services. The chapter concludes with a discussion of the exploratory study of the first year of Relationships Count, a professional learning series for early interventionists.

**Research Problem**

Reflective consultation is a form of professional learning and development that is believed to support various models of relationship-based programs serving infants, young
During reflective consultation, early intervention practitioners have opportunities to explore how their own thoughts, feelings, and actions impact relationships with children and families. This reflective exploration occurs during regularly scheduled group sessions that are facilitated by a reflective consultant. The support provided by a reflective consultant to early intervention practitioners mirrors the type of support early intervention practitioners provide to children and families. The model is based on the infant mental health premise: “Do unto others as you would have others do unto others” (Pawl & St. John, 1998). The following sections include an overview of the development, essential features, and published literature surrounding reflective consultation.

**Historical Perspective**

The concept of reflective consultation emerged in the 1980’s due to an increased focus on the importance of reflective practice. Donald Schön is credited with bringing the discussion of reflective practice into many disciplines. In his seminal book, *The Reflective Practitioner*, he wrote:

> Just as reflective practice takes the form of a reflective conversation with the situation, the reflective practitioner’s relation with his client takes the form of a literally reflective conversation. Here the professional recognizes that this technical expertise is embedded within a context of meanings. He attributes to his clients, as well as to himself, a capacity to mean, know and plan. He recognizes that his actions may have different meanings for his client than he intends them to
have, and he gives himself the task of discovering what they are (Schön, 1983, p. 295).

The Reflective Practitioner was published in 1983 and the concepts of valuing “reflection in action,” “reflection on action,” and “reflection for action” were quickly embraced by many professional fields including medicine, education, mental health and business. Reflective practice is widely recognized as playing a key role in developing a relationship-based approach to promoting positive outcomes for children and families. The purpose of reflective practice is “to generate learning from experience, whether that is the experience of a meeting, a project, a disaster, a success, a challenging interaction, or any other event, before, during or after it has occurred” (Amulya, J., 2004). Reflective practice can occur when early intervention practitioners reflect on their own thoughts, feelings, and actions; engage in reflection on what a young child may be thinking or feeling; or encourage families to reflect on their own thoughts, feelings, and actions. This reflection generates knowledge to support the growth and development of the young child.

Leaders in the field of infant mental health were particularly interested in the application of reflective practices in relation to understanding and supporting the complex dynamics that exist in the relationship triad of infant-parent-professional. In 1988-90, the National Center for Clinical Infant Programs started the Training Approaches for Skills and Knowledge (TASK) initiative to identify key areas for training for all professionals who work with very young children and families (Fenichel, 1992). The TASK work group discussed the intense and complex emotions that are experienced
when working closely with infants and families. Schöns work on the importance of self-
reflection and the influence of reflection on client relationships resonated as a critical
area for professional development. The TASK work group identified the importance of
individual supervision to allow for reflection and the importance of collaboration with
professional peers (Fenichel, 1992). According to Fenichel (1992), the Zero to Three®
National Center for Infants, Toddlers and Families convened a multi-disciplinary team of
professional development providers to share ideas and develop cross-training plans. The
team identified facilitated reflection as a critical element of professional development. A
sourcebook was created based on the work of this team. Learning Through Supervision
and Mentorships to Support the Development of Infants, Toddlers, and Their Families: A
Sourcebook was published in 1992 and is considered a key influence on the promotion
and development of facilitated reflective experiences such as reflective supervision and
reflective consultation (Eggbeer et al., 2007).

**Michigan Association for Infant Mental Health**

The Michigan Association for Infant Mental Health (MI-AIMH) has been widely
recognized for its leadership role in defining principles and practices that promote infant
mental health through strong family and professional partnerships (Weatherston, Kaplin-
Estrin, & Goldberg, 2009). MI-AIMH has advocated for ongoing dyadic reflective
supervision or group reflective consultation as requirements for those who work with
very young children and families. MI-AIMH developed an infant mental health
endorsement credentialing process that includes recommendations and guidelines for
reflective consultation.
Members of MI-AIMH have worked since 1996 to develop, establish, and promote a set of competency guidelines for early childhood educators and early intervention practitioners and a corresponding infant mental health endorsement (IMH-E®) process. These competency guidelines apply to early intervention practitioners as well as other professionals who support infants and families such as public health nurses, early care and education staff, and infant mental health clinicians. The competency guidelines were published in 2002 along with the MI-AIMH Endorsement for Culturally Sensitive Relationship-Focused Practice Promoting Infant Mental Health (Weatherston et al., 2009). As of September 2014, the license for this four-level endorsement system and the accompanying guidelines had been purchased by 21 states and Western Australia (D. Weatherston, personal communication, September, 26, 2014). The states that have adopted the IMH-E® system have joined together to form the League of States. The League advocates for the provision of relationship-focused services for young children and families by professionals who meet the MI-AIMH competency guidelines. Participation in either reflective supervision or reflective consultation is required to receive and maintain infant mental health endorsement (Weatherston, Weigand, & Weigand, 2010). MI-AIMH created Guidelines for Best Practice in Reflective Supervision/Consultation that have been adapted for use in multiple states. An excerpt from the best practice guidelines is provided in Appendix A.

**Role of reflective consultant.** The facilitator of group sessions plays a key role in the construct of the reflective consultation experience. The MI-AIMH Guidelines for Best Practice in Reflective Supervision/Consultation refer to this facilitator as the
According to the MI-AIMH guidelines (2007), the reflective consultant should meet the competency requirements for endorsement and have received ongoing reflective supervision/consultation prior to fulfilling this role. Key competencies for providing reflective consultation include promoting competence, encouraging reflection, and creating a safe environment for discussing sensitive topics (Parlakian, 2002; Heffron & Murch, 2010; Heller & Gilkerson, 2009; Weatherston et al., 2009). According to Schafer (2007), the role of the reflective consultant “is not so much to instruct what to do as it is to help reach a deeper awareness of forces at work” (p.13). Relationships between the reflective consultant and the early intervention practitioner should be characterized by a sense of mutual trust, shared vulnerability, safety, and respect (Bertacchi & Norman-Murch, 1999; Wightman, Whitaker, Traylor, Yeider, Hyden, & Weigand, 2007). “The parallel process of how supervisors [consultants] support providers and providers support parents which in turn, enables parents to best support their children is a powerful aspect of reflective supervision [consultation]” (Stroud, 2010, p. 47). The relationship between the reflective consultant and the early intervention practitioner plays a critical role in the reflective experience.

**Three essential features of reflective consultation.** The MI-AIMH Guidelines for Best Practice in Reflective Supervision/Consultation reference the contribution of the earlier work of Fenichel to the development of the document. According to Fenichel (1992), reflective consultation should contain reflection, collaboration, and regularity. Reflection allows early intervention practitioners to take a step back and process their work with children and families. Heffron, Ivans, & Weston (2005) suggest the use of a
process of “gentle inquiry” to encourage early intervention practitioners to reflect on their thoughts, actions, and feelings with minimal defensiveness. They suggest “gentle inquiry becomes a way to guide a learner into looking at responses that may provoke hesitation because of lack of knowledge about what was ‘right to do,’ shame, fear, or concern about a deeply held cultural belief” (Heffron et al., 2005, p. 332). Collaboration refers to the shared experience as case narratives unfold as well as participation in reflective activities and discussion. Regularity refers to the planned schedule of reflective consultation sessions. Reflective consultation is not a crisis intervention, but a routinely scheduled event for both the early intervention practitioners and the consultant. The regularity of the sessions helps contribute to a safe trusting environment (Parlakian, 2002). Reflection, collaboration, and regularity have been recognized as the three essential features of dyadic and group reflective experiences (Parlakian, 2002, Gilkerson, 2004; Heffron & Murch, 2010; Heller & Gilkerson, 2009).

**Reflective Consultation Literature Review**

The purpose of the literature review was to explore how reflective consultation is implemented, described, and studied. During the initial search for published work on reflective consultation, three distinct search words/phrases were used including: reflective consultation, reflective supervision, and reflective consultation/supervision. The search words/phrases were entered into 18 academic databases. Specifically, Academic Search Complete; Academic Search Premier; CINAHL Plus with Full Text; e-Book Collection (EBSCOhost); Education Full Text (H.W. Wilson); Education Research Complete; Education Resource Information Center (ERIC); FRANCIS; Health Source:
Nursing/Academic Edition; MEDLINE; MEDLINE Complete; MEDLINE with Full Text; Professional Development Collection; Psychology and Behavioral Sciences Collection; PsychINFO; Sociological Collection; Teacher Reference Center; and TOPICsearch databases were searched as well as Google Scholar. This resulted in 166 publications. The body of publications was further reduced by excluding those that used the term “reflective” as an adjective for consultation or supervision versus as a construct or referenced professions outside the field of early childhood intervention and education (e.g., medical professionals). The remaining 67 publications were categorized as conceptual or empirical. The conceptual publications included books and articles published by invitation and in peer-reviewed journals that included descriptions of reflective supervision or reflective consultation. The empirical publications were further evaluated to only include those with reflective consultation or reflective supervision as the unit of a systematic investigation. In order to meet this criterion, the work had to include an operational definition of the construct (i.e., reflective consultation or reflective supervision), demonstrate experimental control for the construct, or intentionally examine the impact of the construct alone or as part of a package. The references for each of the empirical publications were then reviewed to make sure all relevant work had been located. Lastly, I contacted reflective consultation experts for information regarding work that may be “in-progress” and not yet published. My communications with experts consisted of phone conversations and email correspondence and resulted in six projects that are in progress. Search efforts resulted in over 60 conceptual publications, three (3) empirical publications, and six (6) in-progress projects, which are included in my
literature review. I provide a review and summary of conceptual publications followed by a synthesis of empirical research.

**Implementation and format of reflective consultation and supervision.** As mentioned earlier, reflective consultation is emerging as a term used to refer to facilitated group reflective supervision sessions (Summers et al., 2007; Watson & Neilsen Gatti, 2012; Watson, Harrison, et al., 2013). My search indicated that “reflective supervision” is more commonly used than “reflective consultation.” Reflective supervision is referenced as a dyad that includes a reflective supervisor and supervisee and as a group experience that includes a facilitator and several early intervention practitioners. “Reflective consultation” is described as a group format for reflective supervision (MI-AIMH, 2007; Watson & Neilsen Gatti, 2012; Watson, Harrison, et al., 2013). Reflective supervision and reflective consultation are identified as required or strongly recommended professional development components for Early Head Start, for infant mental health clinicians providing Medicaid billable services in Michigan; for home visitors in New Mexico, for early childhood mental health consultants in Kansas, Louisiana, Michigan, and Minnesota; and for early intervention service providers in Australia, Illinois, Arizona, Pennsylvania, and Minnesota (Alexander et al., 2012; Duran, Hepburn, Irvine, Kaufmann, Anthony, Horen, & Perry, 2009; Gilkerson & Kopel, 2005; Mann, Boss, & Randolph, 2007; Norman-Murch, 2005; O’Rourke, 2011; Weatherston et al., 2009; Weatherston et al., 2010). Despite the implementation of reflective supervision and reflective consultation within several large professional development systems, there is a lack of consistent use of terminology to identify format. Inconsistent phrasing leads
to questions about how to define critical elements as well as how to identify benefits that may be unique to dyadic or group reflective experiences. In the following section, I summarize general benefits that are attributed to participating in facilitated reflective experiences that were identified as reflective consultation or reflective supervision.

**Benefits of reflective consultation and supervision.** As stated earlier, my review of literature included searching for articles and publications about “reflective supervision,” “reflective consultation,” and “reflective supervision/consultation.” The search yielded numerous articles that were published in newsletters, by invitation in Zero to Three® Journal, or in peer-reviewed journals such as Infants and Young Children Journal and Infant Mental Health Journal. The majority of articles were non-empirical and offered descriptions of need for and benefits of participating in reflective consultation and reflective supervision. Most authors began by stating the importance of reflecting on thoughts and feelings for professionals who work with children and families in home-settings. Several authors note that while children and families qualify for home-based services because of complex stressors in their lives, those who provide intensive services in intense situations are often underprepared for their work (Bernstein, 2002; Heffron et al., 2005; Jones Hardin, 1997; O’Rourke, 2011; Stroud, 2010; Weatherston, 2007).

My review of the literature resulted in identifying the potential for reflective consultation and supervision to influence knowledge, feelings, and attitudes about work with children and families. A summary of the literature indicates that reflective consultation and supervision can support early intervention practitioners’ development of relationship-based competencies by
- strengthening awareness that a parent’s experience, history, values and feelings impact how a parent relates to his/her child as well as to the early intervention practitioner (Norman-Murch, 2005; Steinberg & Kraemer 2010; Weatherston, 2007);

- providing an opportunity to consider how stressors impact an individual family as well as how issues such as substance abuse, domestic violence, racism, poverty, and grief impact the early intervention practitioner (Bailey et al., 2012; Gilkerson, 2004; Jones Harden, 1997; Neilsen Gatti, Watson, & Siegel, 2011; Osofsky, 2009);

- identifying the focus of early intervention as working with families to support a child’s development rather than providing services to a child without family participation and involvement (Geller, Wightman, & Rosenthal, 2010; Gilkerson, 2004; O’Rourke, 2011; Shahmoon- Shanok, 2009);

- moving away from discipline-specific interventions to supporting family competence as parents learn to coach and guide their child’s development (Geller et al., 2010; Shahmoon-Shanok & Geller, 2009);

- developing awareness of a professional’s own cultural values and deeply rooted beliefs that can impact relationships with children, families, and colleagues (Emde, 2009; Heffron, Grunstein, & Tilmon, 2007; Larrieu & Dickson, 2009; Norona, Heffron, Grunstein, & Nalo, 2012; Stroud, 2010; Virmani & Ontai, 2010);
• developing reflective practice skills by supporting reflection on action, discussing reflection for action, and modeling reflection in action (Grabert, 2009; Heffron et al., 2005; Heffron & Murch, 2010; Neilsen Gatti et al., 2011; Norman-Murch, 1996; Virmani & Ontai, 2010); and

• recognizing caregiver-child interactions as the foundation for development of social emotional competence and gaining confidence in ability to support positive caregiver-child interactions (Bernstein & Edwards, 2012; Emde, 2009; Summers et al., 2007).

My synthesis of the literature indicates that there is believed to be a relationship between reflective consultation and changes in early intervention practitioners’ sense of competence and confidence. In particular, by participating in reflective consultation, early intervention practitioners may strengthen the relationship-based competencies needed for family-centered practices. However, in order to study the connection between reflective consultation and its impact on practice, it is necessary to identify what occurred that lead to change. Several authors agree, and stated that research is needed that can operationally define what occurs during reflective supervision and reflective consultation in order to effectively measure the impact of those experiences (Eggbeer et al., 2010; Heffron & Murch, 2010; Watson, Gallen, et al., 2013).

**Published empirical studies of reflective consultation.** My review of the literature resulted in three empirical studies in peer-reviewed journals. The studies were selected because they included an operational definition of the construct (i.e., reflective consultation or reflective supervision) or intentionally examined the impact of the
construct alone or as part of a package. I provide a summary of each study followed by a synthesis of the findings across all three studies.

**Infant mental health mentor model.** In my review of the first study, I summarize the qualitative research of an infant mental health mentor model of support for early intervention practitioners (Summers, et al., 2007.) Reflective consultation was defined as a construct that included one-on-one regularly scheduled meetings, as-needed problem-solving meetings, meetings between mentors and supervisors, and, in one program, group reflective consultation meetings. Professionals with expertise in infant mental health and identified as “infant mental health mentors” facilitated individual and group reflective consultation sessions. Discussion of video-taped caregiver-child and home visitor-caregiver interactions were an integral component of the model. The participants included home-visitors from three Early Head Start and two early intervention programs. The data collection included 43 in-depth interviews with 16 home visitors, 10 administrators, and three mentors as well as observation of videotapes and observation of one group reflective consultation session. Data were analyzed using a constant comparative method. The findings indicate that the home visitors felt supported and more confident in their ability to support families after working with infant mental health mentors. Their data analysis indicated that the video-tape discussion and feedback provided key learning experiences. The authors describe the group sessions as the “most evolved” form of reflective consultation. They noted that “by including all staff, the learning that occurs during reflective consultation synthesizes disciplinary perspectives…It encourages individual and agency growth” (p. 222). A limitation of this
study is the broad use of the term “reflective consultation.” The authors use this term to describe all interactions between the infant mental health mentors and home-visitors. The study supports the need for early intervention practitioners to participate in ongoing professional development experiences that encourage reflection on work with families and children. The study does not contribute to defining how the process of group reflective consultation occurs.

**Minnesota early intervention reflective consultation project.** In my review of the second study, I summarize the research surrounding a reflective consultation project for early interventionists in Minnesota. In 2012, Watson and Neilsen Gatti published an article examining the pilot year of a reflective consultation project provided to two interdisciplinary teams of early interventionists within the same community. The 14 participants served children birth to 3 years and their families. An infant mental health specialist with a Ph.D. in clinical psychology facilitated monthly reflective consultation sessions. The participants were divided into two groups that met for 2-hour monthly sessions for a total of 8 sessions. The research measures included providing a pre- and post-survey about reflective practices and conducting interviews with 5 participants and the reflective consultant. According to the authors, the small number of participants did not allow for statistical analysis of survey results. Key points and notable quotes were derived from the analysis of interviews. The findings indicated the participants found the experience to be valuable and meaningful. The participants described that they gained new perspectives that shifted their understanding and strengthened their relationships with families. The authors note that the participants asked their administrators for
professional development funds to be allocated for the continuation of reflective consultation rather than attendance at conferences. This study contributes to the intentional examination of reflective consultation as a construct for supporting professional growth. A limitation of this study is that the researchers did not observe or describe the content of what occurred during the reflective consultation sessions. This is a limitation because it is not possible to isolate what contributed to the positive perception of change by the participants.

Watson and Neilsen Gatti have maintained involvement in research of this particular reflective consultation project over seven years. At a poster session at the Division for Early Childhood of the Council for Exceptional Children’s 29th Annual International Conference on Young Children with Special Needs and Their Families, Watson, Harrison, Neilsen Gatti, & Cox (2013) presented data that examined the reflective consultation project over time. In particular, the authors were interested in exploring work stress and the perceived impact of reflective consultation. The methods for answering these questions included analyzing surveys and semi-structured interviews of early interventionists. The results indicated that “over time” reflective consultation had an impact on how early interventionists “felt” about their work; how they “thought” about their work; and their “ability to remain open” (Watson, Harrison, et al., 2013). The research surrounding this reflective consultation project has involved the use of surveys, scales, and focus group interviews to explore perspectives and attributes of early interventionists who continued to participate in the series, early interventionists who stopped participating, and early interventionists who chose not to participate. A current
limitation of the Minnesota project is the absence of operational definitions for what occurred during reflective consultation sessions. While it is evident that many of the participants perceive the experience as beneficial, there is still a need for clear descriptions of procedures that occurred during reflective consultation that lead to the change in attitudes and feelings about early intervention work.

**Critical components of reflective supervision.** In my review of the third study, I summarize the results of an examination of the construct of reflective supervision. Tomlin, Weatherston, and Pavkov (2014) published an article entitled “Critical Components of Reflective Supervision: Responses from Expert Supervisors in the Field.” In their introduction, the authors note “no published studies to date have documented agreement by experts about definitions or core elements related to reflective supervision” (p. 72). In response to this research problem, the authors disseminated a survey to a panel of experts on reflective supervision/consultation. The authors define experts as those who had published or presented about reflective supervision and some who had experience providing reflective supervision, individually or in groups. The authors used a three-phase Delphi method to gather information and reach consensus about critical components of reflective supervision. The method is based on an iterative process for reaching agreement. The first phase of the study included eliciting responses to nine open-ended questions from 35 experts. The analysis of the responses led to the identification of six themes that included

- qualities a supervisor demonstrates;
- behaviors a supervisor demonstrates;
• mutual behavior and qualities;
• structure of reflective supervision sessions;
• process of reflective supervision sessions; and
• behaviors/characteristics a supervisee demonstrates (p. 74-75).

In the second and third phase, participants in the study ranked items within each category a second and third time. The authors note that this is a preliminary study and results indicate that it is possible to arrive at consensus definitions for core components of reflective supervision. They cite the need for additional research that would include the perspectives of professionals who receive reflective supervision. While this study provides an important first step towards defining reflective supervision and consultation, a major limitation is that the definitions were derived from the perspectives of a small number of experts who provide reflective supervision. The authors did not explore differences experienced by participants who receive dyadic reflective supervision and those who receive a group reflective consultation. An area of future study would be to compare definitions of critical components from experts and participants of dyadic and group experiences.

**Synthesis.** The review of three research projects provided the opportunity to consider early intervention practitioner perceptions of the impact of reflective consultation and to examine expert definitions of critical elements of the structure and process of reflective supervision. Table 1 provides a synthesis of the methods and findings and includes the identified format for reflective consultation in each study.
Table 1

*Synthesis of Reflective Supervision/Consultation in Empirical Studies*

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Participants</th>
<th>Reflective Supervision/Consultation Format</th>
<th>Data Collection Methods</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summers et al., 2007</td>
<td>Qualitative</td>
<td>16 Home Visitors 10 Administrators 3 IMH Mentors</td>
<td>Scheduled individual sessions Scheduled group sessions As needed individual meetings</td>
<td>Interviews Observation of selected video feedback sessions</td>
<td>Home visitors describe importance of feeling supported and feeling more confident in ability to support others</td>
</tr>
<tr>
<td>Watson &amp; Neilsen Gatti, 2012</td>
<td>Mixed Method</td>
<td>16 Early Interventionists</td>
<td>Monthly group sessions</td>
<td>Pre- and Post Survey Interviews</td>
<td>All participants found it to be valuable and a preferred form of professional development</td>
</tr>
<tr>
<td>Tomlin et al., 2014</td>
<td>Delphi Study</td>
<td>35 IMH experts with experience providing reflective supervision</td>
<td>Scheduled individual sessions Scheduled group sessions</td>
<td>Three rounds of surveys developed through iterative process of analyzing results from prior responses</td>
<td>It is possible to arrive at consensus definitions of critical components of reflective supervision/consultation</td>
</tr>
</tbody>
</table>
The first two studies describe different constructs for reflective consultation. Summers et al. (2007) define reflective consultation as regularly scheduled and as-needed individual and group interactions between home visitors and infant mental health mentors. Watson and Neilsen Gatti (2012) define reflective consultation as regularly scheduled monthly meetings between an infant mental health expert and a team of early interventionists. Neither study provided specific and detailed information about what occurred during reflective consultation. Participants in each study valued their relationship with an infant mental health expert and felt the reflective experience contributed to their growth as professionals. Participants felt that reflective consultation strengthened their skills at working with families and decreased feelings of stress (Summers et al., 2007; Watson and Neilsen Gatti, 2012; Watson, Harrison et al., 2013).

Independently, each study offers information that can help build the evidence base for reflective consultation. The limitations of these studies reveal the current state of reflective consultation as a loosely defined process. The third study addressed this gap by listing critical components of reflective supervision as identified by experts in the field. The critical components address both dyadic and group reflective experiences. Without a consensus on operationally definitions of core components of the group format for reflective consultation, it is difficult to design research that can accurately assess its impact. In the following section, I describe several in-progress research studies that are addressing the research gap.

**In-Progress research.** In order to learn more about ongoing research projects, I spoke with four researchers in the field of reflective consultation and supervision. I
began by contacting Deborah Weatherston, the executive director of the Michigan Association for Infant Mental Health and Christopher Watson, co-director of the Center for Early Education and Development. I enlisted their support to identify contact information for two additional researchers who were studying reflective supervision and reflective consultation. I received responses to the following questions

- Does your study involve reflective groups or reflective supervisor/supervisee dyads?
- Is reflective supervision/consultation the focus of your study or a component of what you are studying?
- What is the purpose of your research or focus of exploration? (e.g. measure/describe impact, identify salient features, evaluate specific project)
- What methods are you using to collect data? (e.g. interviews, observation, focus groups, satisfaction scale, self-efficacy scale, surveys)
- What is the professional role of the participants in reflective supervision/consultation? (e.g. early interventionists, infant mental health clinicians, early care and education staff)
- Who is/are the lead researcher(s) on this study?
- Is there anything else you would like to share about your research?

The survey results indicated one current research project that involves the development and use of evaluation tools to measure the satisfaction of participants as well as to
describe facilitator and participant sense of self-efficacy during the process of dyadic and group reflective supervision. (S. Shea, personal communication, September, 2013).

Another research project involves the development of the Reflective Interaction Observation Scale, which will measure salient features of reflective supervision dyads (C. Watson, personal communication, July 2013). In addition, current research projects include identifying traits such as temperament and mindfulness of early interventionists who receive group reflective consultation; a study of the perceptions of early interventionists’ use of reflection during work with families, and evaluating statewide capacity for including reflective supervision in professional development systems (C. Watson, A. Tomlin, & D. Weatherston, personal communication, July – October, 2013).

The results of the survey identified only one current research project that is examining the content of what occurs during reflective supervision and the focus is on dyadic experiences (C. Watson, personal communication, July, 2013).

Clearly, more work needs to be done to identify and define what occurs during group reflective consultation. The in-progress research of Shea and Watson will contribute to defining the role of the reflective supervisor and salient feature of reflective supervision. My survey results did not indicate any in-progress studies that focus on the defining features that are specific to group reflective consultation sessions. The variety of experiences offered as reflective supervision and reflective consultation contribute to the difficulty in creating an evidence-base that demonstrates measurable outcomes.

There is a need for research that will offer an in-depth description of what happens during
group reflective consultation sessions and how those experiences benefit early intervention practitioners.

**Practice Problem**

As stated previously, I have identified two key problems associated with reflective consultation: a research problem and a practice-based problem. The practice problem involves the need for professional development to support family-centered practices in early intervention. Gilkerson (2004) was referring to the work of early intervention practitioners when she wrote “Practice problems are not usually about content or often about development. We know a lot about what to do, the challenge is being able to carry out the approaches given the emotional complexity of the families served, the personal pressures on the practitioner, and the stressors on programs” (p.426).

Pressures on early intervention practitioners include complying with federal and local paperwork demands, teaming with professionals from different disciplines as well as providing services in home and community settings (Fleming et al., 2011; Salisbury et al., 2010). In addition, early interventionists identify feeling inadequately prepared to address complex family issues such as mental illness, substance abuse, poverty, domestic violence, and language barriers between families and practitioners (Alexander et al., 2012; Bernstein, 2002; Bruder & Dunst, 2005; Summer et al., 2007). Summaries provided in the literature repeatedly indicate a need for professional learning opportunities that strengthen the relationship-based approach necessary for early intervention practitioners to build effective positive relationships with families (Bailey,
Scarborough, Hebbeler, Spiker, & Malik, 2004; Brotherson et al., 2010; Bruder & Dunst, 2005; Bruder et al., 2009; Dunst, Trivette, & Hamby, 2007).

**Defining Early Intervention for Birth to Three**

The Program for Infants and Toddlers with Disabilities (Part C) was included in the Individuals with Disabilities Education Act (IDEA) in 1986. According to the Office of Special Education Programs, Part C of IDEA is “a federal grant program that provides assistance for states to operate statewide comprehensive programs of early intervention services for infants and toddlers who are: (a) developmentally delayed; (b) at a substantial risk of delay, due to diagnosed factors and conditions; or (c) those at risk due to other factors” ([http://ectacenter.org/~pdfs/pubs/nnotes21.pdf](http://ectacenter.org/~pdfs/pubs/nnotes21.pdf)). In order for a state to be eligible to receive funding for Part C services, early intervention services must be available to every eligible child and his/her family within the state and the governor must designate a lead agency to receive and administer the grant. These lead agencies include departments of education, departments of community health, and departments of public health. The services are provided by special education teachers, developmental specialists, speech therapists, occupational therapists, social workers, physical therapists, and psychologists.

In practice, early intervention services look very different between and within states. These differences are based on the service model being implemented and the primary setting for services. Part C of IDEA requires that "to the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children
without disabilities participate" (34 CFR §303.12(b)). By definition, natural environments mean "settings that are natural or normal for the child's age peers who have no disabilities" (34 CFR §303.18). Increased attention has been paid to the concept of natural environments and more service delivery systems are moving from center-based models to providing all or most services in the home with an emphasis on family-centered practices and cohesive team approaches towards work with children and families (Hebbeler, Spiker, Morrison, & Mallik, 2008). However, many states are not yet consistently implementing early intervention services that meet the family capacity building intent of Part C of IDEA (Dunst et al., 2014; Hebbeler et al., 2007). Inadequate early intervention personnel preparation is a barrier for delivering family-centered services in natural environments (Bruder & Dunst, 2005; Bruder et al., 2009; Center to Inform Personnel Preparation Policy and Practice in Early Intervention and Preschool Education, 2007; Stayton, Smith, Dietrich, & Bruder, 2012).

**Defining Family-Centered Practices in Early Intervention**

Leaders in the field of early intervention identify the development of relationship-based competencies as the foundation for effective intervention (Division for Early Childhood, 2014). These competencies include skills, knowledge, and attitudes, which promote positive outcomes for children and families. According to Edelman (2004), there is no context in which relationships are not a critical element of successful early intervention. Infants and toddlers who are identified as eligible for early intervention services need parents, caregivers, and early interventionists to work together on their behalf to provide effective intervention.
The role of the early interventionist is to promote optimal growth and development for infants, toddlers, and their families. Because the early interventionist is only with a child for a short time, it is the parent and caregivers who provide the daily opportunities for the child to practice new skills. The early intervention service triad of practitioner, caregiver, and child differs from clinical services that focus on the dyad of clinician and patient. The work of the early interventionist includes strengthening the parent-child relationship and identifying family routines that provide opportunities to practice emerging skills (Dunst et al., 2007).

According to McWilliam (2011), “early intervention was designed to assist the adults in a child’s life, not the child….children will actually receive more help and more relevant help if interventionists support the adults” (p. 15). In order to effectively support the adults, early interventionists need to be prepared to address sensitive issues that arise when raising a child with a disability as well as complexities that are involved with providing home-based services (Bernstein, 2002; Tomlin & Hadadian, 2007). As early interventionists work in homes with families, they encounter challenges that many families are striving to overcome such as mental illness, poverty, history of trauma, substance abuse, cramped/crowded housing, violence in the home, violence in the neighborhood, and/or instability of resources (Jones Hardin, 1997; Tomlin & Hadadian, 2007). In addition, families may speak a different language than the early interventionist; may have had prior negative experiences with educational/service agencies; may be caring for multiple children during the home visit; and may hold different beliefs about behavior, discipline and child development (Stroud, 2010). Given that the lives of
families are so varied and complex, early interventionists need support developing the competencies necessary for building strong relationships with the families they serve.

The Workgroup on Principles and Practices in Natural Environments, which is part of the Part C Settings Technical Assistance Community of Practice of the Office of Special Education Programs [OSEP], published a guide in 2008 which lists key principles and concepts for providing early intervention services with a focus on the relationship with the family as the primary medium of intervention. According to the workgroup, early interventionists should “engage with the adults to enhance the confidence and competence in their inherent role as the people who teach and foster the child’s development” and the family-provider relationship should be characterized by “mutual trust, respect, honesty and open communication” (p. 4). The shift to providing services in natural environments with a focus on supporting family competence has focused attention on the skills early interventionists need in order to work effectively with families and children. The challenges inherent in providing home-based services add a sense of urgency to identifying professional learning opportunities that support the development of these competencies.

**Relationship-Based Competencies and Recommended Practices**

Relationship-based competencies include skills, knowledge and attitudes needed to work effectively with colleagues and families to promote positive outcomes for children. Competencies include how to gather, share, receive, and process information as well as interpret one’s own responses to interactions with others. Relationship-based competencies support a family-centered approach to early intervention service delivery.
Leading early childhood professional organizations recommend a relationship-based approach when working with infant and toddlers. These organizations include the American Academy of Pediatrics, American Speech-Language Hearing Association, National Association for the Education of Young Children, National Head Start Association, and Division for Early Childhood (DEC) of the Council for Exceptional Children (Bailey et al., 2012; Sandall, Hemmeter, Smith, & Mclean, 2005). DEC recommends specific evidence-based practices that include the development of relationship-based competencies for all professionals who work with young children with disabilities and their families.

In 2014, Division for Early Childhood published a revision of DEC Recommended Practices in Early Intervention/Early Childhood Special Education. According to the authors, the purpose of the document is to “bridge the gap between research and practice by highlighting those practices that have been shown to result in better outcomes for young children with disabilities, their families, and the personnel who serve them” (p. 1). The authors note that sensitive and responsive interactions are the foundation for every child’s social, emotional and intellectual growth. The following DEC recommended practices connect to a relationship-based approach to service delivery:

- “Leaders create a culture and a climate in which practitioners feel a sense of belonging and want to support the organization’s missions and goals” (p. 4).
- “Leaders develop and implement an evidence-based professional development system of approach that provides practitioners a variety of support to ensure they
have the knowledge and skills to implement the DEC Recommended Practices” (p. 5).

- “Practices that treat families with dignity and respect: are individualized, flexible and responsive to each family’s unique circumstances” (p. 8).

- “Practices that include the participatory opportunities and experiences afforded to families to strengthen existing parenting knowledge and skills and promote the development of new parenting abilities that enhance parenting self-efficacy beliefs and practices” (p. 8).

- “Practices that build relationships between families and professionals who work together to achieve mutually agreed upon outcomes and goals that promote family competencies and support the development of the child” (p. 8).

- “Practitioners build trusting and respectful partnerships with the family through interactions that are sensitive and responsive to cultural, linguistic, and socioeconomic diversity” (p. 8).

- “Practitioners support family functioning, promote family confidence and competence, and strengthen family-child relationships by acting in ways that recognize and build on family strengths and capacities” (p. 9).

- “Practitioners use coaching or consultation strategies with primary caregivers or other adults to facilitate positive adult-child interactions and instruction intentionally designed to promote child learning and development” (p. 11).
“Practitioners use communication and group facilitation strategies to enhance team functioning and interpersonal relationships with and among team members” (p. 12).

These recommended practices demonstrate relationship-based competencies such as gentle inquiry; reflecting on thoughts, feelings, and actions; and active listening are necessary throughout the assessment, planning, intervention, and monitoring processes.

According to DEC, early interventionists who work with very young children and their families must develop relationship-based competencies in order to provide effective intervention services. The literature discussed in the following section indicates that many early interventionists need guidance to develop and strengthen these competencies.

**Research-to-Practice Gap**

The *DEC Recommended Practices* were created to inform both pre-service and in-service learning experiences. The practices are based on empirical research as well as guidance from leaders in the field of early childhood special education. Despite the availability of published research and evidence-based resources to support improvement of early intervention services, “less than half of the statewide early intervention systems in the United States report having a workforce that it adequately trained to serve infant or young children with disabilities” (Bruder et al., 2009). Furthermore, numerous studies explore the gap between what early interventionists know is best practice and what actually occurs during their work with children and families (Bailey et al., 2012; Bruder et al., 2011; Crais, Roy, & Free, 2006; Fleming et al., 2011).
Another area of study has surrounded feelings of competence and confidence of early interventionists. Competence of early interventionists is defined as believing that one knows the skills needed to support children and families (Bruder et al., 2011). Confidence is defined as feeling effective in the ability to use those skills to support children and families (Bruder et al., 2011). In a large national study of Part C services, only 38% of early interventionists reported feeling confident in their family-centered practices, and only 5% felt competent in these practices (Center to Inform Personnel Preparation Policy and Practice in Early Intervention and Preschool Education, 2007). In addition to the findings about perceived competence and confidence, many early interventionists who provide allied health services such as physical therapy or occupational therapy describe having had little formal training to support family-centered practices during their work with infants and very young children (Bruder & Dunst, 2005; Chiarello & Effgen, 2006; Geller et al., 2010). According to the literature, there is a discrepancy between what early interventionists know and put into practice, a significant number of early interventionists who feel a lack of competence in their ability to support families, and a pervasive lack of formal training in family-centered practice. Clearly, there is a need for pre-service and in-service early interventionists to learn, internalize, and implement relationship-based practices and strategies, which have been identified as crucial for effective intervention. Evidence gathered from focus groups, surveys, interviews and observations document this need from both a family and an early interventionist perspective (Bailey et al., 2004; Campbell & Halbert, 2002; Chiarello &
Several Part C agencies and early intervention supervisors have identified facilitated reflection such as reflective consultation as a method for supporting the development of relationship-based practices (Gilkerson & Kopel, 2005; NECTAC, 2011; Neilson Gatti et al., 2011; Norman-Murch, 2005; O’Rourke, 2011). Reflective supervision and reflective consultation are included as components of professional development for Part C Service providers in Arizona, Illinois, Minnesota, and Pennsylvania (Alexander et al, 2012; Gilkerson & Kopel, 2005; Norman-Murch, 2005; Watson & Neilson Gatti, 2012). It is recommended by the Early Childhood Technical Assistance Center as an effective approach to developing and maintaining high-quality Part C services. As a result, the Part C Coordinator for early intervention services in Oakland County, Michigan decided to offer reflective consultation as a form of professional learning to strengthen the relationship-based approach that is necessary for effective early intervention.

**Exploratory Study**

My research on reflective consultation began with an exploratory study of the first year of Relationships Count, a monthly series of reflective consultation sessions. The Relationships Count series was developed and first offered to early interventionists in 2012-2013. I received permission from the Institutional Review Board at Kent State University to conduct an exploratory study of perceptions of Relationships Count by
conducting interviews after the conclusion of the series. The approved consent form is provided in Appendix B.

**The Relationships Count Series 2012-2013**

The Relationships Count series was developed in response to the need for professional development for early interventionists. In Michigan, special education services are mandated from birth through age 26. Infants and toddlers who meet the eligibility requirements receive special education services through their local school district. The Part C Coordinator is responsible for ensuring early intervention services comply with federal and state requirements. Her work includes offering professional learning opportunities that will support effective practices in early intervention.

In Oakland County, MI, the Part C Coordinator supported programs in making a shift from providing early intervention services in school settings to home-based settings. This change occurred to align with federal and state requirements for the provision of services in natural environments. As services moved to families’ homes, administrators, and early interventionists began requesting professional development opportunities to support this change in practice. According to the Part C Coordinator, the landscape for providing home-based support for parents and caregivers was perceived as challenging and early interventionists reported feeling unprepared, ineffective and afraid of working so closely with families (D. Koger, personal communication, November, 2013).

The goal of the Part C Coordinator was to provide a professional development experience that would help create a more effective early intervention workforce. In particular, she identified that she wanted to support early interventionists in becoming
more “open, authentic and present” with families. She identified that her early interventionists were looking to develop skills such as “how to be better, less judgmental and more open during home visits” (D. Koger, personal communication, November, 2013). After reading about the reflective consultation project in Minnesota (Watson & Neilsen Gatti, 2012), she decided to include reflective consultation in her professional learning plan for early interventionists (D. Koger, personal communication, July, 2012).

The Part C Coordinator recruited a former early interventionist who was endorsed by MI-AIMH as an Infant Mental Health Specialist (IMH-E III®) to assist in developing and facilitating the series of reflective consultation sessions. The Relationships Count series included 8 monthly sessions that addressed relationship-based competencies and provided time for reflective discussion about cases presented by early interventionists.

**Data Collection and Analysis**

At the conclusion of the Relationships Count series, three early interventionists were recruited to discuss their participation and experience. The recruitment process consisted of an invitation to discuss their experience in the series. Three early interventionists volunteered to participate and signed consent to be interviewed (see Appendix B). Semi-structured interviews of three early interventionists were conducted six weeks after the conclusion of the series. Interview participants were asked to reflect on: (a) their level of satisfaction with the series, (b) how the series connected to their work with families and colleagues and (c) how the series compared to other pre-service and in-service learning opportunities.
Satisfaction and professional learning. The interview participants indicated that they were highly satisfied with the series and that this type of professional learning was new to them. Reflection consultation was not included in any of their previous pre-service or in-service learning experiences. All three interview participants expressed a desire for the series to continue, and each felt that it was beneficial for new and experienced professionals. The responses indicated that what occurred during the series encouraged the interview participants to reflect on the relationship-based competencies that have been shown to lead to positive child and family outcomes and are linked to parent satisfaction of services.

Work with families. Each interview participant shared insights about wanting to fix things for the families they serve. They identified that listening and building a relationship is the first step to providing effective intervention. One interview participant stated “It reoriented me to just remembering that sometimes I just need to be there and I need to be a very good listener and I have to shut off that switch that I have to fix it in order for everyone to feel better.” Another interview participant reflected “It reminded me of the importance of listening. The importance of leaving space for them and all the good advice in the world doesn’t matter if someone isn’t in the right place. They have to feel like you are working together.” The third interview participant said, “I need help sometimes realizing that I have to leave and that I can’t fix it for them.”

Work with colleagues. The interview participants discussed how their district team relationships impacted their sense of competency and how families perceived early
intervention services. Two interview participants expressed that not all of their district team members utilized a family-centered approach. One interview participant shared:

There are some on our staff who are more comfortable with that than others and some that would like to still keep their discipline really at the forefront. It is hard to change. You feel like you are losing a piece of who your identity has been forever when you give up that discipline.

They felt this series would be beneficial for professionals who were trained in a more discipline-specific approach, and each interview participant wished their team had participated in the series.

The common themes expressed during the interviews about how the series addressed team collaboration, culturally sensitive practices, listening skills and family-focused attitudes reflect relationship-based competencies that are necessary for effective early intervention. The interview participants described the series as “critical” and “valuable” and stated it should be a “mandatory requirement” for early intervention professionals. As a result, the Part C Coordinator made the decision to offer to continue the series for a second year. During a personal communication, she reported:

We received great feedback. They felt very supported and they felt they learned skills. I noticed they were actually utilizing some of the reflective practice approaches with one another. I could see a real sense of community among the participants. In particular, I saw staff moving from a place where they felt very insecure and lacked confidence in their skill
set to a place where they felt more confident in their work. It was really nice to see the personal growth that I am not sure would have happened without this group. I don’t think there were supports built into the work day outside of this group. For me personally, I could see tremendous growth among the teachers who participated. We felt it was so positive that we decided to offer it again and in a second location so we could accommodate even more early interventionists (D. Koger, personal communication, October 2013).

It is clear from participant interviews and the shared perspective of the Part C Coordinator that early interventionists felt better prepared to support families as a result of participation in the Relationships Count series. This study is limited in that it does not address exactly how these results were achieved.

**Chapter Summary**

The exploratory study was limited to the exploration of the perceptions of the interview participants at the conclusion of the series. Based on these limitations, I determined that an area for further study would be to examine what happened during the second year of the Relationships Count series and the perceived benefits for early interventionists. The current study addressed both the research problem that surrounds reflective consultation and the practice problem found within the field of early intervention. Observation and documentation of what occurred during the Relationships Count series allowed for an in-depth study of how the activities, case presentations, and interactions supported the development of relationship-based competencies. The findings
will include concrete descriptions of what occurred during sessions as well as how early interventionists perceived benefitting from those experiences. In the following chapter, I will describe how a qualitative case study of the second year of the Relationships Count Series provided an opportunity to examine core components of facilitation and participation as well as how the series supported the development of relationship-based competencies and strengthened the competence and confidence of early interventionists.
CHAPTER II

METHODOLOGICAL APPROACH

My review of the literature in the previous chapter identified a research problem and a practice problem as related to reflective consultation and professional development needs of early intervention practitioners. First, research is needed to better and more consistently define what happens when reflective consultation is delivered. Second, research is needed to explain how reflective consultation may support the development of relationship-based competencies and strengthen early interventionists' feelings of competence and confidence. I implemented qualitative case study methods to examine what happened during Relationships Count, a series of reflective consultation sessions. My research focus included exploring the perceived benefits for early interventionists as they participated in each session and discussed the impact on their feelings and attitudes about their work.

Chapter 2 includes a description of the qualitative case study methods including a description of the unit of study, the data collection procedures, and the data analysis process. In Figure 1, I provide an overview of the study framework. The overview summarizes the research questions and methods used to describe and better understand what happened during the Relationships Count series and to identify perceived benefits for early interventionists. Through the analysis process, I refined the focus of my study to include identifying core components of facilitation and participation as well as the extent to which early interventionists perceived the series supported the development of
relationship-based competencies and strengthened feelings of competence and confidence.

**Statement of Research Problem:** There is a lack of published empirical evidence regarding the content and construct of group reflective consultation sessions

**Statement of Practice Problem:** Early interventionists need professional development opportunities to nurture and sustain strong relationships with families

**Purpose of Study:** Identify what happened during a reflective consultation professional learning series and the perceived benefits for early interventionists

**Method of Study:** A qualitative case study approach with researcher as participant, observer, and interviewer

**Unit of Study:** 10 sessions of Relationships Count during 2013-2014 school year

| Data Collection: | Observe, record, and transcribe sessions of Relationships Count; interview early interventionists; use field journal and audio-recorder to document researcher thoughts and observations |
| Data Analysis: | Code, compare and analyze transcribed Relationships Count sessions, interviews, and research notes to refine initial research questions and generate key findings |

**Initial Question #1:** What happened during the Relationships Count series?

**Refined Questions:**
- What were core components of facilitation?
- What were core components of participation?

**Initial Question #2:** What were perceived benefits for early interventionists?

**Refined Questions:**
- How did interview participants describe benefits of the series?
- How were particular relationship-based competencies developed during the series?
- How were feelings of competence and confidence strengthened during the series?

*Figure 1. Overview of study. This figure provides an overview of the research questions and methods used to study the Relationships Count series.*
Qualitative Case Study Approach

According to Simons (2009), “case study is an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, programme or system in a ‘real life’ context” (p.23). Case study approaches have been used to evaluate and examine projects and programs in education since the 1960s (Simons, 2009). The defining feature of the case study approach is the selection of the case, which is typically referred to as the unit of study. The unit of study is considered to be a “bounded system” because it has a finite beginning and ending (Creswell, 2007).

The unit of study was the Relationships Count series and was limited to participation during the 2013-2014 school year. According to Stake (1995), an intrinsic case study approach offers a holistic understanding of the unit of study. An intrinsic case study approach provided an opportunity to address a primary research question for this study: What happened during the Relationships Count series?

For the present study, the case study approach was combined with basic qualitative research methods. Several authors share Merriam’s (2009) assertion that case study is an approach rather than a specific methodology (Creswell, 2007; Savin-Badin & Major, 2013; Simons, 2009; Stake, 1995). In qualitative case study research, basic qualitative methods such as interviews, observation, and comparative data analysis are used to generate meaning and understanding of a specific phenomenon and to develop understanding of the people involved in the research (Merriam, 2009; Savin-Baden & Major, 2013). Thus, the research methods utilized to explore the Relationships Count series included observation, interviews, note taking, and comparative analysis of data.
An intrinsic case study approach combined with qualitative methods provided an opportunity to explore what happened during the series, as well as examine perceived benefits for early interventionists.

**Terminology**

In the following sections, the term “the series” will refer to the Relationships Count professional learning series. The term “consultant” will be used to refer to the reflective consultant who facilitated the series. The term “early interventionist” will refer to early intervention participants of the series. The term “interview participants” refers to four early interventionists who were interviewed about their experience as participants in the series.

**Context of Study**

Identifying the context and setting for the Relationships Count series provides key information for understanding the study’s two research questions. The first question related to defining what happened during the series. The second question related to describing perceived benefits for early interventionists. Providing contextual information about the development of the series and the recruitment of early interventionists sets the stage for the findings presented in Chapter 3.

The Relationships Count series was offered to early interventionists employed within Oakland County, Michigan. The Part C Coordinator provides early intervention professional learning support and monitors compliance for 28 school districts within Oakland County. Individual districts offer services for the children and families who reside within the district boundaries. The Part C Coordinator is responsible for ensuring
that each district program complies with state and federal requirements for early intervention services. Through work with districts, the coordinator identified that many programs were not offering services that met the federal requirements for services occurring in natural environments and did not meet recommendations for family-centered practices. As a result, programs were asked to provide more early intervention services in home rather than classroom settings. (D. Koger, personal communication, April 2012).

The Part C Coordinator identified receiving concerns from school district special education administrators as well as questions from early intervention staff related to the complexities of providing home-based services. She shared that early interventionists reported feeling challenged in their ability to offer support to families who were struggling with issues such as poverty, mental illness, substance abuse and domestic violence. In addition, she noted that the majority of early interventionists were Caucasian middle-class females serving a culturally, linguistically and socio-economically diverse population. The Part C Coordinator began working with an infant mental health specialist to create a professional learning plan. The specialist was hired as the reflective consultant and was charged with designing and facilitating a model of reflective consultation. Her model was influenced by the success of a reflective consultation project for early interventionists in Minnesota (Watson & Neilson Gatti, 2012). The Relationships Count series followed the guidelines for reflective consultation that were established by the Michigan Association for Infant Mental Health (MI-AIMH). The
series was developed as a professional learning support to address early intervention challenges and concerns (D. Koger, personal communication, October, 2013).

The Relationships Count series was offered to early interventionists from all 28 districts supported by the Intermediate School District. The Part C Coordinator and reflective consultant developed a brochure to promote the series. According to the brochure, participation would provide “an in-depth understanding of family-centered practice by focusing on a relationship building approach.” The primary focus of the series was for participants to “create new perspectives and establish skills…while finding ways to initiate and maintain a reflective work environment” (“Relationships Count Brochure,” 2013). The Part C Coordinator distributed the brochure during early intervention meetings and to an early intervention listserv that is maintained by the Intermediate School District. A copy of the brochure is provided in Appendix C. Early interventionists were informed that participation in the series was voluntary, and there was no cost or reward for attending the sessions. Early interventionists were able to count participation in the series towards district requirements for professional development. The Relationships Count series was first offered in 2012-2013. As mentioned in Chapter 1, early interventionists requested that the series continue after the first year. The positive reports about the series led to the continuation and expansion of the offering in 2013-2014.

**Unit of Study**

As stated previously, the unit of study for this research was Relationships Count: A Professional Learning Series for Early Interventionists. The series was provided to 10
early interventionists during 2013-2014 school year. Each session was facilitated by the consultant and consisted of monthly sessions for small groups of early interventionists. The series was offered twice in two different locations during the school year. Both locations were included in this study. Five early interventionists participated in six sessions at each location.

**Format**

The consultant structured the format of each session to include silent reflection, case presentations, competency-building activities, and distribution of supplementary resources. Table 2 represents a typical schedule and description of activities that occurred throughout each session. During case presentations, early interventionists volunteered to share stories about working with particular families or about issues with colleagues. The consultant offered guiding questions for case presentation (see Appendix D for a list of the guiding questions). The questions included reflective prompts such as

- What do you want us to know about the child and his/her family?
- How does language/culture impact your relationship with the family?
- How does it feel to be with this family?

After a case presenter had finished describing the case, the reflective consultant facilitated a group discussion. The focus of the discussion was the exploration of the relationships and feelings experienced by the case presenter as well as the feelings experienced by the listeners. The expectation for each session was that a case presenter would have the opportunity for reflection with the support of the consultant and other early interventionists. A more detailed account of the session format including core
components of facilitation and participation is provided in Chapter 3 as a response to the question: What happened during the Relationships Count series?

Table 2

*Typical Relationships Count Session Schedule and Description of Activities*

<table>
<thead>
<tr>
<th>Time (PM)</th>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5:00-5:15</td>
<td>Arrival</td>
<td>Early interventionists arrive and engage in informal discussion about work</td>
</tr>
<tr>
<td>5:15-5:20</td>
<td>Reading of quote and silent reflection</td>
<td>Consultant reads a selected quote. Group sits in silence for a timed minute of silent reflection</td>
</tr>
<tr>
<td>5:20-5:35</td>
<td>“Check-in”</td>
<td>Consultant asks each person to share how she is feeling and to share any updates about situations mentioned during previous case presentations</td>
</tr>
<tr>
<td>5:35-5:45</td>
<td>Distribution and discussion of</td>
<td>Consultant shares resources she created as well as published articles about reflective consultation or about promoting relationships and infant mental health</td>
</tr>
<tr>
<td></td>
<td>supplemental material</td>
<td></td>
</tr>
<tr>
<td>5:45-6:00</td>
<td>Planned activity or extended discussion of supplemental materials</td>
<td>Early interventionists participate in competency building activities or group discussion about supplemental material</td>
</tr>
<tr>
<td>6:00-6:55</td>
<td>Case presentation and group discussion</td>
<td>An early interventionist offers a detailed description of a professional situation (case) that she finds challenging. Consultant facilitates reflective group discussion about case</td>
</tr>
<tr>
<td>6:55-7:00</td>
<td>Closing quote</td>
<td>Consultant reads a second quote</td>
</tr>
</tbody>
</table>
**Setting**

The series occurred during the evening in two separate locations. Early interventionists identified 5:00 – 7:00 PM as an optimal time for sessions because it would not interfere with daytime responsibilities and would allow for sufficient commuting time (D. Koger, personal communication, October, 2013). Early interventionists were required to select one location and only attend sessions at that site. Six sessions occurred at each site located at early childhood education centers in different regions of the county. For research purposes, the locations will be referred to as Site A and Site B. Site A was selected because it was located in the southwest region of the county. Site B was located in the central region of the county. Both sites were included in this study.

**Participants**

The participants included the consultant, 10 early interventionists, and the researcher. As the researcher, I attended each session of the series as both a participant and an observer. I engaged in group discussion and participated in group activities, but did not present a case to the group. Savin-Badin and Major (2013) refer to “balanced participation” in qualitative research. They note that for balanced participation to occur the researcher “strives to balance between the role of the insider and outsider, participating occasionally, but not fully” (p. 396). By participating in discussion and activities, I aimed to build the sense of trust necessary for the consultant and early interventionists to fully engage in reflective consultation.
**Reflective consultant.** The series was developed and facilitated by a reflective consultant. She is a former early interventionist who has over thirty years of experience working in special education. She has a Master’s degree in Education and is endorsed by the Michigan Infant Mental Health Association (MI-AIMH) as an Infant Mental Health Specialist, IMH-E® (III). She meets the qualifications for a reflective consultant as established by the Michigan Association for Infant Mental Health Endorsement for Culturally Sensitive Relationship-Focused Practice Promoting Infant Mental Health. Her qualifications include a level III infant mental health endorsement, over 50 hours of experience receiving reflective supervision, and participation in MI-AIMH sponsored training for providing reflective supervision. In accordance with the MI-AIMH recommendations for reflective consultants, she received reflective supervision during the course of the series. Her reflective supervision consisted of monthly dyadic meetings with a clinical infant mental health mentor, IMH-E® (IV).

**Early interventionists.** Ten early interventionists participated in the series and represented seven different school districts. Each early interventionist was a member of her school district early intervention team. To protect the confidentiality of participants, as well as the anonymity of their colleagues and families, identifying characteristics were omitted or limited throughout this publication. Characteristics of participants are represented in Table 3. This table summarizes the diversity of experience, education, and professional background of the early intervention participants. The demographic data provided in the table indicates that more than half of the early interventionists participated in the first year of the series. At Site A, three of the five participants worked
for the same school district as part of an early intervention team for over five years. The
remaining two Site A participants were new to early intervention and were from different
districts. At Site B, four early interventionists participated in year 1 of the series. The
fifth early interventionist at Site B was working in her first year as an early
interventionist.

Table 3

*Characteristics of Early Intervention Participants*

<table>
<thead>
<tr>
<th>Characteristics</th>
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<th>%</th>
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<td>Gender</td>
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<td></td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>100</td>
</tr>
<tr>
<td>Race/Ethnicity:</td>
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<td></td>
</tr>
<tr>
<td>Caucasian</td>
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<td>100</td>
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<tr>
<td>Years of experience as early interventionist:</td>
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</tr>
<tr>
<td>Less than a year</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Two to ten years</td>
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<td>20</td>
</tr>
<tr>
<td>More than ten years</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>Discipline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Education Teacher</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Speech Language Pathologist</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Social Worker</td>
<td>1</td>
<td>10</td>
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<tr>
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<td>50</td>
</tr>
<tr>
<td>Site B</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>Experience in Relationships Count:</td>
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<td>70</td>
</tr>
<tr>
<td>Second year</td>
<td>3</td>
<td>30</td>
</tr>
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</table>
Researcher. I am a doctoral candidate in the Special Education program at Kent State University. I have a Master’s degree in Early Childhood Education and I am endorsed by the Michigan Association for Infant Mental Health (MI-AIMH) as an Infant Family Specialist, IMH-E® (II). I received the MI-AIMH McKinney Diversity Fellowship in 2009, which included participation in two years of reflective consultation. I have served as a member-at-large for the state board of the Michigan Association for Infant Mental Health. I have developed a professional relationship with the reflective consultant through collaborative work with MI-AIMH. At the Intermediate School District, I am an early childhood behavior consultant for education staff. I have worked in the same department as the Part C Coordinator for eight years, and I have no official responsibilities for early intervention staff. It was through my interest in models of reflective consultation and my professional relationships with the Part C Coordinator and the reflective consultant that I became involved in studying the Relationships Count series. I reside in a suburban community within the region served by the Intermediate School District.

University Approval, Consent Process, and Confidentiality

The present study “Relationships Count: A Professional Learning Series for Early Interventionists” was proposed, submitted, and approved by the Kent State University Institutional Review Board (IRB) for the protection of human subjects in three phases. The initial proposal involved the observation of Relationships Count sessions, transcription of session audio recordings, and interviews with early interventionist participants. The IRB granted approval for the initial proposal on October 9, 2013. The
original proposal was modified to include the use of rating instruments. The dissemination of a rating scale for early interventionist participants was approved on January 23, 2014. The dissemination of a survey to the families of the early interventionist participants was approved on May 27, 2014.

All consent processes were followed in accordance with the IRB approved proposal. The consent forms for participation in the study of the Relationships Count series and for participating in the interview process are provided in Appendix E and Appendix F. Early interventionists were informed about the intent to study the series during the first session held in October. Early interventionists were informed that I would be observing, documenting my observations, and transcribing audio recordings of each session. They were assured that anonymity would be maintained in all presentations of research findings - oral and written. Names and other personally identifiable information have been excluded from all presentations of findings. Each early interventionist signed the IRB approved consent form in order to acknowledge her participation in the study. Four early interventionists consented to be interviewed about their participation in the series. The interview participants signed consent for interviews to be recorded and transcribed. Each interview participant reviewed a transcription of her interview.

Early interventionists were assured that their views and experiences would remain confidential and any identifying information about their work, their colleagues or their families would not be included in the published dissertation. According to American Psychological Association (2010), when researchers use case studies to describe their
research, they are prohibited from disclosing “confidential, personally identifiable information concerning their patients, individual or organizational clients, students, research participants or other recipients of services” (p. 17). The authors stated that one option is to disguise or limit some aspects of the case “so that neither the subject nor third parties are identifiable” (p. 17). In order to maintain the confidentiality of participants and protect the anonymity of their colleagues and families, descriptions of specific personal and professional characteristics were limited in this study.

**Data Collection Methods and Procedures**

In order to examine what happened during the Relationships Count series and to identify perceived benefits for early interventionists, I collected data from multiple sources. Using multiple sources of data is referred to as data triangulation and increases the validity of qualitative research (Creswell, 2007; Merriam, 2009). Data collection methods included observation and recording of sessions, semi-structured interviews with early intervention participants, completion of rating instruments by early intervention participants and families, written and audio documentation of research experience, and comparative analysis of data. The process of collecting and analyzing data began in November, 2013 and concluded in July, 2014. Figure 2 represents a timeline of the data collection and analysis methods.
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<td>Compare findings from notes, codes, concept maps, and surveys</td>
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*Figure 2.* Timeline of data collection and analysis. This figure provides a timeline for data collection during session observations and interviews as well as data analysis.

**Relationships Count Session Observation and Field Notes**

A primary source of data was the documentation of experiences that occurred during the series. I attended 10 sessions as both a participant and an observer. I documented my thoughts and observations in a field note journal while participating in each session. Documentation of the researcher’s thoughts and observations are key
pieces of data in qualitative research (Charmaz, 2006; Merriam, 2009). My field notes contained descriptions of my perceptions of the experience as a participant as well as general observations about facilitation by the consultant and participation of early interventionists. At the conclusion of each session, I recorded a five-minute verbal reflection. During these recordings, I noted the tone of the evening and specific thoughts, which might be helpful during the transcription and coding process. These reflections were recorded on a password-protected mobile device. I transcribed these reflections and included them with my field notes as documentation of what occurred.

**Relationships Count Session Recording and Transcription**

In addition to the documentation of my observations, each session was audio-recorded. The consultant received permission from all participants to record the Relationships Count sessions that occurred from November through May. She used the session recordings to reflect on her role as consultant and to plan for future sessions. In accordance with my approved IRB proposal, I had access to the recordings for transcription purposes. The sessions were audio-recorded on a digital recorder. After each session, I downloaded the digital recordings by inserting the memory card into my password-protected computer. Each session was transcribed by listening to the recording and entering text into a Microsoft Word document. Transcription documents were saved on a password-protected computer. The audio-recordings were deleted from the computer after the transcription was completed.
Semi-Structured Interviews

Semi-structured interviews were conducted with four early intervention participants during the latter half of the school year. These interviews provided an opportunity to explore how the early interventionists connected what happened during each session to their feelings and attitudes about their work with families and colleagues. During semi-structured interviews, a researcher asks established questions and includes additional questions in response to the participant’s comments (Merriam, 2009). The semi-structured format is less rigid than a structured interview. The flexibility of the format provided an opportunity to ask questions that were relevant to the responses as well as the experiences of the early interventionists. A list of the established guiding interview questions is provided in Appendix G.

Early intervention interview participants. Early intervention interview participants were recruited in February during a Relationships Count session. Participation was voluntary, and there were no rewards or risks associated with the interview process. The recruitment process consisted of a request for notification from any participants willing to be interviewed about their experience in the Relationships Count series. Four early interventionists responded via email to the interview request. These four early interventionists represented a diverse range of the experience and disciplines found within the whole group. Two interview participants attended sessions at Site A and two attended sessions at Site B. One interview participant had been working in early intervention for over thirty years and one interview participant was experiencing her first year as an early interventionist. In terms of professional training,
two interview participants were educators, one was a physical therapist, and one was a
speech and language pathologist. Two interview participants attended the first year of the
Relationships Count series and participated in the interview process for the exploratory
study. None of the interview participants worked for the same district. The diversity of
characteristics represented maximum variation sampling. According to Merriam (2009),
“maximum variation sampling allows for responses that “represent the widest possible
range of characteristics of interest for the study” (p. 79).

**Interview setting.** The interview participants determined the location and time of
the interviews. I asked interview participants to identify convenient locations that would
allow for recorded conversations. Three interviews were conducted in school district
offices, and one was conducted at my home. The interviews were scheduled according to
the availability of the interview participants. The interviews occurred between March
and May. They took place before, after and during the school day. The length of each
interview ranged from 35 – 55 minutes.

**Interview process.** I began each interview by referring to the experience as more
of a discussion about the series rather than an “interview.” I prepared guiding questions
and informed interview participants that I was curious to learn about what they wanted
me to know about their experience. The guiding questions are available in Appendix G.
As I participated in the interview process, my goal was to maintain a stance that was
“nonjudgmental, sensitive and respectful” (Merriam, 2009, p. 109). I considered my
beliefs as I listened to participant responses in order to follow up with questions that
would help me better understand their unique perspectives. Each interview concluded
with the following question: “If you were to describe the Relationships Count Series to another professional, how would you describe it?” Each interview participant gave permission to be contacted for a follow-up interview if necessary. No follow-up interviews occurred.

**Interview recording and transcription procedures.** I recorded the interviews on a password-protected mobile device. I listened to the recordings and transcribed text into a Microsoft Word document. I listened a second and third time to check for accuracy and correct errors. The transcribed interview document was emailed to each interview participant. Each interview participant completed a review of her transcript, which provided an opportunity to check for accuracy of meaning as well as an opportunity to delete or edit statements. Three interview participants confirmed that no changes were necessary. One interview participant changed one word of her transcribed document. The review and confirmation of meaning is referred to as a “member check” in qualitative research (Merriam, 2009). Completing a member check with each early intervention interview participant increased the authenticity and credibility of what was gathered during the interview process.

**Data Analysis**

The session and interview data were analyzed to respond to the research questions: (1) what happened during the Relationships Count series? and (2) what were the perceived benefits for early interventionists? The data were analyzed following recommendations and guidelines for qualitative research established by Charmaz (2006), Corbin and Strauss (2009), Creswell (2007), Friese (2014) Merriam (2009), and Simons
(2009). Overall, qualitative data analysis is an iterative process that begins during data collection. Thus, my analysis process occurred across four interdependent phases. The first phase included reviewing the documentation of my research perspective as I participated, and review of the observed and transcribed data (Creswell, 2007; Merriam, 2009; Simons, 2009). The second phase included the coding and categorizing of data. Specifically, I used a data analysis process that included a priori coding, line-by-line open coding to develop a structured codelist, applying the structured codelist to data to highlight text from sessions and interviews, and axial coding to generate new understanding of highlighted text (Charmaz, 2006; Creswell, 2007; Friese, 2014; Merriam, 2009). The third phase included creating concept maps based on interview responses (Charmaz, 2006; Simons, 2009). Concept maps allowed for the integration of what was learned during the coding process with the perspectives of the interview participants. The fourth phase of comparative analysis, included refining research questions based on examining what was learned during prior phases. Refining initial research questions during analysis and interpretation is an integral component of qualitative research (Agee, 2009; Cresswell, 2007). Each phase is described in greater detail in the following sections.

**Data Analysis Phase One: Researcher Documentation**

Phase one of data analysis occurred throughout my participation and observation of the Relationships Count series. I documented my observations during and immediately following participation in each session. I reviewed my documented observations as the series progressed. Each session of the series lead to new insights
about what was occurring and how early interventionists perceived the experience. I recorded my insights as memo notes. The periodic review of memo notes is recommended during analysis and interpretation of findings (Charmaz, 2006).

**Data Analysis Phase Two: Four-Stage Coding Process**

Phase two of data analysis involved coding and categorizing text. At the conclusion of the series, the transcribed text documents of the audio-recordings of sessions, interviews, and field notes were downloaded into ATLAS.ti for computer assisted qualitative analysis. Analyzing coded data and organizing the coded text into categories provided the opportunity to explore what happened during the series and how participation supported the development of relationship-based competencies and feelings of competence and confidence. The coding and categorizing of data occurred in four linear stages. The first stage involved the use of a priori codes. This was followed by open coding, applying a structured codelist, and axial coding. Figure 3 provides a summary of what occurred during each stage as well as citations to support coding methods. Each stage is described in detail in the following sections.

**First stage coding.** During the first stage, I uploaded transcribed text from 10 sessions and four interviews into ATLAS.ti. The use of prior literature to determine initial codes is known as an a priori coding process (Creswell, 2007; Savin-Baden & Major, 2013). The transcription of one session was coded using three a priori codes that labeled session discussion according to (a) relationships between early interventionist participants, (b) relationships between early interventionists and their district colleagues, and (c) relationships between early interventionists and their families. These codes
**Four-Stage Coding Process**

Code, compare, and analyze transcribed Relationships Count sessions and interviews.

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**Stage 1**

A priori coding of one session using code labels to identify discussion about relationships with colleagues, with families, with session participants (Creswell, 2007).

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**Stage 2**

Line-by-line open coding of five sessions and four interviews. Codes selected from competencies identified in literature and from themes emerging from data. Code labels assigned categorical prefixes and operationally defined to form structured codelist (Charmaz, 2006; Merriam, 2009; Friese, 2014).

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**Stage 3**

Structured codelist used for line-by-line coding of all 10 sessions and 4 interviews. New codes generated and defined during coding process are added to structured codelist. Peer review of structured codelist and data (Charmaz, 2006; Merriam, 2009; Friese, 2014).

---

**Stage 4**

Axial coding process used to compare structured codelist and coded text to identify key quotations and re-organize into new categories of super-families and families (Friese, 2014).

---

*Figure 3.* Overview of four-stage coding process. This figure illustrates the four coding methods that were used to analyze the data as well as citations for each method.
were based on the findings from the exploratory study described in Chapter 1. After the first stage was completed, I examined the coded text and determined that relationship codes were too broad and did not sufficiently address the research questions. This examination led to my decision to use a line-by-line open coding process to determine relevant codes for analysis.

**Second stage coding.** The second stage of coding involved line-by-line open coding of the text from five sessions. I implemented line-by-line open coding for five of the ten sessions in order to generate a structured and operationally defined codelist. Open coding involves the development of codes by examining and categorizing data (Corbin & Strauss, 2008). During this stage, I identified and operationally defined code labels as suggested by Friese (2014). I arranged the code labels by category to create a structured codelist. Each code label included a categorical prefix. The use of coding categories and categorical prefixes is based on recommendations for coding within the ATLAS.ti system (Friese, 2014). The coding categories represented: (a) AL – strategies used by facilitator to support adult learning (b) BAR – barriers to building relationships with families (c) COMP - competencies that support strong relationships with families (d) FEEL – identification and discussion of feelings and (e) RC – perceived benefits of Relationships Count. After the five sessions were coded and categorical prefixes were assigned, I reviewed code labels and coded text to create consistent operational definitions for each label. Table 4 provides examples from each category of an operationally defined code label.
Table 4

Sample of Structured Codelist and Operational Definitions

<table>
<thead>
<tr>
<th>Prefix</th>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL_</td>
<td>Model</td>
<td>Reflective consultant models relationship-based competencies such as active listening, gentle inquiry, supportive interactions, reflection in action during group discussion</td>
</tr>
<tr>
<td>BAR_</td>
<td>Family situation</td>
<td>Situations that could make it challenging for the family and early interventionist to connect such as language barriers, illness, substance abuse</td>
</tr>
<tr>
<td>COMP_</td>
<td>Perspective taking</td>
<td>Early interventionists demonstrate taking the perspective of family members/colleague when discussing work situations</td>
</tr>
<tr>
<td>FEEL_</td>
<td>Grief and loss</td>
<td>Family or participant feelings of grief and loss</td>
</tr>
<tr>
<td>RC_</td>
<td>Problem solving</td>
<td>Mention of difficulty in trying to support without problem-solving – include examples and non-examples</td>
</tr>
</tbody>
</table>

**Third stage coding.** The third stage of the coding process involved applying the structured codelist to transcriptions from every session and interview by identifying text that represented each code and code category. The use of a structured and operationally defined codelist is recommended by Friese (2014). New codes were generated during this process and were added to the structured codelist. After completion of coding of text, the reflective consultant was enlisted to compare the transcribed sessions with the structured codelist. As stated earlier, the use of member check in qualitative analysis is
recommended to establish credibility (Merriam, 2009). The consultant read the transcripts and identified what she perceived as common themes or key concepts. Next, she compared her themes with the structured codelist. No missing themes or key concepts were identified, and accuracy of codes and code definitions was established. Because the interview participants discussed their experience in the series, I opted to select a different person to compare the structured codelist to the interview transcripts. The consultant would have been able to recognize interview participants by their responses. The Part C Coordinator was selected to compare the structured codelist with transcribed interviews. Identifiers such as name and work site of interviewee were removed from the transcribed text. The Part C Coordinator confirmed that the structured codelist identified themes and concepts represented during the interviews.

**Fourth stage coding.** The fourth stage of the coding process involved reviewing all text that had been coded and categorized during the third stage. I utilized an axial coding process to develop new categories and generate a deeper understanding of the coded text (Friese, 2014). I began by reviewing the code categories and coded text within the categories. I identified key quotations that could serve as exemplars for codes and coding categories. Through the axial coding process, different ways of categorizing and filtering the data emerged. The ATLAS.ti program refers to cross-categorical filters as “super-families.” Super-families represent a way of grouping categories into broad themes. I identified super-families that corresponded to each research question. The super-families were subdivided into smaller categories referred to as “families.” The key
quotations were assigned to new families in ATLAS.ti. Next, I created a binder of all key quotations categorized by family and super-family. An outline of the binder is provided:

1. Super-family (A) What happened during the Relationships Count Series?
   
   a. Family 1 Descriptions/expectations
   
   b. Family 2 Role/actions of reflective consultant
   
   c. Family 3 Role/actions of participants

2. Super-family (B) What are the perceived benefits for early interventionists?
   
   a. Family 1 Development of Skills
   
   b. Family 2 Reflecting on Thoughts and Feelings
   
   c. Family 3 Sense of competence and confidence

**Data Analysis Phase Three: Concept Mapping**

The third phase of data analysis included creating concept maps. According to Piantanida & Garman (2009), it is possible to lose sight of the participant experience during data coding and analysis due to the close examination of isolated portions of text. I created concept maps while listening to the audio-recording of each interview. Re-listening to the interviews allowed for me to reconnect with how early interventionists perceived their experience. Concept maps are a “means of representing data visually…to organize individual perspectives” (Simons, 2009, p. 122). I created concept maps to connect findings from the coding phase about what happened during Relationships Count sessions with perceived benefits for early interventionists. After reviewing coded interview text, I identified four themes for concept mapping: (a) structure, (b) competence, (c) confidence, and (d) support. I designated a piece of chart paper for each
theme. Next, I listened to the audio-recordings of the four interviews and used different color markers to record perspectives from each early intervention interview participants. This helped to identify the critical elements of structure as well as perceived benefits for early interventionists. The process of concept mapping helped to organize my findings by creating a visual representation of the thoughts and feelings of early intervention interview participants.

**Data Analysis Phase Four: Comparative Analysis**

During the fourth phase of analysis, I compared the organization of data within the coded binder and the data gathered during the concept mapping process. The comparative method advanced my conceptual understanding of the series by exploring how I interpreted different forms of data (Charmaz, 2006). I followed a questioning framework developed by Srivastava and Hopwood (2009) by asking myself: (a) “What are the data telling me?” (b) “What is it I want to know?” and (c) “What is the relationship between what the data are telling me and what I want to know?” In response to these questions, I compared the analyzed data with my research questions. In this final phase, I refined my initial research questions to address my new understanding of the data. As stated earlier, in qualitative research, initial research questions may be modified as a result of knowledge and findings generated during analysis (Agee, 2009). Table 5 provides a side-by-side view of the initial research questions and the refined sub-questions. The findings from the four phases of analysis are presented in Chapter 3 and organized in response to these refined sub-questions.
Table 5

*Side-by-Side View of Initial and Refined Research Sub-Questions*

<table>
<thead>
<tr>
<th>Initial Research Questions</th>
<th>Refined Research Sub-Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>What happened during the Relationships Count series?</td>
<td>What were core components of facilitation?</td>
</tr>
<tr>
<td></td>
<td>What were core components of participation?</td>
</tr>
<tr>
<td>What were the perceived benefits for early</td>
<td>How did interview participants describe benefits of the series?</td>
</tr>
<tr>
<td>interventionists?</td>
<td>How were particular relationship-based competencies developed during the series?</td>
</tr>
<tr>
<td></td>
<td>How were feelings of competence and confidence strengthened during the series?</td>
</tr>
</tbody>
</table>

**Trustworthiness and Validity of Methods and Findings**

To ensure the trustworthiness and validity of research methods and findings, data were collected from multiple sources in order to examine what happened during the Relationships Count series and the perceived benefits for early interventionists. The triangulation of data from the sessions, field notes, and interviews created a multi-dimensional picture of the series. In addition, surveys were distributed to early interventionists to elicit anonymous ratings about aspects of their relationship with the reflective consultant. Surveys were also distributed to families at the conclusion of the series to gather information about how families described aspects of their relationships.
with their early interventionist. The peer review of the data analysis, interview participant review of transcription, and use of survey instruments contributed to the trustworthiness and validity of findings (Merriam, 2009).

**Member Check and Peer Review**

The reflective consultant and Part C Coordinator provided a member check and peer review for this study. Member checks and peer reviews increase the credibility and validity of qualitative research (Merriam, 2009). During a member check, a participant or respondent reviews raw data or findings to confirm accuracy and authenticity of meaning. (Merriam, 2009). The consultant reviewed session transcriptions and the structured code list to check for validity of interpretations and coding. The consultant reviewed two drafts of the findings presented in Chapter 3 to confirm there were no violations of confidentiality and to confirm anonymity of early interventionists, their colleagues, and their families was preserved. During a peer review, a colleague examines raw data to assess if the findings seem plausible (Merriam, 2009). The Part C Coordinator reviewed interview transcripts and the structured code list to confirm identification of key categories for coding and analysis purposes. Interview participants provided member checks when they confirmed the accuracy of the data collected during the interview process. Each interview participant reviewed her interview transcript for accuracy of content as well as meaning. The interview participant and consultant member checks and the peer review contributed to the validity of the analysis process and the findings.
Survey Instruments

The use of survey instruments was added to procedures for the study in order to gather data about how the early interventionists perceived their relationship with the reflective consultant as well as how families described their relationship with their early interventionists. For the study, the purpose of the survey instruments was to serve as a probe to gauge the perceptions of early interventionists and the families they serve. Results are included in Chapter 3. Additional methods and procedures for administering and interpreting these instruments in future studies are included in Chapter 4.

Reflective Supervisor Rating Scale. During my analysis of what was occurring during sessions, I documented my perceptions of the strong relationships that were being developed by the consultant and the early interventionists. In order to check the validity of my perceptions of the participant experience, I asked each early interventionist to anonymously complete a rating scale that would assess how she described her relationship with the consultant. The Reflective Supervision Rating Scale was developed by Jordana Ash in 2010. According to the author, it has been used to assess the relationship between reflective supervisors and supervisees in Colorado and Pennsylvania. The author of the scale granted permission for use with participants of the series and for a copy to be included in the appendices (J. Ash, personal communication, 2013). A copy of the scale is available in Appendix H. The scale was distributed during the February session of Relationships Count in each location. Early interventionists were given a stamped envelope and asked to complete the scale and mail back the response.
No identifying information was required, and all 10 participants returned the completed survey. A discussion of the results is included in Chapter 3.

**Early Intervention Parent Survey.** During sessions and interviews, I documented early interventionists’ accounts of the strong relationships that they were developing with the families they serve. Because relationships are reciprocal and transactional, a lack of family perspective about their relationship with their early interventionist limits the trustworthiness of the findings. With the permission of the author of the original scale, I adapted the Reflective Supervisor Rating Scale to address how families perceived their relationship with their early interventionists. The new measure is referred to as the Early Intervention Parent Survey. A copy of the survey is provided in Appendix I. The Part C Coordinator consented for distribution of the anonymous survey to the families of early interventionists who participated in the Relationships Count series. Early interventionists were given blank surveys along with stamped envelopes and asked to share the surveys with families. Approximately 75 surveys were distributed to families, and 25 completed surveys were returned. The results are discussed in Chapter 3.

**Role of Researcher**

Qualitative research differs from quantitative approaches because the researcher is the principal instrument of data collection, analysis and interpretation (Merriam, 2009). It is impossible for a researcher to divorce the impact of prior knowledge and experience from the subject of research. During bracketing, a researcher identifies the biases and perceptions that could influence data collection, analysis, and interpretation (Creswell,
Bracketing increases the validity of the presentation of findings. The researcher should reveal prior experiences because those experiences shape the story being told. “The subjectivity of the researcher is an inevitable part of the frame. It is not seen as the problem but rather, appropriately monitored and disciplined as essential in understanding and interpreting the case” (Simons, 2009, p. 24). Unlike in quantitative research, when a research bias may negatively impact the validity of the findings, the role and perspective of the qualitative researcher contribute to the findings.

Before I present my findings in Chapter 3, it is relevant and necessary to describe my experience with reflective consultation models in order to identify biases that could influence my analysis and interpretation. Prior to embarking on this study, I worked in the field of early care and education in Oakland County, Michigan for over 20 years. I had the opportunity to participate in a different reflective consultation series that met monthly with a focus on diversity. My experience in this deep ongoing reflection about working with young children and families caused a shift in how I engaged in and perceived my work. As I began to take the time to pause and reflect on the relationships I built with families and teachers, I was better able to listen to what families and teachers were telling me.

My experiences led me to wonder if reflective consultation sessions could have such a powerful impact on how others engage in and perceive their work. I decided I needed to take a step out of the work that was most familiar to me (classroom-based early childhood education) and step into a world that was less familiar to me (home-based early intervention) in order to explore the role of reflective consultation in strengthening
professional competencies. My experience with the process of reflective consultation and lack of first-hand experience working in homes with families allowed for me to take a more objective look at the development of relationship-based competencies as early interventionists participated in the Relationships Count series. Despite my lack of early intervention experience, I am aware of the complexities involved in working with families in home-settings. I was not seeking to demonstrate if reflective consultation “worked” but to understand what happened during the course of the Relationships Count series and how that connected to the development of relationship-based competencies and feelings of professional competence and confidence.

**Chapter Summary**

The purpose of the study was to explore what happened during the series and to examine the perceived benefits for early interventionists. In the following chapter, I will report findings based on my analysis and interpretation of data collected during sessions and interviews. The findings will be arranged around the initial research questions that were refined to include sub-questions related to descriptions of core components of facilitation and participation as well as early interventionists’ perceptions of the development of relationship-based competencies and the strengthening of competence and confidence.
CHAPTER III

RESULTS

The study findings presented in Chapter 3 include a description of the activities and interactions that occurred during a year-long reflective consultation series and an examination of how the series supported feelings of competence and confidence of the early intervention participants. Relationships Count: A Professional Learning Series was provided to 10 early interventionists during the 2013-2014 school year. A qualitative case study was used to examine what happened during the Relationships Count series and the perceived benefits for early interventionists. Data collected included observational field notes, audio recordings of 10 sessions, and interviews with four early intervention participants. The analysis process involved coding, comparing, and interpreting data using concept mapping and a computer-assisted data analysis software program, ATLAS.ti. Key findings include the identification of core components of Relationships Count as well as the perceived benefits for early interventionists.

A summary of key findings is presented in Table 6. The findings are organized by two initial research questions that were refined as a result of the analysis outlined in Chapter 3. The questions included describing what happened during the series and identifying perceived benefits for early interventionists. During the data analysis process, the first question was refined to include the identification of core components of facilitation by the consultant and of participation by the early interventionists. The second question was refined to include an examination of how the series supported the
development of specific relationship-based competencies and strengthened the confidence and competence of early interventionists.

Table 6

*Initial Research Questions and Summary of Key Findings*

<table>
<thead>
<tr>
<th>Initial Research Questions</th>
<th>Summary of Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What happened during the Relationships Count series?</td>
<td>The consultant facilitated case presentations, reflective group discussion, competency-building activities and article discussion. The consultant taught and modeled gentle inquiry, reflection, and active listening as a relationship-based approach to providing support and promoting competence. Early interventionists discussed, observed, practiced, and experienced using gentle inquiry, reflecting on thoughts and feelings, active listening, and supporting without problem-solving in order to promote feelings of competence and confidence.</td>
</tr>
<tr>
<td>What were perceived benefits for early interventionists?</td>
<td>Interview participants described learning necessary skills and feeling supported. Early interventionists developed the following relationship-based competencies: gentle inquiry, reflecting on thoughts and feelings, active listening, providing support, and promoting competence. Early interventionists identified feeling more competent and confident in their ability to support families.</td>
</tr>
</tbody>
</table>
The findings were based on an analysis and interpretation of interactions between the reflective consultant and early interventionists during the Relationships Count series, perspectives from early interventionists, and my own perspective as a participant and observer. Information about specific family and work situations is shared only as it relates to what happened during the series. As referenced in Chapter 2, in accordance with the American Psychological Association, I limited information to protect confidentiality of the early interventionists and preserve the anonymity of their colleagues and families. The purpose of this study was not to explore the specific challenges encountered by early interventionists during their work with colleagues and families, but to identify what happened during the series and to examine perceived benefits of participation.

**What Happened During the Relationships Count Series?**

The first initial research question (research question 1) addressed what happened during the Relationships Count series. The data analysis led to the refining of the question to include sub-questions related to the examination of core components of the series in terms of facilitation by the consultant and participation by the early interventionists. Table 7 summarizes refined sub-questions and key findings for research question 1. Overall, the findings indicate that the consultant facilitated by establishing guidelines, planning activities, sharing resources and modeling a relationship-based approach to providing support. The early interventionists participated by discussing, observing, practicing and experiencing gentle inquiry, reflection, and active listening within a supportive context that promoted competence.
### Table 7

**Summary of Key Findings for Initial Research Question One: What Happened during the Relationships Count Series?**

<table>
<thead>
<tr>
<th>Refined Sub-Questions</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are core components of facilitation by the reflective consultant?</td>
<td>1. Consultant established guidelines and format for case presentation and reflective discussion</td>
</tr>
<tr>
<td></td>
<td>2. Consultant planned and implemented relationship-based competency building activities</td>
</tr>
<tr>
<td></td>
<td>3. Consultant shared and discussed relationship-based competency resources</td>
</tr>
<tr>
<td></td>
<td>4. Consultant taught and modeled gentle inquiry, reflecting on thoughts and feelings, and active listening as a relationship-based approach to providing support and promoting competence.</td>
</tr>
<tr>
<td>What are core components of participation of early interventionists?</td>
<td>1. Early interventionists discussed challenges, strengths, and vulnerabilities during case presentations</td>
</tr>
<tr>
<td></td>
<td>2. Early interventionists observed reflective process and practiced following guidelines for reflective discussion</td>
</tr>
<tr>
<td></td>
<td>3. Early interventionists discussed, observed, and practiced the use of relationship-based competencies during activities and reflective discussion</td>
</tr>
<tr>
<td></td>
<td>4. Early interventionists discussed, observed, practiced, and experienced providing and receiving support within a relationship-based approach that promoted feelings of competence and confidence</td>
</tr>
</tbody>
</table>
Core Components of Facilitation

The first refined sub-question for research question 1 addressed the facilitation of the series. The role of the consultant was to facilitate a reflective professional learning experience for early interventionists. The series was developed to strengthen relationship-based competencies and to help early interventionists feel better prepared to provide home-based services. In order to meet those expectations, the consultant incorporated case presentation and reflective group discussion with the teaching of relationship-based skills and practices. Facilitation of the series included establishing guidelines and a format for case presentation and reflective discussion; planning and implementing competency building activities; sharing and discussing resources; and modeling a relationship-based approach to providing support and promoting competence.

Establishing guidelines for case presentation and reflective discussion. The consultant shared a handout at the beginning of the series that identified guidelines for reflective consultation. These guidelines were based on the Michigan Association for Infant Mental Health’s (MI-AIMH) “Best Practice Guidelines for Reflective Supervision/Consultation.” An excerpt from the guidelines is provided in Appendix A. These guidelines include expectations for the reflective consultant as well as for participants of reflective consultation. These expectations are based on relationship-based competencies that are needed to create a safe and trusting environment for reflective consultation. Early interventionists identified adherence to these expectations as a core component of the structure of the series. The expectations included

- suspending judgment;
- avoiding/delaying problem-solving;
- listening for the emotional experience;
- noticing physical sensations/emotional reactions;
- remaining curious;
- accepting ambiguity; and
- noticing resistance/anger/sadness/irritation.

According to my observations and the recollections of the interview participants, the consultant referenced these expectations during case presentations as well as during other activities and group discussions.

I observed the consultant as she demonstrated how to follow these guidelines while facilitating reflective discussion about case presentations. She did not rush in to offer quick solutions to the dilemma presented. She modeled how to use gentle inquiry comments and questions to promote deeper understanding. She prompted the case presenter to reflect on her emotional experience and to notice positive or negative feelings that arose during the presenting of the case. She encouraged the case presenter to remain curious and offered possible questions or strategies for gathering more information about the case. Modeling the guidelines for reflective consultation and prompting early interventionists to follow the expectations offered opportunities to observe and practice relationship-based competencies.

The analysis of the data indicated that the consultant established a format for the case presentation and reflective discussion. It should be noted that the case presentations
were not assigned prior to each session. At beginning of each session, the consultant asked if anyone had “something they would like to talk about” with the group. The subject of the case presentation was limited to professional situations or challenges encountered during work with families or colleagues. Early interventionists volunteered to present cases during each night of the series. The consultant shared that she was prepared to provide sample case presentations for reflective discussion if there were no volunteers.

Each case presentation began with a description of a case including details about the family and child or colleagues who were involved as well as the nature of the dilemma. The case presenter was allocated 20-30 minutes to discuss the case without interruption. During my observations, I noted that the consultant reminded other early interventionists to “hold off” on asking questions until the presenter finished her presentation. Following each presentation, the consultant facilitated a reflective discussion about the situation. Each early interventionist was given the opportunity to ask a “clarifying question” about the case. Some examples of clarifying questions asked during the series included close-ended questions such as “How many children lived in the home?” and “How long have you worked with this family?” After the presenter had responded to these clarifying questions, the consultant engaged the case presenter in a discussion about the case. I observed the consultant modeling the guidelines for reflective consultation when she made statements such as “Let’s stick with that for a moment. Your sense was she was not engaged with him when you were together” and “It sounds like you were hoping to have more contact with her and it is frustrating that you
can’t get into the house that much.” After observing the dialogue between the case presenter and the consultant, the other early interventionists were invited to join in the discussion by using gentle inquiry statements. The structure and guidelines established for the case presentation and reflective discussion provided a model for a relationship-based approach to providing support.

**Planning and implementing activities.** Over the course of the series, the consultant planned and implemented three activities to support the development of relationship-based competencies. The activities provided opportunities to practice listening skills, identify feelings that arise during home-visits, and reflect on the influence of past experiences. I observed the facilitation of each of the following activities and analyzed transcripts of what was discussed.

**Active listening activity.** The first activity was developed to practice and experience active listening skills. During this activity, early interventionists were asked to work in groups of two to practice listening to a three-minute case presentation without interrupting. The speaker was prompted to discuss a challenging situation with a family that had occurred in the past. Each early interventionist had the opportunity to be a listener and a speaker. The consultant facilitated a discussion about the activity after each early interventionist exchanged roles.

**Identification of feelings activity.** According to the consultant, the second activity was developed to practice identifying and reflecting on feelings. For the second activity, the consultant prepared a list of 11 statements that represented what a parent might say to an early interventionist during a home visit. The consultant asked early
interventionists to identify the feelings they experienced as she read each statement. The statements included: “You are the only one who understands my child and how hard it is for me,” “Can you watch him for 10 minutes while I run to the store to get diapers?” and “What is my child really doing? I don’t see any progress.” The consultant facilitated a group discussion about the different feelings that were evoked during the reading of each statement. During the group discussion, the consultant prompted reflection on personal experiences that influenced how early interventionists felt as she read each statement. She said:

Sometimes when you want to describe a feeling – anger isn’t the right word – there is something more nuanced than that and you don’t always know what that is. So that was part of the exercise and the other part is that how you feel is based on who you are….How often do we stop and say “how is this making me feel in this moment?” Feelings are really important to acknowledge when we are working with families.

Her comments prompted early interventionists to discuss and reflect on the different feelings they experienced as they heard each statement and how our perspectives influence the different emotions that were experienced.

*Thought-provoking question activity.* According to the consultant, the third activity was selected to encourage further reflection on past experiences. This activity was adapted from an activity recommended in *A Practice Guide to Reflective Supervision* (Costa & Sullivan, 2009, pp. 170-171). For this activity, the consultant asked each early
interventionist to select a piece of paper from a box. The consultant introduced the activity by saying:

So this is a box and inside this box are some thought provoking questions and I am going to give everybody a chance to answer one….If you feel like you can’t answer one then you can pick another one and choose between the two….Whatever gets said – hold in confidence to make sure everyone is protected and safe here. You can choose to share as much or as little as you want. It is possible that I might ask a follow-up prompt or something. But you have the right to say “No - I am done talking about this.”

I observed as early interventionists responded to questions such as “How did family members react to you when you were angry or happy or sad as a child?” “Talk about a parent who you struggled to get along with and why do you think that is?” and “The most challenging or rewarding part of a home visit is…” The consultant facilitated a discussion based on responses to the questions. For example, one early interventionist shared:

_Early Interventionist A:_ ‘So how did family members react when you were angry or sad?’

Ok, well I was the first girl with two boys ahead of me a year apart each – so they basically laughed at me and tormented me when I was mad and threw stuff at me.

_Consultant:_ What about your parents?

_Early Interventionist A:_ My parents – my dad got in on it a little bit and then my mom would yell “Stop it!” and then I would scream and run to my room. I put myself away from me.
Consultant: So you were sad

Early Interventionist A: No - more like I was angry

Consultant: How do you think you incorporated that into who you are today?

Early Interventionist A: I probably became more – I think it affected me more when I was younger because I didn’t have good self-image in a way but now I roll with things a lot easier.

Another early interventionist responded to the question: “Talk about yourself as a child – What were you like? What feelings do you have about how you see yourself then?”

Early Interventionist B: Well as a child I was pretty quiet. I was quite shy. I was a pretty happy kid. I don’t remember ever really getting in trouble. My whole childhood I didn’t hear anybody yell in my house. So if I was at school and someone yelled I just wanted to go home. And even now I can’t stand it if people are yelling – I start to shake. I just do not do well with that…

Consultant: I wonder if that is how you are with others

Early Interventionist B: …Definitely is a big part of who I am. And the sensitivity you have as a kid makes you a sensitive adult. I am very careful and try not to hurt people’s feelings because I know what that felt like.

As each early interventionist selected and responded to a question, the consultant encouraged reflection on how their responses connect to their work with families.

The consultant described developing these activities in order to strengthen competencies recommended in the guidelines for reflective consultation. The consultant provided opportunities for early interventionists to engage in the activities as well as
discuss how it felt to participate in the activities. During these activities, I observed as early interventionists practiced and discussed the development of competencies such as active listening and reflecting on thoughts and feelings.

**Sharing and discussing resources.** The consultant prepared resources to distribute during each session. These resources included articles about reflective consultation and about professional practices that promote infant mental health. The consultant developed resources to help guide the case presentation and reflective discussion process. The consultant distributed a guide she created for presenting a case that included questions to help the case presenter focus her discussion. The case presentation guide is provided in Appendix D. She developed and shared a list of gentle inquiry statements after receiving a request from an early interventionist to “write down” the strategies she used during sessions for gathering information and prompting reflection. The list of gentle inquiry statements is provided in Appendix J. The consultant shared resources that supported the development of gentle inquiry and active listening skills and addressed the interests and needs of early interventionists.

**Teaching and modeling a relationship-based approach.** I observed the consultant as she taught and modeled the use of relationship-based competencies throughout the series. Her facilitation of case presentations and group discussions provided multiple opportunities for early interventionists to explore how gentle inquiry and active listening encouraged reflection on thoughts, feelings, and actions. Through her facilitation of activities and distribution of resources, she taught active listening skills and prompted reflection about the feelings, attitudes, and experiences that influence
working with families and young children. Her interactions modeled an approach to providing support and promoting competence. The consultant facilitated interactions and activities during which discussed, observed, practiced, and experienced a relationship-focused approach to offering support and promoting competence.

**Core Components of Participation**

The second research sub-question for research question 1 addressed core components of participation. While it was the consultant who determined structure and facilitated discussion, an examination of core components of participation during activities will add to the understanding of what happened during the series. I observed that early interventionists participated by discussing challenges involved in providing home-based services, practicing skills needed to nurture positive relationships, and experiencing opportunities to receive and provide support. Core components of participation included discussing work experiences as well as practicing and observing skills such as gentle inquiry, reflecting on thoughts and feelings, active listening, and providing support.

**Case presentations and reflective discussion.** During case presentations, early interventionists shared personal stories about their work with colleagues and families. Early interventionists discussed feeling challenged about how to offer support to families who experience difficulties such as financial insecurity, crowded housing, trauma, divorce, substance abuse, mental illness, and terminal diagnoses. One early interventionist discussed the complexity of developing a positive relationship with a family who had a history of negative experiences with other home-visiting programs and
medical professionals. One early interventionist described feeling as if she was the only form of support for a particular parent who was very isolated. One early interventionist discussed feeling worried about the mental health of a parent and concerned about the impact of a call to Child Protective Services. One early interventionist shared that she was struggling to connect with a parent who seemed to consistently interact in a “negative” way with her daughter. Some early interventionists described working in a supportive team environment, and others felt isolated in their district. During the course of the series, every early interventionist shared feeling overwhelmed by the amount of paperwork that is required to provide early intervention services. The willingness of each early interventionist to participate by sharing challenges and vulnerabilities offered opportunities to observe how the consultant used gentle inquiry and active listening to prompt reflection and provided opportunities to practice using these skills to provide support to each other.

The early interventionists participated by practicing the MI-AIMH guidelines for reflective consultation and following the series format for case presentation and reflective discussion. One interview participant shared:

I think it great that the roles are determined like you are the one to present the case study and everybody else’s role is to comment and reflect and ask questions for clarification and not give advice. Those rules are very important. It gives us a chance to practice what we are supposed to be doing with families.

As a participant in the series, I observed and practiced not interrupting during the case presentation, asking clarifying questions, paying attention to feelings, asking reflective
questions, and developing awareness of “problem-solving” impulses. I recorded in my journal the internal struggle I felt when I wanted to share a solution to a problem and I had to remain silent. An interview participant described the experience of curbing her problem-solving impulses:

I sit there in Relationships Count and people share their stories and I think “How could I fix this? How could I help you with that? Here is my strategy for this…” and we can’t do that we just have to sit there and listen. And it is really hard to do that – to stop your thinking and just sit there and listen. It is really hard to stop your thinking, but then you see how, by not interrupting, the presenter finds her own solutions….I think about this when I am with families.

Early interventionists referenced the MI-AIMH expectations and the series format as they reflected on their own interactions during the reflective discussion. One early interventionist asked the consultant “Is it ok if I ask this type of question?” Another early interventionist paused during the reflective discussion and asked “Is this problem-solving?” Core components of participation in the case presentation and reflective discussion included observing how the consultant facilitated the experience as well as practicing and discussing skills such as gentle inquiry, active listening, and avoiding problem-solving. During case presentation and reflective discussion, early interventionists had opportunities to feel supported as well as provide support by using skills that promote feelings of competence.

**Planned activities and shared resources.** I observed as early interventionists participated in the series by engaging in planned activities and discussing resources
shared by the consultant. Participation in the activities allowed early interventionists to practice and develop skills such as active listening and reflecting on thoughts and feelings. Early interventionists indicated that they would like to continue to participate in similar activities in future sessions. Interview participants described the active listening activity as being an “impactful,” “amazing,” and “profound” experience.

I observed as early interventionists participated in discussions about resources by making connections between their work with families and the content of the articles. During one discussion about an article that referenced promoting parental competence, an early interventionist described having an “Aha” moment. She stated that she realized that during her work with a particular family, she had been focusing primarily on how to help the young child feel competent at communicating. She noticed that she had missed indicators that the father was feeling ineffective at communicating with his son. She discussed plans for working with the family that included reinforcing the father’s interest in reading with his child. Her comments demonstrated that participation in the series included engaging in discussion as well as reflecting on how new learning applies to work with families.

**Providing and receiving support.** I observed early interventionists discussing their work with families and sharing feelings of not knowing what to do and questioning if what they were doing was helping. Early interventionists identified feeling alone and not having team support to ponder these questions. At times, early interventionists asked direct questions such as “What should I do?” “Was this the right thing to do?” and “What resources are available?” The consultant and other early interventionists
responded to these questions by prompting more reflection with questions such “What have you tried?” or “What happened when you tried that?” They also responded by describing similar experiences or having similar concerns. During a discussion about a student in hospice care, an early interventionist asked “Have you ever experienced a student passing? Because I have.” Her tone of voice conveyed the message that this difficult experience was one they shared and that support was available. I observed the early interventionists sharing concrete resources such as the name of a hospice provider or answers to specific questions about paperwork and procedures. Through reflective discussion and informal conversation, I witnessed the consultant and early interventionists providing support to each other. The MI-AIMH guidelines identify the importance of delaying problem-solving and reflecting on the difficulty of “holding” a problem that can’t be solved. One early interventionist shared that her participation in the series allowed her to practice giving support in a way that promoted competence by allowing others to discover their own strengths and solutions. She shared her belief that the series provided her with opportunities to reflect on how it felt to need and receive support from others.

**Summary of What Happened during the Relationships Count Series**

According to my data analysis, the structure and guidelines established by the consultant as well as her facilitation of the case presentation, reflective discussion and activities contributed to the professional development of early interventionists. The consultant facilitated learning by modeling the practices she was teaching so that early interventionists had the opportunity to experience the support she was describing.
Through this format, early interventionists discussed, observed, practiced, and experienced a relationship-based approach to addressing challenges and providing support. Based on my analysis, this approach consisted of the following relationship-based competencies: gentle inquiry, reflecting on thoughts and feelings, active listening, providing and receiving support, and promoting competence. In the following section, I describe how early interventionists perceived that the series supported the development of each competency as well as strengthened feelings of competence and confidence.

**What Were Perceived Benefits for Early Interventionists?**

The second initial research question (research question 2) explored the perceived benefits of Relationships Count. The data analysis led to the refining of the question to include:

- How did interview participants describe benefits of the series?
- How were particular relationship-based competencies developed during the series? and
- How were feelings of competence and confidence strengthened during the series?

Table 8 represents the refined sub-questions and key findings for research question 2. After completing the data analysis steps, it became clear that early interventionists felt challenged in their ability to provide support to all families and they perceived participation in the series supported the development of competencies and led to increased feelings of competence and confidence. The next section begins by identifying benefits of the series as perceived by early interventionists.
### Table 8

*Summary of Key Findings for Initial Research Question Two: What Were Perceived Benefits for Early Interventionists?*

<table>
<thead>
<tr>
<th>Refined Sub-Questions</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>How did interview participants describe benefits of the series?</td>
<td>Interview participants identified that benefits included learning necessary skills and feeling supported.</td>
</tr>
</tbody>
</table>
| How were particular relationship-based competencies developed during the series? | The following relationship-based competencies were developed through discussion, observation, practice, and experience:  
  1. Gentle inquiry  
  2. Reflecting on thoughts and feelings  
  3. Active listening  
  4. Supporting without problem-solving  
  5. Promoting feelings of competence and confidence |
| How were feelings of competence and confidence strengthened during the series? | Early interventionists described learning skills and feeling supported in a way that strengthened their sense of competence at addressing challenges encountered during work with colleagues and families  
  Early interventionists described learning skills and feeling supported by the consultant and by each other which lead to feeling confident in their ability to use these skills to support families |

**Described Benefits**

The first refined sub-question for research question 2 asked how early interventionists described benefitting from attending the series. At the beginning of the series, the consultant stated: “My hope is that you get strengthened in terms of the things
you are doing well and that you get supported and partnered with in the places that you struggle.” Throughout the series, early interventionists discussed challenges encountered during work with families and colleagues. Early interventionists identified feeling overwhelmed by some of the challenges that families experienced such as financial insecurity, mental illness, substance abuse, domestic violence, and terminal diagnoses. Early interventionists discussed feeling frustrated or unsupported by colleagues and administrators. Early interventionists identified that their work could feel “very isolating.” Early interventionists noted the importance of the support they felt from the consultant and each other as well as the importance of the skills they were developing. I asked each interview participant to provide a description of the series. The exact question I posed was: “How would you describe Relationships Count to another early interventionist?”

*Interview Participant 1:* I would say it is a series where you get to work with people from your profession. You get support from not only the facilitator, but also from the people in the series. You are learning active listening skills and learning how to develop relationships with families and learning strategies about how to work with families and talk with families. Supportive. I think supportive would be a key word.

*Interview Participant 2:* It is an opportunity to connect with other people within your profession. It is an opportunity to learn and an opportunity to try to resolve emergent situations. There are times when things pop up and you need to talk
about it and there may be no one to talk about it with. You need to process your own feelings – I think that is really important too. We get so wrapped up that we forget to process our feelings. I do feel bad for the families sometimes, but I have to move on, too. I am not a good processor of feelings.

 asked Participant 3:  It is a necessary part of something I do and I would not have developed professionally without it. It has given me a chance to practice skills, to realize things, given me a chance to not worry about anything and to just learn with everyone else who feels the same way and needs the same things. It is very isolating doing this [early intervention work] in a district. Nobody else really gets it, and I need the experience, the confidence, and the language to explain what I do to other people.

 asked Participant 4:  I would say it is a group of people who are led by someone from infant mental health who has a lot of experience being in homes with families and working with families through their grief process and through their learning process and who has a wealth of knowledge about how to best help us interact with families. It helps us look at how families are reacting and what that might make us feel about them or make us feel about a situation or what we bring as people into this. It helps us look at what we are bringing into a situation so we can see what those dynamics are and so we can be more aware of what is going on and how to walk with parents on this journey.

 A synthesis of their responses indicated primary benefits included feeling supported and learning skills to better support others. The four interview participants
identified the Relationships Count series as a much-needed support for addressing professional challenges. Two interview participants stated that the series should be “mandatory” for all early interventionists. All four interview participants expressed a desire for the series to continue. Interview participants identified that their experience in the series nurtured the development of relationship-based competencies, increased their feelings of being supported, and strengthened feelings of confidence in their ability to provide support to others.

Development of Relationship-Based Competencies

The second refined sub-question for research question 2 asked how particular relationship-based competencies were developed during the series. After examining session transcripts and interview transcripts during the data analysis process, I identified five specific competencies that were developed during the course of the series. These competencies included gathering information through gentle inquiry, reflecting on thoughts and feelings, active listening, providing support without problem-solving, and promoting competence. In the following section, I will describe the manifestation of each relationship-based competency during the series; provide examples of how the competency was addressed, and share insights from interview participants.

Gentle inquiry. Early interventionists discussed, observed, practiced, and experienced the use of gentle inquiry comments and questions. These statements began with phrases such as “I noticed…”, “I was wondering…”, and “Can you tell me more about…?” Gentle inquiry is a strategy for gathering information and promoting reflection through the use of comments and questions. The consultant modeled the use of
gentle inquiry to gather information during check-in conversations, article discussions, and the case presentations. She shared a list of comments and questions that promoted gentle inquiry. Early interventionists discussed and practiced using these statements during group discussions. Early interventionists experienced and observed gentle inquiry as an effective way to gather sensitive information and prompt reflection without provoking defensive reactions.

**Gentle inquiry example.** At the beginning of the series, one interview participant requested help learning “how and what to ask” when working with families. She stated that she did not have prior experience working in early intervention. She asked the group for phrases to use and questions to ask when observing families during home visits. The consultant shared her list of gentle inquiry statements. The interview participant stated that participation in the series helped her learn strategies to communicate more effectively with families. In particular, she noted using the “I notice” or the “Can you tell me more about that?” prompts that the consultant used during group discussion. She commented that it was “helpful” observing the reflective discussion when the consultant asked clarifying and reflective questions instead of jumping to conclusions or making assumptions. She stated that she felt more comfortable asking questions and she felt confident that she had developed strong relationships with the families on her caseload because of what she learned and experienced during the series.

**Perceived benefits of learning gentle inquiry skills.** Early interventionists discussed, observed, practiced, and experienced using gentle inquiry statements during reflective discussions and informal interactions. The preceding example describes the
development and benefit of gentle inquiry skills for the least experienced interview participant. However, the development of this competency was also perceived as beneficial by the most experienced interview participant:

I think that what I found helpful was the list of open-ended questions to guide conversations with parents or staff. Even though I don’t remember each of the questions [during a home visit] – it helps me to stop and think about it before I just ask a question. It helps me pause and think: “what are those questions?” It helps me slow down before I jump in.

The use of gentle inquiry comments and questions to gather information and prompt reflection was perceived as a foundational competency within a relationship-based approach to providing support.

**Reflecting on thoughts and feelings.** Early interventionists discussed, observed, practiced, and experienced reflecting on thoughts and feelings during the series. Early interventionists learned how to encourage reflection through the use of gentle inquiry statements. Early interventionists experienced benefits of reflecting on thoughts and feelings by examining how those reflections influence their work with families. The case presentation and group discussion provided opportunities for early interventionists to observe and experience reflection in action.

**Reflective practice example.** During a case presentation, one early interventionist shared that she had experienced negative feelings about a parent who seemed to engage in mostly negative interactions with her child. The consultant prompted the early interventionists to “tell me a little more about your thinking about that mom’s
perspective.” As the early interventionist began to share more details about the case, she began to reflect on the experience from the mother’s perspective. By examining her negative feelings in the context of the mother’s experience, she began to consider new approaches for offering support to this family. She identified opportunities to build on positive interactions and small successes rather than focusing on attempting to change negative interactions. At the end of the session, she noted feeling more hopeful about her ability to work effectively with this family. During later sessions, she shared anecdotes about the positive relationship she had formed with this parent and the developmental progress of her student. She described “the excitement on mom’s face when she asks me how she [daughter] is going. She [daughter] is talking non-stop now and she wasn’t talking at all before.”

The interaction between the consultant and early interventionist provides an example of how the consultant facilitated reflection on thoughts and feelings and how that reflection supported a shift in perspective. The new perspective influenced how the early interventionist interacted with the family and, ultimately, led to the perception of better outcomes for the parent and child. It also benefited other early interventionists who had the opportunity to discuss, observe, and experience reflective practice in action.

**Perceived benefits of reflecting on thoughts and feelings.** Interview participants shared becoming more aware of the impact of reflective practices on their work with families. One interview participant identified that she felt a deeper commitment to engage in family-centered practices as a result of two years in the series. She stated, “I experienced first-hand how to be – how the reflection process led me to make changes
and led me to realizations. I want to share that practice and benefit with everybody else [on her team].” She described how participation in the series helped her shift from a therapy-focused model of early intervention service delivery to a more collaborative consultative model of working with families and supporting parental competence:

What was helpful was seeing the contrast between the consultative model and the therapy model and seeing the difference in how parents were feeling. I realized the power of how self-reflection actually worked for me and then I realized that I had to provide time for my team members to experience it, too.

Early interventionists observed how the consultant facilitated reflective discussion using active listening and gentle inquiry. They reflected on their thoughts and feelings and discussed how these reflections shaped their practices and interactions with families. Promoting and engaging in reflective practices were perceived as key competencies for developing a relationship-based approach to working with colleagues and families.

**Active listening.** The consultant defined the process of “paying careful attention to what is being said” as “active listening.” She demonstrated active listening by not interrupting and by restating what she heard expressed during case presentations. She shared resources, facilitated activities, and modeled listening without interrupting and restating what she heard. One interview participant appreciated the consultant’s focus on active listening: “I am so goal oriented. It takes a lot to get through to me to just listen.” Throughout the series, many early interventionists discussed the impact of participation on their ability to listen to others.
Active listening example. During the listening activity, the act of listening without interruption prompted early interventionists to experience the potential for uninterrupted listening to provide information to the speaker as well as the listener. During the reflective discussion after the activity, the consultant asked early interventionists to describe their feelings about being a speaker and a listener. Early interventionists identified the difficulty in listening without interruption. Several early interventionists also noted that they listened more carefully because they could focus on the words of the speaker rather than focus on developing a solution. One early interventionist realized that she was able to see her dilemma from a new perspective as a result of speaking about it without interruption. She connected her experience in the listening activity with how families might feel when sharing information. She said she might learn more about her families if she could quiet her thoughts and focus on listening to their stories.

Perceived benefits of learning active listening skills. Early interventionists reflected on the listening skills they were learning and how they experienced opportunities to practice and strengthen those skills. One early interventionist realized that she learned more about herself and the situation when given the opportunity to speak without interruption. One early interventionist noted the focus on active listening helped her remember to focus on the family. She said, “You always feel like you have so much to do, but you are only with a family for one tiny bit of their huge week and if they have something to tell you, you should listen to it.” An interview participant, with over 20 years of experience providing early intervention services, identified that observing how
the consultant facilitated the case presentation helped develop her own active listening skills.

It was so educational to watch how the reflective consultant guides her listening and guides our listening to these case studies and what her comments are and how she elicits feelings from us. I think it has made me a better listener. I still need to work on that a lot. But I think it was so much more helpful to watch that over time and do it several times – to get it more ingrained in us to listen and not be ready to jump in and say something.

Early interventionists recognized that actively listening to families can promote stronger relationships between parents and professionals. One interview participant shared:

Last week I was in a two-hour meeting with a family because they had a lot of questions. And they just needed me to hear some things…they were upset and crying. They wanted me to hear what they thought special education meant to them.

Each interview participant indicated that her experience in the series impacted her ability actively listen and pay careful attention to the words and action of others. Active listening was perceived as an important competency for gathering information as well as a critical skill for providing relationship-based support.

**Support without problem-solving.** Gentle inquiry, reflective practice, and active listening are competencies included within the relationship-based approach to providing support. The consultant modeled how to use these skills while following the recommended MI-AIMH guideline for “avoiding/delaying problem-solving.” The
consultant shared articles and facilitated discussions about providing support while moving away from the role of expert problem-solver. Early interventionists discussed, observed, practiced, and experienced supportive approaches that avoided problem-solving. Early interventionists reflected on their feelings of competence as they addressed professional challenges in a context that nurtured reflection rather than promoted “quick fix” solutions.

**Support without problem-solving examples.** The consultant taught listening skills and encouraged reflection within the context of addressing professional challenges during case presentations and discussion. She promoted awareness of how easy it is to shift into the role of problem-solver. During a reflective group discussion after a case presentation, the consultant reflected “I realized we quickly moved into problem-solving, and I want to make sure this is what you need right now.” During reflective group discussion, early interventionists developed awareness about the types of questions they were asking and support they were providing. Early interventionists reflected on their impulses to provide support during the group discussion when they asked such as “I have a resource to share. Should I wait until the end?” or “Is it ok to ask a question now?” or “Is that problem-solving?” During the group discussion, early interventionists demonstrated awareness of the importance of providing support by listening and prompting reflection so that the case presenter felt supported and confident in her ability to address her own challenges.

**Perceived benefits of learning methods to provide support without problem-solving.** Interview participants discussed how developing an awareness of problem-
solving impulses helps to strengthen the ability to offer support to families and strengthen families’ sense of competence. One interview participant shared: “you can enable a parent to be a better parent without going in and doing things for them. It really does take away their sense of self-worth when you are always going in to fix something because it implies that they were doing something wrong.” She said she has reminded colleagues: ‘look - let’s stop and watch the child and let’s stop and listen to mom and not be so quick to solve anything or do anything or make a suggestion. Let’s just stop and wait and see what the child is doing and mom’s reactions are.” She stated:

I had another social worker tell us that “you can’t drag a family along any faster than they can walk and you have to just walk hand in hand with them”. And I think this series just exemplifies this. It is what we talk about -just walking with them and seeing how they are doing and feeling your way with them versus telling them what to do.

During the series, early interventionists experienced providing and receiving support from the consultant and each other within a context that promoted competence by slowing down, listening, and curbing the impulse to offer “expert” solutions.

**Promoting competence.** Promoting competence was a skill that was addressed throughout the series. The consultant stressed the importance of promoting parental competence during her reflective discussions and through the distribution of supplemental materials. Early interventionists discussed and reflected on their interactions with families and identified methods of providing support that promoted competence as well as methods that led families to feel less competent. The consultant
demonstrated that acknowledging strengths and efforts promoted competence. She encouraged perspective taking to explore how a parent might feel when an “expert” steps in to offer a quick solution to a complicated problem. The consultant demonstrated a model of a relationship-based approach to providing support while promoting competence through her use of gentle inquiry, reflection, and active listening as well as her avoidance of assuming the role of “problem-solver.” Early interventionists had the opportunity to observe and experience this model of support during case presentations and reflective discussions.

*Promoting competence example.* During a case presentation, an early interventionist shared an experience she was having with a mom and a son. The early interventionist felt like she had not been effective in providing the supports the mother requested. As the early interventionist began to discuss the case, she began to speak faster and faster. She described complicated factors in the life of the family and she described the mother as feeling “overwhelmed.” The consultant was sitting next to the early interventionist. She turned to face her and began speaking slowly:

*Consultant:* It almost sounds like you are picking up some of her overwhelmingness

*Early Interventionist C:* I am. I am.

*Consultant:* And exhaustion

*Early Interventionist C:* I do. I feel like that every day after work and I have to decompress.

*Consultant:* That is part of the parallel process that happens. When we sense ourselves getting revved up and dis-regulated it is sometimes in response to or because of
the parent getting revved up and they are getting that way because their child is.

For the next three or four visits, what is it you would like to give her or help her with?

As the early interventionist and consultant continued this discussion, the early interventionist began to slow the pace of her conversation. This interaction provides an example of how the consultant modeled the use of gentle inquiry, reflection, and active listening to provide support in a way that promoted competence. The early interventionist appeared calmer and identified strategies that could help her learn more about the specific needs of this family. Becoming aware of her own feelings and developing a plan for working with the family supported her sense of competence in this situation and her confidence in her ability to support families, in general.

**Perceived benefits of learning methods that promote competence.** Interview participants shared that their experience in the series influenced how they viewed and supported families. One early interventionist participant described receiving an email from a caregiver for one of her students. She noted that the caregiver admitted feeling “incompetent” in her ability to support a child with special education needs. She thanked the early interventionist for helping her learn what to do and for helping her feel more competent. The early interventionist said, “this is exactly what we want - for someone to make that kind of move from feeling powerless to realizing they can make a big difference. I know I was paying attention to that caregiver and trying to be an active listener and asking questions as well as providing information.” An interview participant shared that participation in the series helped her recognize that she has a tendency to
“mother” parents who were the same age as her children. She identified that she tries to pause and reflect on whether her interactions are too “helpful” or if they promote the parents’ ability to support their child.

**Summary of Development of Relationship-Based Competencies**

During the course of the series, early interventionists had many opportunities to discuss, observe, practice, and experience the use of relationship-based competencies. The consultant modeled and demonstrated gathering information through gentle inquiry, reflecting on thoughts and feelings, active listening, supporting without problem-solving, and promoting competence. Early interventionists perceived that these skills and methods provide a foundation for a relationship-based approach to serving others. Early interventionists perceived that their experiences during the series increased their ability to build strong relationships with families.

**Strengthening Competence and Confidence of Early Interventionists**

The third refined sub-question for research question 2 asked how feelings of competence and confidence were strengthened during the series. After completing the data analysis process, it became clear that the relationship-based approach developed during the series strengthened perceived feelings of competence and confidence. Early interventionists reported feeling more competent at knowing what to do and how to be with families. Early interventionists reported feeling more confident that their relationship-based approach was benefitting children and families. Through discussion, observation, practice, and experience of a relationship-based approach, early
interventionists felt more competent and confident in their ability to effectively support families.

**Competence.** The findings indicated that early interventionists felt better prepared to meet the needs of families due to the skills that were developed and the support that was received during the course of the series. Interview participants discussed how the series strengthened their ability to listen to families, to ask questions, to build relationships with others, and to consider how much of their own life to share with families. Interview participants noted the importance of the feelings of support they received and how that influenced how they provide support to others. One interview participant reflected on the parallels between the support provided during the series and the support she provides for her families:

*Interview Participant:* It [complex needs of families] can be overwhelming. I am overwhelmed just talking about it. That is why going to Relationship Counts gives me an opportunity to let it out and let it go. I don’t feel tense or anything during those exchanges.

*Interviewer:* Maybe it is the container for you. You talked about being that container for your families sometimes. Maybe that space in Relationships Count is that container for you.

*Interview Participant:* Yes. It gives me a chance to practice needing the container and gives me the opportunity to practice being the container for somebody else.

**Confidence.** During group discussions and interviews, early interventionists described the importance of the relationships they were forming with the consultant and
each other. The theme of feeling isolated and alone arose during sessions and interviews. Early interventionists described how feeling of isolation can impact confidence in working effectively with families. One interview participant shared:

“I feel a sense of isolation when other people say ‘You are so lucky. All you do is play all day.’ But this work is hard. It really is such a complex job and every day and every situation is different. You can’t even count on what you are going to go in and do because that goes out the window when there is a crisis going on or other questions that pop up.”

She referenced the title of the series “Relationships Count” and made a connection that the title applied to her work with families as well as the relationships that were developed during the series. The supportive interactions between the consultant and early interventionists and between each other led to increased confidence in their ability to work with families. As early interventionists discussed professional challenges, the consultant modeled how to listen and provide support without rushing in to provide a solution. After an early interventionist had mentioned a challenging situation with a colleague, the consultant said, “Your feelings are shared by everyone at this table and it doesn’t help fix your situation, but other people have been there.” When a newer early interventionist reported feeling defeated by comments expressed by her district colleagues, another early interventionist shared “You are exactly what an early interventionist should be. You have a kind heart and spirit….This is not an easy job and I don’t think I could do it without a supportive team.” The early interventionist responded “I have been thinking a lot about the professional advice and suggestions you shared. I
know I will take what was given to me and use it to make my home visits better for both myself and the family.” The support provided during the series allowed early interventionists to feel a stronger sense of confidence in their ability to work effectively with families. The words of one interview participant reflect the importance of the series on her development as a professional:

The reason it is important to continue going to the series is because it is so easy to fall back into the pattern of wanting to fix things. The series is like the lifeline that you always go back to. You might meander in one direction or another, but a monthly session that is regular is an anchor. You are re-oriented to where you need to be so that you can be your best.

**Summary of Perceived Benefits**

During the course of the series, early interventionists identified developing relationship-based competencies that led to strengthened feelings of competence and confidence. Support for promoting the competence and confidence of families was paralleled by the support early interventionists felt through their participation in the series. One early interventionist shared that the series helped her feel calmer as well as more competent:

When you are stressed you can’t learn anything – you are in a state of disconnect.

The series gave me permission to focus on my families in a way that helped promote their health, well-being and their sense of just being happy.

The series served as a model for how to be with families by allowing early interventionists to experience a relationship-based approach that promoted their own
feelings of competence and confidence. The series consisted of opportunities for early interventionists to learn about gentle inquiry, reflective practice, active listening, providing support, and promoting competence. An email from the consultant to the early interventionists and me exemplifies the level of support provided during the series. She wrote:

If I had hand-picked a group of ladies to work with this year, I could not imagine a group with so much wisdom, strength, compassion and commitment. Each one of you, even those that I have known for many years, has challenged, surprised and inspired me to also continue on my own journey of reflection and growth. Your openness and willingness to share so much of yourselves, albeit in different ways and at different times, always seems to support and strengthen each other, often just when someone needs it the most. The sense of connectedness and caring that I feel from each of you for each other is so beautiful. I can only wonder at the hope and care you have each brought to your families each week. They probably never imagined the level of support they would receive when they first were signed into special education.

I am honored and grateful for all of you as a group, and each of you as an individual, who have welcomed me, (and this process), into your life. Thank you for your commitment, not only to this work, but to each other.

This email provides an example of the respect and admiration that the consultant held for each early interventionist. Her strength-based approach promoted feelings of competence and confidence and allowed early interventionists to experience how it felt to give and receive support for addressing challenges within a relationship-based framework.
Survey Results

As mentioned in Chapter 2, I used two quantitative measures to explore the trustworthiness of my findings. The first measure was the Reflective Supervisor Rating Scale provided in Appendix H. This scale was used to probe how early interventionists perceived their relationship with the reflective consultant. The second measure was the Early Intervention Parent Survey provided in Appendix I. This survey was used to create a snapshot of how families describe their relationship with their early interventionist.

Early Interventionists’ Perceptions of Relationship with Reflective Consultant

Based on my observations of the first four Relationships Count sessions, it appeared that early interventionists were developing strong relationships with the consultant. In order to gauge the accuracy of my impressions, I distributed the Reflective Supervision Rating Scale to collected anonymous responses from each early interventionist. The anonymous survey was selected as a method of data collection to provide an opportunity for each early interventionist to share her perspective about the experience without the pressure of being identified. Through my observations at each site, it was clear that the early interventionists cared about each other and about the reflective consultant. The survey results were compared with my observational data. The results indicated that early interventionists perceived their relationship with the reflective consultant to be trusting, safe and supportive. They perceived that the consultant allowed time for early interventionists to generate their own solutions. They
also perceived that their reflective consultant listened carefully and wanted to know how they felt about the experience in reflective consultation. These findings indicated that my perception of the strong relationships being formed by the consultant and early interventionists matched their perceptions of the relationship.

**Families’ Perceptions of Relationship with Early Interventionists**

During the Relationships Count sessions and interviews, early interventionists described building positive relationships with the families they serve. The research questions for this study did not examine family perspectives. However, I felt it was important to gather information that could probe how families perceive their relationships with early interventionists who participated in the Relationships Count series. As stated in Chapter 2, due to the reciprocal and transactional nature of relationships, I wanted to gather data from the families’ perspective to compare with the early interventionists’ perceptions of strong professional-family relationships. The 10 early interventionists distributed the Early Intervention Parent Survey to approximately 75 families. The survey results offer a glimpse into how 25 families perceived their relationships with early interventionists who participated in the series. No information was gathered from the 50 families who did not participate so the results cannot be considered as representative of all families. The results indicated that each of the 25 families identified experiencing a trusting relationship with their early interventionist and felt nurtured, safe, and supported. The majority of responses indicated that families perceived that their early interventionist listened carefully, wanted to know how they felt about what is happening, and allowed time to come up with solutions for challenging situations. The
survey concluded with an open-ended prompt to list three words to describe their relationships with their early interventionist. The most frequently used words were supportive, trusting and caring. I entered all of the words provided by families into an application available at www.wordle.net. This application creates a visual representation of words that is called a “word cloud.” The words entered most frequently are depicted in a larger font. The word cloud in Figure 4 provides a visual representation of the words used by families to describe their relationship with their early interventionist.

Figure 4. Word cloud created from Early Intervention Parent Survey. This figure illustrates the words that 25 families used to describe their relationships with early interventionists. The words “supportive,” “trusting” and “caring” are given prominence because they were used most frequently.
Chapter Summary

The purpose of this study was to identify core components of the Relationships Count series and perceived benefits for early interventionists in order to explore connections between reflective consultation and change in professional feelings and attitudes. The findings indicate core components of facilitation and participation contributed to a relationship-based approach to supporting the professional development of early interventionists. Specifically, the findings indicate that discussion, observation, practice, and experience of the relationship-based approach were associated with perceived development of competencies including gentle inquiry, reflecting on thoughts and feelings, active listening, providing support without problem-solving, and promoting competence. In addition, early interventionists identified strengthened feelings of competence and confidence in their ability to support families. In the following chapter, I discuss the key findings within the context of the literature on reflective consultation and the professional preparation of early interventionists.
CHAPTER FOUR

DISCUSSION

I based the study of the Relationships Count series on the premise that there is a relationship between reflective consultation and changes in early intervention practitioners’ sense of competence and confidence. After a review of the literature, I hypothesized that attending this series of reflective consultation sessions would deepen perceived understanding of relationship-based competencies needed for early interventionists to provide family-centered early intervention services. In order to study the connection between reflective consultation and its impact on practice, it was necessary to begin with an examination of what occurred during the course of the Relationships Count series. The description of findings presented in Chapter 3 illustrates how this series of reflective consultation sessions was facilitated and how early interventionists participated. Further, the findings included an explication of changes in early interventionists’ perceptions related to the development of relationship-based competencies and strengthened feelings of competence and confidence.

In this chapter, I discuss the convergence of the findings from the current study with past and relevant literature. Next, I discuss the unique contributions of the study that extend what was understood within the current literature. Implications for professional development practices and policies are included. Lastly, I discuss the limitations of this study and recommendations for future research.
Convergence and Extension of Definition of Reflective Consultation

The review of the literature in Chapter 1 identified the limited number of published empirical studies about reflective consultation and a corresponding lack of operational definitions for what occurs during group reflective consultation sessions. Throughout the literature, different terms (i.e. reflective supervision and reflective consultation) are used to identify similar constructs and similar terms are used to identify different constructs (i.e. dyadic and group experiences). The current study addressed this research problem by identifying and defining what occurred during a series of reflective consultation sessions. The description of core components of facilitation and participation during the Relationships Count series provide a level of detail about reflective consultation that had not been available. The findings support and extend empirical and conceptual definitions for the content and construct of reflective consultation as a form of professional learning and development.

Defining Format

The format of regularly scheduled monthly group sessions that were facilitated by an infant mental health consultant aligns with the general description of a reflective consultation project in Minnesota (Watson & Neilsen Gatti, 2012). The participants in the current study and the Minnesota study provide early intervention services to children birth to three and their families. The scheduled regularity of the Relationships Count sessions and the group format support the general definition for reflective consultation as it occurred in Minnesota and as it is recommended in the guidelines published by the Michigan Association for Infant Mental Health.
Identifying Essential Features

As mentioned in Chapter 1, Fenichel (1992) identified regularity, collaboration, and reflection as three essential features for reflective supervision. In addition to the documented regularity of the Relationships Count sessions, I observed collaboration and reflection during the series. According to the findings, the early interventionists identified support, reflection, and collaboration as key attributes of the series. Schön’s (1983) concepts of “reflection in action,” “reflection on action,” and “reflection for action” were evident as early interventionists discussed events that occurred in the past, thoughts and feelings about what was happening during sessions, and what they planned to do in the future. The findings align with past literature about the essential nature of regularity, collaboration, and reflection during facilitated reflective sessions.

Defining Core Components

The current study extends the definition of reflective consultation beyond the identification of a group construct with three essential features by describing core components of facilitation and participation. The findings support and extend what was learned during a Delphi study published in 2014. Tomlin, Weatherston, and Pavkov (2014) conducted the study to gather consensus from infant mental health experts about critical components of dyadic and group reflective supervision. Expert consensus was found around the designation of categories that included processes and structures of reflective supervision, as well as behaviors, characteristics, and qualities of reflective supervisors and supervisees (Tomlin et al., 2014). The study of the Relationships Count series contributes to further defining the process and structure of reflective consultation.
(identified in the Delphi study as group reflective supervision). Findings related to the critical components of process and structure indicate that the reflective consultant established guidelines and a format; planned and implemented relationship-based competency building activities; and shared and discussed resources. Findings also contribute to the understanding of the behavior of the facilitator and participants during reflective consultation sessions. The relationship-based approach that was discussed, observed, practiced, and experienced during the series included gentle inquiry, reflecting on thoughts and feelings, active listening, supporting without problem-solving, and promoting competence.

The Delphi study demonstrated that it is possible for experts to come to consensus on the labeling of critical elements of reflective supervision. The authors indicated this was a preliminary study and the perspectives of supervisees and non-experts should be included in future research. Findings from the study of the Relationships Count Series identify and define critical components of what happened during a series of reflective consultation sessions based on my observation and analysis. The findings support and extend what was learned from the Delphi study by providing a level of detail that was not addressed in prior published research. My research methods extend what is known about reflective consultation because the data collection and analysis were derived from the perspectives of early interventionists who received consultation, as well as my own perspective as participant and observer of each reflective consultation session.
Benefits for Early Interventionists

The purpose of the current study was not only to define what occurred during reflective consultation but also to explore perceived benefits for early interventionists. Based on the analysis of interview data, early interventionists described participation in the series as a highly valuable experience because they learned skills, felt supported, and felt more competent and confident in their ability to support others. During the initial study of a reflective consultation project in Minnesota, Watson and Neilsen Gatti (2012) reported that early interventionists found reflective consultation to be more beneficial than other forms of professional development (e.g. attending conferences or participating in workshops.) During the continued study of the Minnesota reflective consultation project, Watson, Harrison, et al. (2013) found that early interventionists believe ongoing participation impacts the way they think and feel about their work and supports their ability to remain “open” during interactions with families. Summers et al. (2007) found that early interventionists feel better prepared to address the mental health needs of children and families after receiving reflective consultation. The perspectives of early interventionists in each study illustrate a shared perception that reflective consultation nurtures and supports professional growth.

The current study extends the literature by exploring how the Relationships Count series strengthened feelings of competence and confidence of early interventionists and enhanced the development of particular relationship-based competencies. Definitions for competence and confidence were based on the work of Bruder, Dunst, and Mogro-Wilson (2011). Competence of early interventionists was defined as believing that one knows
the skills needed to support children and families. Confidence was defined as feeling effective in the ability to use those skills to support children and families. My interpretation of findings presented in Chapter 3 indicated that experiencing the practical application of relationship-based competencies in a decontextualized setting with reflective feedback provided the opportunity to discuss and observe how this approach reduced stress and strengthened feelings of being supported.

**Practical application of relationship-based competencies.** The hands-on experience and practical application of skills during the series led to strengthened feelings of competence in the ability to work with families. Early interventionists discussed, observed, practiced, and experienced using relationship-based competencies over the course of the series. As mentioned in Chapter 3, one early interventionist expressed her concern that she did not know how to talk with parents and gather relevant information during home visits. After the series had concluded, she stated that she felt confident in her ability to build strong relationships with families and that she knew what questions to ask and what to say to parents. She said this knowledge came from observing how the consultant interacted with her and others during the series as well as from the resources that the consultant shared.

The practical application of skills during reflective consultation also led to strengthened feelings of confidence in the ability to support parental competence. Discussing, observing, practicing and experiencing skills such as gentle inquiry, reflecting on thoughts and feelings, active listening, and supporting without solving, contributed to strengthening beliefs that these skills are necessary when working with
families. As exemplified in this quote from Chapter 3, one early interventionist shared “I sit there in Relationships Count and people share their stories and I think ‘How could I fix this?’ …. then you see how, by not interrupting, the presenter finds her own solutions. I think about this when I am with families.” As early interventionists observed the impact of relationship-based competencies used during reflective consultation, they developed confidence in the benefits gained from using a relationship-based approach to support families.

**Decontextualized setting.** Early interventionists reported that the activities and case presentations that were part of the reflective consultation sessions strengthened skills used during work with families. Practice of skills such as active listening and identifying feelings in the decontextualized setting of the group sessions led to strengthened feelings of competence. As reported in Chapter 3, one early interventionist said about active listening “I think it was so much more helpful to watch over time and do it several times – to get in more ingrained in us to listen.”

**Reflective feedback.** Opportunities to examine family-centered practices during case presentations and receive feedback from the reflective consultant and other early interventionists supported the perceived ability to develop strong relationships with families. For example, as mentioned in Chapter 3, one early interventionist described having negative feelings about a parent who exhibited negative interactions with her child. The reflective prompts provided by the consultant encouraged the early interventionist to examine the situation differently. This reflective feedback changed how the early interventionist perceived the relationship between herself and the parent
and between the parent and child. As a result, the early interventionist changed how she interacted with the parent and reported how this led to positive outcomes for the child and parent.

**Stress reduction.** Core components of facilitation and participation of the series are connected to early interventionists’ descriptions of the stress relieving properties of reflective consultation. As reported in Chapter 3, one early interventionist shared the importance of knowing that she had a monthly opportunity to discuss challenges encountered with families. Even though she did not present a case to the group, she identified that she felt more confident in her ability to support families because she felt like she was not alone and that she had the experience and wisdom of the Relationships Count group to support her if needed. As referenced in Chapter 3, another early interventionist stated “When you are stressed you can’t learn anything – you are in a state of disconnect.” Several early interventionists identified that the regularity, format, resources, and opportunities for discussion reduced feelings of stress so that they felt calmer and better prepared to support their families.

**Strengthened feelings of support.** Findings from this study indicate that feeling supported by fellow early interventionists and the reflective consultant was a key benefit of participation in the series. As reported in previous chapters, early intervention work is described as isolating and being part of a community and sharing similar experiences during the series was identified as a critical benefit for early interventionists. The feeling of support occurred because the reflective consultant demonstrated DEC recommended leadership practices that created a “culture and a climate in which practitioners feel a
sense of belonging” (Division Early Childhood, 2014, p. 4). Interview participants noted the value of the support and connection they experienced during the series. Specifically, early interventionists highlighted the importance of feeling supported and providing support to each other due to the complexity of family situations and the challenge of feeling isolated as a home-based early interventionist. As reported in Chapter 3, during an interview, one early interventionist referenced the title of the series. She laughed when she came to the realization that each of the relationships “count” – the relationships between parents and children, her relationships with her families, and the relationships between the consultant and all of the early interventionists who attended the series.

**Convergence and Extension with Early Intervention Practice-Based Problem**

A practice-based problem prompted the development of the reflective consultation series that was the subject of this study. The Relationships Count series was created because early interventionists within a large Midwestern county reported feeling unprepared to address challenges encountered when providing services in home settings. The concerns expressed to the Part C Coordinator by early interventionists and their supervisors mirror concerns identified within the field of early intervention. A national survey of early interventionists reported that only 38% of early interventionists reported feeling confident in their family-centered practices, and only 5% felt competent in these practices (Center to Inform Personnel Preparation Policy and Practice in Early Intervention and Preschool Education, 2007). Findings from the exploratory study and the current study of Relationships Count support published research findings (Summers et al., 2007; Watson & Neilsen Gatti, 2012) that early interventionists perceive reflective
consultation experiences as beneficial. Further, early interventionists who attended the series described the experience as a highly valuable form of professional development that should be “mandatory” for early interventionists. Nine of the ten early interventionists, who participated in the second year of Relationships Count, returned for the third year. One early interventionist did not return only because she moved out of the state. Nine additional early interventionists joined the series for the third year. Clearly, the Relationships Count series meets a need for early interventionists in Oakland County and meets the professional development goals of the Part C Coordinator. Early interventionists reported feeling more confident in their ability to ask questions, to engage in reflective practice, to listen to families with less judgment, and to interact with families in ways that support the families’ sense of competence as parents and caregivers.

**Implications**

The perceived benefits of the Relationships Count series lead to implications for policy and practice. Implications include identifying and offering professional development opportunities that provide hands-on experience and practical application of skills needed for a relationship-based approach to early intervention service delivery. As represented in Chapter 3, the data analysis resulted in the identification of five relationship-based competencies that were addressed during the series: gentle inquiry, reflecting on thoughts and feelings, active listening, supporting without problem-solving and promoting competence. These competencies align with DEC Recommended Practices that highlight the skills needed for families and professionals to work together
to achieve mutually agreed upon outcomes and goals that promote family competencies and support the development of the child” (Division for Early Childhood, 2014, p. 8).

**Professional Development Providers**

Based on perceived benefits of the Relationships Count series, professional development providers may want to consider exploring the use of the findings in their own practices. As a professional development provider, I was interested in synthesizing the findings in a format that could be applied to my work in early care and education. In the fall of 2014, I began to facilitate two reflective consultation groups for early childhood specialists who provide support to preschool teachers. In order to be mindful of core components of facilitation and participation as well as the development of relationship-based competencies, I created a self-checklist for reflective consultation sessions. This checklist could be used by early intervention professional development providers to prompt reflection on thoughts, feelings, and interactions before, during, or after reflective consultation sessions.

**Reflective Questions for Professional Development Providers:**

- Did my relationship-based approach include
  - Gentle inquiry?
  - Reflecting on thoughts and feelings?
  - Active listening?
  - Supporting *without* problem-solving?
  - Promoting competence?
- Did I model each competency?
• Did practitioners have the opportunity to discuss, observe, practice, and experience each competency?

• Did I provide feedback about use of relationship-based competencies during the session?

• Are there resources, activities, or discussion prompts that could strengthen development of each competency?

• Did I perceive that practitioners left the session feeling supported or more competent?

• Why or why not?

• Do I need to follow up with anyone in between sessions?

Policy

The current study identifies critical components of reflective consultation that may be helpful for making decisions about how to provide reflective professional learning opportunities. Implications for policy suggest that the construct of reflective consultation should be considered when determining which professional learning opportunities best meet the needs of early interventionists. The findings from the current study and the Minnesota project (Watson & Neilsen Gatti, 2012, Watson, Harrison, et al., 2013) indicate that the monthly group format for reflective consultation is perceived as beneficial by early interventionists. The monthly time commitment of two hours is minimal compared to the perceived impact of the experience. It is important to note that the reflective consultant in each study met the MI-AIMH recommendations for having
the clinical and infant mental health expertise to facilitate reflective consultation. Policy considerations should be to invest in research and program evaluation of reflective consultation projects in order to further define essential features of the group format, expertise of the reflective consultant, and to connect these features with perceived benefits for early interventionists, children and families.

**Limitations**

In a general sense, application of the findings of this study should be approached with caution. It cannot be stated that reflective consultation leads to a more competent and confident early intervention workforce. The study was limited to examining what happened during this particular series and the perceptions of the early intervention participants. In addition, the findings are limited to my subjective interpretation of the data. Member checks and peer reviews add validity to qualitative research methods, but ultimately, findings are influenced by the perspective of the researcher (Merriam, 2009; Piantanida & Garman, 2009). Specific limitations of qualitative case study research also include issues surrounding the reliability, generalizability and validity of findings (Merriam, 2009). These limitations are addressed in the following paragraphs.

One specific limitation of this study relates to the reliability of findings due to the impact of my presence on the behavior of the early interventionists and the reflective consultant. I attended each session as a participant and observer. I opted to participate in reflective discussion and activities in order to contribute to feelings of trust and security that are needed when disclosing challenges and vulnerabilities. The early interventionists shared many revealing aspects of their work with families and colleagues, and it did not
appear that my presence was a barrier to their discussion. It is more likely that my presence impacted the behavior of the reflective consultant by providing opportunities for peer reflection that are not typically available. The consultant and I discussed the series as it progressed and as she provided member checks of the transcribed session recordings. These discussions may have provided additional support for the consultant to reflect on her role and maintain her focus on the structure and best practice guidelines for reflective consultation.

A second specific limitation of this study relates to the generalizability of findings due to previously established professional relationships between the reflective consultant and some of the early interventionists. The reflective consultant was a former early interventionist who had been employed within the same county as the early intervention participants. The strength of the relationships established by the consultant with early interventionists during the series may have been influenced by previous interactions. The early interventionists’ familiarity with the consultant does not impact the validity of the research findings, but may have contributed to feelings of safety, trust, and respect during the series.

A third specific limitation of this study and published research about reflective consultation relates to the validity of findings due to the lack of connection between early intervention practitioner perspectives to child and family outcome data. I developed the Early Intervention Parent Survey to allow for parent perspectives to be included in the study. The early interventionists distributed 75 surveys to their families after the series concluded. The survey was returned at a response rate of 33%. The data collected
provided descriptive information about how 25 respondents perceived their relationship with their early interventionist. It is not possible to interpret the reason 50 families chose not to participate. It is not possible to draw a connection between the 25 responses and participation in the Relationships Count series. An area for further research could be a more controlled design and distribution of the survey which could be compared to identify parallels between the relationship between the reflective consultant and early interventionists and between the families and early interventionists.

**Recommendations**

Due to the limited number of published empirical studies of reflective consultation, the main recommendations are for researchers about how to move the research agenda forward. The lack of consistent terminology for the construct of reflective consultation should be addressed in future research, practice, and policy recommendations. However, core components of facilitation and participation in the Relationships Counts series were connected to strengthened feelings of competence and confidence to such a degree that the relationship-based approach experienced during the series warrants further examination. Based on perspectives of the study participants and alignment with existing conceptual, empirical, and in-progress work, we can begin to say with some assurance that the construct of group reflective consultation as an approach to professional development when comprised of core components such as discussion, observation, practice and experience of a relationship-based approach leads to perceived benefits that include strengthened feelings of competence and confidence in the ability to deliver family-centered services.
An area for future research could be to study the relationship-based approach that was identified during the data analysis. The approach consisted of gentle inquiry, reflecting on thoughts and feelings, active listening, supporting without problem-solving, and promoting competence. This approach provided an opportunity for early interventionists to discuss, observe, practice, and experience relationship-based competencies within the context of addressing professional challenges. An area for further study could be to explore the role of key elements of this approach within the constructs of group reflective consultation, dyadic reflective supervision, or other professional development offerings. Quantitative measures such as the confidence and competence appraisals used by Bruder et al. (2011) could be used to assess pre and post reflective consultation feelings and attitudes in concert with measures that assess the presence of a relationship-based approach during sessions.

After evidence-based definitions for reflective consultation have been established, a second area of research could be to link shifts in feelings and attitudes that occur during reflective consultation with child and family outcome data. Surveys such as the Parent Early Intervention Survey capture some data about how parents perceive their relationship with their early interventionist. The survey could be designed to identify parallel processes between interactions that occur during reflective consultation and during home visits. Bailey, Raspa, and Fox (2012) recommend looking at family outcomes beyond family satisfaction data. An evaluation of family outcome data for early interventionists who participate in evidence-based forms of reflective consultation might generate understanding about the impact for children and families.
Conclusion

The study of the Relationships Count series addressed what happened during the series and the perceived benefits for early interventionists. The series of reflective consultation sessions was offered as a form of professional learning with the goal of helping early interventionists feel better prepared to provide family-centered services during home visits. The study was developed to explore how the series related to changes in early interventionists’ sense of competence and confidence. In order to study the relationship between the series and its impact on practice, it was necessary to identify what lead to change. Through their participation in the series, early interventionists discussed, observed, practiced, and experienced a relationship-based approach to addressing challenges. Early interventionists identified that feeling supported, in addition to the development of skills, contributed to strengthened sense of competence and confidence. The relationship-based approach of gentle inquiry, reflecting on thoughts and feelings, active listening, supporting without solving, and promoting competence served as a parallel process for the support early interventionists can provide to families and colleagues.
APPENDIX A

EXCERPT FROM MICHIGAN ASSOCIATION FOR INFANT MENTAL HEALTH GUIDELINES FOR REFLECTIVE SUPERVISION/CONSULTATION
Appendix A

Excerpt from Michigan Association For Infant Mental Health Guidelines for Reflective Supervision/Consultation

Best Practice Guidelines for the Reflective Supervisor/Consultant

- Agree on a regular time and place to meet
- Arrive on time and remain open, curious and emotionally available
- Protect against interruptions, e.g. turn off phone, close door
- Set the agenda together with the supervisee(s) before you begin
- Respect each supervisee’s pace/readiness to learn
- Ally with supervisee’s strengths, offering reassurance and praise, as appropriate
- Observe and listen carefully
- Strengthen supervisee’s observation and listening skills
- Suspend harsh or critical judgment
- Invite the sharing of details about a particular situation, infant, toddler, parent, their competencies, behaviors, interactions, strengths, concerns
- Listen for the emotional experiences that the supervisee is describing when discussing the case or response to the work, e.g. anger, impatience, sorrow, confusion, etc.
- Respond with appropriate empathy
- Invite supervisee to have and talk about feelings awakened in the presence of an infant or very young child and parent(s)
- Wonder about, name and respond to those feelings with appropriate empathy
- Encourage exploration of thoughts and feelings that the supervisee has about the work with very young children and families as well as about one’s response(s) to the work, as the supervisee appears ready or able
- Encourage exploration of thoughts and feelings that the supervisee has about the experience of supervision as well as how that experience might influence his/her work with infants/toddlers and their families or his/her choices in developing relationships.
- Maintain a shared balance of attention on infant/toddler, parent/caregiver and supervisee
- Reflect on supervision/consultation session in preparation for the next meeting
- Remain available throughout the week if there is a crisis or concern that needs immediate attention
Best Practice Guidelines for the Reflective Supervisee/Consultee

• Agree with the supervisor or consultant on a regular time and place to meet
• Arrive on time and remain open and emotionally available
• Come prepared to share the details of a particular situation, home visit, assessment, experience, or dilemma
• Ask questions that allow you to think more deeply about your work with very young children and families and also yourself
• Be aware of the feelings that you have in response to your work and in the presence of an infant or very young child and parent(s)
• When you are able, share those feelings with your supervisor/consultant
• Explore the relationship of your feelings to the work you are doing
• Allow your supervisor/consultant to support you
• Remain curious
• Suspend critical or harsh judgment of yourself and of others
• Reflect on supervision/consultation session to enhance professional practice and personal growth
Appendix B

Consent for Exploratory Study

Informed Consent to Participate in a Research Study

Study Title: Relationships Count: A Case Study of a Professional Development Project to Support Relationship-Based Practices in Early Intervention

Principal Investigator: Jennifer Champagne

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

Purpose:

As more early interventionists shift to providing services to families in home settings, there is an increased need for professional development to support this change in practice. New interventionists in the field report needing guidance and more experienced interventionists request additional support as programs shift to providing more home based services with an increased focus on professional-family partnerships. Based on these conversations with administrators and interventionists, there is an identified need for more professional development to include competencies related to relationship-based practices. As a result an 8-part training series was developed which focused on professional use of self, child development, and caregiver-child relationships combined with time set aside for reflective consultation around cases presented by participants.

This specific project would study 3 participants’ perceptions of their experience in the year-long professional development series and how that experience related to their work in homes with families.

Procedures

As a participant, you would participate in two face-to-face interviews over the course of four weeks. The researcher will conduct both interviews at a time, date, and place of your choosing within these time frames. Interviews are expected to last between 30 -60 minutes each and will focus on your experiences in the Relationships Count Series as well as discussion around types of professional learning experiences you have experienced in the past and would like for the future. These questions will be explored
during the first interview with each participant. A second interview will provide an opportunity to explore issues raised during the first interview and to explore issues which may have been raised in other participant first interviews. These interviews will be transcribed into written form for data analysis.

**Audio and Video Recording and Photography**

Each interview will be recorded. Participants will have the choice of video or audio recordings. Participants will have the option of viewing/listening to recording and deleting any/or all responses.

Transcripts of all recordings will be created during the study. Transcripts will not be labeled using personally identifiable information. Transcripts will be maintained indefinitely. They will be stored in a locked file cabinet. Individual notes taken during interviews as well as documents will be maintained indefinitely by researcher. Participant will be aware that their images will recorded and excerpts of interviews may be viewed during conference presentations. The researcher will maintain anonymity of participants in all presentations of research findings - oral and written. Names and other personally identifiable information will be excluded from all presentations of finding.

**Benefits**

The potential benefits of participating in this study may include a continuation of this professional learning series in future years. The interviews could also provide opportunities for each participant to reflect on and deepen knowledge about lessons learned during the training series.

There is an identified need in the field of early intervention to provide relationship based approaches to work with infants, children and their families. Reflective supervision/consultation is a recommended practice to support this approach; however there is a lack of empirical evidence to support the impact of reflective supervision on family centered practices. Participants who volunteer to be part of the interview process will know that their comments will be used to impact their future learning experiences as well as the experiences of others.

**Risks and Discomforts**

Participation is not anticipated to cause physical, psychological, social or legal harm. Participants will respond to questions regarding how the professional development series impacted work with colleagues, children and families.
Privacy and Confidentiality

Your study related information will be kept confidential within the limits of the law. Any identifying information will be kept in a secure location and only the researchers will have access to the data. Research participants will not be identified in any publication or presentation of research results; only pseudonyms will be used.

Your research information may, in certain circumstances, be disclosed to the Institutional Review Board (IRB), which oversees research at Kent State University, or to certain federal agencies. Confidentiality may not be maintained if you indicate that you may do harm to yourself or others.

Voluntary Participation

Taking part in this research study is entirely up to you. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue your study participation.

Contact Information

If you have any questions or concerns about this research, you may contact Jennifer Champagne at 248-420-0493 or Dr. Sanna Harjusola-Webb at shwebb@kent.edu. This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at 330.672.2704.

Consent Statement and Signature

I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I understand that a copy of this consent will be provided to me for future reference.

_________________________________________  __________________
Participant Signature                      Date
APPENDIX C

BROCHURE FOR THE RELATIONSHIPS COUNT SERIES IN 2013-2014
Appendix C

Brochure for the Relationships Count series in 2013-2014

Relationships Count:
A Professional Learning Series for Early Intervention Service Providers

Have you ever wondered...
"The parents want completely different things for this child. How do I handle this?" or
"This family seems so isolated. Am I their only support?" or
"Some families experience so much chaos it feels impossible to be effective." If so, this workshop is for you!

This 8-part series will provide participants with an in-depth understanding of family centered practice, focusing on the relationship building approach of infant mental health. Competencies from the Division for Exceptional Children and Michigan Association for Infant Mental Health will be reviewed and discussed, along with specific strategies to address the complexity of working in the home with families with very young children. Participants will have the opportunity to discuss their work with the guidance of a reflective facilitator. Participants will explore topics in three areas: (1) Professional use of self, (2) Child development, (3) Caregiver-child relationships using an active and cooperative learning approach. The primary focus of this series is for participants to create new perspectives and establish skills for work with children and families, while finding ways to initiate and maintain a reflective work environment.

Location
Wednesdays, 5:00 – 7:00pm
Farmington Alameda ECC
32400 Alameda Street
Farmington 48336

Thursdays, 5:00: 7:00pm
Clawson Baker Center
626 Phillips
Clawson 48017

Dates:
Oct. 9  Nov. 6
Dec. 4  Jan. 8
Feb. 5  Mar. 5
Apr. 2  May 7

Oct. 10  Nov. 7
Dec. 5  Jan. 9
Feb. 6  Mar. 6
Apr. 3  May 8

*The session is offered 2 times each month: Wednesday evenings in Farmington or Thursday evenings in Clawson. Participants should choose the location that works best for them.

Audience: This workshop is for Service Providers working with families who have children birth to 3 years of age. Early Intervention Teachers, Speech Therapists, Occupational Therapists, Physical Therapists, School Social Workers, School Psychologists, and Early On® Service Providers are welcome!

Presented By: Marian Orihel, M.Ed., IMH-E (III), Infant Mental Health Specialist

Registration Information:
Registration is limited to 12 at each site.
Please register in advance with Marian at imhconihel@gmail.com
APPENDIX D

CASE PRESENTATION GUIDING QUESTIONS
Appendix D

Case Presentation Guiding Questions

Possible questions to consider when presenting a case....

1. What do you want to share about the child?
   a. Who is this child? Description
   b. Age at referral, reason for referral, current age, developmental profile
   c. Strengths, challenges, interests of the child
   d. How and when did you begin to work with the child/family?

2. What about the people in the life of the child?
   a. Who is in the home with this child?
   b. Who has primary caretaking responsibilities? What caregiving capacities have you observed?
   c. What strengths have you noticed with the caregiver? Impressions?
   d. Who else is in the family home, or has a role in the life of the child?
   e. How do the caregivers relate to the baby? Do they seem attentive, responsive?

3. How does language/culture impact your relationships with family members and caregivers?
   a. Are there language barriers between you and primary caregivers?
   b. Do you and/or the caregivers hold contrasting views about parenting decisions such as discipline, screen time, soothing, feeding, accepting help from outside resources?
   c. Do you and/or the caregivers hold contrasting views about child behavior such as crying, sleeping, eating, misbehaving or communicating?

4. What has happened in the life of the child and family?
   a. Before birth? During or after birth?
   b. Any separations/losses, medical problems, family mental health issues, abandonment, parental absences, etc.
   c. Current family circumstances?
   d. Protective factors/access to support/worries/risks/concerns

5. What about you?
   a. How does it feel to be with this family?
   b. What is/are your major struggles/successes?
   c. What have you tried? What has worked?
   d. What strengths do you bring to this family?
   e. What can we help you with?
APPENDIX E

CONSENT FOR DISSERTATION STUDY
Appendix E

Consent for Dissertation Study

Informed Consent to Participate in a Research Study

Study Title: Relationships Count: A Qualitative Case Study of a Professional Learning Series for Early Interventionists

Principal Investigator: Jennifer Champagne

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

Purpose:

As more early interventionists shift to providing services to families in home settings, there is an increased need for professional development to support this change in practice. New interventionists in the field report needing guidance and more experienced interventionists request additional support as programs shift to providing more home-based services with an increased focus on professional-family partnerships. Based on these conversations with administrators and interventionists, there is an identified need for more professional development to include competencies related to relationship-based practices. As a result an 8-part training series was developed which focused on professional use of self, child development, and caregiver-child relationships combined with time set aside for reflective consultation around cases presented by participants.

This specific project would study your participation in the year-long professional development series and how that experience relates to work in homes with families and with colleagues.

Procedures
At this stage in the research, the process will be generally defined as documenting the perceptions and experiences of participation in the series. The researcher will take notes during the sessions and will have access to audio recordings of the sessions to transcribe conversations which took place during each session. All identifying information will be excluded from transcriptions. A peer reviewer will review transcriptions with the researcher to identify common themes.
As a participant, you will have the opportunity to participate in two face-to-face interviews over the course of four months. The researcher will conduct both interviews at a time, date, and place of your choosing within these time frames. Interviews are expected to last between 30-60 minutes each and will focus on your experiences in the Relationships Count Series. These interviews will be transcribed into written form for data analysis by the researcher. You will be asked to read transcripts and check for accuracy of meaning and will have the opportunity to omit any details you would not like included in the analysis. After you have approved the transcript, a peer reviewer will have access to transcripts. If you choose to volunteer for the interviews, a secondary consent form will be used to document your consent in the interview process.

**Audio and Video Recording and Photography**

Each session will be recorded by the facilitator for the purpose of reflection and preparation for the next session. The facilitator will share access to the recording to the researcher for transcription purposes. Transcripts of recordings will be created during the study. Transcripts will not be labeled using personally identifiable information. Transcripts will be maintained indefinitely. They will be stored in a locked file cabinet. Individual notes taken during observations as well as documents will be maintained indefinitely by researcher. The researcher will maintain anonymity of participants in all presentations of research findings - oral and written. Names and other personally identifiable information will be excluded from all presentations of finding.

**Benefits**

The potential benefits of participating in this study may include a continuation of this professional learning series in future years.

There is an identified need in the field of early intervention to provide relationship based approaches to work with infants, children and their families. Reflective supervision/consultation is a recommended practice to support this approach; however there is a lack of empirical evidence to support the impact of reflective supervision on family centered practices. Participants in the series will know that their comments will be used to impact their future learning experiences as well as the experiences of others.

**Risks and Discomforts**

Participation is not anticipated to cause physical, psychological, social or legal harm.

**Privacy and Confidentiality**

Your study related information will be kept confidential within the limits of the law. Any identifying information will be kept in a secure location and only the researchers will have access to the data. Research participants will not be identified in any publication or presentation of research results; only pseudonyms will be used.
Your research information may, in certain circumstances, be disclosed to the Institutional Review Board (IRB), which oversees research at Kent State University, or to certain federal agencies. Confidentiality may not be maintained if you indicate that you may do harm to yourself or others.

**Voluntary Participation**

Taking part in this research study is entirely up to you. You may choose not to participate in the series or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue your study participation.

**Contact Information**

If you have any questions or concerns about this research, you may contact Jennifer Champagne at 248-420-0493 or Dr. Sanna Harjusola-Webb at shwebb@kent.edu. This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at 330.672.2704.

**Consent Statement and Signature**

I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I understand that a copy of this consent will be provided to me for future reference.

_________________________________________  ______________________
Participant Signature                         Date
APPENDIX F

CONSENT FOR INTERVIEW PROCESS
Appendix F

Consent for Interview Process

Relationships Count: A Qualitative Case Study of a Professional Learning Series for Early Interventionists

PRINCIPAL INVESTIGATOR: JENNIFER CHAMPAGNE

I agree to participate in an audio-taped interview about my experiences as a participant in the Relationships Count Training Series as part of this project and for the purposes of data analysis. I agree that Jennifer Champagne may audio-tape this interview. The date, time and place of the interview will be mutually agreed upon.

_________________________________________ ____________________________
Signature Date

I have been told that I have the right to listen to the recording of the interview before it is used. I have decided that I:

____want to listen to the recording  ______do not want to listen to the recording

Sign now below if you do not want to listen to the recording. If you want to listen to the recording, you will be asked to sign after listening to them.

Jennifer Champagne may / may not (circle one) use the audio-tapes made of me. The original tapes or copies may be used for:

_____this research project _____publication _____presentation at professional meetings

_________________________________________ ____________________________
Signature Date
APPENDIX G

GUIDING INTERVIEW QUESTIONS
Appendix G

Guiding Interview Questions

1. So to start, I’m curious about your experiences in early intervention. What is your role/experience?

2. What are your overall impressions of the Relationships Count Series?

3. What experiences in the series stand out to you?

4. How would you describe your level of satisfaction with the series?

5. In what ways did your experiences with Relationships Count connect to your experiences with the families you serve?

6. In what ways did your experiences with Relationships Count connect to your work with colleagues?

7. One last question: If you were to describe the Relationships Count Series to another professional, how would you describe it?
APPENDIX H

REFLECTIVE SUPERVISION RATING SCALE
Appendix H

Reflective Supervision Rating Scale

<table>
<thead>
<tr>
<th>Instructions: Circle one of the 4 given options on the right to rate your opinion of each statement below. Each sentence begins with “My supervisor[s]...”</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.) ...and I have formed a trusting relationship.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.) ...and I have established a consistent supervision schedule.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.) ...questions encourage details about my practice to be shared and explored within the supervision session.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.) ...is engaged throughout the entire session.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.) ...is both a teacher and a guide.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.) ...makes me feel nurtured, safe, and supported during supervision.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.) ...shows me how to integrate emotion and reason into case analyses.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.) ...has improved my ability to be reflective.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.) ...allows me time to come to my own solutions during supervision.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.) ...explores my thoughts and feelings about the supervisory process itself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11.) ...and I together set the agenda for supervision.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12.) ...thinks with me about how to improve my observation and listening skills.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13.) ...listens carefully for the emotional experiences that I am expressing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14.) ...encourages me to talk about emotions I have felt while consulting and working with families.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15.) ...keeps families’ and children’s unique experiences in mind during supervision.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16.) ...wants to know how I feel about my consultation or practice experiences.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17.) ...helps me explore cultural considerations in my work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Developed by Jordana Ash, L.CSW, IMH-E(I)58
2016, Mental Health Partners, Boulder, CO
APPENDIX I

EARLY INTERVENTION PARENT SURVEY
Appendix I

Early Intervention Parent Survey

**Early Intervention Survey**

Instructions: Circle one of the 4 given options on the right to rate your opinion of each statement below. Each sentence begins with: "My early interventionist..."

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) ...and I have formed a trusting relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2) ...and my child have formed a trusting relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3) ...is both a teacher and a guide</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4) ...helps me feel nurtured, safe and supported</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5) ...and I set the agenda together for what happens during our visits</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6) ... allows me time to come up with my own solutions for challenges I am having or that my child is experiencing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7) ...thinks with me about how to cope with situations that are challenging</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8) ...listens carefully to what I am saying</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9) ...encourages me to explore what my child might be thinking or feeling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10) ...wants to know how I feel about what is happening</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Three words I would use to describe my relationship with my early interventionist:

________________________________________________________

________________________________________________________

________________________________________________________

Adapted from Reflective Supervision Rating Scale developed by Jordana Ash, LCSW, IMH-E[V]^®
APPENDIX J

GENTLE INQUIRY STATEMENTS
Appendix J

Gentle Inquiry Statements

*Examples of questions/comments to encourage reflective thinking/collaborative relationship work:*

- Can you tell me more about that?
- Does this remind you of another time?
- Have you seen this before?
- Have you felt this way before?
- What is it like for you to be with your baby?
- Do you have any idea what your baby is trying to tell you?
- How do you know when he wants fed,... (changed, held, played with)?
- Have you noticed any times that this has been better? Why do you think it was?
- How does your partner feel about this?
- Do you think it might help if...?
- Why do you think you (or he/she) feel that way?
- Can you tell me about your biggest concern this week?
- What do you think might be causing...?
- What have you tried before?
- Do you think you might be willing to try something different?
- What makes it hard to... hear him cry, for you to say no, to watch him struggle...?
- Do you ever wonder about....?
- How does it make you feel when your baby ......?
- Have you thought about...?
- What concerned you the most this past month?
- How can I support you and your child today?
- Is there anything you would like me to find out about, (help with, look for, etc.)

*Other phrases to encourage communication/exploration of situation:*

I wonder if... (you can tell me more about that visit, etc ....
I wonder why ... (you think your child responded that way, etc,...
I wonder where or when (you learned that, etc ...
I wonder what (your child is experiencing, thinking, feeling, etc ...
I saw that... I noticed that... I heard that... I am amazed that... I experienced that... I am concerned that....
Sometimes a baby likes/needs/wants/shows us/tells us ....
I have seen some children respond to...
I can hear that this is really difficult (frustrating, sad, scary, disappointing, exciting, etc.) for you...
I am curious about...
How wonderful, (important, exciting) for you that your baby recognizes your voice, (watches where you go, copies what you do)

*Marian Orithal, M.Ed, BMH-Ed (III), 2012, Early On - Relationships Count Series*
REFERENCES
REFERENCES


from: http://www.uconnucedd.org/pdfs/projects/per_prep/ConfidAndCompet-
Bruder_Dunst_Mogro-Wilson%202011.pdf.


Consultation Programs. Washington, DC: Georgetown University Center for Child and Human Development.


Hebbeler, K., Spiker, D., Morrison, K., & Mallik, S. (2008). A national look at the characteristics of part c early intervention services. *Young Exceptional Children Monograph Series No. 10.*


