Journal of Marital & Family Therapy

Journal of Marital and Family Therapy
doi: 10.1111/jmft.12016

PREDICTORS AND PROCESSES ASSOCIATED WITH HOME-BASED FAMILY THERAPISTS' PROFESSIONAL QUALITY OF LIFE

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This study examined whether home-based family therapists' (HBFT) workload and clinical experience were associated with therapists' professional quality of life directly and indirectly through self-care activities and frequency of clinical supervision. Hypotheses were tested using structural equation modeling with a sample of 225 home-based therapists. Results suggested that therapists' workload and HBFT experience significantly predicted therapists' professional quality of life. These associations between therapists' workload and HBFT experience were partially mediated through participation in self-care and frequency of clinical supervision. Implications for improving therapists' quality of life are discussed as a function of therapists' workload, clinical experience, self-care, and supervision.

Clinical work can have a negative emotional and psychological impact on therapists. Therapists' interactions with families and exposure to their descriptions of stress and trauma can produce feelings of depression, anxiety, and burnout (Farber & Heifetz, 1982; Rosenberg & Pace, 2006; Sprang, Clark, & Whitt-Woosley, 2007). Thus, it is imperative to understand the factors that can protect against these negative outcomes. Therapists who do not adequately attend to their own self-of-the-therapist concerns are less likely to provide their clients with quality service (Durtschi & McClellan, 2010). Furthermore, theoretical descriptions of home-based therapy have repeatedly suggested that providers engaging in these services face additional demands related to their unique roles and responsibilities (Macchi & O'Conner, 2010).

Although a great deal of literature has been written describing home-based family therapy and the impact of this service on therapists (Boyd-Franklin & Bry, 2000; Cortes, 2004; Snyder & McCollum, 1999; Woods, 1988), much of this past work has been theoretical speculation about these processes. We extend previous research on therapists' professional quality of life by quantitatively testing the direct effects from therapists' home-based family therapy (HBFT) experience and perceived workload on their professional quality of life using survey data from 225 licensed therapists currently providing home-based family therapy services. Additionally, we examine self-care and frequency of clinical supervision as potential mediators of the association between clinical experience and perceived workload.

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This study was supported by a contract with the Kansas Department of Social and Rehabilitation Services, Division of Disability and Mental Health Services.

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REVIEW OF THE LITERATURE

Professional Quality of Life

Professional quality of life is defined as "the quality one feels in relation to their work as a helper" (Stamm, 2011) and is comprised of three domains: (a) compassion satisfaction, (b) burnout, and (c) compassion fatigue. Compassion satisfaction reflects the degree to which therapists experience satisfaction and fulfillment from their work and the services they provide. Burnout is a gradual process of experiencing stress over time that results in therapists' feelings of depletion and dissatisfaction in their work. Compassion fatigue is similar to experiencing symptoms of posttraumatic stress disorder (PTSD) resulting from therapists' exposure to clients with a history of trauma. Several work-related factors (e.g., high caseload demands, lack of supportive work environment, lack of supportive social network) have been found to impact the levels of each domain (Killian, 2008).

Several studies have determined that workload and years of experience have been found to impact the domains of professional quality of life. The effects of clinicians' increased workload can result in a more negative perceived professional quality of life (Deighton, Gurris, & Traue, 2007). Clinicians' increased workload, defined as the number of hours per week with families, results in lower rates of compassion satisfaction and higher rates of compassion fatigue and burnout (Craig & Sprang, 2010; Lawson & Myers, 2011; Sprang et al., 2007). More years of experience has predicted increased compassion satisfaction (Craig & Sprang, 2010), whereas less years of experience has revealed higher levels of compassion fatigue and burnout (Sprang et al., 2007). Thus, clinicians with less experience appear to be at greater risk, compared with more seasoned clinicians. Whereas these studies have examined several factors affecting the individual domains of professional quality of life separately, the current study advances past work by examining the effects on professional quality of life as a unified construct.

Home-based family therapists are especially at risk of burnout due to travel demands, experiencing isolation due to spending long periods away from the office without contact with other professionals, working in unfamiliar communities, and managing caseloads heavily laden with high-risk, multiproblem families (Macchi & O'Conner, 2010). Furthermore, therapeutic progress with multiproblem families is often subtle and slow. Clinicians providing many hours of home-based services while observing subtle client change may assume that their therapeutic efforts are inconsequential, thus contributing to increased feelings of burnout (Meyers & Cornille, 2002). The stress associated with the high demands of working with complex cases contributes to therapists' risk of distress or impairment. Kagan and Schlosberg (1989) suggest that navigating unfamiliar home environments and surrounding communities and monitoring personal safety may place an additional burden on therapists that can lead to increased levels of stress. McWey, Humphreys, and Pazdera (2011) discovered that clients and therapists experience a duality associated with several aspects of HBFT involving perceived benefits coupled with potential barriers to treatment. Examples of stress-inducing duality arise as clients demonstrate naturalistic behaviors while simultaneously experiencing the vulnerability of being observed and therapists balance between an expert versus a nonexpert stance.

Mediating Effect of Therapist Self-Care

Despite therapists' common assumption that self-care improves professional quality of life, this has been proposed far more than it has been tested. One study examining therapist self-care strategies discovered that self-care was not associated with compassion satisfaction, compassion fatigue, and burnout (Killian, 2008). Much of the remaining literature on self-care is speculation in need of empirical evaluation. Professionals dedicated to helping others in need tend to have high levels of caring, compassion, and empathy and are often willing to put aside their own needs to care for others (Meyer & Ponton, 2006). However, Barnett, Johnston, and Hillard (2005) suggest that "the very nature of our [clinical] work requires us to focus on the needs of others, and we may fall into the trap of overlooking our own needs" (p. 259). The association between perceived workload and professional quality of life and the association between clinical experience and

professional quality of life are proposed to be mediated by the effects of therapist self-care. Several articles opine the need for family therapists to engage in a regular program of self-care to manage work-related pressures (Meyer & Ponton, 2006; Negash & Sahin, 2011; Woodford, Bordeau, & Alderfer, 2006; Woolston, Berkowitz, Schaefer, & Adnopoz, 1998). Involvement in regular self-care may enable the therapist to be more fully aware of personal needs in relation to the effects that their home-based work has on their professional well-being (Baker, 2003).

Eastwood and Ecklund (2008) examined the relationship between self-care practices and levels of compassion fatigue with a sample of residential treatment childcare workers. They discovered that positive self-care practices such as engaging in a hobby, reading for pleasure, and taking pleasure trips have a significant association with lower risk of compassion fatigue. Similarly, Lawson and Myers (2011) examined career-sustaining behaviors that reflected such self-care practices as: spending time with family, maintaining a sense of humor, maintaining balance between professional and personal lives, and maintaining professional identity. They discovered that these behaviors were positively associated with counselor compassion satisfaction and reducing compassion fatigue and burnout. A regular practice of self-care may also contribute to a better sense of balance between work and personal life (Matheson & Rosen, 2012).

Mediating Effect of Clinical Supervision

The association between perceived workload and professional quality of life and the association between clinical experience and professional quality of life are also proposed to be mediated by the frequency of clinical supervision. Scholars have observed the instrumental role clinical supervision can have on the work of family therapists (Lawson & Myers, 2011; Negash & Sahin, 2011). While these conceptual pieces describe the invaluable role of clinical supervision, there is actually very little empirical support for the proposed effects of supervision on professional quality of life. Lawson and Myers (2011) noted that respondents placed a lower priority on receiving regular supervision than other self-care practices. Despite the lower level of interest in clinical supervision, clinical supervision is widely believed to support and strengthen home-based family therapists. However, prior assumptions on the role of supervision in improving clinicians' professional quality of life have yet to be empirically examined. This study aims to shed light on the expected positive effects of clinical supervision on professional quality of life.

This study examines the effects of home-based family therapists' clinical experience and perceived workload on therapists' professional quality of life. Although there is initial evidence to suggest that having a higher workload and being less experienced can result in a lower professional quality of life, the underlying mechanisms for this relationship are not well understood.

Research Hypotheses

This study will examine two potential mechanisms: frequency of self-care and supervision. This study contributes to the literature by providing a more sophisticated data analysis of variables affecting therapists' quality of life, in a relatively large sample of home-based family therapists. Additionally, prior studies have examined each subdomain of professional quality of life separately, but have yet to examine how workload and experience influence this more complete conceptualization of professional quality of life as a whole.

We make the following hypotheses based upon the issues addressed in previous articles examining the relationships among our variables of interest. Our *first hypothesis* suggests that increased workload will be related to lower levels of professional quality of life (Craig & Sprang, 2010; Lawson & Myers, 2011; Sprang et al., 2007). Our *second hypothesis* posits that therapists with less home-based family therapy (HBFT) experience will be associated with lower levels of professional quality of life (Craig & Sprang, 2010; Deighton et al., 2007; Sprang et al., 2007). Our *third hypothesis* proposes that therapists' increased use of self-care will mediate the effects of workload and experience on professional quality of life (Eastwood & Ecklund, 2008). Finally, our *fourth hypothesis* is that therapists' increased use of clinical supervision will mediate the effects of workload and in-home clinical experience on professional quality of life (Lawson & Myers, 2011).

METHOD

Sample

A survey was developed and emailed to 831 licensed clinicians who were currently trained to deliver home-based family therapy, representing each of the mental health professions in a Midwestern state (i.e., psychologists, social workers, marriage and family therapists, and professional counselors). The current sample is comprised of 225 licensed therapists who responded (27% response rate) to the email inviting respondents to complete an online survey prior to attending a training workshop. Completion of this state-sponsored workshop was required to receive the certification necessary for billing Medicaid reimbursement of home-based family therapy services. Over 85% of the clinicians in the current study were women. Licensed social workers comprised 59% of the sample, 19% were licensed marriage and family therapists, 11% were psychologists, and 10% were counselors. Between professions, the only difference in regard to the variables tested in the model was that counselors received significantly more supervision, on average, than social workers or psychologists, $F(3, 214) = 3.46$, $p < .05$. In terms of experience, 47% of the clinicians in this study had <1 year of HBFT experience, 28% had between 1 and 3 years of experience, 20% had 4–10 years of HBFT experience, and 5% had more than 10 years of experience. The clinicians reported working in different settings, including 26% in community mental health centers, 57% with private contractors, and 16% in private practice. On average, the clinicians had 8.96 active HBFT cases ($SD = 7.60$) and 71% had never received any formal training in home-based family therapy.

Measures

Perceived workload. One item was used to measure perceived workload: "How would you describe your workload related to the amount of clients you have?" Response categories ranged from 1 = *underutilized—I could use more work*; 2 = *comfortable—I have enough work, but do not feel overloaded*; 3 = *unsure*; 4 = *slightly overworked—I need a small decrease in my workload*; 5 = *overwhelmed—I have more work than I can handle*. Higher scores indicated a higher perceived level of workload. We acknowledge that using a single-item measure has limitations. A single-item measure is less reliable than a measure with multiple items about the same construct (Kline, 2011). Single items are also prone to social desirability bias, and thus responses on perceived workload may be overestimated. However, using a single-item measure, compared with a multiple-item measure, would have the effect of attenuating the strength of the relationship between variables. Thus, the bias in the strength of the statistical associations is likely underestimating the strength of the true effect in the population and may in fact be stronger than those relationships reported in this study.

HBFT experience. One item asked respondents to indicate the number of years they have been specifically practicing home-based family therapy. Response categories ranged from 1 = < 1 year to 5 = *more than 10 years*.

Frequency of self-care. One item was used to measure engagement in self-care activities: "How often do you engage in activities that you consider as self-care?" Response categories ranged from 1 = *rarely,* 2 = *monthly,* 3 = *weekly,* 4 = *daily,* and 5 = *several times per day*.

Frequency of supervision. One open-ended item was used to measure the frequency of supervision: **"**How many hours of supervision do you receive per week?" Participants wrote in the number of hours of supervision received. Responses ranged from 0 to 4 hr per week.

Professional quality of life. The Professional Quality of Life Scale, fourth revision (ProQOL R-IV; Stamm, 2005), was used to measure professional quality of life. The ProQOL R-IV contains the following subscales: (a) compassion satisfaction, (b) burnout, and (c) compassion fatigue. Examples of the items comprising compassion satisfaction included "I get satisfaction from being able to help people" and "I am pleased with how I am able to keep up with helping techniques and protocols." Sample items from burnout included "I have beliefs that sustain me" (reversed) and "I feel overwhelmed by the amount of work or size of my caseload I have to deal with." Sample items measuring compassion fatigue/secondary trauma included "I am preoccupied with more than one person I help" and "I avoid certain activities or situations because they remind me of

frightening experiences of the people I help." The items within each subscale were averaged to maintain the original metric of the scale (0 = *never,* 1 = *rarely,* 2 = *a few times,* 3 = *somewhat often,* 4 = *often,* and 5 = *very often*). This measure has not been subjected to rigorous analyses of its psychometric properties, but is a widely used measure of professional quality of life in over 200 peer-reviewed manuscripts (for a complete bibliography, see www.proqol.org). Alpha reliability coefficients for each subscale of the ProQOL in the current study were $\alpha = .84$ for compassion satisfaction, $\alpha = .72$ for burnout, and $\alpha = .79$ for trauma/compassion fatigue. The burnout and trauma/compassion fatigue subscales were reverse–coded, and a latent variable of professional quality of life was created with these three subscales. Higher scores on the professional quality of life latent construct indicate higher levels of professional quality of life (i.e., lower burnout and trauma/compassion fatigue, and higher compassion satisfaction).

Control variables. Therapist gender, average HBFT caseload, and formal HBFT training were included as control variables in the model. Gender was coded as 1 = *female* and 2 = *male*. One item assessed the average number of HBFT cases on clinicians' caseload (1 = 0–5, 2 = 6–8, 3 = 9–11, and 4 = 12 or more). Formal HBFT training was also controlled for (0 = no, 1 = yes).

Analytic Plan

The proposed model was tested with structural equation modeling, using Mplus 6.0 (Muthén & Muthén, 1998–2011) and maximum likelihood estimation. Full information maximum likelihood estimation (FIML) was used to estimate missing values following the procedures outlined by Acock (2005). To determine whether supervision and self-care mediated the impact of workload and HBFT experience on professional quality of life, a bootstrap analysis of the indirect paths was conducted. Another potential concern with some of our measures is that like so many other studies that use Likert-type scales, this does not yield ratio-level data. Thus, it is important to consider whether or not the results are reliable and whether the assumption for maximum likelihood estimation of multivariate normality is met. However, it has been suggested that as long as ordered categorical variables have at least 5 ordinal categories, and are normally distributed, then maximum likelihood estimation within SEM is acceptable (Finney & DiStefano, 2006). Each variable was examined with descriptive statistics, and the skewness and kurtosis fell in the acceptable range (Kline, 2011); thus, we proceed with increased confidence using our measures and maximum likelihood estimation methods.

RESULTS

Table 1 presents the mean scores, standard deviations, and correlations for variables used in this study. Our primary goal was to analyze direct and indirect relationships between our variables of interest: perceived workload, HBFT experience, frequency of self-care, frequency of supervision, and professional quality of life. To compute the degree to which our variables were interrelated, we used a structural equation model to test each of our hypotheses simultaneously in the same model. Figure 1 shows the results of the structural equation model. The direct effects of (a) perceived workload on professional quality of life and (b) HBFT experience on professional quality of life were tested. Additionally, two mediator variables (i.e., frequency of supervision and self-care activities) were added to this model to account for the underlying mechanism between (a) perceived workload and professional quality of life, and (b) HBFT experience and quality of life. Therapist gender, average HBFT caseload, and whether the clinician had received any formal HBFT training were included as control variables in the model and were regressed on the outcome variable, professional quality of life. The residuals for the burnout and compassion fatigue indicators of professional quality of life were correlated. Model fit was evaluated using the model fit indices recommended by Kline (2011) and (McDonald & Ho, 2002). Goodness of model fit indices indicated a good fit between the proposed model and the data (Kline, 2011): χ^2 (19) = 27.712, $p = .09$; comparative fit index (CFI) = .943; Tucker–Lewis index (TLI) = .942; root mean square error of approximation (RMSEA) = .045 (90% CI = <.001, .079); and standardized root mean square residual (SRMR) = .053. In addition, the standardized factor loadings for the indicators of professional quality of life loaded significantly on the latent construct (range from .52 to .92), providing empirical evidence for the convergent validity of the construct.

Table 1
Means, Standard Deviations, and Correlations between Study Variables (N = 225)

Variable	1	2	3	4	5	6	7
1. Perceived Workload	___						
2. HBFT Experience	−.12†	___					
3. Frequency of Self-Care	−.19*	.01	___				
4. Frequency of Supervision	.09	−.11	.09	___			
5. Compassion Satisfaction	−.27**	.20*	.41***	.12	___		
6. Compassion Fatigue	−.29**	.20*	.08	.18†	.35***	___	
7. Burnout	−.53***	.35***	.30**	.16	.57***	.64***	___
M	2.82	1.96	3.46	1.52	2.83	4.06	3.69
SD	1.21	1.17	.88	1.08	.55	.56	.61

Note. HBFT = Home-based family therapy.
†$p < .10$. *$p < .05$. **$p < .01$. ***$p < .001$ (two-tailed).

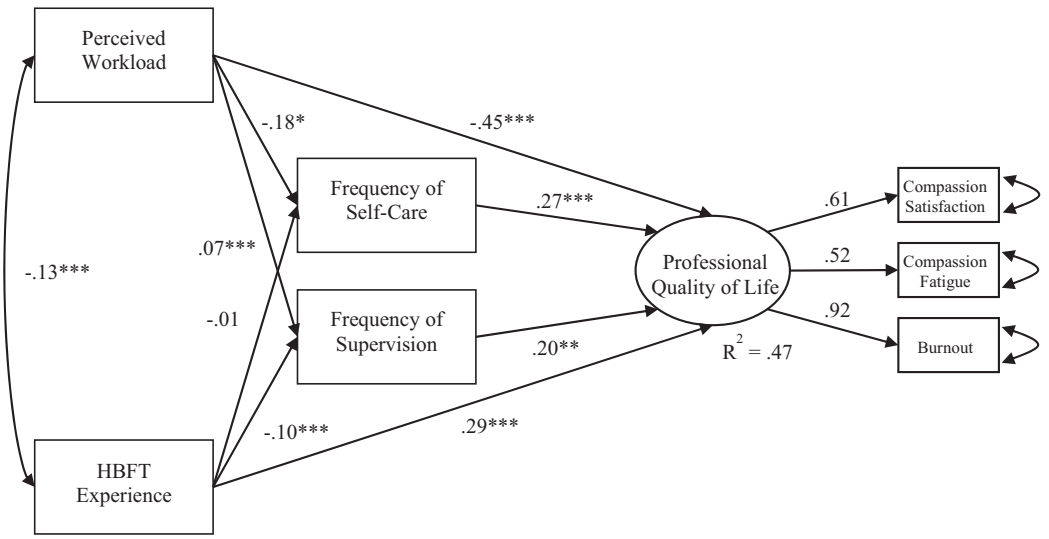

Figure 1. Model with frequency of self-care and frequency of supervision partially mediating the impact of HBFT experience and perceived workload on professional quality of life among HBFT therapists (N = 225). Note: Model fit indices: χ^2 (19) = 27.712, p = .09; CFI = .943; TLI = .942; RMSEA = .045 (90% CI = <.000, .079); SRMR = .053. Standardized coefficients reported. HBFT = home-based family therapy. Gender, professional affiliation, HBFT caseload, and HBFT training were included as control variables in the model and were all regressed on the professional quality of life latent variable. The residuals between frequency of self-care and frequency of supervision were correlated, as were the residuals for compassion fatigue and burnout.
*$p < .05$. ***$p < .001$ (two-tailed).

Figure 1 contains standardized path coefficients in the model. Higher perceived workload was significantly related to decreased frequency of self-care ($\beta = -.18$, $p < .05$), greater frequency of supervision ($\beta = .07$, $p < .001$), and lower levels of professional quality of life ($\beta = -.45$, $p < .001$). HBFT experience was related to less frequent supervision ($\beta = -.10$, $p < .001$) and

higher levels of professional quality of life ($\beta = .29$, $p < .001$), but exhibited no association with self-care behaviors. HBFT experience and perceived workload also significantly covaried in the model, in that more experience as a home-based family therapist was related to perceiving the workload to be lighter ($r = -.13$, $p < .001$). Finally, more frequent self-care ($\beta = .27$, $p < .001$) and supervision ($\beta = .20$, $p < .01$) were significantly related to higher levels of professional quality of life. This model accounted for 47% of the variance in professional quality of life.

To test whether frequency of self-care and frequency of supervision mediated the influence of perceived workload and less HBFT experience on professional quality of life, bootstrapping analyses were conducted (Preacher & Hayes, 2008). The bootstrapping approach is a relatively novel method for assessing specific indirect effects or mediation, and is capable of testing multiple mediators simultaneously. The basic idea behind bootstrapping procedures, as it would be used to test mediation, is to use resampling techniques (with replacement) to compute numerous subsamples from the original data that can be used to obtain more reliable values for the standard errors of the corresponding mediating pathways (for further details see Preacher & Hayes, 2008).

Each hypothesized mediating effect was tested with a 95% confidence interval and 2,000 bootstraps. Three significant indirect pathways were found predicting professional quality of life. *First*, a higher perceived workload was related to a higher frequency of supervision, and more supervision was related to a better professional quality of life for the therapist ($\beta = .02$, $p < .05$, CI = .001, .03). Thus, frequency of supervision mediated the relationship between a higher perceived workload and professional quality of life. These results for this indirect pathway can be interpreted as follows: for one standard deviation unit increase in perceived workload, professional quality of life will increase .02 standard deviation units, via its prior effect on frequency of supervision, while keeping control variables constant. The *second* indirect effect found that a higher perceived workload was also related to lower self-care, whereas self-care was positively associated with a higher professional quality of life ($\beta = -.05$, $p < .001$, CI = $-.07$, $-.03$). In other words, self-care was found to mediate the relationship between perceived workload and professional quality of life. The *third* indirect effect found that therapists with more HBFT experience were related to having decreased frequency of supervision and that decreased supervision was also associated with having a higher professional quality of life ($\beta = -.02$, $p < .01$, CI = $-.01$, $-.03$). Thus, supervision frequency mediated the relationship between HBFT experience and professional quality of life.

DISCUSSION

The purpose of the current study was to explore the direct effects of home-based family therapists' perceived workload and HBFT experience on their professional quality of life and the potential mediating effects of self-care and supervision. The results indicated that a higher perceived workload and having less HBFT experience were directly related to lower levels of professional quality of life. Our study revealed that a higher perceived workload was also related to engaging in less self-care activities and receiving more supervision. Therapists with less HBFT experience were also found to receive more frequent supervision. HBFT experience was not related to frequency of self-care. Receiving more supervision and a higher frequency of self-care activities were both related to a higher professional quality of life. Finally, bootstrapped tests of the indirect pathways revealed that the frequency of supervision mediated the relationship that HBFT experience and perceived workload had on professional quality of life, whereas frequency of self-care only mediated the relationship between perceived workload and professional quality of life.

Effects of HBFT Workload on Professional Quality of Life

A previous study discovered that increased client load potentially exposes a therapist to additional client trauma that can lead to decreased compassion satisfaction, increased compassion fatigue, and eventual burnout (Sprang et al., 2007). Our data also revealed this significant inverse relationship between perceived workload and professional quality of life. There are several implications specifically related to these findings for home-based family therapists. The more hours providing HBFT may correspond with increased work stress. Home-based family therapists experience a number of additional responsibilities that may be linked with increased stress in their

job performance, including complex cases often requiring additional case management, travel time, feelings of isolation due to time away from colleagues and resources available at the office, limited access to the support of a clinical supervisor, as well as stressors encountered within the home environment (i.e., cleanliness; interruptions from unexpected visitors, TV sounds, and phone calls; and safety-related issues in the client family's home and/or community (Lawson & Myers, 2011). Adjusting home-based family therapist's workload may entail some of the following: limiting case loads, providing additional time to complete documentation, and increasing accessibility to resources and support. Future research could examine whether these adjustments could improve the quality of clinical work and reduce the stressors associated with that workload.

Effects of In-Home Clinical Experience on Professional Quality of Life

Deighton et al. (2007) found that, despite accumulated exposure to clients with trauma, years of experience comprise a protective factor against clinical burnout. Indeed, results from the current study provide empirical support to that statement. Thus, more experienced home-based family therapists have an advantage over less experienced home-based family therapists in obtaining higher levels of professional quality of life in HBFT. One possible explanation for this is that with increased HBFT experience, opportunities arise for refining clinical skills and improving therapeutic effectiveness while also learning to better manage the concomitant stressors associated with this unique clinical work. In turn, this increased competence may result in higher levels of professional quality of life. However, to be clear, the current study does not specifically test acquisition of therapeutic skill and mastery as the link between experience and professional quality of life. Certainly, this finding could also be understood as a selection effect, such that therapists who experience decreased professional quality of life may choose to leave home-based work and those who enjoy it have longer work histories. Conversely, those with limited HBFT experience may have a limited repertoire of experiences from which to draw on for conceptualizing and addressing client issues.

Mediating Effects of Therapist Self-Care on Professional Quality of Life

Our data revealing the link between self-care and professional quality of life corroborate Eastwood and Ecklund's (2008) previous finding that suggested that clinicians with increased frequency of self-care practices reported less stress and lower rates of burnout. The results of our study further suggest that increased use of self-care practices may be an important piece of the process in understanding how workload may relate to professional quality of life. This is good news for home-based family therapists who may not have direct control over the size of their caseload because they do have control over a salient mechanism responsible for maintaining higher levels of professional quality of life: self-care.

HBFT clinical experience, on the other hand, was not related to self-care. This may be because home-based family therapists' self-care practices have more to do with the demands and stresses of their work occurring at any level of experience. Based upon the conceptual work of Carroll, Gilroy, and Murra (1999), therapist self-care should optimally be an ongoing, multifaceted program rather than limited to specific, periodic activities that are reactive to increases in stress.

Mediating Effects of Clinical Supervision on Professional Quality of Life

Clinical supervision has the capacity to provide support, resources, and assistance to home-based family therapists struggling with issues of job stress and associated isolation. This study confirmed what Lawson and Myers (2011) have previously suggested that clinical supervision has the potential to improve a therapists' professional quality of life. Questions arise that compel one to look beyond the mere frequency of clinical supervision toward the quality and effectiveness of supervision that may be established over time.

Supervision is often thought of as an important stepping stone for ensuring quality clinical services are being rendered to clients (Cortes, 2004; Zarski, Greenbank, Sand-Pringle, & Cibik, 1991). As supervision appears to provide positive benefits to the home-based family therapists' professional quality of life, therapists' engagement in clinical supervision has the potential to enhance improvements in clinical effectiveness and may also improve staff retention (Eastwood & Ecklund, 2008).

Limitations

This study bears several limitations that should be noted. This study was cross-sectional; thus, longitudinal inferences cannot be made from these results. Next, although these findings suggest that more therapist self-care and clinical supervision have a positive effect on home-based therapists' professional quality of life, it remains unclear what specific self-care behaviors and supervisory approaches are most beneficial. It is likely that there are specific approaches and activities that are more impactful than others. Uncovering these specific factors would provide both clinicians and supervisors with important information about how best to increase their professional quality of life and what activities are most likely to help reenergize their professional identity. A therapist using self-care in response to stress may experience a different benefit than one who engages in self-care activities through an ongoing, intentional program to prevent the occurrence of stress. Additionally, it is possible that the observed association between self-care and professional quality of life may be caused by a third variable, such as the unique personality or environmental characteristics of the therapist. In other words, we cannot rule out from these correlationally based findings that some unmeasured aspect about the therapist or the environment is what is truly driving this observed relationship. These findings should also be considered in light of the somewhat lower response rate of 27%, and these reported results may underestimate or overestimate the true effects in the population. The current and previous studies have not examined the circumstances that may prompt a therapist to engage in self-care activities or request clinical supervision. Further, data revealing an average frequency for supervision and self-care mask potential fluctuations that may occur over time and under varying circumstances.

Related to these concerns about limited quantitative research on the benefits of therapists' self-care and supervision, our analyses relied heavily on single items in the measurement. There are a number of weaknesses with using single items as it relates to reliability and validity. For example, internal reliability cannot be established with only one item. Further, validity may be compromised, especially if the underlying construct of interest is multifaceted. Measurement with a well-established measure that has already been demonstrated to be valid and reliable would have been preferred, but we were not aware of any such measure. Future research should work toward this purpose of improving the measurement of self-care and supervision. It is perhaps surprising that more quantitative research has not been carried out in this area that therapists so commonly discuss as important to therapists' professional quality of life and ultimately in respect to the quality of service provided to our clients. Also, our measure of therapists' perceived workload limited our ability to determine whether that construct simply reflects perception of workload or the effect of the actual number of hours of providing home-based services. Similarities between the definitions of perceived workload and burnout in the ProQOL may have unintentionally inflated the level of correlation between the two measures. A subsequent study should explore possible meaningful differences between the two terms. Finally, the sample was comprised of relatively few marriage and family therapists. MFTs consist of only 7% of all licensed therapists in our state; thus, we oversampled MFTs with 19% in this study. Although MFTs did not differ from the other disciplines in regard to the variables being studied, it is important to acknowledge that results might differ in samples comprised solely of marriage and family therapists.

Implications for Future Studies

Future research should evaluate differing theoretical approaches to supervision and common factors that underlie positive processes throughout supervision that can impact professional quality of life. Additionally, future research should test whether varying types of self-care may yield differing results for perceived professional quality of life. Furthermore, it will be important to identify ways that clinical training and supervision can foster the establishment of an ongoing self-care regimen for trainees.

Additional studies are needed to explore situations and circumstances that may influence therapists' decisions and engagement in the use of self-care and clinical supervision. Furthermore, exploring therapists' use of self-care and clinical supervision may improve our understanding of specific ways they impact professional quality of life. Overall, we call upon researchers to begin gathering quantitative data to test many of our long-held assumptions, such as the importance of

self-care and clinical supervision, to test whether, how, and under what conditions they impact clinicians and client outcomes.

Conclusions

This study found that workload and clinical experience had a direct impact on home-based family therapists' professional quality of life that was partially mediated by the frequency of self-care activities and clinical supervision. The discovery of these significant mediating roles of therapist self-care and clinical supervision suggests the potential relevance of these activities to improve home-based family therapists' professional quality of life. Expanding our understanding of these practices has the potential to guide therapists' development and to inform the use of ongoing self-care and supervisory support. If continued exploration reveals more specific characteristics of self-care and supervision and potential effects on professional quality of life, then it is conceivable that guidelines and policies could be developed to support therapists and supervisors in their attempts to utilize effective self-care. Improving support for therapists attempting to meet the demands of an already-burdened mental health system has the added potential of guiding agencies and clinical supervisors to meet those demands. A refined focus on therapists' developmental and clinical support has the potential to improve therapists' professional quality of life, work experiences, and effective provision of client services.

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