A Qualitative Inquiry into the Systemic Influences upon the Wellness of Home and Community Based Counselor

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A QUALITATIVE INQUIRY INTO THE SYSTEMIC INFLUENCES UPON THE
WELLNESS OF HOME AND COMMUNITY BASED COUNSELORS

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Submitted to the School of Education

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In partial fulfillment of the requirements of
the degree of Doctor of Philosophy

By
Elizabeth Moore

December 2018
A QUALITATIVE INQUIRY INTO THE SYSTEMIC INFLUENCES UPON THE
WELLNESS OF HOME AND COMMUNITY BASED COUNSELORS

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ABSTRACT

A QUALITATIVE INQUIRY INTO THE SYSTEMIC INFLUENCES UPON THE WELLNESS OF HOME AND COMMUNITY BASED COUNSELORS

By

Elizabeth A. Moore

December 2018

Dissertation Supervised by Dr. Debra Hyatt-Burkhart

Home and community based counseling services have become instrumental to the treatment of children and adolescents struggling with mental illness. Counselors working in these systems of care face significant challenges in this unique setting. Most home and community based counselors (HCBCs) face these challenges as recent graduates, not having adequate preparation for the home setting, while receiving little supervision. HCBCs have reported feeling isolated and unsupported and question their effectiveness as counselors. Macchi, Johnson, and Durtschi’s (2014) results point to the importance of self-care to HCBC wellness, especially when the HCBC is lacking supervision. Yet, we are unable to glean from prior research which self-care strategies may benefit the HCBC. It is also unclear how systemic factors may affect HCBC wellness. A broad review of the literature revealed that studies examining the individual and organizational factors that may influence counselor wellness have yielded
inconclusive results. Individual interviews were conducted with eight HCBCs and four supervisors working for three different home and community counseling agencies and data were analyzed using constructivist grounded theory methods. Out of the grounded analysis, this researcher identified seven concepts: helping others, confronting the realities of the work, taking care of yourself, finding support, striving for work-life balance, and moving forward. The experiences shared by the HCBCs and supervisors make it clear that it is not just the individual practices that matter, organizational and supervision practices impact wellness as well. Recommendations for supervisors, HCBCs, counselor educators and agencies are provided.
DEDICATION

This dissertation is dedicated to all of the great women in my life, especially my mom, Cathy Mason, who taught me that I could truly do anything if I put my mind to it.
ACKNOWLEDGEMENTS

This dissertation would not have been possible without the support of my committee, family, cohort, and friends. Just as it takes a village to raise a child, it really does take a village to write a dissertation. I am proud to say that I relied on my village!

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I am very grateful for my family’s support. Mom and Dad, thank you for swooping in when Derik was out of town and I desperately needed help. It was comforting knowing that even when I was not available, Olivia and Will were spending valuable time with you. Uncle Bruce and Aunt Jennifer, thanks for asking about my study when we would see each other. I don’t think I realized it at the time, but you were holding me accountable. It helped me to reach some clarity each time I would talk about my progress or lack of progress in some cases!
Derik, thanks for joining me on this journey— for better or worse. I do wish I could have spared you the pain of reading the whole manuscript! Thank you for your encouraging words and for understanding how important this is to me. I was most amazed that you took the time to explain to Olivia and Will why this work was so important. Your actions and words communicated utter support and that meant the world. Thanks for stepping up when I couldn’t— all those meals that you have cooked, the games that you have played with the kids, and for “picking up” the house when it was needed. I see us as a team, more than ever, and it feels so good!

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Will, thank you for understanding that even though I was working more, I love you and will always be here when you need me. I really appreciate your sense of humor. Your laughter is infectious and brings a smile to all of our faces. Though I did not have as much time with you, Olivia, and Dad, I learned how to make the most of and savor the valuable time that we had together. I relished volunteering at the Halloween party and the opportunity to see your Haunted Gingerbread House at the PPG display. That was so much fun!
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CHAPTER I: THE PROBLEM

Overview

The Adoption and Assistance and Child Welfare Act of 1980 (PL 96-272), the Federal Education of the Handicapped Acts Amendments, Part H, and Knitzer’s (1982) work, Unclaimed Children, spurred the development of home and community-based counseling services for children and families faced with emotional and behavioral challenges (Cornett, 2011; Snyder & McCollum, 1999). The legislation “made it clear that Congress intended Federal social service funding to be used, first, to maintain children in their homes as long as their safety was not compromised” (Snyder & McCollum, 1999, p. 229). Knitzer’s (1982) work documented that an astonishing two-thirds of children with mental health needs were not receiving treatment. In response to these mandates and findings, home and community-based counseling services were conceived to reduce barriers to treatment, prevent hospitalization, and whenever possible encourage families to remain intact (Cornett, 2011; Snyder & McCollum, 1999). Since their inception, home and community-based services (HCBS) have been found to effectively reduce the cost of treatment, decrease rates of hospitalization, and improve outcomes for children and their families (Mann & Hyde, 2013).

Counselors are an integral part of these systems of care. Often HCBSs (e.g., intake and referral, crisis intervention, consultation, and individual, couple, and family therapy) are provided by counselors with Master’s degrees. In these roles, the home and community-based counselor (HCBC) faces unique challenges (Macchi & O’Conner, 2010; Snyder & McCollum, 1999; Werrbach, 1992) as they strive to serve a complex caseload that often includes “multiproblem and multichallenged families” (Lawson,
In an effort to maintain clients in the least restrictive environment, home and community based services are provided to both children and adults. Despite the potentially chaotic and unpredictable nature of this nontraditional therapeutic setting, HCBCs must work with the family to create a space for counseling, and boundaries in the therapeutic relationship must be carefully defined and maintained (Adams & Maynard, 2000; Lawson, 2005; Macchi & O’Conner, 2010; Snyder & McCollum, 1999).

These unique circumstances present significant challenges to the counselors who work within them. Research findings indicate that graduate counseling programs fail to adequately prepare counselors for home-based work (Adams & Maynard, 2000; Christensen, 1995; Stinchfield, 2004; Worth & Blow, 2010). In addition, HCBCs indicate that they receive infrequent supervision (Lawson & Foster, 2005). This is a concerning finding considering home and community based counseling opportunities are often entry level positions and a majority of HCBCs are recent graduates with little experience (Worth & Blow, 2010). As field staff are often afforded little supervision (Lawson & Foster, 2005), many HCBCs feel isolated and unsupported (Bowen & Caron, 2016; Macchi & O’Conner, 2010; Zarski, Sand-Pringle, Greenbank, & Cibik, 1991). Unfortunately, the very crux of the service, offering viable, accessible, and quality treatment for clients at risk for out of home placement may become nearly impossible without adequate counselor training, supervision, and self-care practices.

To attempt to address the concerns and challenges inherent in home-based work, studies have focused on the counselor competencies necessary for the provision of home-based treatment (Hammond & Czyszczon, 2014; Macchi & O’Conner, 2010; Stinchfield, 2004; Tate, Lopez, Fox, Love & McKinney, 2014; Woodford, Bordeau, & Alderfer,
2006) and the need for ongoing training and supervision (Hammond & Czyszczon, 2014; Lawson, 2005; Stinchfield, 2004; Zarski et al., 1991). Conceptual articles have highlighted models of home-based treatment and challenges inherent in the work (Cortes, 2004; Macchi & Conner, 2010). It was not until recently that research began to focus on the implications of supervision, workload, and self-care on home-based counselor wellness (Macchi, Johnson, & Durtschi, 2014). Macchi et al. (2014) discovered that work experience and workload predicted the professional quality of life of a sample of home-based family therapists. Greater work experience and the perception of a more manageable caseload were associated with an enhanced professional quality of life (Macchi et al., 2014). Further, Macchi et al. (2014) found that the frequency of supervision mediated the association between experience and workload on professional quality of life and the frequency of self-care practices mediated the association of workload on the professional quality of life. Given Macchi et al.’s (2014) findings, one would expect self-care to be imperative, especially to home-based counselors lacking regular supervision, a phenomenon noted by Lawson and Foster (2005). Without adequate self-care and supervision, the home and community based counselor may have more difficulty functioning personally and professionally.

Outside of the research conducted by Macchi et al. (2014), counselor wellness, as it pertains to home-based counseling practice, has been largely unexplored. The existing literature fails to address HCBC wellness, individual self-care practices, and agency practices that are beneficial to the well-being of HCBCs. Learning more about HCBC and agency practices that support wellness would benefit counselors, supervisors, counselor educators, agencies, and managed care organizations. It is hoped that
supervisors will be able apply the study’s findings directly to their practice as they assess
wellness and self-care practices, provide strategies for self-care, and develop improved
standards for supervision and training.

The aim of this study is to learn more about the process of maintaining wellness inside and outside of one’s work as a HCBC. Using grounded theory, a theoretical model of HCBC wellness will be advanced by conducting in-depth interviews with HCBCs to determine how systemic influences and individual counselor practices may interact to maintain counselor wellness. This chapter will describe the importance of counselor wellness to clinical practice. The wellness constructs most frequently referenced in the literature will be defined. A summary of the extant research surrounding the systemic factors that influence counselor wellness will be provided. Finally, an overview the research questions, qualitative approach, and methodology of this inquiry will be presented.

**Counselor Wellness**

**Wellness Defined**

Though many definitions and models of wellness exist in the literature, it is generally agreed that wellness is a multidimensional, salutogenic, and synergistic construct that exists on a continuum (Roscoe, 2009). Across models, the dimensions noted most often include social, emotional, physical, intellectual, spiritual, psychological, occupational, and environmental wellness (Roscoe, 2009). Myers, Sweeney, and Witmer’s (2000) definition of wellness captures the holistic and individual nature of wellness. Myers et al. (2000) define wellness as:

A way of life oriented toward optimal health and well-being in which body, mind,
and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving (p. 252).

Wellness is deeply ingrained in the history and roots of counseling (Myers, 1991, 1992). In addition, wellness has been described as the “cornerstone of the counseling profession” (Blount & Mullen, 2015, p.100). Despite the importance of wellness, much of counselor training and supervision focuses on the negative effects of the work (vicarious trauma, burnout, and compassion fatigue), while ignoring the potential for satisfaction and growth from even the most challenging counseling work (Hyatt-Burkhart, 2014). Myers (1991) reminded us that wellness must be the focus personally and professionally:

We must take pride in a paradigm that establishes our unique contributions as resulting from a commitment to a philosophy of wellness. To achieve this end, we need to start at home with the development of wellness life-styles in ourselves and our families. We cannot promote what we do not first believe and model. If wellness truly is a goal for our clients, it must be for each of us as well, and in all the various systems which we function (Premise 6, Action Task 8).

Wellness continues to be as integral to the counseling profession today as it was at the end of the 20th century, when wellness paradigms were first espoused and rigorous research into the conceptualization and assessment of wellness began (Blount & Mullen, 2015; Myers, 1991, 1992). In 2010, in response to the initiative 20/20: A Vision for the Future of Counseling, the American Counseling Association (ACA) adopted a unified definition of counseling that included wellness as a key component (Kaplan, Tarvydas, & Gladding, 2014). According to this definition, counseling is “a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness [emphasis added], education, and career goals” (Kaplan et al., 2014, p. 366). The 2016 Council for Accreditation of Counseling and Related Educational
Programs (CACREP) standards emphasize wellness in reference to human growth and development, addiction, and family counseling (CACREP, 2015). Further, the 2016 CACREP standards task counseling programs to provide a curriculum that includes “ethical and culturally relevant strategies for promoting resilience and optimum development and wellness across the lifespan” (p. 11), acknowledges the “role of wellness and spirituality in the addiction and recovery process” (p. 19), and encourages practice that fosters “family wellness” (p. 30). It is clear that wellness should be the core of our professional identity.

As Myers (1991) stated, to be able to maximize client wellness, counselors must practice and model wellness. Yet, parallel requirements for tending to the wellness of counselors are missing from the 2016 CACREP standards. The 2016 CACREP standards state that the counseling curriculum must provide “self-care strategies appropriate to the counselor role” (CACREP, 2015, p. 10). However, the standards do not emphasize the instrumental role of counselor educators and university supervisors in assessing, nurturing, and ensuring counselor wellness in training and beyond (CACREP, 2015). The 2014 ACA (American Counseling Association) Code of Ethics provides guidance for counselors, counselor educators, and supervisors. Counselors are reminded to “engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities” (ACA, 2014, p. 8). In addition, the 2014 ACA code of ethics states that educators must “provide appropriate accommodations that enhance and support diverse student well-being and academic performance” (p. 15).
To foster counselor wellness and assist counselors with adhering to a wellness approach, wellness models of supervision have been developed (Blount & Mullen, 2015; Hayden, Williams, Canto, & Finklea, 2015; Lenz & Smith, 2010). These supervision models arose in response to counseling wellness paradigms such as the Wheel of Wellness (Myers et al., 2000) and Indivisible Self Model of Wellness (IS-Wel) (Myers & Sweeney, 2004, 2008), and the growing realization that counselor wellness is often a missing component in counselor training and supervision (Blount & Mullen, 2015; Hayden et al., 2015; Lenz & Smith, 2010). These models specifically target professional counselors (Lenz & Smith, 2010), counselors-in-training (Blount & Mullen, 2015), and counselors working with trauma survivors (Hayden et al., 2015).

**Constructs of Counselor Wellness**

Counseling work can negatively impact counselors (Brockhouse, Mstefi, Cohen, & Joseph, 2011; Hyatt-Burkhart, 2014; Kadambi & Truscott, 2004; Killian, 2008; Kulkarni Bell, Hartman, & Herman-Smith, 2013; Sprang, Clark, & Whitt-Woosley, 2007; Thompson, Amatea, & Thompson, 2014; Williams, Helm, & Clemens, 2012), and counselor impairment has been recognized to be problematic (Lawson, 2007; Lawson & Venart, 2005; Holliman & Muro, 2015). Less is known about the phenomenon of wellness among counselors (Lawson & Myers, 2011; Hyatt-Burkhart, 2014). Researchers are focusing time and effort to uncover the preventative and resiliency factors associated with the wellness of counseling professionals (Ben-Porat & Itzaky, 2009; Brockhouse et al., 2011; Hyatt-Burkhart, 2014; Kulkarni et al., 2013; Lawson, 2007; Lawson & Myers, 2011; Macchi et al., 2014). Additionally, researchers are
attempting to discern how wellness factors may prevent and buffer the negative effects of the work (Kulkarni et al., 2013; Thompson et al., 2014; Williams et al., 2012).

Though there have been many terms referenced in the literature, the constructs most commonly used to describe and measure counselor well-being are wellness (Myers, 1991, 1992; Myers et al., 2000; Roscoe, 2009), professional quality of life and compassion satisfaction (Stamm, 2010), and sense of coherence (Antonovsky, 1996). Instruments have been developed to quantify an individual’s level of wellness, professional quality of life, and sense of coherence and quantitative studies attempt to understand how systemic influences may enhance, maintain, or reduce wellness. However, a quantitative approach is inadequate to identify the systemic factors inherent in the nature of home and community based work and how these factors may influence HCBC wellness.

**Professional quality of life and compassion satisfaction.** Professional quality of life refers to the satisfaction and happiness that one is able to derive from one’s work (compassion satisfaction), and the negative effects of the work, often referred to as compassion fatigue (Stamm, 2010). According to Stamm’s (2010) conceptualization of professional quality of life, compassion fatigue is comprised of burnout and secondary stress. The professional quality of life of the helper (i.e., compassion satisfaction and compassion fatigue) is influenced by the work environment, the individual characteristics of the helper, and exposure to trauma in one’s work (Stamm, 2010).

**Sense of coherence.** Antonovsky’s (1996) salutogenic model of health urges health professionals to focus on health promotion by conceptualizing health along a continuum of “healthy” and “dis-ease” instead of “health/illness” and “well/diseased” (p.
14). Antonovsky was inspired by female survivors of Nazi concentration camps, many of whom despite their adversity adjusted well physically and mentally (Bowman, 1996). Instead of treating illness and symptoms, he encouraged practitioners to consider a person’s sense of coherence, the ability to find meaning, comprehend life’s challenges, and use one’s resources to cope (Antonovsky, 1996). Antonovsky was frustrated with the medical community’s emphasis on prevention, risk factors, and illness, contending that a pathogenic orientation poses a moral dilemma by ignoring the whole person and the “salutary factors” that may be health sustaining. Following the medical model, patients are taught to identify and minimize risk factors (Antonovsky, 1996). Antonovsky (1996) used the analogy of rescuing someone who is drowning to illustrate efforts to treat illness and disease. According to Antonovsky (1996), following the medical model, extreme life-saving measures are applied “downstream” (p. 12) to save someone who is drowning. Using the same analogy, the “upstream” (Antonovsky, 1996, p.13) measures include preventative efforts to prevent swimmers from entering the dangerous waters. The salutogenic model would consider those drowning, the conditions of the river, and the other swimmers (Antonovsky, 1996). Antonovsky (1996) stated, “to remain with the metaphor: we are all, always, in the dangerous river of life. The twin question is: How dangerous is our river? How well can we swim?” (p. 14).

**Individual Factors of Counselor Wellness**

It is theorized that individual factors such as self-awareness, years of experience, and engagement in self-care behaviors may facilitate wellness and prevent symptoms of vicarious trauma, burnout, and compassion fatigue among professionals in the field (Figley, 2002; Lawson & Vernart, 2005; McCann & Pearlmann, 1990). In addition,
experts believe that a personal history of trauma, a challenging caseload, and greater exposure to client traumatic material will negatively affect counselor wellness (Killian, 2008; Lawson & Vernart, 2005; McCann & Pearlmann, 1990). In the past decade, researchers have attempted to identify the individual factors that are associated with wellness among mental health clinicians across disciplines using quantitative and qualitative methods (Hyatt-Burkhart, 2014; Killian, 2008; Kulkarni et al., 2013; Lawson, 2007; Lawson & Myers, 2011; Linley, Joseph, & Loumidis, 2005; Macchi et al., 2014, Sprang et al., 2007; Williams et al., 2012 ). These studies have begun to elucidate how coping strategies (i.e., self-care behaviors) and years of experience affect counselor wellness. The effects of experience, self-care, and exposure to trauma on one’s ability to carry out and be satisfied with the work continue to remain uncertain. Research to date has produced inconsistent and inconclusive results.

**Self-care behaviors.** Killian (2008) interviewed twenty clinicians (i.e., social workers, counselors, marriage and family therapists, and Ph.D. counseling psychologists) in order to identify the coping strategies perceived to be beneficial when working with trauma survivors. In Killian’s (2008) study, clinicians perceived debriefing with colleagues and supervisors, exercise, and spiritual practices as important coping strategies. Lawson (2007) administered the Career Sustaining Behaviors Questionnaire (CSBQ; Stevanovic & Rupert, 2004) and ProQOL-IIIR (Stamm, 2005) to a sample of 1000 members of the American Counseling Association. Using the CSBQ, participants rated the importance of 34 career-sustaining strategies (e.g., maintain self-control over work responsibilities, maintain self-awareness, and receive regular supervision) “in helping the counselor to function effectively and maintain a positive attitude” (Lawson,
2007, p. 23). In Lawson’s sample, counselors who had lower scores of burnout and higher scores of compassion satisfaction endorsed a sense of humor, self-awareness, a work-life balance, objectivity, a positive outlook, time with friends and family, spirituality, staying abreast of literature in the field, quiet leisure, a strong professional identify, and continuing education as practices that support and sustain their work as a counselor.

While self-care strategies have been identified, the efficacy of these coping skills in protecting and enhancing counselor wellness has not been empirically validated in the literature (Bober & Regehr, 2006; Killian, 2008; Lawson, 2007; Thompson et al., 2014). Bober and Regehr’s (2006) study found that there was no association between the frequency of engaging in self-care and a reduction of secondary stress symptoms. Similarly, affective coping style and specific self-care strategies did not explain compassion satisfaction, compassion fatigue, and burnout (Killian, 2008). Lawson’s (2007) study contradicts the existing conceptual literature that indicates that regular vacations, engaging in physical activities, putting thoughts of clients aside, self-reflection, frequent breaks, and personal therapy are effective self-care practices, as these self-care practices were not frequently practiced by counselors in the sample (Lawson, 2007). Emotionally negative or avoidant coping strategies such as denial and venting were found to be associated with increased reports of work stress (Killian, 2008), and other maladaptive strategies such as distraction, self-blame, and substance abuse have been associated with burnout (Thompson et al., 2014).

**Wellness.** Greater levels of compassion satisfaction (Thompson et al., 2014) and wellness (Lawson & Myers, 2011) were found to be associated with reduced levels of
burnout and reduced levels of compassion fatigue. Hyatt-Burkhart (2014) interviewed a sample of child and adolescent residential mental health workers specializing in trauma work. The mental health workers were experiencing high levels of both compassion satisfaction and compassion fatigue. The mental health workers described finding satisfaction in their work despite the negative effects of managing difficult caseloads complicated by trauma (Hyatt-Burkhart, 2014). Hyatt-Burkhart’s findings support the body of research indicating that wellness and compassion satisfaction may buffer the negative effects of the work (Lawson & Myers, 2011; Thompson et al., 2014).

**Years of experience.** In addition to self-care, the impact of years of experience on the professional quality of life of clinicians has been explored (Baird & Jenkins, 2003; Linley & Joseph, 2007; Thompson et al., 2014). However, these studies have produced conflicting results. For instance, Baird and Jenkins (2003) found that younger clinicians were more likely to experience burnout. Kulkarni et al. (2013) and Macchi et al. (2014) found an association between greater levels of experience and compassion satisfaction. Linley and Joseph (2007) found an opposite phenomenon in their research; years of experience was associated with higher levels of compassion fatigue. Whereas Thompson et al. (2014) analysis indicated that length of time in the field did not predict compassion fatigue. Of these studies, only one study to date, Macchi et al. has been conducted with a sample of home-based clinicians.

It is evident that a pathological view of the work has been a primary focus in the literature (Hyatt-Burkhart, 2014). There is a much greater emphasis on what makes us ill or keeps us from becoming ill, instead of what keeps us well (Antonovsky, 1996; Bober & Regehr, 2006; Elwood, Mott, Lohr, Galovski, 2011; Hyatt-Burkhart, 2014; Thompson,
et al., 2014; Williams et al., 2012). In addition, this researcher discovered that the results from these empirical studies (Baird & Jenkins, 2003; Bober & Regehr, 2006; Killian, 2008; Kulkarni et al., 2013; Linley & Joseph, 2007; Macchi et al., 2014; Thompson et al., 2014; Williams et al., 2012) conflict with one another or are inconclusive. The factors associated with counselor wellness have become a recent focus in the literature (Kulkarni et al., 2013; Lawson & Myers, 2011; Macchi et al., 2014); however, only one study evaluates the professional quality of life of home-based clinicians (Macchi et al., 2014). While Macchi et al.’s (2014) study identified that frequency self-care mediates the effect of workload on professional quality of life for a sample of home-based family therapists, the specific self-care strategies utilized by these therapists were not explored. Qualitative analyses that explore the nature of HCBC wellness are needed.

Organizational Factors of Counselor Wellness

Given the systemic nature of home and community based interventions and the challenges inherent in the work, it is necessary to look more broadly at agency factors that promote wellness. It has been suggested that organizational factors may mediate or moderate the effect of trauma work on counselor wellness (Ben-Porat & Itzhaky, 2009; Killian, 2008; Pearlman & Maclan, 1995; Skovholt, Grier, & Hanson, 2001; Trippany, Kress, & Wilcoxon, 2004). Workshops and continuing education regarding the risk and prevention of vicarious trauma, burnout, and compassion fatigue have been recommended in the literature (Ben-Porat & Itzhaky, 2009; Killian, 2008; Pearlman & Maclan, 1995; Trippany et al., 2004). Supervision and peer consultation have also been theorized to protect against and prevent vicarious traumatization and compassion fatigue (Ben-Porat & Itzhaky, 2009; Skovholt et al., 2001).
Qualitative and quantitative analyses have supported the conceptual literature (Killian, 2008). Counselors have indicated that a demanding caseload, lack of supportive work environment, lack of supervision and other social supports, are risk factors for compassion fatigue and burnout (Killian, 2008). Counselors (Lawson & Myers, 2011) and psychologists (Stevanovic & Rupert, 2004) have endorsed case consultation as a career sustaining behavior, a personal and professional practice used to improve wellness. In addition, counselors who indicate higher levels of compassion satisfaction and lower levels of burnout were more likely to endorse the importance of continuing education and maintaining control over work responsibilities as career sustaining behaviors (Lawson, 2007). These studies indicate that case consultation, supervision, agency support, continuing education, may be organizational factors that protect against compassion fatigue and burnout and enhance counselor wellness.

Up until the past decade, there was little empirical evidence that supervision and other organizational factors would reduce vicarious trauma and facilitate compassion satisfaction (Bober & Regehr, 2006). Bober and Regehr’s study (2006) contradicted previous theoretical models that suggest supervision would reduce or prevent vicarious trauma. Despite the finding that therapists who valued supervision were more likely to engage in it, Bober and Regehr (2006) discovered that engaging in supervision was not associated with reduced levels of secondary trauma symptoms.

To address this contradiction, recent studies have used advanced statistical methods such as path analysis (Williams et al., 2012), multiple regression (Brockhouse et al., 2011; Killian, 2008; Kulkarni et. al, 2013; Thompson et al., 2014), and structural equation modeling (Macchi et al., 2014) to ascertain whether compassion fatigue,
compassion satisfaction, and counselor wellness can be predicted, mediated, or
moderated by supervision and other organizational factors. Thompson et al. (2014) found
that 31% of compassion fatigue and 66.9% of burnout was predicted by perceptions of
working conditions, mindfulness, coping strategy use, and compassion satisfaction.
Killian’s (2008) model accounted for 41% of the variance of compassion satisfaction as
predicted by social support, work hours, and internal locus of control, 54% of compassion
fatigue as predicted by work drain, powerlessness over systems serving clients, emotional
self-awareness, and history of trauma, and 74% of burnout as predicted by frustrations
with agency policy, lack of recognition for work, low morale, neuroticism, and feelings
of strong negative affect.

Of these studies, the work related factors that may affect compassion fatigue,
burnout, and compassion satisfaction include: work drain, lack of control over one’s
work, frustration regarding agency policies, lack of recognition, low morale, social
support, work hours, and working conditions. It is interesting to note that Killian’s and
Thompson et al.’s models did not predict all of the variance in compassion fatigue,
burnout, and compassion satisfaction. This indicates that there may be other factors
impacting professional quality of life that were not measured in the study or that the
measures used did not effectively represent the variables entered into the analysis.

Williams et al. (2012) randomly selected community mental health centers from
which to obtain a sample of 131 mental health counselors who completed measures of
childhood trauma, personal wellness, supervisory working alliance, job satisfaction,
workload, and vicarious trauma. Contrary to what was expected, workload and
organizational culture did not affect the development of vicarious trauma. Similarly,
Brockhouse et al. (2011) found that organizational support as measured by the Perceived Organizational Support Scale (Eisenberger, Stinglehamber, Vandenbergh, Sucharski, & Rhoades, 2002) did not moderate the relationship between vicarious exposure and growth.

Macchi et al. (2014) is the only study to date that assessed the professional quality of life of home-based clinicians, specifically those who self-identified as home-based family therapists. Macchi et al. (2014) explored the relationship between workload, experience, frequency of self-care activities, and frequency of clinical supervision on the professional quality of life of home-based family therapists. A higher perceived workload was associated with more frequent supervision and, subsequently, a better professional quality of life (Macchi et al., 2014). In addition, higher perceived workload was associated with reduced self-care, and self-care was found to be associated with greater professional quality of life (Macchi et al., 2014). For counselors, engaging in more self-care was associated with higher levels of professional quality of life (Macchi et al., 2014). Macchi et al. also discovered that greater work experience was associated with reduced rates of supervision and improved professional quality of life. The effects of supervision varied depending on the experience of the home-based family therapist. If the home-based counselor was less experienced, supervision acted to improve professional quality of life for those who perceived themselves as having a challenging workload (Macchi et al., 2014).

The studies referenced above provide a foundation to better understand the organizational factors necessary for improving professional quality of life and protecting against the effects of vicarious trauma. However, they certainly do not provide a
complete picture of the process of maintaining a professional quality of life for HCBCs. The studies contradict one another, and it is unclear which agency practices improve professional quality of life (Killian, 2008; Thompson et al., 2014; Williams et al., 2012) and whether supervision improves wellness and protects against compassion fatigue and burnout (Bober & Regehr, 2006; Macchi et al., 2014). Further, each study utilizes different measures to approximate differing variables and the results indicate unexplained variance (Bober & Regehr, 2006; Killian, 2008; Macchi et al., 2014; Thompson et al., 2014; Williams et al., 2012). While reviewing the literature, this researcher found that the results from these studies contradict one another. Additional studies are needed to explore the means for enhancing the professional quality of life for counselors, specifically HCBCs. Qualitative analyses are well-suited to exploring an area of study that is little researched (Creswell, 2013). Qualitative studies are needed to identify the unique agency and supervisory practices associated with wellness of HCBCs (Ben-Porat & Itzhaky, 2009; Killian, 2008; Lawson, 2007).

**Special Considerations of HCBCs**

**Challenges inherent in home-based services**

As described above, it has been documented that systemic factors may influence HCBC wellness in general, but the systemic factors specific to maintaining HCBC wellness have not been explored in depth. Practicing in the home and in community settings, outside of the traditional outpatient setting, further challenges the professional counselor. Many HCBCs provide services to children and their families. The children receiving these services have a mental health diagnosis, may be involved with larger systems such as the juvenile justice and/or child protection agencies, and are at risk for
out of home placement (Hodas, 2004). The HCBC’s caseload often includes children and families who have a history of mental health concerns, trauma and loss, lack of support systems, and a lower socioeconomic status (Werrbach, 1992). By providing services in the home, community, or school, counselors are able to target the behaviors and symptoms in the environment in which they occur (Hodas, 2004). However, Macchi and O’Conner (2010) note that increased distractions (e.g., phone ringing, neighbors visiting, and noises in the background) occur in the home and present as an additional stressor to the counselor. There may also be safety concerns present in the home and/or community that may present additional challenges, specifically to the novice HCBC (Fuller, 2004).

**The Provision of Behavioral Health and Rehabilitation Services (BHRS)**

**A Unique Home and Community Based Service**

In Pennsylvania, BHRS were added to the Medical Assistance fee-schedule of services in 1994 to provide individualized services to youth with serious mental health concerns and their families (Bicksler, 2012). BHRS were designed to prevent hospitalization and out of home placement by addressing the behaviors and presenting problems in the natural settings such as the home, school, and/or community. Though BHRS follow Child and Adolescent Service System Program (CASSP) principles, the method of delivery is highly individualized, leaving the treatment modality to the discretion of the master’s-level clinician and the treatment team (Bicksler, 2012).

In recent years, BHRS have undergone scrutiny as a result of overuse of Therapeutic Staff Support (TSS), the bachelor’s-level mental health professional, and subsequent high costs of service, adoption of “cookie cutter” prescriptions of care, extended length treatment, over prescription, and lack of monitoring the outcomes and
effectiveness of interventions (Bicksler, 2012). BHRS has been suggested to be most
effective when treatment is individualized, collaborative with families, and least intrusive
while including natural supports and other systems of care, such as child protective
services, case management, and school teachers (Bicksler, 2012). However, as opposed
to in-home family based models of treatment, a system of care that involves
implementing supervised evidence-based family systems methods using a team based
approach with frequent supervision and oversight (Macchi & O’Conner, 2010), the
method of delivery within BHRS is left to the discretion of the clinician and the treatment
team (Hodas, 2004). Also, BHRS HCBCs are only required to receive supervision at a
rate of one hour per month (Hodas, 2004). The HCBC providing BHRS faces the
possibility of experiencing isolation from colleagues, reduced supervision, a lack of
agency support, challenging caseloads, and the pressure of providing individualized
treatment. In addition, counselors entering the BHRS field as recent graduates with less
experience may be more susceptible to compassion fatigue and burnout (Macchi et al.,
2014; Worth & Blow, 2010).

Statement of the Problem

While many studies have focused on the provision of home and community based
counseling (Cortes, 2004; Macchi & O’Conner, 2010; Macchi et al., 2014; Woodford et
al., 2006) and the supervision and training of in-home family therapists (Lawson, 2005;
Zarski et al., 1991), the individual and organizational factors that support home and
community based counselor wellness have not been studied. Macchi et al.’s (2014) study
is the only investigation to date exploring the professional quality of life of home-based
counselors. Macchi et al.’s study found that supervision and self-care mediate the impact
of perceived workload on professional quality of life. However, the study was unable to ascertain the self-care strategies and organizational practices that are beneficial to in-home counselor well-being (Macchi et al., 2014).

In addition, the current literature has not produced consistent findings regarding the individual and organizational factors that may mediate and moderate counselor wellness. Additional research is necessary to determine whether HCBCs, such as BHRS counselors, maintain wellness similarly to the model described by Macchi et al. (2014). Macchi et al. (2014) found that self-care has the ability to improve the professional quality of life of home-based family therapists, and for therapists who perceive having an overwhelming workload, supervision improved professional quality of life. Knowing this and the challenging nature of BHRS work (Bicksler, 2012; Hodas, 2004), it would be pertinent to develop a model of HCBC wellness detailing the systemic factors necessary to counselor wellness. A model of HCBC wellness would inform counselor, counselor educator, agency, and managed care practices. The objective of this study is to implement a grounded theory study to develop a model of HCBC wellness that describes the process of maintaining wellness of master’s-level BHRS counselors, the individual and organizational practices involved, and the challenges and barriers to maintaining wellness.

**Significance of the Study**

There is a gap in the literature addressing the self-care and wellness of HCBCs. The research literature has addressed models of home-based family therapy (Macchi & O’Conner, 2010), the professional quality of life of home-based family therapists (Macchi et al., 2014) and special considerations for training and supervision of
home-based counselors (Lawson, 2005; Macchi & O’Conner, 2010; Woodford et al., 2006; Zarski et al., 1991). In order to provide the most effective treatment for clients, counselors must tend to self-care, personal and professional wellness, and receive adequate training and supervision. Learning more about HCBC self-care and supervision processes would benefit counselors, supervisors, counselor educators, agencies, and the managed care organizations. Though BHRS is a system of care unique to Pennsylvania, similar home and community based counseling services have been established across the United States as a result of legislation and mandates requiring that programs be established to meet the needs of children at home and in the community. Like BHRS, these other home and community based counseling services offer individualized treatment that does not ascribe to a manualized, highly supervised, evidence based approach.

Using qualitative data from in-person interviews with BHRS counselors, a theory of HCBC wellness will be developed using grounded theory. This model of HCBC wellness, specifically BHRS counselor wellness, will describe the systemic factors involved in maintaining counselor wellness. This model will include self-care, supervision, and agency practices that sustain counselor wellness. Other factors necessary for counselor wellness may be uncovered. It is hoped that the findings will assist supervisors and agencies with providing improved support for HCBCs who lack regular guidance, oversight, and supervision.

Central Questions

The central question of this grounded theory study is “how do systemic influences affect the wellbeing of HCBCs?” In grounded theory, research questions are initially
written in very general terms, and as the study progresses and data are collected the
research questions become more focused as a theory emerges from the data (Sprenkle &
Piercy, 2010). The research process from creation of the research questions, data
collection, data analysis, is recursive and often involves revising and focusing the
research questions after the initial data analysis (Creswell, 2013; Sprenkle & Piercy,
2010). In addition to the above overarching question, the following subsidiary questions
will be explored:

1. How do HCBCs and HCBC supervisors define wellness as a HCBC?
2. What do HCBCs do to stay well?
3. What do HCBCs and HCBC supervisors perceive to be the role of individual
   wellness practices (cognitions, affect, and behaviors) in maintaining counselor
   wellness?
4. What do HCBCs and HCBC supervisors perceive to be counselor
   characteristics (i.e., personal characteristics or personal practices) that
   contribute to counselor wellness?
5. What are HCBCs’ and HCBC supervisors’ perceptions regarding the role of
   supervision in maintaining and/or promoting counselor wellness?
6. What are HCBCs’ and HCBC supervisors’ perceptions regarding the role of
   the agency in maintaining and/or promoting wellness?
7. What are the HCBCs’ and HCBCs supervisors’ perceptions regarding the role
   of other systemic factors in maintaining and/or promoting wellness?
Research Paradigm and Qualitative Approach

The aim of this inquiry is to advance a theoretical model of HCBC wellness grounded in data obtained from in-depth interviews with master’s-level BHRS HCBCs. This qualitative analysis utilizes a grounded theory approach, couched in principles of social constructivism and action participatory research (Charmaz, 2014). Grounded theory is rooted in the post-positivist belief that theory can be generated through the rigorous scientific method of gathering data from qualitative interviews and systematically reviewing and coding the data for actions, processes, and meaning using Corbin and Strauss’s (1990) constant comparison method of data collection and analysis (Charmaz, 2014; Creswell, 2013). Charmaz (2014) states, “coding links collecting data with developing an emergent theory” (p. 19).

Grounded theory can be described as “reductionistic, logical, empirical, cause-and-effect oriented, and deterministic” (Creswell, 2013, p. 24). Despite these post-positivist underpinnings, this study is also informed by a social constructivist framework that takes into account and makes explicit the researcher’s bias and values so that the researcher can interpret and analyze the data accounting for the multiple perspectives of the research subjects (Charmaz, 2014). Creswell (2013) recommends that the investigator “set aside, as much as possible, theoretical ideas or notions so that the analytic, substantive theory can emerge” (p. 89). In addition, Charmaz (2014) recommends the researcher must acknowledge their role in the research as a social construction, instead of viewing the work as an absolute rendering of the phenomenon of interest. For this reason, it is relevant to review the researcher’s experiences, biases, and values to reflect upon how these factors can influence the study from the beginning to the
end, as research questions are being formulated, throughout the interview process, and
during data analysis (Charmaz, 2014).

It is important to address this researcher’s interest in the area of self-care and
BHRS, in particular, to understand the researcher’s own values and biases regarding self-
care and supervision practices. This investigator first became concerned with self-care
practices of counselors-in-training and master’s-level professional counselors while
involved in doctoral studies and the supervision of practicum students. At the time, also
employed as a master’s-level BHRS counselor, the researcher was aware of the
challenges inherent to the provision of in-home services. While this researcher was able
to obtain weekly supervision of home-based counseling work to fulfill doctoral internship
requirements, most master’s-level clinicians only receive one hour of supervision per
month. Because most BHRS master’s-level positions do not require licensure, it is an
ideal position for recent graduates. However, the lack of supervision given the
complicated nature of the children and families receiving services is concerning. This
researcher reflected upon her values and biases when designing the research questions
and continued to reflect upon how researcher values and biases may influence gathering
and analyzing data. These procedures will be described in detail in Chapter 3.

In the spirit of action participatory research, the results generated will lay the
groundwork for evaluating and transforming supervision and self-care practices of
master’s-level counselors to improve wellness, and ultimately lead to better client
outcomes. It is hoped that the results will inform supervision and self-care practices of
BHRS counselors, and consequently inform the practices of HCBCs working in settings
similar to BHRS. The aim of the study is to develop a theory grounded from interviews
with BHRS counselors, and to use the results to inform stakeholders such as supervisors, counselors, program directors, and managed care agencies that oversee home and community based services.

**Methodology**

**Participant Selection**

The target population of this study was master’s-level HCBCs and supervisors with varying years of experience providing BHRS in western Pennsylvania. Purposive sampling was used in order to recruit a sample of participants able to contribute to developing a theory of home and community based counseling wellness (Berg, 2007; Charmaz, 2014; Corbin & Strauss, 1990). As the initial interviews were analyzed and coded for actions, processes, and meanings, and a theory began emerge, it was necessary to engage in theoretical sampling and return to data collection to recruit additional participants. The purpose of theoretical sampling, as described by Charmaz (2014) is “to elaborate and refine your theoretical categories” (p. 199). The inclusion criteria for selecting the sample included: a) a master’s-level HCBC or supervisor, b) currently working in a BHRS agency, and c) willingness to participate in this study. Participants with varying levels of experience were included in the sample. The inclusion criteria for selecting the theoretical sample was defined by the gaps in categories and theory that became evident during the coding and memo writing of the initial interviews (Charmaz, 2014). Previous research supports the role of years of experience in enhancing professional quality of life (Macchi et al., 2014). Collecting data regarding the role of systemic factors in the maintenance of counselor wellness from experienced and
inexperienced home and community based counselors and supervisors yielded useful information.

**Delimitations of the study.** The study was limited to master’s-level BHRS counselors and supervisors. BHRS is an example of home and community based services that do not adhere to a manualized evidence-based approach to treatment. Manualized treatments have mandated supervision, rigorous training, and ongoing oversight. BHRS in Pennsylvania is an example of a system of care developed to provide individualized home and community based services to children and families at risk for hospitalization or out of home placement. At this time, according to the BHRS supervisors, master’s-level BHRS counselors are required to have one hour of supervision monthly. Of interest are systemic factors that influence counselor wellness, specifically the wellness of counselors providing home and community based services without frequent supervision and direction. The study is limited to BHRS agencies so that the results are not confounded by the perspectives of counselors receiving frequent supervision, training, and oversight that is often inherent in evidence-based, manualized approaches such as family based mental health services (ESFT; Lindblad-Goldberg & Northey, 2013) and multi-systemic therapy (MST; Henggeler, Borduin, Schoenwald, Pickrel, Rowland, & Cunningham, 1998). There is a significant evidence base surrounding these manualized systems of care and the supervisors ascribe to the same theoretical orientation. In order to focus on and explore the wellness of HCBCs that do not receive frequent supervision and oversight, the counselors working within a manualized evidence-based approach were not included in participant selection.
Recruitment

In this qualitative inquiry, a purposive sample of eight to 12 master’s-level BHRS clinicians and four to six BHRS supervisors was selected for semi-structured individual interviews to learn about the systemic influences upon the wellness of HCBCs undertaking the challenging work of BHRS. Master’s-level counselors and supervisors were recruited from BHRS agencies in Western Pennsylvania. The investigator gained permission from Program Directors of BHRS agencies to solicit participation to obtain a purposeful sample of BHRS master’s-level counselors and supervisors. Recruitment occurred via email (Appendix B), flyer, phone calls, and the use of snowball sampling. Snowball sampling entails participants providing referrals of potential participants to the researcher (Berg, 2007). If the researcher does not recruit enough participants upon the initial request, snowball sampling can be helpful to increase sample size (Berg, 2007). Potential participants were provided a brief description of the study and the informed consent (Appendix C) at the time of expressed interest.

Data Collection

Data were collected through individual face-to-face interviews using semi-structured guiding questions. Interviews with participants continued until the data were saturated (Charmaz, 2014; Creswell, 2013). Participants were informed that the data and responses obtained from the interview would be de-identified to protect the identity of the programs and the participants. Individual interviews were audio recorded and transcribed verbatim by this researcher.
Data Explication

Grounded theory is rooted in the post-positivist belief that a theory can be generated through the rigorous scientific method of gathering data from qualitative interviews and systematically reviewing, coding, and categorizing data (Creswell, 2013). The study followed procedures for conducting a grounded theory inquiry as outlined by Charmaz (2014). Charmaz recommends a constructivist approach to grounded theory analysis that emphasizes the role of the researcher in the process (Creswell, 2013). Using Charmaz’ method of grounded analysis, “the researcher makes decisions about the categories throughout the process, brings questions to the data, and advances personal values, experiences, and priorities” of the participants (Creswell, 2013, p. 88).

Initial coding was conducted during which the transcripts were coded line-by-line for participant actions, processes, and meanings. Initial codes were reviewed across interviews and focused codes were created. While conducting focused coding, this researcher identified the most salient codes and some of these codes were elevated to categories. A constant comparative method of data collection and analysis as described by Corbin and Strauss (1990) and Charmaz (2014) was used to code the data and identify categories and patterns across the individual interviews.

Memos were written throughout the research process to include but not be limited to impressions following interviews, transcription, and analysis to document the investigator’s thoughts and hunches of the categories that arose from the data, relationship between the codes of meanings, actions, and processes, comparison of codes across interviews, and the emerging theory (Charmaz, 2014; Creswell, 2013). Early
memos “record what you see happening in the data. Use early memos to explore and fill out your qualitative codes. Use them to direct and focus data collection” (Charmaz, 2014, p. 169). After the process of memo writing begins and categories are developed, it is often necessary to engage in theoretical sampling, to further refine categories and the theory that is developed from the data (Charmaz, 2014). At this point, using constant comparison, the new interviews were coded, past codes were reviewed and possibly re-coded, codes were compared across interviews, memos were written, and data collection and analysis continued until the theory was fully developed. As the study progressed, the memos became more abstract to describe the developing theory reflected in the participant’s accounts (Charmaz, 2014). Advanced memos compared concepts to theoretical categories, data from a single participant across time, participants to participants, and the existing literature with the analysis.

In order to enhance the trustworthiness of the study, this researcher conducted the grounded theory study according to the criteria outlined by Charmaz (2014) and Corbin and Strauss (1990), and utilized recommendations for improving the rigor of qualitative research such as respondent validation and triangulation (Maxwell, 2007). Both Charmaz (2014) and Corbin and Strauss (1990) recommend the following to improve the rigor of one’s grounded theory analysis: simultaneous data collection and analysis, coding for concepts “the basic unit of analysis” (Corbin & Strauss, 1990, p. 420) and categories, line-by-line open coding, writing memo, and engaging in constant comparison and theoretical sampling (Charmaz, 2014; Corbin & Strauss, 1990). Memo writing and maintaining a methodological journal (a record from start to finish of the methodological decisions and the researcher’s rationale for each decision) were implemented to reduce
researcher bias and reactivity (Charmaz, 2014; Corbin & Strauss, 2014; Maxwell, 2008). To further improve the credibility of the analysis, respondent validation was utilized (Maxwell, 2008). After coding was completed, participants were presented with the opportunity to review the transcript for verification. Revisions were made as necessary to reflect participants’ true experiences, practices, thoughts, feelings, and beliefs. Finally, as a form of investigator triangulation, one of Denzin’s multiple lines of action in triangulation, this researcher consulted with the committee chair and colleagues to verify that the codes and subsequent analysis accurately reflect the experiences of the participants interviewed (Berg, 2007).

**Limitations of the Study**

Qualitative research can become threatened by researcher bias and reactivity (Maxwell, 2008). Steps were taken in the data collection and analysis to follow guidelines for grounded theory analysis (Charmaz, 2014; Corbin & Strauss, 1990) to improve rigor, and to reduce the effect of bias and reactivity. The results of the study may be generalized with caution to HCBCs sharing similar characteristics with the participants in the study. Because the sample is delimited to a small sample of BHRS counselors in western Pennsylvania, results may not be generalizable to HCBCs that practice within other BHRS agencies in Pennsylvania or to other types of home and community based counseling services. The results may also be limited by the researcher’s subjective interpretation of codes and categories in the data. Despite every attempt to bracket out the researcher’s experience, the memos, codes, and subsequent interpretations of the data are a reflection of the researcher’s interaction with the literature, research questions, interviews, data, and participants. The codes and the theory
that is grounded in the data were reviewed with participants to validate that the results reflect the experiences of the counselors sampled. The results from the study direct future inquiries into HCBC wellness. Counselor educators, supervisors, and agency and managed care administrators will be aware of factors that may influence HCBC wellness, and efforts may be made to evaluate individual and agency wellness and supervisory practices.

Overview of the Dissertation

In summary, the actions, processes, and meanings that arise in the individual interviews will provide a framework for understanding how systemic influences sustain counselor wellness in the home and community based counseling setting of BHRS in Western Pennsylvania. BHRS is a system of care, similar to many provided across the United States, developed in response to legislation and research that indicated a need for community-based services for youth with behavioral and mental health needs that were at the time greatly underserved (Cornett, 2011; Knitzer, 1982; Snyder & McCollum, 1999). Therefore, stakeholders working in home and community based services, similar to BHRS, may benefit from learning about the wellness practices of BHRS counselors, supervisors, and agencies.

In Chapter I, the background and design of the study, and the overall import and significance of the inquiry have been described. Chapter II offers a review of the literature that will include the following: an overview of wellness and wellness constructs, home and community services, and the research to date on HCBC wellness. Issues related to the professional counselor that will be addressed include the effect of individual and organizational factors on HCBC wellness. Gaps in the literature
The results of the study in relation to each research question will be provided in Chapter IV. In addition, codes that emerged from the data will be described and a theory grounded from the data will be illustrated. Chapter V interprets the results and discusses the implications of the study. Limitations of the study and future directions for research are presented.
CHAPTER II: REVIEW OF THE LITERATURE

Introduction

Central to this inquiry are the challenges that are inherent to home and community based counseling and subsequently, home and community based counselor (HCBC) wellness. Based upon qualitative interviews with HCBCs, this study seeks to advance a model for counselor wellness, the means to which HCBCs stay well despite the difficulties associated with the work.

Chapter II provides a review of the literature regarding home and community based counselors, the challenges thereof, and counselor wellness. The history of children’s mental health needs in the United States and the implementation of HCBS to meet these needs will be described. Behavioral Health and Rehabilitation Services (BHRS), a system of care specific to Pennsylvania, and the challenges posed to the counselor implementing this treatment approach will be reviewed. In addition, the current research relevant to counselor wellness and the means to maintaining wellness as a HCBC will be provided, to include counselor practices (e.g., self-care), counselor characteristics (e.g., training and experience), and organizational practices (e.g., supervision, training, and workshops), as described in the literature. This inquiry will be situated in the extant literature, as gaps and inconsistencies in the research literature are presented. Finally, the theoretical underpinnings of this grounded theory study and qualitative research will be provided.

Historically, home and community based services (HCBS) have been instrumental in serving children and families in need (Bhavnagri & Krolikowski, 2000; Cornett, 2011). Social work, nursing, education, medicine, counseling, and faith-based
organizations have delivered services in the home and community (Bhavnagri & Krolikowski, 2000; Cornett, 2011). In the United States, during the Industrial Revolution, charity organizations employed friendly visitors to address the overcrowding, poverty, illness, and disease that were common at the time (Cornett, 2011). Later, as a result of the Child Guidance Movement and the growing emphasis placed upon addressing children’s behavioral problems in the natural setting, HCBS evolved to include visiting teachers (Cornett, 2011). These teachers supported the child’s educational, behavioral, social, and emotional needs in the home setting (Cornett, 2011). The multifaceted services provided by visiting teachers met the educational needs of the preschool child and supported parents by facilitating access to child welfare programs (Bhavnagri & Krolikowski, 2000). Visiting teachers provided parent education and encouraged parents to be advocates for their children (Bhavnagri & Krolikowski, 2000). According to Bhavnagri and Krolikowski (2000), the teachers also supported businesses in the community by frequenting and purchasing goods from the neighborhood bakeries, markets, and hardware stores. The visiting teachers believed that supporting community businesses would improve living conditions for the children and families (Bhavnagri & Krolikowski, 2000). The visiting teacher program laid the foundation for home and community based counseling services as an example of a systemic service that could meet the needs of the child, the family, and the greater community (Cornett, 2011).

Similar to visiting teacher programs of the past, counseling services today are being implemented in the home and community settings to address the needs of children and their families. These services attempt to reduce the treatment gap that is prevalent in children’s mental health- the gap between the number of children living with a
diagnosable mental, emotional, or behavioral disorder and the number of children and adolescents that actually receive treatment (Bringewatt & Gershoff, 2010; Merikangas et al., 2011). Today, the mental health needs of many children in the United States are largely ignored and untreated (Bringewatt & Gershoff, 2010; National Research Council & Institute of Medicine, 2009; Merikangas et al., 2011; Perou et al., 2013; Substance Abuse and Mental Health Services Administration (SAMHSA), 2013a). This is especially true for marginalized children, those living in poverty, those involved in child welfare or the juvenile justice system, or those whose parents have a history of mental health difficulties (SAMHSA, 2013a). Home and community-based counseling services have proven to be integral to the mental health treatment of children, by providing more accessible treatment as an alternative to foster care, hospitalization, and residential treatment facility placement (Christensen, 1995; Cornett, 2011; Hodas, 2004; Mann & Hyde, 2013; SAMHSA, 2013a).

There are difficulties and nuances associated with the provision of home and community-based counseling that have been recognized by counselor educators (Lawson, 2005; Hammond & Czyszczen, 2014; Macchi & O’Conner, 2010; Stinchfield, 2004; Zarski et al., 1991) and home and community based counselors (Adams & Maynard, 2000; Christensen, 1995; Snyder & McCollum, 1999; Tate et al., 2014; Worth & Blow, 2010). The training and oversight of HCBC has been documented to be lacking and insufficient (Adams & Maynard, 2000; Christensen, 1995; Hammond & Czyszczen, 2014; Lauka, Remley, & Ward, 2013; Lawson, 2005; Lawson & Foster, 2005; Macchi et al., 2014; Worth & Blow, 2010; Zarski et al., 1991). Further compounding these concerns is the fact that, generally, HCBC do not operate under professional standards.
and training requirements that are specific to the field of home and community based counseling, unlike other counseling specialties, such as addiction and marriage and family counseling that can be highly regulated (Hammond & Czysczon, 2014; Stinchfield, 2004). Given these constraints, it is crucial to understand how HCBCs manage to stay well when confronted with a difficult caseload, ethical and safety concerns that accompany the setting, and the challenges of delivering counseling services in the home.

The potential negative effects of the work of counseling are often readily recognized by counselors, supervisors, and others within the field, while less thought is given to the benefits, satisfaction, and growth that can be associated with the work (Elwood et al., 2011; Linley & Joseph, 2007; Hyatt-Burkhart, 2014). This investigation heeds the warnings of Elwood et al. (2011) who challenged supervisors and counselor educators to refrain from expecting counselors to experience secondary traumatic stress, burnout, and compassion fatigue. Elwood et al. (2011) suggest that this expectation could become a self-fulfilling prophesy or worse yet, discourage counselors from engaging in work with those most in need. Much like the work of Lawson and Myers (2011), Linley and Joseph (2007), Hyatt-Burkhart (2014), and Macchi et al. (2014), this study focuses on wellness and seeks to uncover the resiliency and protective factors that may build upon HCBC wellness.

It is pertinent to discover a model for HCBC wellness that can serve as a guide to agencies, stakeholders (e.g., managed care agencies and funding sources), counselors, and counselor educators. Equipped with a framework for understanding counselor wellness, stakeholders will have a means to encourage, maintain, and enhance wellness
of HCBC. It is especially important for stakeholders to have the tools to support the wellness of HCBCs that work within programs, such as BHRS in Pennsylvania, that do not follow a mandated, rigorous supervision and training model often prescribed to evidence-based, manualized approaches. BHRS is one of many systems of care in the United States that offers home and community based counseling services without falling under the umbrella of an evidence-based, manualized approach that utilizes a specific treatment modality replete with training, supervision, and oversight designed to improve fidelity, and track and monitor treatment outcomes. Thus, without this level of oversight, counselors working within BHRS, as HCBCs, may be more vulnerable to experiencing isolation, and subsequently demoralization (Adams & Maynard, 2000; Bowen & Caron, 2016; Christensen, 1995; Snyder & McCollum, 1999). Therefore, it is imperative to understand how HCBCs, outside of evidence-based manualized approaches, are able to stay well. Using the grounded theory approach described by Charmaz (2014), a model for HCBC wellness will be developed grounded in data obtained from in-person interviews with BHRS counselors in Pennsylvania.

The subsequent sections review the current state of children’s mental health in the United States, HCBS as a viable treatment option, and more specifically, BHRS as a system of care in Pennsylvania.

**Mental Health Needs of Children**

Home and community based counseling services have become integral treatment option for children experiencing difficulties in the areas of social, emotional, behavioral, and mental health (SAMHSA, 2013a, 2016). At the time of Knitzer’s (1982) *Unclaimed Children*, it was estimated that three million children were experiencing a mental,
emotional, or behavioral disorder. Yet, only a startling one third of these children were receiving mental health treatment (Knitzer, 1982). Bringewatt and Gershoff (2010) stated, “in a 1999 report on mental health, the Surgeon General estimated that there were between six and nine million children and adolescents with serious emotional disturbances, accounting for between 9 and 13% of all children and adolescents in the United States (SAMHSA, 1999)” (p. 1292). More recent statistics, according to Perou et al. ’s (2013) assessment, approximate that 13-20% of children experience a mental health disorder in a given year. Among youth, untreated or insufficiently treated mental health, emotional, and behavioral disorders have been found to be associated with unplanned pregnancy, school failure, and later involvement with the criminal justice system (SAMHSA, 2013a). More troubling, in 2010, suicide was the second leading cause of death of children between 12 and 17 years of age (Perou et al., 2013). The consequences of inadequate, or in some cases, nonexistent, mental health treatment are dire for youth, families, and society.

**Home and Community Based Counseling Services**

Since 1982, efforts have been made to reduce the treatment gap first identified by Knitzer (1982) and as a result, home and community based counseling services have become integral to improving mental health outcomes for children and adolescents (Cornett, 2011; Snyder & McCollum, 1999). The Child and Adolescent Service System Program (CASSP) was established in 1984 to ensure effective mental health treatment for youth, and assist communities with establishing accessible, culturally-informed, individualized, and family focused treatment (Cornett, 2011; Lourie & Hernandez, 2003). In 1992, SAMHSA established the Comprehensive Community Mental Health
Services for Children and their Families Program, now commonly referred to as the Children’s Mental Health Initiative (SAMHSA, 2013a, 2016). Since 1993, 300 grants and programs have been funded to create “systems of care” that provide a range of coordinated, community-based mental health services (SAMHSA, 2013a, 2016). These community-based mental health services are designed to meet the individual needs of children and adolescents in the least restrictive environment possible (SAMHSA, 2013a, 2016).

**Behavioral Health and Rehabilitation Services**

While federal programs, such as CASSP and the Children’s Mental Health Initiative were being established, individual states were responding to the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989). This legislation widened the scope of Early Periodic Screening Diagnosis and Treatment (EPSDT) to include treatment for mental illness, in addition to preventative and illness-related needs (Development and History of Behavioral Health Rehabilitation Services in Pennsylvania, 2013). Home and community based services were instituted that upheld the principles of CASSP, improved access to mental health care, and provided alternatives to inpatient and residential care that were being widely implemented at the time (Cornett, 2011; Knitzer, 1982). In Pennsylvania, Behavioral Health and Rehabilitation Services (BHRS), a Medicaid funded service, became available to children living with social, emotional, behavioral, and mental health difficulties (Development and History of Behavioral Health and Rehabilitation Services in Pennsylvania, 2013). By 1992, BHRS had been established for 400 children across 17 Pennsylvania county MH/MR offices and agencies (Development and History of Behavioral Health and Rehabilitation Services in Pennsylvania, 2013).
BHRS are home and community based counseling services that are delivered in the child’s home, school, or community, by a master’s-level clinician who serves as a mobile therapist (MT) or a behavioral specialist consultant (BSC). If indicated, a therapeutic staff support (TSS), a bachelor’s-level clinician, works with the family as a role model and assistant to their parents in implementing behavioral and treatment interventions. This individualized, treatment approach was created for children who were not being successfully treated with traditional outpatient services or those who otherwise would have been hospitalized, removed from school, or placed in a group home or residential treatment facility (Bicksler, 2012; Hodas, 2004). The goals of BHRS, as described by Hodas (2004), include, “addressing the child’s needs so that the child remains at home and in the community whenever possible, promoting the child’s normative development, and enhancing family self-sufficiency” (p. 17). To meet these goals, treatment is individualized, flexible, and family and child-focused (Hodas, 2004). The treatment plan and interventions consider the recommendations of each member of the treatment team, e.g., the child, the family, BHRS staff, community supports, and if relevant, school staff, and other agencies such as child welfare and juvenile justice (Hodas, 2004).

As a system of care, BHRS has been criticized because treatment does not always uphold these principles and the provision of services often lacks oversight and monitoring (Bicksler, 2012; Hodas, 2004). In some cases, TSS services have been over prescribed and BHRS have been delivered in a “cookie-cutter” manner that automatically includes MT, BSC, and TSS services, instead of being individualized according to the child’s needs (Bicksler, 2012; Medicaid Health Plans of America, 2013). There was also
criticism that at times, BHRS treatment was continuing longer than was necessary and children and their families were becoming overly reliant on the service (Bicksler, 2012; Medicaid Health Plans of America, 2013). To avoid long term BHRS treatment and treatment dependence, care must be taken to continually clarify goals, treatment expectations, and discharge planning, and to transfer skills to the family, community members, or school staff (Bicksler, 2012; Hodas, 2004). BHRS becomes a viable, cost-effective alternative to other more intensive levels of care when services are prescribed to meet the individual needs of the child, treatment plans are developed collaboratively with families and other providers, measurable goals are identified and monitored, and evidence-based interventions are utilized (Bicksler, 2012; Hodas, 2004). In these instances, BHRS positively impacts children and families who may otherwise not receive counseling services at all (Bicksler, 2012; Hodas, 2004; Medicaid Health Plans of America, 2013-2014).

In addition to the demands placed upon BHRS master’s-level counselors to develop and provide treatment that fosters independence, BHRS counselors face significant challenges as HCBCs. These challenges have been identified by HCBCs, supervisors, and counselor educators (Adams & Maynard, 2000; Bowen & Caron, 2016; Christensen, 1995; Cortes, 2004; Fuller, 2004; Lawson, 2005; Lukenda, 1997; Macchi & O’Conner, 2010; Snyder & McCollum, 1999; Tate et al., 2014; Werrbach, 1992). The results from larger sample quantitative studies (Lawson & Foster, 2005; Worth & Blow, 2010) support the growing concern that HCBCs are further taxed by a lack of supervision and training to adequately prepare them for the work, and to assist them with managing their caseloads (Adams & Maynard, 2000; Christensen, 1995; Hammond & Czyszczon,
Because frequent supervision is often unavailable, training is often lacking, and the work is challenging and isolating, it is necessary to discover the underlying means to wellness for HCBCs, the creative approaches that the HCBCs and agencies institute to maintain HCBC wellness.

**Home and Community Based Counseling Service Challenges**

Qualitative studies have been conducted with HCBCs to identify the pressures and challenges inherent in home and community based work (Adams & Maynard, 2000; Bowen & Caron, 2016; Christensen, 1995; Lauka et al., 2013; Snyder & McCollum, 2000; Tate et al., 2014) and the characteristics of adolescents and their families who have received home-based services (Werrbach, 1999). Results from these studies indicate that HCBCs often work with multiply challenged children and families, conduct counseling in an unstructured and at times chaotic environment (Bowen & Caron, 2016; Christensen, 1995; Lawson & Foster, 2005; Snyder & McCollum, 1999; Werrbach, 1992), and may encounter unsafe situations while in the home or community (Adams & Maynard, 2000; Bowen & Caron, 2016; Christensen, 1995; Fuller, 2004). In addition, from the beginning of treatment to service termination, characteristics of the counseling relationship and the counseling sessions are much different in the home setting than the outpatient setting (Bowen & Caron, 2016; Christensen, 1995; Cortes, 2004; Lauka et al., 2013; Lawson, 2005; Snyder & McCollum, 1999; Woodford, Bordeau, & Alderfer, 2006; Zarski et al., 1991). For HCBCs, trying to adapt counseling training to the home environment can be incredibly challenging and can lead to increased anxiety and demoralization (Adams & Maynard, 2000; Christensen, 1999; Snyder & McCollum, 1999). To compound these challenges, HCBCs have acknowledged that isolation can pervade the work and is further
perpetuated by a lack of quality clinical supervision, little contact with colleagues, and an inability to attend professional trainings and conferences (Bowen & Caron, 2016).

**Multiply Challenged Children and Families**

Home and community based counseling services may vary in their intensity, duration, and treatment modality, but all systems of care were developed to meet the needs of children who experience serious emotional, behavioral, and mental health difficulties in their home, community, and/or school (SAMHSA, 2016). Families who receive HCBS are often burdened with numerous stressors, in addition to trying to meet the emotional and behavioral needs of their child (Adams & Maynard, 2000; Lawson, 2005; Snyder & McCollum, 1999). Families may have difficulty meeting their basic needs for food, shelter, clothing, and safety (Adams & Maynard, 2000; Lawson, 2005; Snyder & McCollum, 1999). Lawson (2005) stated that families presenting for in-home services are often “characterized by a combination of both concrete needs (financial assistance, employment services, transportation, child care, etc.)” and the primary concerns identified at the beginning of treatment (p. 437). This barrage of needs can be overwhelming for the HCBC to address (Adams & Maynard, 2000; Snyder & McCollum, 1999).

Werrbach (1992) conducted a content analysis of 51 case records of families receiving treatment from a home-based program in rural New England to explore the backgrounds of the families that typically presented for home-based therapy. In addition, Werrbach (1992) sought to determine if there were any differences between the adolescents who were placed out of the home after receiving home-based counseling services and the adolescents who successfully were able to avoid placement after
treatment. When comparing the case records of 14 adolescents who had subsequently been placed out of the home and 14 adolescents who had averted placement, Werrbach (1992) did not find a significant difference between the two groups in regards to family demographics and presenting problems. Regardless of placement outcome at the end of treatment, Werrbach (1992) found that children were referred to treatment due to behavior problems, family violence, and difficulties in school, and often presented with several problems at intake (Werrbach, 1992). Further, many of the children were dealing with more severe difficulties such as self-abuse, suicidality, a history of sexual abuse, running away behaviors, and/or a parent with a history of substance abuse (Werrbach, 1992). The severity and intensity of these problems were associated with later placement (Werrbach, 1992). Even though the results from this study can only be cautiously generalized considering Werrbach’s (1992) small sample, the descriptive and content analyses provide an overview of the multiple difficulties and challenges that may be encountered when working with families in the home and community based counseling settings.

Other studies have confirmed Werrbach’s (1992) findings and the concern that the amount of difficulties families face can be overwhelming for the HCBC. For example, Christensen (1995) was interested in learning about the nature of home and community based counseling, in particular, the “experiences” of HCBCs, an area of study that was largely unexplored at the time. Christensen (1995) used snowball sampling to recruit and individually interview ten family therapists who were experienced working in both the home and the office settings. All family therapists had a Master’s degree or higher in the fields of marriage and family therapy, counseling, psychology, social work, or other
related fields and had at one time worked in the home setting (Christensen, 1995). Participants reported that they were unsure of their ability to make lasting change with many families due to the intensity, severity, and sheer number of difficulties that the families were facing. Putting this into perspective, one participant stated, “If you are successful with just one out of 10 families, you are a successful home-based therapist” (Christensen, 1995, p. 312). While another therapist, overwhelmed with the challenges in the home reflected, “I don’t have enough energy or resources to change the environment” (Christensen, 1995, p. 312).

Christensen’s study (1995) is one of the first accounts of the experiences and perspectives of HCBCs. It is important to acknowledge the limitations of Christensen’s (1995) findings. Christensen (1995) was only able to provide information about how ten therapists with home-based family experience perceived and worked in the home setting. The family therapists in Christensen’s (1995) study had difficulty implementing home-based family therapy amidst the distractions and did not make full use of the home environment to join with family members, set limits, develop and test hypotheses, and design interventions, best practices of home-based family therapy (Lawson, 2005; Macchi & O’Conner, 2010; Zarski et al., 1991). It is unclear from Christensen’s study how many of the family therapists were working as a HCBC at the time of the study and whether these results reflect therapists who are proficient, well-trained, and competent in the practice of home and community based counseling. Finally, because many of the therapists interviewed reported preferring the office-setting over the home-setting, participant reports of home and community practice may have been biased (Christensen, 1995).
Though this is an exploratory study with limited generalizability, Christensen’s (1995) findings revealed the difficulty that HCBCs can have due to the overwhelming needs of families. Christensen (1995) confirmed the idea that the home-setting can afford its own set of challenges due to the chaotic and unstructured nature of the setting and some HCBCs view change in the home setting as slower, and struggle with feeling inept to meet the multitude of the family’s needs. From Christensen’s (1995) study, we can extrapolate that guidance and support is needed for HCBCs to learn how to use the home environment to their advantage and manage expectations regarding client and family change and the pacing of sessions and treatment.

Snyder and McCollum’s (1999) results mirror those of Werrbach (1992) and Christensen (1995); families presenting for HCBS often experience significant difficulties (Christensen, 1995; Snyder & McCollum, 1999; Werrbach, 1992). Researchers interviewed three marriage and family therapy interns, who transitioned from office-based to home-based counseling work (Snyder & McCollum, 1999). The interns provided in-home family therapy to families having difficulty managing children’s behavioral difficulties (Snyder & McCollum, 1999). Families were referred for treatment by the local Head Start agency and presented at assessment with additional difficulties such as, depression, posttraumatic stress disorder (PTSD), substance abuse, and conflict within the family (Snyder & McCollum, 1999). Snyder and McCollum (1999) analyzed the data collected from reflective journals maintained by interns and the authors, and transcriptions of two-hour individual interviews with the interns.
Snyder and McCollum (1999) quoted the experience of one student, who stated, “These people’s lives are so much more complicated, with the availability of basics of life being questionable all the time. If they struggle on Maslow’s lowest rung, what will their capacity for therapy really be?” (p. 236). The interns reported being overwhelmed by the complexity of the families’ problems and having difficulty, at times, figuring out where to start in treatment (Snyder & McCollum, 1999).

Recognizing the challenges of home and community based counseling, Adams and Maynard’s (2000) qualitative study aimed to discover the skills that are needed to provide in-home therapy to families, define the nature of home-based therapy, and explore how the families in home-based settings differ from those seen in other settings. To answer these questions, Adams and Maynard conducted two rounds of focus groups with 12 participants (seven supervisors, three counselors, and two counselors-in-training), all graduates of or current students in a graduate program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). Participants indicated that outside of the child’s presenting concerns, many families needed assistance with addressing family conflict, sexual abuse, single parenting, drug and alcohol abuse, severe mental illness, and adolescent development (Adams & Maynard, 2000). HCBCs and HCBCs-in-training struggled to know how to de-escalate conflict during a session and how to incorporate sexual abuse, addiction, and parenting skills training for single parent families into treatment (Adams & Maynard, 2000). Further, the HCBCs and students stated that while the graduate program provided a strong foundation in family therapy techniques and interventions, it did not prepare them for the difficulty of addressing the complex problems many families experience
(Adams & Maynard, 2000). In addition, they felt unprepared for the level of collaboration with larger systems and case management skills that were needed (Adams & Maynard, 2000).

Most recently, Bowen and Caron (2016) interviewed 12 rural HCBCs to determine how the HCBCs perceived that they were prepared to practice in the home setting and how they experienced the challenges in their work. Bowen and Caron’s sample included rural HCBCs varying in terms of age, gender, and years of experience. The HCBCs described a highly stressful and unpredictable work environment that included work with families who had a history of domestic violence, child abuse, and may have a long history of involvement in child protective services (Bowen & Caron, 2016). The experiences of Bowen and Caron’s participants were similar to those of the HCBCs described by Adams and Maynard (2000), Christensen (1995), and Snyder and McCollum (1999). The challenges that the families confront on a daily basis can be overwhelming for the HCBC (Bowen & Caron, 2016, Adams & Maynard, 2000; Snyder & McCollum, 1999), especially when the training provided is not readily transferrable to the home setting (Adams & Maynard, 2000; Bowen & Caron, 2016; Christensen, 1995).

**Nature of the Therapeutic Setting**

While the intensity and number of problems families face can become a treatment barrier for some HCBCs, it is also important to consider aspects of the therapeutic setting that are unique to HCBS. From start to finish, counseling in the home and community is much different than counseling that occurs in the office setting. The counselor must build a rapport and working relationship with the family while being a guest in the home
Distractions must be managed and if possible utilized as opportunities to challenge the family (Bowen & Caron, 2016; Christensen, 1999; Lawson, 2005, Lawson & Foster, 2005) and the counselor's expectations regarding pacing, length of each session, and the nature of change must be accommodated to the families’ needs in the home and community setting, and each family’s capacity for change (Adams & Maynard, 2000; Christensen, 1995; Snyder & McCollum, 1999). The qualitative studies conducted by Christensen (1995), Snyder and McCollum (1999), Adams and Maynard (2000), and Bowen and Caron (2016) provide valuable information about how HCBCs perceive and manage the counseling setting.

Many of the participants in Christensen’s (1995) study expressed negative views toward the work, speaking to difficulties building rapport with mandated clients, overcoming distractions, and maintaining safety (Christensen, 1995). Largely, Christensen’s (1995) participants indicated that they had difficulty confronting families in the home because they struggled with “the feeling of being guests in their clients’ homes” (p. 312). The family therapists reported that they found the home environment to be either helpful or overly distracting (Christensen, 1995). However, a majority of participants found the conditions of the home (e.g., smoking, parasites, noise, and pets) to be a barrier to providing effective treatment (Christensen, 1995). As a result, seven out of ten therapists preferred working in the office setting (Christensen, 1995)

Despite the challenges of the work, the family therapists interviewed by Christensen believed that home-based work resulted in positive changes in many families with whom they worked, but observed change to be “slower and more subtle”
(Christensen, 1995, p. 312). A few family therapists reported using the information obtained in the home to generate hypotheses but did not use the information further to inform treatment planning, goal setting, or interventions (Christensen, 1995). One family therapist indicated that he managed distractions by requesting the family to set limits and if this was ineffective, he adjusted his approach to working with the family (Christensen, 1995). This therapist was also one of the few therapists (three out of ten) who reported completing family therapy courses and specialized marriage and family therapy training (Christensen, 1995).

Snyder and McCollum’s (1999) accounts of the experiences of interns learning to do home-based work are similar to those described in Christensen’s (1995) study. The interns reported an initial process of gaining familiarity with clients and families. The family therapy interns were inundated with information from the referral source and information in the home (Snyder & McCollum, 1999). Their senses were flooded by sights, sounds, and smells (e.g., photographs, symbols of faith, music, and television) (Snyder & McCollum, 1999). Snyder and McCollum stated that, “a second source of familiarity was the expectations typically associated with visiting someone in their home. The interns reported that simply being in a person’s home made the encounter feel ‘friendly’...” (p. 233). However, Snyder and McCollum’s (2000) interns were trained to incorporate the information obtained in the home setting to build rapport with families, inform assessment, and develop treatment interventions, whereas, many of the family therapists in Christensen’s (1995) study only used the information to develop hypotheses. Students found that the quantity and intensity of family problems, the distractions, and the familiarity experienced in the home often slowed the pace of
counseling, necessitating longer counseling sessions (Snyder & McCollum, 1999). In addition, as described by Christensen (1995), positive change in the family and child was found to occur more gradually due to the complexity of the family’s problems (Snyder & McCollum, 1999).

Although students were prepared both to expect distractions and slower pacing, the differences between home and clinic-based work created feelings of dissonance for the students (Snyder & McCollum, 1999). Students experienced anxiety as they had to adjust previously learned office-based practices to the home setting (Snyder & McCollum, 1999). Aspects of Snyder and McCollum’s (1999) study stand in stark contrast to Christensen’s (1995) study. Snyder and McCollum documented the process of learning to do home-based counseling for interns providing home and community based counseling within a University-sponsored program. Snyder and McCollum (1999) found that while learning to provide home and community based counseling, students had to navigate initial feelings of familiarity and their experiences challenged their previous experiences and views of counseling, leading to increased anxiety. As they redefined counseling to meet the needs of the family in the home, students developed new interventions and strategies, adjusted their expectations, and began to accept the challenges of the work while acknowledging the benefits, thereby reducing anxiety (Snyder & McCollum, 1999). The students received an orientation that included HCBCs as guest speakers, individual and group supervision, and also engaged in journaling to track their experiences throughout the internship (Snyder & McCollum, 1999). These luxuries afforded the students an opportunity to work through their difficulties and grow as a HCBC. Snyder and McCollum (1999) describe the process of learning to do home-
based counseling for those who receive frequent, ongoing supervision within a program sponsored by a University. Though individual and group supervision, journaling, and orientation may benefit HCBC-in-training, it is unknown whether these practices are provided for and utilized by HCBCs to sustain wellness.

Like Christensen (1995) and Snyder and McCollum (1999), the HCBCs and HCBCs-in-training in Adams and Maynard (2000) study indicated having difficulty managing expectations about client change and pacing. “Some found it not very ‘rewarding work’ because they couldn’t see much improvement” (Adams & Maynard, 2000, p. 47). HCBCs and HCBCs-in-training were not prepared for the slow nature of change in the work due to the families’ multi-layered problems (Adams & Maynard, 2000). The HCBCs experienced “impatience and frustration at the ‘slow progress’ many of these families made” (Adams & Maynard, 2000; p. 47). For these HCBCs and HCBCs-in-training, case management became more integral to treatment than counseling, a disappointing reality for counselors eager to tackle the child’s identified problem and underlying family dynamics (Adams & Maynard, 2000).

In addition to pacing, the nature of change achieved, and counseling setting differences, HCBCs may find themselves struggling with what was described by Bowen and Caron (2016) as shared isolation, ethical ambiguity, and the high-intensity nature of the job. Bowen and Caron’s (2016) sample of HCBCs found home and community based work to be isolating. Isolation, as a theme, arose across the research topics of preparedness, professional development, challenges of the work, and gender-specific experiences (Bowen & Caron, 2016). It was a challenge for the HCBCs to complete all of the paperwork and manage a caseload that necessitated long hours driving to and from
clients (Bowen & Caron, 2016). Both the amount of paperwork and the travel time reduced the time available for conference attendance and time spent in the office, leading to a sense of isolation from colleagues (Bowen & Caron, 2016). Male HCBCs expressed that they had little contact with other male counselors as most counselors within the agencies were predominately female (Bowen & Caron, 2016). The male HCBCs stated that their approaches often differed from that of their female colleagues and the ideas of the male HCBCs were not always validated within supervision (Bowen & Caron, 2016).

However, even though isolation appeared as a theme across the research topics explored by Bowen and Caron (2016), it is important to consider that the research questions may have influenced the participants’ responses. The second question that was asked of participants was, “Can you tell me about how isolation from colleagues, because of the nature of the job, has influenced your preparedness in the home-based counseling experience?” (p. 132). The question may have yielded different results if it had been asked in a manner that did not assume that isolation impacted preparedness and the work. On the contrary, past literature confirms that the practice of home and community based counseling has the potential to be isolating (Zarski et al., 1991; Lawson, 2005; Lawson & Foster, 2005). In addition, the participants of Bowen and Caron’s (2016) study did not question the impact of isolation on the work and instead were readily able to provide examples of how they experience isolation. The past literature and detailed accounts provided lend credibility to Bowen and Caron’s (2016) findings.

Ambiguous ethical situations such as gray areas of mandated reporting, challenges to confidentiality, difficulty maintaining supervision and training, and challenges to personal boundaries were also frequently encountered by the rural HCBCs
(Bowen & Caron, 2016). While the office setting lends itself to creating boundaries, sometimes rigid, the home setting seems to invite boundary testing that may include offering the counselor a meal, asking the counselor personal questions, and giving the counselor gifts (Bowen and Caron, 2016; Lauka et al., 2013; Worth & Blow, 2010). Because home and community based counseling is not professionalized and is not recognized as a counseling subspecialty compared to addictions and marriage and family counseling for example, in general, HCBCs practice without any guidelines as to training, supervision, or credentialing (Hammond & Czyszczon, 2014). Moreover, there is not an ethics code specific to HCBC practice (Bowen & Caron, 2016; Hammond & Czyszczon, 2014). In part due to these reasons, Bowen and Caron’s (2016) sample of rural HCBCs had difficulty understanding how to proceed in certain situations and “desired the consensus of the profession in regard to the interpretation of the ethical guidelines” (p. 137).

Like Bowen and Caron (2016), Worth and Blow (2010) and Lauka et al. (2013) explored the perceptions of HCBCs to the unique ethical situations encountered in the home and community. Worth and Blow (2010) and Lauka et al. (2013) conducted survey studies with a sample of HCBCs and a sample of HCBCs and outpatient counselors, respectively. Worth and Blow (2010) were interested in learning what strategies home-based therapists utilize to maintain safety in the home and community. At the time, research regarding the ethical considerations of home based therapy was lacking and home-based practices were not addressed in the ethics codes governing social work, counseling, and marriage and family therapy disciplines (Worth & Blow, 2010). In addition, Worth and Blow (2010) reported that large sample studies were needed that
explored the work of “generic home-based therapists” (p. 461), therapists not ascribed to a particular treatment model (e.g., multi-systemic therapy, functional family therapy, and ecosystemic structural family therapy). Worth and Blow (2010) defined home-based therapy as “therapy services delivered in whole or in part in the home setting to all or part of a family” (p. 459).

A survey was administered to randomly selected members of the American Association for Marriage and Family Therapy (AAMFT), the National Association of Social Workers (NASW), and the American Counseling Association (ACA) who identified as home-based therapists (Worth & Blow, 2010). A total of 174 responses was received. The survey included 57 Likert scale items that explored the therapeutic alliance, characteristics of home-based therapists, safety, structure of therapy, training, therapist’s view of effectiveness, client characteristics, and ethical challenges (Worth & Blow, 2010). One open-ended item requested information about an ethical dilemma that occurred while providing home-based therapy. The ethical challenges identified by home-based therapists included concerns regarding maintaining confidentiality (drop-in visits by neighbors and friends, lack of privacy to conduct sessions in the home, and non-clients requesting information regarding clients), boundary violations (asking for transportation, offering food or drink to therapists), legal issues (violating legal directives), and difficulty managing distractions (Worth & Blow, 2010).

Lauka and colleagues (2013) studied perceptions of ethical situations amongst HCBCs and outpatient counselors, by administering a survey to 821 counselors which 120 counselors completed (response rate of 14.8%). The sample consisted of an equal number of outpatient counselors and home-based counselors in an effort to determine if
perceptions regarding ethical situations varied between the two groups. The survey consisted of 21 items that described ethical situations that are frequently encountered by in-home counselors. Each item was accompanied by a Likert scale response ranging from 1 = never ethical to 5 = always ethical. One open ended question at the end of the survey asked respondents to describe other ethical situations encountered that may not have been addressed in the 21 previous items.

Lauka et al. (2013) found that the attitudes of in-home and outpatient counselors toward in-home counseling ethical situations were not significantly different. Overall the mean responses to ethical situations that could be harmful to the client were lower and close to 1, ‘never ethical’; whereas, the mean responses for ethical situations that did not pose an immediate, obvious, negative consequence to clients were rated a 2 or above, rarely or sometimes ethical. Counselors encountered some situations as described in the items of the survey, such as, visitors arriving at the home during counseling sessions, clients engaged in illegal activities, and blurred boundaries (e.g., being invited to birthday parties and eating with dinner with clients) (Lauka et al., 2013). The ethical situations not mentioned in the survey but endorsed by participants included a lack of quality supervision, inadequate training and preparation for counselors, and supervisors who have less experience with in-home counseling than the counselors themselves (Lauka et al., 2013). The nature of the therapeutic setting for HCBCs clearly can become problematic, posing unique ethical concerns, and has the potential to be even further exacerbated by inadequate training and oversight (Adams & Maynard, 2000; Bowen & Caron, 2016; Christensen, 1995; Lauka et al., 2013; Lawson & Foster, 2005; Snyder & McCollum, 1999; Worth & Blow, 2010).
Safety

Among HCBCs, safety has also been noted to be an issue (Adams & Maynard, 2000; Bowen & Caron, 2016; Christensen, 1995). Accounts and perceptions of the safety concerns associated with home and community based counseling vary in the literature (Adams & Maynard, 2000; Bowen & Caron, 2016; Christensen, 1995; Fuller, 2004). Interestingly, personal safety was not always at the forefront for the counselors, supervisors, and counselors-in-training who were interviewed by Adams and Maynard (2000) and the family therapists who were interviewed by Christensen (1995). Instead, the main concern was for client safety (Adams & Maynard, 2000). Counselors and counselors-in-training struggled to address family concerns, challenge the family, resolve conflict, and close the session positively, in order to maintain the safety in the home (Adams & Maynard, 2000). For example, in Christensen’s (1995) investigation, when asked, “How do you feel about seeing families in the home alone?” (p. 311), one therapist responded, “Families can be explosive, and I am concerned for family members that remain in the home after I leave…. I am cautious not to arouse too much emotion and tension” (p. 311).

Other accounts of safety issues have been more extreme (Bowen & Caron, 2016; Christensen, 1995; Fuller, 2004). HCBCs have recalled instances where their personal safety has been jeopardized. A family therapist from Christensen’s (1995) study stated “I must watch boundaries and safety. I work in the housing projects and do not see clients in the home after 2:30pm because of personal safety--and the stress is overwhelming” (p. 311). More extreme instances of personal safety have been documented by counselors (Bowen & Caron, 2016) and by Fuller (2004) who wrote a conceptual article designed to
highlight challenges of home and community based work. Fuller (2004) described a striking account of what a HCBC may encounter upon arriving at the home. Fuller (2004) stated, “Entering a client’s home after an initial crisis call can be a delicate moment and it is never certain whether you will be greeted with a cup of tea, a knife, a gun, or a snarling dog” (p. 179). The participants in Bowen and Caron’s (2016) study described situations in which the counselor was threatened with a knife, there was a homeless man living in a closet of the home, and a counselor walked in on a couple having sex.

While these accounts exist in qualitative studies (Adams & Maynard, 2000; Christensen, 1995; Bowen & Caron, 2016) and conceptual articles (Fuller, 2004), it is unclear how likely or often a HCBC would encounter these situations. Additionally, perceptions of safety concerns encountered within day to day work as a HCBC may differ according to years of experience (Worth & Blow, 2010). Worth and Blow (2010) found that more experienced HCBCs were less concerned with safety concerns (Worth & Blow, 2010). Therefore, concerns for safety may lead to increased anxiety for novice HCBCs (Worth & Blow, 2010) and HCBCs working within agencies that lack guidelines for intervening during a crisis or an emergency (Adams & Maynard, 2000). Safety concerns of home and community based counseling work have been red flagged by experts and counselors, prompting them to recommend a team-based approach when necessary and when possible (Fuller, 2004; Bowen & Caron, 2016; Christensen, 1995). However, often HCBCs must work independently due to billing procedures that allow only one therapist to bill at a session (Bowen & Caron, 2016).
HCBCs can experience anxiety and discomfort working with families due to perceived safety concerns or difficulty managing values and beliefs regarding the family and the home setting (Glebova, Foster, Cunningham, Brennan, & Whitmore, 2012). These feelings may hinder rapport building and the therapeutic alliance (Glebova et al., 2012). The Therapist Comfort Scale (TCS; Glebova et al., 2012) was developed by Glebova to assess therapists’ feelings of comfort and safety with the neighborhood, the home, and family interactions. Glebova et al. (2012) administered the TCS and the Emotional Bonding subscale of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) to therapists at four intervals in treatment, T1 (beginning), T2, T3, and T4 (termination). The Emotional Bonding Subscale of the WAI was administered to caregivers at T2, T3, and T4. Interestingly, contrary to what Glebova et al. (2012) expected, therapist comfort did not change over time. Once a therapist was uncomfortable working with a particular family, the discomfort persisted. Feelings of therapist discomfort and safety were associated with lower client (at T4) and therapist ratings of the therapeutic alliance (at T1, T2, T3, and T4) (Glebova et al., 2012). Therapist discomfort was significantly correlated with reduced caregiver working alliance at the end of treatment. This phenomenon was only observed at the end of treatment. T2 and T3 caregiver ratings of working alliance were not correlated with ratings of therapist comfort. Therefore, it seems that persistent therapist discomfort may reduce the caregiver's ratings of the therapeutic alliance at the end of treatment (Glebova et al., 2012). Glebova et al. (2012) concluded that, "perhaps over time clients become increasingly aware of or unable to tolerate persistent therapist discomfort, which eventually impacts their own feelings of connection with the therapist" (p. 58).
Even though the therapists studied received extensive training and supervision necessary to provide multisystemic therapy (MST), Glebova et al. (2012) found that they were less comfortable working with families of lower socioeconomic status, families receiving financial assistance, and families living in poorer neighborhoods. This finding may be indicative of the level of experience of the HCBCs sampled. A majority of the therapists were recent graduates (2.6 years post degree) with an average of 9 months of experience providing MST (Glebova et al., 2012).

Glebova et al.’s results may only be cautiously generalized to HCBCs. Glebova’s sample was small (51 therapists) and only reflected the comfort of MST HCBCs with an average of 2.6 years of experience post graduate experience and only 9 months of MST experience. It is unclear whether seasoned HCBCs or HCBCs ascribing to treatment approaches outside of MST experience therapist discomfort with low-income clients living in poorer neighborhoods (Glebova et al., 2012). In addition, the sample was predominantly female (71%) and White (86%), and therefore did not yield information about the therapist comfort of males and counselors of other ethnic backgrounds (Glebova et al., 2012). Glebova et al. (2012) concluded that additional training and supervision is integral to reducing therapist discomfort in order to mitigate the debilitating effect that discomfort may have on the working alliance and possibly treatment outcomes, especially for disadvantaged clients.

**Demoralization**

The challenges posed by the home and community setting and the problems presented by families, as mentioned in the previous sections, can be significant for HCBCs and have the potential to be debilitating (Adams & Maynard, 2000; Bowen &
HCBCs and HCBCs-in-training have reported feeling demoralized and unsure of their ability to help and make a difference in the families’ lives (Adams & Maynard, 2000). Therapists interviewed by Christensen (1995) expressed doubt in their ability to be effective home-based family therapists, confront families in the home setting, and manage distractions. In Snyder and McCollum’s study, student interns began to doubt their abilities and the effectiveness of the therapy process as they witnessed, first hand, their clients’ struggles. They reported feeling increased anxiety about how to effectively provide treatment in the home (Snyder & McCollum, 1999). Rural HCBCs indicated that home-based work is highly stressful, even overwhelming at times, and it can be difficult to adapt the clinic-based approaches taught during continuing education programs to the home and community setting (Bowen & Caron, 2016). Though the rural HCBCs did not speak directly to feeling demoralized, they were frustrated with the amount of paperwork, intensity of the work, isolation, and the lack of agency support for clinical supervision and professional development (Bowen & Caron, 2016). However, most concerning was Adams and Maynard’s (2000) finding that the supervisors were unaware that the HCBCs and HCBCs-in-training were struggling with these feelings.

Unique to all of the studies (Adams & Maynard, 2000; Bowen & Caron, 2016; Christensen, 1995; Snyder & McCollum, 1999), the interns in Snyder and McCollum’s (1999) study were able to learn to manage the feelings of anxiety and demoralization when provided with clinical supervision, group supervision, and journaling. The interns creatively adapted techniques and interventions learned in the clinic setting to the home setting. As a result, the interns’ expectations regarding pacing of treatment and length of
each session evolved. As interns discovered that they could effectively intervene and increase the session to 90 minutes as opposed to the traditional 60 minutes, their anxiety decreased and their confidence increased (Snyder & McCollum, 1999). Snyder and McCollum’s model could be considered the first model for HCBC wellness. However, Snyder and McCollum’s participants were interns and the findings may not be generalizable to HCBCs. Snyder and McCollum’s model is illustrated in Figure 1.
Figure 1. Process of learning to do home and community based counseling

The findings from Snyder and McCollum’s (1999) study suggest that working in home and community settings has the potential to overwhelm, frustrate, and dishearten the HCBC, so much so that the HCBC can begin to question the effectiveness of interventions. Adams and Maynard (2000) and Bowen and Caron (2016) corroborated Snyder and McCollum’s study (1999). However, Snyder and McCollum’s participants
reaped the benefits of a university-sponsored internship program and were given a medium to confront and challenge the difficult feelings and experiences. As a result, HCBCs discovered ways to adapt interventions, pacing, and expectations more appropriately to the setting and needs of the clients (Snyder & McCollum, 1999).

Unlike the program studied by Snyder & McCollum (1999), BHRS, as a system of care, does not have stringent guidelines for the supervision and training of clinicians. BHRS clinicians may be more apt to become disillusioned from the work and experience demoralization, negatively impacting their wellness. It is important to review current practices and research regarding the training and preparation of HCBCs, as these factors have the potential to safeguard counselors from the negative effects of the work. It will be necessary to determine if the factors uncovered by this study support, add to, or are incongruent with the existing research.

**Training and Preparation of Home and Community Based Counselors**

Many HCBCs have indicated that they are unprepared to provide HCBS and that their graduate training does not readily translate into the home and community settings (Adams & Maynard, 2000; Lauka et al., 2013; Snyder & McCollum, 1999; Stinchfield, 2004; Worth & Blow, 2010). Often HCBCs are recent graduates with little experience in the home and community setting (Worth & Blow, 2010). Inadequate training and supervision may further strain and threaten HCBC wellness (Adams & Maynard, 2000; Christensen, 1995; Snyder & McCollum, 1999). The unique training and preparation needs of the HCBC have been described by Adams and Maynard (2000), Hammond and Czysczcon (2014), Lukenda (1997), Stinchfield (2004), Tate et al. (2014), and Woodford, Bordeau and Alderfer (2006). Several models of HCBC training have been proposed.
(Macchi & O’Conner, 2010; Snyder & McCollum, 1999; Mattek, Jorgensen, & Fox, 2010). These studies illustrate the needs of HCBCs for training, supervision, and agency support, and provide examples of both agency and counselor education training programs, the elements of which may assist HCBCs with improving home-based counseling practice.

**Lack of Preparation for and Training of HCBCs**

Many HCBCs enter home and community based work without experience or specialized training in the provision of counseling in the home and community setting (Christensen, 1995; Lawson, 2005; Lawson & Foster, 2005; Hammond & Czyszczon, 2014; Snyder & McCollum, 1999; Stinchfield, 2004; Worth & Blow, 2010). HCBC lack of training is documented by Adams and Maynard (2000), Bowen and Caron (2016), Christensen (1995), Stinchfield (2004), and Worth and Blow (2010). Christensen’s (1995) study found that many of the family therapists interviewed had difficulties implementing the skills and techniques necessary for successful home-based family therapy. For example, it is necessary to learn how to manage the counseling session, including joining with multiple family members, managing the distractions and session interruptions, conceptualizing using systemic approach, and using the home environment to one’s advantage in treatment (Lawson, 2005). Christensen’s (1995) participants had difficulty coping with distractions and many refrained from using the home environment intentionally during treatment.

Christensen (1995) concluded that the difficulty family therapists had in managing the home setting was evidence of their lack of training and supervision. It is unclear if any of the participants interviewed by Christensen (1995) had any training in
providing counseling in the home and community settings. Of the ten participants in Christensen’s (1995) study, four participants did not have any formal training in marriage and family therapy, three participants reported completing some family therapy courses, and four participants completed both marriage family therapy coursework and training. Christensen (1995) did not indicate whether the marriage and family therapy training included practice considerations in the home and community settings.

Confirming the concerns noted by Christensen (1995), Adams and Maynard’s (2000) sample of HCBCs and HCBCs-in-training reported that graduate training did not adequately prepare them for the challenges of home and community based work. The counselors and counselors-in-training interviewed by Adams and Maynard (2000) stated that they were overwhelmed by the multi-layered problems presented by many families at the start of treatment. In addition, the participants indicated that additional training would benefit HCBCs in the areas of case management, single parenting, child and adolescent mental health, sexual abuse, addiction, crisis intervention, and adolescent development (Adams & Maynard, 2000).

Stinchfield (2004) conducted ten individual interviews with family-based therapists and a focus group with family-based program directors, supervisors, a case manager, and a family-based trainer. Family-based mental health services (FBMHS) are a unique subset of HCBS delivered by a team of two mental health professionals (typically, a bachelor’s-level and master’s-level counselor) who have been trained to deliver ecosystemic structural family therapy (ESFT; Lindblad-Goldberg & Dorthey, 2013). The family-based team provides individual and family counseling and collaborates with other professionals (school teachers, administrators, and counselors,
criminal justice, children and youth, inpatient, and residential facilities) while maintaining 24-hour, 7 day per week availability for crisis intervention (Stinchfield, 2004). The children receiving family-based services were described as at-risk, “children and adolescents with severe emotional and behavioral problems who have not been successful with less intensive mental health services, such as outpatient therapy, and are likely to be placed in more intensive out-of-home services” (Stinchfield, 2004, Counselor’s Role section, para 1.) Family-based therapists participate in extensive training and case consultation (two days per month) and three hours per week of supervision to improve model fidelity and treatment outcomes (Stinchfield, 2004).

Two salient themes emerged from both the individual interviews and the focus group, the importance of joining with clients, families, neighborhoods, and other service providers, and the need to bridge the gap between counselor training programs and community-based programs (Stinchfield, 2004). Despite the extensive initial and ongoing training and supervision received, participants in Stinchfield’s (2004) study indicated that counselors often are not prepared to work with at-risk families, lack the skills needed to collaborate with other providers, and have difficulty joining with families in the home and community settings. Graduate training may provide the knowledge base necessary for home-based work, but participants contended that application-based graduate training is lacking but necessary to develop home and community-based counseling skills (Stinchfield, 2004). Stinchfield (2004) recommended that counselor educators invite guest speakers from multiple disciplines (children and youth, criminal justice, social work, and psychology) to talk about their roles and the importance of cross-agency collaboration.
Stinchfield (2004) cautioned that readers must refrain from generalizing the results due to limitations inherent in the study design. Stinchfield (2004) was unable to cross-check the focus group responses with all of the members, and the interview data yielded only the participants’ perceptions of family-based competencies. However, Stinchfield’s (2004) findings concur with those of Adams and Maynard (2000) and Snyder and McCollum (1999). HCBCs and HCBCs-in-training reported that joining with families (Snyder & McCollum, 1999), case management, and inter-agency, multiple system, collaboration (Adams & Maynard, 2000; Snyder & McCollum, 1999) are essential to home-based practice. Both Adams & Maynard (2000) and Stinchfield’s participants indicated graduate level training does not address these areas adequately. Because the family-based therapists, supervisors, and directors investigated by Stinchfield (2004) perceived training and preparation to be lacking for family-based therapists who receive extensive training and supervision (Stinchfield, 2004), one can reasonably assume that HCBCs working within BHRS programs, lacking minimal supervision and training requirements, may have difficulty with home-based work, the challenges of which may threaten HCBC wellness. Though Stinchfield’s study provided insight into practices that HCBCs believe would be beneficial during graduate training and beyond, like Adams and Maynard (2000), Stinchfield (2004) did not uncover the actual agency and supervisory practices, as perceived by HCBCs, to be beneficial to the work and wellness of HCBCs.

While Adams and Maynard’s (2000) and Stinchfield’s (2004) participants spoke to the need for specific HCBC graduate and on the job training, Bowen and Caron (2016) highlighted the barriers that rural HCBCs experience when seeking and receiving training
and professional development. Bowen and Caron (2016) investigated the perceptions of preparedness of 12 rural HCBCs by asking the following questions,

- How prepared were you to meet the home-based counseling job expectations when you entered the position?
- Can you tell me how isolation from colleagues, because of the nature of the job, has influenced your preparedness in the home-based counseling experience?
- Do you have suggestions for how you could have been helped in preparing for your role as a home-based counselor? (p. 132)

Many participants reported not feeling prepared for working in the home setting, but Bowen and Caron’s (2016) study did not allude to whether graduate training was adequate preparation for practice as a HCBC. Instead, the HCBCs indicated that the on-the-job training received was geared toward the traditional office setting and therefore, adjustments had to be made to the interventions in order to improve their utility in the home and community setting (Bowen & Caron, 2016). The HCBCs believed that evidence-based models specific to the provision of home-based counseling would be much more useful and easier to implement (Bowen & Caron, 2016).

In addition, the HCBCs interviewed by Bowen and Caron (2016) regretted that agency practices interfered with the ability to obtain ongoing training and supervision. The time spent on paperwork and a lack of agency support prevented them from being able to attend conferences and spend more time with colleagues, both of which are practices beneficial to professional development (Bowen & Caron, 2016). Participants also stated that the isolating nature of HCBS and use of group
supervision to address administrative needs prevented them from being able to network with colleagues (Bowen & Caron, 2016). Participants in Bowen and Caron’s (2016) study indicated that these agency practices hindered their ability to function effectively and efficiently in their role. The HCBCs did not indicate which practices were beneficial to their role as a HCBC. This study will explore HCBC perceptions of the agency and supervisory practices that improve counselor wellness, a piece of the puzzle that has been missing from qualitative research to date.

The results from larger scale survey studies (Lauka et al., 2013; Worth & Blow, 2010) confirm that of the qualitative counterparts discussed above (Adams & Maynard, 2000; Christensen, 1995; Bowen & Caron, 2016; Stinchfield, 2004). HCBCs are not adequately trained for home-based work (Lauka et al., 2013; Worth & Blow, 2010). Worth and Blow (2010) found that the home-based therapists surveyed indicated having little experience. Home and community based counseling positions are often entry-level, used by HCBCs to meet requirements for licensure (Worth & Blow, 2010). 83.9% of HCBCs reported that they did not receive graduate training or supervision specific to the provision of home-based counseling and 50% deemed training and supervision necessary (Worth & Blow, 2010).

Lauka et al.’s (2013) investigation focused on exploring HCBC and outpatient counselor attitudes toward ethical situations frequently encountered in HCBS, yet the study yielded surprising results regarding HCBC training and supervision. HCBCs indicated that the lack of adequate training and preparation and the lack of quality supervision for HCBCs presents a grave ethical concern (Lauka et al., 2013). In fact, out of the 41 responses received to the open-ended question that “asked participants to
comment on their own personal experiences regarding ethical issues observed while providing in-home counseling”, the most frequently noted concerns were “unqualified counselors” and “a lack of competent supervision” (Lauka et al, 2013, p. 131). Because HCBCs often have little experience, and graduate training often does not include considerations for home and community practice, it is necessary to identify ways that HCBCs can be successfully supported systemically, by the agency, coworkers, and supervisors.

**HCBC Considerations: Competencies, Curriculum, and Character Traits**

At this time, despite the need, training and supervision standards and certification requirements for HCBCs are absent (Hammond & Czysczzon, 2014; Macchi & O’Conner, 2010; Stinchfield, 2004). In many ways, the infrastructure needed to support HCBC wellness does not exist. As a stepping stone to developing HCBC-specific training and preparation, Hammond and Czysczzon (2014) and Tate et al. (2014) identified competencies specific to the provision of HCBC. Recommendations have been made to improve training (Hammond & Czysczzon, 2014; Tate et al., 2014; Woodford et al., 2006), the characteristics of successful HCBCs have been proposed (Bowen & Caron, 2016; Tate et al., 2014), and curriculum adjustments have been suggested (Woodford et al., 2006).

**Home and community based counseling competencies.** Hammond and Czysczzon (2014) reviewed the literature surrounding home-based family counselors’ (HBFC) training and supervision and found that the ACA ethics code and CACREP standards did not address the unique challenges of the home and community setting, and did not provide training or supervision standards for HBFC. Even the more recent 2016
CACREP standards do not take into account the training and supervision needs of HCBCs. Hammond and Czyszczon (2014) recommended that adaptations should be made to CACREP standards in order to accommodate the training needs of HCBCs. The competencies identified by Hammond and Czyszczon (2014) include: family systems, crisis and trauma, cross-cultural and substance abuse counseling, and child and adolescence. Further, Hammond and Czyszczon stated:

Among the standards for training that seem critical and particularly relevant to HBFC [home-based family counseling] include, but are not limited to, assessment of crisis and crisis needs, knowledge and skill in assessing trauma and trauma needs, advanced knowledge and skill in cultural competencies such as working with families in poverty, gender issues, and avoiding the culture of poverty perspective when working with clients. (Hammond & Czyszczon, 2014, p. 59)

Table 1 details the theories of importance to HCBS, competencies, and the method of training (Hammond & Czyszczon, 2014).
Table 1. Table of Proposed Competencies (Hammond & Czyszczon, 2014)

<table>
<thead>
<tr>
<th>Theory</th>
<th>HBFC Competencies</th>
<th>Training Modality</th>
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| Family systems                      | Assess the family within the larger system  
Assess the power dynamics within the family  
Knowledge of family influence on child and adolescent behavior  
Interventions that engage the whole family                                                                 | Coursework  
Coursework  
Coursework  
Coursework                                                                                       |
| Crisis and trauma                   | Assessment of crisis and crisis needs  
Capacity to connect clients to essential services  
Knowledge and skill in assessing trauma                                                                 | Coursework/University  
Supervision/Field  
Supervision  
Coursework                                                                                      |
| Cross-cultural counseling           | Understand the unique needs of families living in poverty  
Avoidance of the “culture of poverty perspective”  
Capacity to identify services related to unmet needs (dental care, food and clothing, etc.)  
Knowledge and skill in working with minority families  
Familiarity with culturally relevant community resources (churches, mosques, healers, etc.)  
Understanding gender issues in families across different ethnic and racial groups  
Understanding of the unique challenges faced by immigrant families  
                                                                                                 | Coursework  
Coursework  
Field Supervision  
Coursework/Field Supervision  
Coursework  
Coursework                                                                                      |
| Substance abuse counseling          | Identifying and evaluating substance abuse problems  
Developing and assessing interventions                                                                                                                | Coursework  
Coursework/University Supervision                                                                                                               |
| Child and adolescent                | Play-based techniques designed for children  
Sand-tray adaptations for in-home work  
Expressive counseling approaches for children and adolescents                                                                                   | Coursework                                                                                                                                       |
Hammond and Czyszczen (2014) provided the most up-to-date literature review of HCBC competencies. If these competencies are not addressed during graduate training, agencies may need to provide supplemental training. It remains unclear how agencies respond to the needs of HCBCs entering the field without experience, or training specific to home and community based counseling.

Tate et al. (2014) conducted an explorative, qualitative study to better understand counseling competencies necessary for in-home work with young children living in poverty. Tate et al.’s work added to the body of literature exploring home and community based counseling competencies. Little research had been conducted exploring counseling competencies needed to work specifically with children living in poverty, specifically in the home and community settings (Mattek, Jorgensen, & Fox, 2010). To answer this research question, the investigators gathered data from the program’s treatment manual, a focus group with experienced in-home counselors, and in vivo observations of live counseling sessions conducted by experienced in-home counselors. The data from all of these sources, including theoretical memos written throughout the study, were analyzed using Corbin and Strauss’ (1990) open coding procedures to identify categories and subcategories of competencies needed to work as an effective counselor within the particular agency that was the focus of the study. The five areas of competency identified were: specific knowledge sets, case conceptualization, counseling behaviors, flexibility in session, and professional disposition and behaviors.

Though some of the competencies listed by Tate et al. (2014) are specific to the model provided by The Behavior Clinic, the Parenting Young Children Program (Fox & Nicholson, 2003), many of the competencies may also be relevant to home and
community based practice, in general. Again, as found by Adams and Maynard (2000), Snyder and McCollum (1999), and Stinchfield (2004), the importance of joining with multiple family members, the child, and other service providers was emphasized in Tate et al.’s findings (2014). In addition, Tate et al.’s (2014) findings recommend that HCBCs must become competent in culturally-informed conceptualization and practice.

**Home and Community Based Counseling Curriculum.** Given that many entry-level opportunities exist in the HCBS field (Worth & Blow, 2010), Woodford et al. (2006) provided suggestions for tailoring curriculum to better prepare counselors for home-based work. Unfortunately, family counseling textbooks often do not provide consideration for the unique needs of HCBCs (Woodford et al., 2006). It is necessary to supplement family counseling theory textbooks with excerpts from seminal works in the home-based field, such as, Berg (1994), Whittaker et al. (1990), Lindblad-Goldberg, Dore, and Stern (1998) and more recent textbooks written by Westbrook (2014) and Boyd-Franklin and Bry (2000) (Woodford et al., 2006). Experiential classroom activities serve to increase HCBC-in-training awareness of how the counseling process may morph in the home setting and may prepare HCBCs for managing the ethically murky situations that arise (Woodford et al., 2006). Guest speakers, classroom role-plays, and mock home-based sessions with fellow classmates are recommended (Woodford et al., 2006). During these experiences, the HCBC-in-training learns to use the contextual cues in the home environment to inform assessment and ease rapport building (Woodford et al., 2006). The HCBC-in-training also has the opportunity to learn how to be a guest in the home, respect cultural differences, and extend the clinical hour as is often necessary when counseling in alternative settings (Woodford et al., 2006). Hypothetical situations
can be role-played to increase preparation for anxiety-provoking events such as volatile situations, threats to confidentiality of having neighbors and friends entering the home during a session, and boundary testing (Woodford et al., 2006). Woodford et al. (2006) suggested for any situation to arise by carrying mace and dog biscuits, a cell phone for emergency calls, and clear directions to the client’s home.

**HCBC character traits.** In addition to the need for experiential training exercises and graduate preparation targeting home and community based counseling, most applicable to all HCBCs regardless of treatment approach is the need for self-care and the development of professional disposition and behaviors conducive to home-based practice (Tate et al., 2014). Tate et al.’s (2014) data analysis uncovered the importance of a strengths-based approach, maintaining an open-minded stance, the use of supervision to receive and accept critical feedback, having “true grit” (p. 377), and therapist comfort with working with children and families living in poverty to counseling practice. *True grit* was defined by Tate et al. (2014) as perseverance through the most difficult sessions and the application of a social justice framework in order to actively seek to improve client and family well-being. Bowen and Caron’s (2016) participants also identified professional behaviors such as, positivity, authenticity, and “the right attitude” (p. 136). Each of the HCBCs interviewed alluded either indirectly or directly to the need to maintain a positive attitude (Bowen & Caron, 2016).

These characteristics, true grit, positivity, authenticity, and the right attitude may protect a HCBC from the challenges of the work. Tate et al. (2014) and Bowen and Caron’s (2016) findings point to the importance of the individual HCBC’s traits and behaviors associated with successful home and community based counseling practice. It
remains to be seen whether these qualities prove integral to HCBC wellness, specifically BHRS HCBC wellness.

**Home and Community Based Counseling Training Models**

Several examples exist in the literature that highlight training approaches for HCBCs-in-training (Adams & Maynard, 2000; Snyder & McCollum, 1999; Mattek et al., 2010) and for HCBCs (Macchi & O’Conner, 2010; Mattek et al., 2010). It is important to have an understanding of the training models and training considerations for HCBC. If relevant and applicable, these strategies can be applied by agency administrators, counselor educators, and supervisors to improve HCBC wellness. Whether home and community based counseling agencies, as a whole, use these strategies to address a lack of training and preparation for the setting, remains to be seen.

**Solution focused home-based family therapy.** The marriage and family therapy interns interviewed by Snyder and McCollum (1999) were trained to implement a solution focused approach and provide 90 minutes of therapy weekly to families referred by a local Head Start agency. Support for interns included an initial orientation during which a therapist who is experienced with providing home based therapy discussed challenges and strategies, journaling that acted as self-supervision, group and individual supervision, individual case consultation, live supervision, and consultation with referral sources. The journals were reviewed with supervisors at several points throughout the home-based internship. These supports provided interns with a medium to explore and resolve their struggles (Snyder & McCollum, 1999). Snyder and McCollum (1999) stated that during supervision, “in turn, they could share what had worked or not worked for each of them individually, thus building their pool of strategies and stimulating the
development of yet new ideas” (Clinical Supervision section, para 2.). Through the extensive training, orientation, and supervision process, students came to appreciate the benefits of home-based counseling and accept the challenges (Snyder & McCollum, 1999). Students became more acutely aware of the need to explore child and family interests, strengths, and the role of spirituality in the family’s lives in both the home and the clinic setting (Snyder & McCollum, 1999).

**University-Agency Collaboration within MFT program.** In response to the concerns noted by Adams and Maynard’s (2000) participants, changes were made to the Marriage and Family Therapy (MFT) curriculum and subsequently, the following areas were added to their MFT training program: home and community based counseling case studies, specific interventions for assisting clients mandated for treatment, and ways to work collaboratively with other systems and agencies as a multi-disciplinary team. The MFT program also began to process with students their expectations regarding session pacing and the change process in the home and community based settings. The agencies participating in the study adapted their training and supervision policies to clarify the agency protocol when confronted with a crisis and to provide further education in the areas of crisis intervention, single parenting, coordinating with other systems, and case management skills (Adams & Maynard, 2000).

Adams and Maynard’s study (2000) illustrates how qualitative research can be instrumental in improving training practices for counselors and counselors-in-training. In a similar manner, in this study, the perceptions and experiences of HCBCs working within the less structured, less supervised BHRS system of care, will be used to develop a
model for HCBC wellness that will include agency, supervisory, and individual strategies for promoting and sustaining wellness.

**Home-based counseling young children living in poverty.** Mattek et al. (2010) developed a training program for interns providing home-based counseling to young children living in poverty, who are experiencing significant emotional and behavioral difficulties. The services were provided through a partnership between five local universities and a community mental health agency. The year-long training program included 20 hours of training on the following topics: poverty, safety, child development, clinical skills, play-based techniques, cross-cultural counseling, and child management therapy (CMT) which is the model utilized by the program (Mattek et al., 2010). Students viewed videotapes of seasoned home-based counselors, engaged in role-plays, observed home visits, and implemented the model under live supervision. Prior to carrying a caseload, students practiced play-based techniques and rapport building by working with children at the Behavior Clinic, a special therapy classroom designed for children ages birth to three years (Mattek et al., 2010).

Even after home-based counselors became proficient in delivering the treatment model in the home, most home visits continued to occur in pairs to reduce safety concerns and allow one counselor to work with the parents while the other counselor worked with the child (Mattek et al., 2010). Supervision was provided throughout the year-long internship at a rate of one-hour individual and one-hour group supervision per week (Mattek et al., 2010). Mattek et al. (2010) evaluated the home-based counselors’ ratings of self-efficacy by administering the Counselor Activity Self-Efficacy Scales (CASES) during the first and final weeks of the internship. Mattek et al. (2010) found
that the self-efficacy of HCBCs-in-training significantly increased from the initial to final administration of the CASES. HCBCs-in-training also reported that they were highly satisfied with the clinical experience and the training (Mattek et al., 2010).

**HBFT partnership.** Regardless of the espoused treatment approach, the Home-Based Family Therapy (HBFT) Partnership in Kansas has provided training and the necessary credentialing for home-based counselors, social workers, and psychologists providing Medicaid funded mental health services (Macchi & O’Conner, 2010). Since 2006, 535 therapists in Kansas have received training through the HBFT Partnership (Macchi & O’Conner, 2010). The training provided by the HBFT Partnership was far-reaching, extending to 29 community agencies, 5 private contractors, and 41 private practitioners, across all 105 counties in Kansas (Macchi & O'Conner, 2010). Unfortunately, the HBFT partnership is no longer providing training to Kansas providers due to statewide budget cuts (S. L. Rucker, personal communication, August 24, 2016). Even though trainings are not being offered by the HBFT Partnership, the learning modules and website resources remain.

The components of the HBFT Partnership provide an example of a framework for HCBC training. Macchi & O’Conner (2010) stated,

> the objectives and principles guiding the development of each component include providing focused knowledge and skill development, prioritizing the use of supervision, facilitating therapist self-care strategies, providing multiple opportunities for ongoing support and collegial relationships, and encouraging therapist collaborations and consultation. (Mission and Objectives Session, para 1.)

An integral part of the training involved experiential practice to encourage HCBCs to adapt the evidence-based strategies to home and community based practice, which may be unique for each HCBC. Opportunities were created during the training to begin to
integrate treatment interventions into one's work in an effort to prevent difficulties
HCBCs can experience trying to assimilate newly learned concepts to their practice
(Bowen & Caron, 2016). The core training spans over the course of one day and includes
evidence-based interventions for home and community based practice, use of self-care to
manage stress, and the importance of supervision to HCBS. HCBCs learn to use the
Professional Quality of Life Scale (ProQOL-IV; Stamm, 2002) to monitor burnout,
compassion fatigue, and compassion satisfaction (Macchi & O’Conner, 2010). Videoconferences and online training modules are available on the HBFT
Partnership website to provide professional development trainings related to specific
DSM-V diagnoses, ethical situations encountered in HCBS, self-care, and supervision
(Macchi & O’Conner, 2010).

The HBFT Partnership provided system-wide support for HCBCs in Kansas,
addressing many of the challenges described by the existing research, such as isolation
(Bowen & Caron, 2016), difficulty finding training and interventions applicable to home
and community based counseling (Adams & Maynard, 2000; Bowen & Caron, 2016;
Lauka et al., 2013; Stinchfield, 2004; Worth & Blow, 2010), and demoralization (Adams
& Maynard, 2000). The training modules addressed the competencies identified in the
HCBCs were provided with tools to monitor wellness and encourage self-care. Given
that this program is not available to HCBCs in Pennsylvania, it remains unclear how
BHRS HCBCs maintain their wellness and how agencies and supervisors support HCBC
wellness without the assistance of a training program like the HBFT Partnership.
The training programs developed by Mattek et al. (2010), Macchi and O’Connor (2010), and Snyder and McCollum (1999) are not widely available to HCBCs-in-training. Opportunities exist in only a few graduate programs. Further, the HBFT Partnership is only available to HCBCs working in Kansas. The findings from these nascent studies may not be applicable to HCBCs who practice outside of evidence-based manualized approaches or University-supported programs (Macchi & O’Conner, 2010; Mattek et al., 2010; Snyder & McCollum, 1999). The next section will describe research findings supporting a lack of supervision within home and community based counseling settings.

**Lack of Supervision of HCBCs**

Lawson (2005) maintained that supervision is crucial for those HCBCs with little training and experience. Tate et al. (2014), Hammond & Czyszczon (2014), and Stinchfield (2004) cautioned that regardless of the level of experience, quality supervision is integral for HCBCs due to the difficult, complicated nature of the work. Unfortunately, supervision both in terms of quantity and quality has been found to be a luxury for some HCBCs (Lawson & Foster, 2005), reserved for those who practice within evidence based manualized approaches such as multi-systemic therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009), and ecosystemic structural family therapy (ESFT; Lindblad-Goldberg, Jones, & Dore, 2004), or the fortunate few who are able to participate in an extensive training program within their graduate level counseling program (Snyder & McCollum, 1999; Mattek et al., 2010).

In many cases, HCBC receive little supervision (Lawson and Foster, 2005; Macchi et al., 2014) despite the complexity of delivering home-based services (Lawson
Lawson and Foster surveyed a sample of 120 home-based counselors to learn more about the ego development and supervision of HCBCs representing 38 agencies in Virginia. 15% of HCBCs were receiving supervision one time per month or less and 56% of HCBCs were receiving weekly supervision. 74.2% of Lawson and Foster’s sample believed that they were “under-supervised” and were unsatisfied with the quality and quantity of supervision (p. 157). In addition, the HCBCs in Lauka et al.’s (2013) sample reported that many supervisors do not have experience providing HCBS.

At this time, there are no supervision guidelines, standards, or models for the supervision of HCBCs (Hammond & Czysczczon, 2014). Best practices for the supervision of home-based counselors have been provided by Lawson (2005), Hammond and Czysczczon (2014), and Tate et al. (2014). According to Hammond and Czysczczon (2014) quality supervision must be valued and supported systemically throughout HCBS agencies. Supervision must be provided in terms of the developmental need of the HCBC (Hammond & Czysczczon, 2014, Lawson, 2005). However, due to the difficult nature of the work, weekly supervision is recommended even for the more seasoned HCBCs (Tate et al., 2014). Live supervision is ideal for novice counselors or when treatment progress is not being made (Hammond & Czysczczon, 2014; Lawson, 2005). Hammond and Czysczczon (2014) also recommend videotape reviews during supervision. According to Hammond and Czysczczon (2014), supervisors need to be licensed with home and community based counseling experience and should be available to supervisees to provide consultation during times of crisis. Further, supervision is improved if the supervisor meets the family during the initial session and assist with the intake and assessment (Hammond & Czysczczon, 2014).
Lawson (2005) reviewed the home-based counseling literature and found evidence of a lack of preparation of home-based counselors and inadequate supervision, despite unique needs of home-based counselors. Lawson (2005) suggested that the supervision of home-based counselors address nuances of managing sessions (e.g., scheduling, distractions in the home, and pacing), using the home environment in structuring treatment, involving additional systems (informal and formal supports), and managing safety. Specific strategies for home-based supervision suggested by Lawson (2005) include live supervision, pre and post session debriefing, review of audio or video recordings, shadowing, field supervision (accompanying a colleague once per month on a case to provide feedback), and group supervision. Case consultation is suggested for more experienced counselors (Lawson, 2005). Lawson’s conceptual article points convincingly to specific needs of home-based counselors, concerns regarding lack of supervision, and under preparation of counselors for home-based work. Due to under preparation, supervision becomes a ground for additional training and resources for novice counselor.

Tate et al. (2014) argued for the use of quality supervision to monitor the development of HCBC competencies. “Previous research has indicated, for example, that in home counselors who receive adequate supervision and ‘feel well supported’ are more able to maintain a strengths focus and to work in collaboration with families (Lawson & Foster, 2005, p. 159)” (Tate et al., 2014, p. 379). The key to fostering these competencies is receiving supervision from an experienced counselor with home-based counseling experience. The development of these competencies can be monitored and feedback can be provided in supervision to further develop skills.
It is known that quality clinical supervision is perceived by home and community-based counselors to be critical (Bowen & Caron, 2016; Worth & Blow, 2010; Lauka et al., 2013). However, supervision and oversight is not always a reality (Bowen & Caron, 2016; Lauka et al., 2013; Lawson & Foster, 2005). Live supervision as recommended by Lawson (2005) and Hammond and Czyszczon (2014) may not be possible due to limited agency resources. Thus, it is reasonable to assume that the quantity and quality of supervision received by HCBCs varies. Even a small amount of supervision can be beneficial and can contain elements that may be deemed to be crucial to HCBC wellness. This study will seek to determine specific supervision and agency practices that sustain HCBC wellness. The next section of the literature review describes HCBC wellness research, findings to date, and gaps in the literature.

**Home and Community Based Counselor Wellness**

An abundance of literature focuses on the challenges of HCBCs (Adams & Maynard, 2000; Bowen & Caron, 2016; Christensen, 1995; Lawson, 2005; Snyder & McCollum, 1999; Worth and Blow, 2010) and recommendations for graduate education, supervision and training of HCBCs (Hammond & Czyszczon, 2014; Lawson, 2005; Stinchfield, 2004; Tate et al., 2014; Zarski et al., 1991). It is important for counselor educators, supervisors, and counselors to be aware of the challenges inherent in the work and make strides to improve training and supervision. Many suggestions for training, supervision, and monitoring of the possibilities for therapist discomfort and demoralization have been provided. Little is known regarding HCBCs perceptions of wellness within the home-based practice. Only scant literature exists that explores HCBC wellness (Macchi et al., 2014). There is a dearth of literature surrounding the
lived experiences of HCBCs (Hammond & Czyszczon, 2014) and the perceptions of HCBCs as to the strategies that improve and sustain wellness.

Macchi et al. (2014) surveyed a sample of HCBCs to determine the influence of experience, self-care, perceived workload, and supervision on HCBC professional quality of life. Of the 831 licensed clinicians who were invited to participate in the study, 225 therapists responded. All of the participants completed the survey before attending a training workshop required to receive the Medicaid certification necessary to bill for services. The sample included licensed social workers (59%), licensed marriage and family therapists (19%), psychologists (11%), and professional counselors (10%). Years of experience ranged from less than a year (47%), one to three years (28%), four to ten years (20%), and greater than ten years (5%). Macchi et al. (2014) tested the effect of workload and years of experience on professional quality of life of home-based family therapists using structural equation modeling to determine the potential mediating role of supervision and frequency of self-care.

Macchi et al. (2014) found a higher perceived workload was associated with more frequent supervision, reduced self-care, and a lower professional quality of life, whereas, greater years of experience was significantly associated with engagement in less supervision and a higher professional quality of life (Macchi et al., 2014). Frequency of self-care behaviors was not found to be related to years of experience (Macchi et al., 2014). For the HCBCs sampled, engaging in more frequent self-care, and more frequent supervision was associated with higher levels of professional quality of life (Macchi et al., 2014). Using bootstrapping, Macchi et al. (2014) discovered three indirect pathways that significantly predicted professional quality of life: perceptions of workload were
found to be related to more frequent supervision, and more frequent supervision was
associated with a greater professional quality of life; more experience was associated
with reduced rates of supervision and the reduced frequency of supervision was related to
an improved professional quality of life; and finally, perceptions of a more overwhelming
workload were related to reduced engagement in self-care behaviors, and self-care
behaviors were associated with a greater professional quality of life (Macchi et al.,
2014). According to Macchi et al.’s (2014) findings, the effects of supervision vary
depending on the experience of the home-based family therapist. If the home-based
family therapist is less experienced, supervision acts to improve quality of life.

While Macchi et al.’s (2014) study supports the link between self-care and
supervision and an improved professional quality of life, specific self-care and
supervision practices beneficial to home-based family therapists remain
unidentified. Macchi et al.’s (2014) study also has several limitations. The study is
cross-sectional and therefore does not speak to the effect of supervision and self-care
over time (Macchi et al., 2014). Further, as Macchi et al.’s (2014) tested model only
accounted for 47% of the variance in professional quality of life, much of the variance
remains unexplained. The unexplained variance may indicate that there are variables
missing from the analysis that better predict professional quality of life or that the
measures utilized do not accurately represent the variables. Macchi et al. (2014) noted
that single-item measures, as used to approximate frequency of self-care and supervision,
years of experience, and perception of workload, do not always accurately assess the
variable of interest. Caution must be exercised in generalizing Macchi et al.’s (2014)
results. Only home-based family therapists who receive training essential for Medicaid
reimbursement were sampled. It is possible that Macchi et al.’s sample of HCBCs, having received training in the provision of home-based counseling, may not reflect HCBCs in general, who may not receive training and oversight that commonly accompany evidence-based models. Macchi et al. (2014) recommend that future research focus on assessing the impact of different self-care strategies and supervision practices on counselor professional quality of life and on improving existing measures of self-care. However, it is first necessary to identify the strategies used by HCBCs and home and community based agencies to sustain HCBC wellness.

Macchi et al.’s (2014) investigation is the only study to date that addresses HCBC wellness. The conceptual literature supports the role of individual factors such as self-awareness, years of experience, and engagement in self-care behaviors for improving and sustaining counselor wellness (Figley, 2002; Lawson & Vernart, 2005; McCann & Pearlman, 1990). It has also been suggested that supervision, workshops, and continuing education may guard against compassion fatigue and burnout (Pearlman & MaClan, 1995; Skovholt et al., 2001). Over the past several decades, quantitative and qualitative research has attempted to identify whether specific individual characteristics and practices and organizational practices may be associated with improved counselor professional quality of life (Ben-Porat & Itzhaky, 2009; Bober & Regehr, 2005; Brockhouse et al., 2011; Hyatt-Burkhart, 2014; Killian, 2008; Kulkarni et al., 2013; Lawson, 2007; Lawson & Myers, 2011; Linley et al., 2005; Macchi et al., 2014; Sprang et al., 2007; Stevanovic & Rupert, 2004; Williams et al., 2012). Unfortunately, these studies have yielded inconsistent and inconclusive results and point to the need for
additional qualitative research to identify factors associated with HCBC wellness prior to further quantitative studies.

**Maintaining wellness: Individual and organizational practices**

Bober and Regehr (2005) conducted a quantitative survey study with a sample of 259 clinicians working within programs treating survivors of violence. Bober and Regehr (2005) were interested in confirming the proposed impact of frequency of self-care behaviors, personal history of trauma, hours spent working counseling, and hours spent specifically with victims of trauma, on traumatic stress symptoms. Participants responded to a survey that included a demographic questionnaire (age, gender, years of experience, education, hours per week counseling victims of trauma, and types of trauma treated), the Impact of Event Scale (IES; Zilberg, Weiss, & Horowitz, 1982), the Traumatic Stress Institute (TSI) Belief scale (Pearlman, 1996), and the Coping Strategies Inventory (CSI; Bober, Regehr, & Zhou, 2006). The IES is a measure of secondary stress symptoms and the TSI Belief scale is a measure of vicarious trauma symptoms (Bober & Regehr, 2005). The coping strategies inventory evaluates the respondents’ attitudes toward recommended self-care practices (leisure, self-care, and supervision) and the time actually spent engaging in the activities (leisure, self-care, supervision, and research and development) (Bober & Regehr, 2005). Pearson’s correlations were calculated to determine if demographic variables and coping strategies were associated with scores on IES and TSI Belief scales. Hours spent per week counseling \((r = .25, p \leq .001)\) and hours spent per week counseling victims of trauma \((r = .31, p \leq .001)\) were found to be significantly positively associated with the IES total scores. More time spent counseling victims of trauma and providing counseling in general was associated with greater levels
of distress. Age was found to be negatively associated with level of distress as measured by the IES. The older the counselor, the less likely they are to be experiencing distress from the work.

Scores on the CSI-Beliefs indicated that the counselors surveyed believed in the usefulness of recommended self-care practices (leisure, supervision, and self-care) (Bober & Regehr, 2005). However, a belief in the utility of the coping strategies was not associated with the time spent in the self-care and leisure domains (Bober & Regehr, 2005). Those who believed that supervision was important, were more likely to report engaging in supervision ($r = .18, p \leq .01$) (Bober & Regehr, 2005). However, closer interpretation of the Pearson correlation of this result shows a small correlation between the belief of that supervision is important and the time spent in supervision ($R^2 = .03$, further meaning that only 3% of the variance in the time spent in supervision is accounted for by the belief that supervision is important). Counselors believing in the importance of self-care were more likely to engage in supervision ($r = .18, p \leq .01$) and research and development ($r = .17, p \leq .05$). However, these are also small correlations with $r^2 = .03$. Again, only 3% of the variance in time spent in supervision and time spent in research and development were predicted by the counselor’s belief in the importance of self-care. Bober and Regehr (2005) did not find an association between the numbers of hours spent counseling victims of trauma and frequency of coping strategy use. Interestingly, no association was found between frequency of engagement in self-care, supervision, leisure activities, and the level of distress as measured by the IES. The TSI-Belief scale was found to be negatively associated with time spent participating in leisure activities ($r = -.32, p \leq .05$, $r^2 = .10$, medium correlation) (Gravetter & Wallnau,
Thus, those with a greater amount of maladaptive beliefs spent less time in leisure activities (Bober & Regehr, 2005).

Bober and Regehr (2005) believe that their results support the greater importance of organizational support for counselors working with traumatized clients, as opposed to self-care as traditionally described in conceptual articles and reference books (e.g., vacations, leisure activities, and time with family). Bober and Regehr (2005) contend that “there is no evidence that using recommended coping strategies is protective against acute symptoms of distress” (p. 7). Instead, it is recommended that organizations provide support for counselors by monitoring caseloads and traumatic exposure (Bober & Regehr, 2005). Bober and Regehr (2005) compared the professions’ focus on self-care to the victim-blaming that often occurs by society in response to survivors of trauma. Instead of emphasizing individual counselor strategies, Bober and Regehr (2005) believe that the onus is on organizations to establish practices “that limit the traumatic exposure of any one individual” (p. 8).

These results must be interpreted with caution. Correlations do not speak to a cause-and-effect relationship between variables or to “why the two variables are related” (Gravetter & Wallnau, 2012, p. 520). Much of the Bober and Regehr’s (2005) data was analyzed by calculating Pearson correlations. Independently calculating $r^2$ to determine the strength of the relationship using Bober and Regehr’s Pearson correlations found small to medium correlations and little of the variance in traumatic stress symptoms was explained by the overall weekly time spent counseling, age, and weekly time spent counseling survivors of trauma. Multiple regression was conducted to determine if any of the variables predicted IES and only one variable significantly contributed to the
model, hours per week working with survivors of trauma ($R = .27, F = 11.46, p = .001$), explaining only 7% of the total variance of PTSD symptoms as measured by the IES. Though the model significantly predicts symptoms of traumatic stress, the results also indicate that much of the variance remains unexplained (Bober & Regehr, 2005).

Bober and Regehr’s (2005) study also fails to explore the impact of individual and organizational factors upon counselor wellness. Because compassion satisfaction can co-exist with compassion fatigue, as found by Hyatt-Burkhart (2014), it is important to learn what factors may support compassion satisfaction and therefore counselor wellness. Following up on Bober and Regehr’s (2005) study, Killian (2008) interviewed a sample of twenty clinicians with clinical backgrounds that ranged from social work, counseling psychology, counseling, and marriage and family therapy to identify coping strategies used by the clinicians, and to understand the effect of trauma work on the helping professional. Four categories were uncovered during data analysis: recognizing work stress, risk factors, definitions of self-care, and specific self-care strategies (Killian, 2008).

The clinicians reported that at times the difficulty and stress of the work manifested itself in headaches, difficulty sleeping, anxiety and intrusive thoughts, distractedness, disconnection, forgetfulness, and a lack of energy (Killian, 2008). Killian’s (2008) participants identified risk factors for burnout and compassion fatigue and the necessary components of self-care. The risk factors identified are as follows (listed from most frequently mentioned to least frequently mentioned): demanding caseload/“workaholism” (Killian, 2008, p. 36), personal history of trauma, supervision, unsupportive work environment, lack of social supports, one’s worldview,
and self-awareness. The self-care behaviors described by the clinicians to be important to maintaining well-being included: *debriefing* or *processing*, *exercise*, and *spirituality* (Killian, 2008, p. 36). Debriefing or processing refers to time spent with supervisors and colleagues discussing caseload difficulties, as well as the time spent with family and friends in an effort to decompress after work (Killian, 2008).

Using the themes obtained from the qualitative study, Killian (2008) surveyed 104 ethnically diverse therapists (48% White, 21% African American, 21% Latina, and 10% Asian) to determine whether the individual and organizational factors identified in the qualitative study predict counselor professional quality of life (compassion satisfaction, compassion fatigue, and burnout). Several instruments were administered to approximate social support, personal trauma history, affective coping style, self-care strategies, burnout, compassion satisfaction, compassion fatigue, work stressors and resources, and work drain (Killian, 2008). Killian (2008) analyzed the data using correlation and multiple regression. Killian (2008) found that social support, work hours, and internal locus of control at work accounted for 41% of the variance in compassion satisfaction; work drain, lack of morale, neuroticism accounted for 74.1% of the variance in burnout; and, finally, feeling powerless, work drain, emotional self-awareness, and trauma history accounted for 54% of the variance in compassion fatigue.

These results point to the protective role of self-awareness, improved work morale, balance between work-life responsibilities, social support, maintaining an internal locus of control at work, and monitoring workload (Killian, 2008). Coping style and self-care strategies as measured by Killian (2008) were not found to predict compassion satisfaction, compassion fatigue, and burnout. Utilizing negative/avoidant
coping strategies, such as denial and venting, was positively associated with work stress. As expected, “proactive” coping strategies, such as supervision, social support, and reducing workload, were positively associated with reduced work stress (Killian, 2008, p. 40).

Killian’s (2008) findings corroborate those of Bober and Regehr’s (2005) findings. The use of specific self-care strategies (e.g., exercise, leisure time, supervision, prayer, and meditation) were not related to compassion fatigue, compassion satisfaction, and burnout (Killian, 2008). It is possible that the self-care measure utilized by Killian (2008) was not an accurate representation of each clinician’s self-care practices. Looking at the descriptions of self-care provided by the participants in the qualitative portion of Killian’s study, self-care was described as, “modeling for our clients”, “those items that I do for myself as proactive, to keep from experiencing burnout, or the physiological problems”, and “trying to deal with as much of the day during my day and leaving it there” (Killian, 2008, p. 36). Self-care may be more than the traditional description of strategies provided in the conceptual literature (e.g., taking vacation, leisure time, spending time with friends, and exercise) and it may become instead, the importance of managing risk and protective factors as mentioned by Killian’s (2008) participants. Self-care may also include monitoring work-life balance by seeking to reduce caseload, if needed, to prevent work drain, and relying on social support at work and at home to buffer stress. These factors (social support, work hours, and internal locus of control at work) were found by Killian (2008) to significantly predict compassion satisfaction.

Like Bober and Regehr (2005) and Killian (2008), Lawson (2007) was interested in determining whether specific coping strategies are more likely than others to be
associated with counselor wellness. Lawson (2007) administered the Pro-QOL III-R (Stamm, 2005) and the Career Sustaining Behavior Questionnaire (CSBQ; Stevanovic & Rupert, 2004) to a random sample of 1000 ACA members. 501 usable surveys were returned and the data was analyzed by running descriptive statistics and t-tests and analyses of variance to determine between group differences on the variables studied (Lawson, 2007). Lawson compared the career sustaining behaviors practiced by the most and least satisfied counselors, as measured by a global satisfaction scale. Fourteen CSBs were associated with greater satisfaction: maintaining a sense of humor, time with partner and family, work-life balance, self-awareness, control over work, spirituality, staying abreast of the literature, being interested in the work, reflecting on the positive, maintaining objectivity, engaging in quiet leisure, strong professional identity, continuing education, and time with friends (Lawson, 2007).

In Lawson’s sample, counselors who had lower scores of burnout and higher scores of compassion satisfaction endorsed many of the same career sustaining behaviors as satisfied counselors: a sense of humor, self-awareness, a work-life balance, objectivity, a positive outlook, time with friends and family, spirituality, staying abreast of literature in field, quiet leisure, a strong professional identify, and continuing education, as practices that support and sustain their work as a counselor. Lawson’s (2007) study contradicted the existing conceptual literature that indicated that regular vacations, engaging in physical activities, putting thoughts of clients aside, self-reflection, frequent breaks, and personal therapy are effective self-care practices (Lawson, 2007). Those self-care practices were not frequently practiced by counselors in the sample (Lawson, 2007). Lawson’s sample included community, private practice, and school counselors but did
not distinguish between home-based and office-based counselors. Further, because Lawson’s study used the CSBQ to determine which strategies counselors endorse, it is possible that counselors may implement other strategies to maintain wellness. Lawson (2007) called for qualitative research to uncover additional means for maintaining wellness within counseling work.

Kulkarni et al. (2013) sought to understand the role of individual and organizational factors as risk or protective factors for counselor wellness in a sample of domestic violence clinicians. The Areas of Worklife Scale (AWS), ProQOL-IV, a measure of coping skills (Bober & Regehr, 2006), and supervisor quality (Himle, Jayaratne, & Thyness, 1989) were administered to a group of 236 domestic services providers, recruited from two domestic violence coalition LISTSERVs (Kulkarni et al., 2013). Kulkarni analyzed the effects of the risk and protective factors on wellness using hierarchical multiple regression. Coping variables, employment variables, including supervision quality, and demographic variables were entered into the first stage of the analysis (Kulkarni et al., 2013). The AWS subscales were entered into the second step of the regression (Kulkarni et al., 2013). The AWS assesses for problematic areas in one’s work where discrepancies exist between work requirements and one’s personal values and needs (Kulkarni et al., 2013). The domains of the AWS include: workload, control, reward, community, fairness, and values (Kulkarni et al., 2013).

Kulkarni’s findings support the positive effects of quality supervision, engaging in self-care, experience, and matching personal and workplace values and the detrimental effects of workload and lack of control and autonomy over one’s work. In the first step of the analysis, supervision and self-care were found to be negatively associated with
burnout and self-care was negatively associated with secondary traumatic stress (Kulkarni et al., 2013). However, these effects were not significant in step two of the analysis (Kulkarni et al., 2013). Shared values as measured by AWS, and experience were positively associated with compassion satisfaction (Kulkarni et al., 2013). Workload was positively related to secondary traumatic stress and burnout (Kulkarni et al., 2013). Experiencing decreased control and autonomy over one’s work was associated with secondary traumatic stress (Kulkarni et al., 2013). Interestingly, contrary to what was expected, the amount of time spent in leisure activity was positively associated with secondary traumatic stress and burnout in the initial model entered into the analysis (Kulkarni et al., 2013). When the AWS variables were entered into the next step of the regression, the effects of leisure activity were no longer significant (Kulkarni et al., 2013).

The results from Kulkarni et al.’s (2013) study are limited by the self-report nature of the measures used, and the lack of distinction in the sample between part-time and full-time employees (Kulkarni et al., 2013). Kulkarni et al. (2013) recommended additional studies are needed to further understand the process of compassion satisfaction using a sample of providers with a wider range of work experience (Kulkarni et al., 2013). It would be beneficial to less experienced domestic violence providers to have an awareness of the coping strategies deemed crucial to practice by seasoned domestic violence providers (Kulkarni et al., 2013). Similarly, in this study, the perceptions of experienced HCBCs may uncover systemic practices, useful to less experienced HCBCs, that otherwise would remain in the periphery.
Theoretical Foundation of the Study

This qualitative study is guided by a constructivist grounded theory approach (Charmaz, 1996, 2014; Charmaz & Bryant, 2011), the tenets of symbolic interactionism (Blumer, 1979), and Blumer’s term “sensitizing concepts”. At this time, quantitative research has failed to adequately investigate HCBC wellness. HCBC wellness has not yet been the subject of a qualitative investigation, despite the appropriateness of a qualitative approach given the lack of research in the area. A qualitative study, focusing exclusively on wellness as perceived by home and community based counselors and supervisors, may uncover additional professional behaviors and characteristics and organizational practices associated with HCBC wellness.

Constructivist Grounded Theory

In 1967 Anslem Strauss and Barney Glaser published *The Discovery of Grounded Theory*, and articulated the grounded theory method of qualitative research in an attempt to improve the rigor of qualitative studies, which at the time were not held in high regard (Charmaz, 2008, 2014; Creswell, 2013). Grounded theory is rooted in the concepts of pragmatism and symbolic interaction (Blumer, 1969) (Corbin & Strauss, 1990). Glaser and Strauss’ earliest statement of the method has been described by Creswell (2013) to be “reductionistic, logical, empirical, cause-and-effect oriented, and deterministic” (p. 24). The grounded theory method as originally proposed by Glaser and Strauss, required that the researcher refrain from conducting a literature review to maintain an objective and passive relationship with data collection and data analysis, in order for the theory to emerge fully from the data (Charmaz, 2008; Charmaz & Bryant, 2011). Many years later, Corbin and Strauss (1990) provided researchers with systematic procedures for
conducting a grounded theory study while maintaining the objectivist stance initially outlined by Glaser and Strauss (1967).

Methods of data collection and analysis vital to a grounded theory study, according to Corbin and Strauss (1990), include simultaneous data collection and data analysis, the identification of concepts that appear repeatedly in the data using open coding and axial coding, creation of categories defined by grouping similar concepts together, the use of theoretical sampling and saturation, and the constant-comparison method of data analysis. The grounded theory researcher uses these methods and writes theoretical memos to build a theory that describes a process (Corbin & Strauss, 1990). Theoretical memos are written by grounded theory researchers as categories are developed and defined, in order to expand upon the emerging theory, compare data, codes, and categories, and explore ideas and hunches (Charmaz, 1996; 2008; 2014; Charmaz & Bryant, 2011; Corbin & Strauss, 1990).

Charmaz (2008) disagreed with Glaser and Strauss’s disregard for the role of the researcher and Glaser’s lack of concern for credibility (Charmaz, 2008). Charmaz (2008) was concerned that “their research reports emphasized generality, not relativity, and objectivity, not reflexivity” (p. 399). It is from this concern that Charmaz (2008, 2014) developed the constructivist grounded theory approach. Charmaz trained under both Glaser and Strauss and incorporated many of Glaser and Strauss’s grounded theory procedures with her own constructivist approach in an attempt to rectify concerns regarding researcher bias and a lack of credibility (Charmaz, 1996, 2008, 2014; Charmaz & Bryant, 2011). Charmaz believed that the research process is a co-construction and the researcher must take an active, reflexive role during the inquiry. Charmaz did not
discourage the literature review, though she acknowledged that it is vital to explain the reason for conducting or delaying a literature review as each choice affects the study differently.

Charmaz’s constructivist approach emphasizes theory co-construction and reflexivity. The researcher systematically gathers and codes the data, writing theoretical memos, while engaging in constant-comparisons with the data, theoretical sampling, coding for actions, and using focused coding to identify categories and their properties (1996, 2008, 2014; Charmaz & Bryant, 2011). The researcher in a constructivist grounded theory study makes values, beliefs, and experiences explicit at each decision point in the study. When the researcher engages in reflexivity, data analysis is most likely to reflect the experiences and actions of the study’s participants (Charmaz, 2014).

“Sensitizing concepts” is a term coined by Herbert Blumer, and a strategy applied by Charmaz to constructivist grounded theory methods (p. 30). Sensitizing concepts are identified based upon the researcher’s knowledge and past experiences, and the literature review, as being concepts relevant to the research, only to be incorporated into data analysis if the concepts represent to the actions and processes identified by the study’s participants (Charmaz, 2014). The researcher is aware of the themes that have been identified in the literature and past experience as being crucial to the training, preparation, wellness, and supervision of HCBCs. The themes concerning HCBC preparation, supervision, training, and wellness that have arisen from the literature review in chapter two, that included a conglomeration of quantitative, qualitative, and conceptual articles, have become “sensitizing concepts” in this study. Adhering to the constructivist grounded theory method will improve the credibility of the study and will assist the
researcher with determining which sensitizing concepts earn their merit in the data (Charmaz, 1996, 2008, 2014; Charmaz & Bryant, 2011).

**Chapter Summary**

HCBS have become instrumental to meeting the mental health needs of children and adolescents (Christensen, 1995; Cornett, 2011; Hodas, 2004; Mann & Hyde, 2013; SAMHSA, 2013a). Home and community based counseling services can be challenging to implement (Adams & Maynard, 2000; Christensen, 1995; Lawson, 2005; Hammond & Czyszczon, 2014; Macchi & O’Conner, 2010; Snyder & McCollum, 1999; Stinchfield, 2004; Tate et al., 2014; Worth & Blow, 2010; Zarski et al., 1991), especially given that many HCBCs are recent graduates with little experience and their graduate training may not include home and community based interventions (Adams & Maynard, 2000). HCBCs can experience isolation and demoralization as a result of the difficulties of the work, a lack of supervision and monitoring, and little contact with colleagues (Adams & Maynard, 2000; Bowen & Caron, 2016; Christensen, 1995; Snyder & McCollum, 1999).

Qualitative studies have generated rich data and themes regarding the challenges of home-based work (Adams & Maynard, 2000; Bowen & Caron, 2016; Christensen, 1995; Snyder & McCollum, 1999). These investigations are limited in their scope and generalizability due to the small samples utilized in each study; however, the data gathered and the themes that were generated from the intensive interviews and focus groups have repeatedly surfaced across studies, increasing the credibility of these findings. With confidence, it can be stated that often families receiving home and community based counseling are experiencing multiple problems and are involved with
multiple systems, placing additional demands on HCBCs (Christensen, 1995; Snyder & McCollum, 1999; Werrbach, 1992).

Though these qualitative studies (i.e., Adams & Maynard, 2000; Bowen & Caron, 2016, Christensen, 1995; Snyder & McCollum, 1999) point to the difficulties associated with the work, each study contributes significant and unique findings to the literature base. Christensen’s (1995) study found that some HCBCs, who are not provided with training and supervision, may not acquire the skills necessary for successful home and community based practice. As they are overtaken by the distractions, lack of structure, and a multitude of problems families face, the family therapists unfortunately became disillusioned with the work (Christensen, 1995). In contrast, Snyder and McCollum’s (1999) study provides a snapshot of the experiences of HCBCs who, despite the difficulties and challenges of HCBS, grow from the work and master the skills necessary for successful practice. Adams and Maynard’s (2000) study increased awareness within the counseling field that experiences of demoralization can affect many HCBCs. Bowen and Caron (2016) found that isolation and ethical ambiguity frequently accompanies home and community based work. HCBCs doubted their ability to apply trainings to the home setting and make decisions regarding ethical dilemmas (Bowen and Caron, 2016).

To further research, studies are needed to determine how HCBCs stay well despite these challenges. Without shifting the direction of research, the literature illustrates a clouded, negative, one-sided view of home and community based counseling. Instead of as intended calling the profession to action to improve training and continuing education for HCBCs, the literature documenting the challenges of HCBCs may discourage counselors from pursuing home and community based work. In
addition, counselor educators may question the appropriateness of HCBS as a training opportunity and may be discouraged from working collaboratively with agencies to create opportunities for students to learn to provide counseling in these unique settings.

Additional research is needed regarding HCBC wellness and agency practices that may improve and sustain counselor wellbeing. The current HCBC wellness research is scant and has been quantitative in nature, and therefore does not identify HCBC perceptions of the “salutary factors” (Antonovsky, 1996, p. 14), both individual and organizational, that are of import to counselor wellness (Macchi et al., 2014). Bowen & Caron (2016) and Tate et al. (2014) hint at the importance of professional behaviors that may foster success as a HCBC including, maintaining positivity, authenticity, “the right attitude” (Bowen & Caron, 2016, p. 136), open mindedness, and client and family strengths. Supervision and accepting feedback were found to be critical characteristics of a competent HCBC (Tate et al., 2014). Outside of these studies, HCBC perceptions of strategies that promote and sustain HCBC wellness has not been explored.

Counselor wellness, in general, has been investigated, using quantitative and qualitative analyses, but as of yet, the results have been inconclusive and cross comparisons have been difficult because each investigation uses different measures to approximate the variables being analyzed (Bober & Regehr, 2005; Killian, 2008; Kulkarni et al., 2013; Macchi et al., 2014). Among the quantitative studies (Bober & Regehr, 2005; Killian, 2008; Kulkarni et al., 2013; Macchi et al., 2014), much of the variance remained unexplained by the variables entered into the analysis, indicating that either, the measures may not have accurately captured the variables or that additional variables, yet to be identified, may explain the remaining variance in the models.
The literature surrounding home and community based counseling has focused on the challenges and implications associated with the work, aside from Macchi et al.’s (2014) study, the first investigators to explore HCBC wellness. This qualitative inquiry seeks to extend the research of Macchi et al. (2014), Bowen and Caron (2016), and Tate et al. (2014) by developing a model for HCBC wellness, specifically among BHRS HCBCs. Unlike evidenced-based home counseling models, BHRS HCBCs do not follow a manualized approach that would include additional oversight, supervision, and monitoring to enhance fidelity and treatment outcomes. A model for counselor wellness grounded in data obtained from BHRS HCBCs would serve as a guide and starting point for agencies, counselor educators, and HCBCs to improve the retention and wellness of HCBCs, a noted concern in the field (Adams & Maynard, 2000; Christensen, 1995; Bowen & Caron, 2016; Snyder & McCollum, 1999). Charmaz’s constructivist grounded theory approach will be followed to meanings, actions, and processes associated with HCBC wellness (Charmaz 1996, 2008, 2014; Charmaz & Bryant, 2011).
CHAPTER III: METHODOLOGY

Introduction

To date, the individual and organizational factors that may sustain home and community based counselor (HCBC) wellness have yet to be the subject of qualitative inquiry. A thorough review of the HCBC literature yielded conceptual articles and empirical studies concerning theories of in-home family therapy (Cortes, 2004; Macchi & O’Conner, 2010; Woodford, Bordeau, & Alderfer, 2006), challenges of the work (Bowen & Caron, 2016; Christensen, 1995; Worth & Blow, 2010), ethical considerations (Bowen & Caron, 2016; Hammond & Czysyczcon, 2013; Lauka et al., 2013; Worth & Blow, 2010), the supervision and training of in-home family therapists (Hammond & Czysyczcon, 2013; Lawson, 2005; Zarski, Sand-Pringle, Greenbank, & Cibik, 1991), and counseling competencies (Tate et al., 2014). The research literature has focused on the impact of individual and organizational factors upon counselor wellness, vicarious growth, compassion satisfaction, and compassion fatigue amongst therapists (Brockhouse et al., 2011), clinicians treating sexual abuse (Killian, 2008), domestic violence counselors (Kulkarni et al., 2013), home-based family therapists (Macchi et al., 2014), and mental health counselors (Thompson et al., 2014).

Quantitative studies have used advanced statistics such as path analysis (Williams et al., 2012), structural equation modeling (Macchi et al., 2013), and multiple regression (Brockhouse et al., 2011; Killian, 2008; Kulkarni et al., 2013; Thompson et al., 2014) to determine whether the level of trauma symptoms, compassion fatigue, vicarious growth, compassion satisfaction, and wellness can be predicted, mediated, or moderated by supervision or other individual and organizational factors.
The results from these quantitative studies have been inconclusive (Brockhouse et al., 2011; Killian, 2008; Williams et al., 2012; Macchi et al., 2014) and the role of supervision and organizational support in counselor wellness is yet to be determined. In addition, these results must be interpreted with caution, as the models generated were limited by the variables entered into the analysis. For instance, Thompson et al.’s (2014) study found that 31% of the variance of compassion fatigue and 66.9% of the variance of burnout was explained by perceptions of working conditions, mindfulness, coping strategy use, and compassion satisfaction. Killian’s (2008) analysis found that social support, work hours, and locus of control explained 41% of compassion satisfaction and work drain, powerlessness over systems serving clients, emotional self-awareness, and history of trauma explained 54% of compassion fatigue. Williams et al. (2012) indicated supervision did not mediate vicarious trauma. Further complicating matters, different measures were utilized in the quantitative studies, making cross-study comparisons problematic (Brockhouse et al., 2011; Killian, 2008; Kulkarni et al., 2013; Macchi et al., 2014; Thompson et al., 2014; Williams et al., 2012).

Only recently has the wellness of HCBCs been studied by Macchi et al. (2014). Macchi et al. investigated the mediating effect of self-care and supervision on the impact of perceived workload and years of experience on professional quality of life of home-based family therapists (Macchi et al., 2014). However, Macchi et al.’s (2014) quantitative study only examined the potential mediating effect of the quantity of self-care and supervision on the impact of perceived workload and years of experience on professional quality of life. Macchi et al.’s (2014) results did not indicate the specific practices that improved the home-based family therapist wellness. The counseling
literature has yet to produce conclusive research indicating the counselor, supervisor, and agency characteristics and practices that may improve counselor wellness. Until the variables important to counselor and HCBC wellness are identified, quantitative studies will be unable to fully examine the impact of systemic practices upon HCBCs.

The systemic practices that may facilitate wellness of HCBCs, specifically those working in the field of Behavioral Health and Rehabilitation Services (BHRS), is of interest in this qualitative investigation. No research exists exploring the individual and organizational factors that may affect the wellness of HCBCs afforded little supervision, such as BHRS clinicians. The scant research in the field of home-based counselor wellness (Macchi et al., 2014) has focused on the impact of the frequency of self-care and supervision, and did not uncover the specific individual and organizational practices that may influence counselor wellness. To fill this gap, qualitative research is needed. In general, qualitative analyses are well-suited to exploring an area of study that is little researched (Creswell, 2013). Qualitative research is conducted when “a problem or issue needs to be explored” (Creswell, 2013, p. 47). Through qualitative analyses, we are able to learn the complex details of a phenomenon and the how and why something occurs, directly from the individuals being studied, in their own words.

Though there are similarities between the provision of in-home family therapy, as described by Macchi and O’Conner (2010), and BHRS, BHRS counselors face the possibility of additional challenges due to the nature of the services. BHRS HCBCs do not follow a manualized treatment approach. In addition, BHRS HCBCs receive infrequent supervision and may experience isolation from coworkers as found in Bowen and Caron’s (2016) study, because BHRS is not a team-delivered service. Learning more
about the wellness practices of BHRS counselors and the BHRS agencies would inform
counselor, counselor educator, agency, and managed care practices. Improved standards
for supervision of home-based counselors and additional organizational practices may be
developed to encourage and sustain HCBC wellness.

**Purpose of the Study**

The objective of this inquiry is to better understand the individual and
organizational processes through which master’s-level BHRS clinicians maintain
wellness, and barriers or boosts to this process. The central question of this investigation
is, “how do systemic influences affect the wellness of BHRS HCBCs?” A theory of
HCBC wellness, grounded from the qualitative data from individual interviews with
BHRS clinicians, will be put forth with this investigation. A model for sustaining HCBC
wellness will add to the literature base, which to date, has focused largely on the
challenges of home and community based work (Bowen & Caron, 2016; Lawson, 2005;
Lawson & Foster, 2005) and implications for counselor training and supervision
investigated the role of the frequency of supervision and self-care in mediating the effects
of workload and experience on professional quality of life, but did not provide
information as to the strategies that may promote or sustain wellness. The results from
this study will add to the extant literature the systemic practices most integral to HCBC
wellness.

**Research Design**

The aim of the current study is to employ grounded theory methods to discover a
model of counselor wellness and the individual, agency, and supervision practices that
sustain master’s-level BHRS counselor wellness. Grounded theory is rooted in the post-positivist belief that a theory can be generated through the rigorous scientific method of gathering data from qualitative interviews and systematically reviewing and coding the data for common actions, meanings, and processes using Corbin and Strauss (1990) “constant comparative” approach to data analysis (Charmaz, 2014). Grounded theory can be described as “reductionistic, logical, empirical, cause-and-effect oriented, and deterministic” (Creswell, 2013, p. 24). The grounded theory procedures of Glaser and Strauss emphasized the neutral, objective investigator and the importance of refraining from a literature review as to not force the data (Charmaz, 1996; 2014; Charmaz & Bryant, 2011). According to Glaser and Strauss’ approach, the investigator is charged with taking a passive and objective stance, delaying a literature review, in order to be completely open toward discovering the theory that emerged, as if magically, from the data (Charmaz & Bryant, 2011).

This qualitative inquiry utilizes the grounded theory approach of Charmaz (2014) couched in the principles of social constructionism and constructivism (Charmaz, 2014; Hansen, 2004). Charmaz (2014) studied under both Anslem Strauss and Barney Glaser. It is from this direct experience that Charmaz (1996, 2014) put forth constructivist grounded theory in response to Glaser and Strauss’s disregard for the role of the researcher, the context, and the participants in shaping the grounded theory (Charmaz & Bryant, 2011). Charmaz (2014) further explains:

Constructivist grounded theory adopts the inductive, comparative, emergent, and open-ended approach of Glaser and Strauss’s (1967) original statement. It includes the iterative logic that Strauss emphasize in his early teaching, as well as the dual emphases on action and meaning inherent in the pragmatist tradition… Constructivist grounded theory highlights the flexibility of the method and resists mechanical application of it” (p. 12-13).
Unlike Glaser and Strauss, Charmaz (2014) believes that there are times when a literature review is necessary and beneficial as long as the findings of the literature review are treated as “sensitizing concepts” and only incorporated into the study when they have their significance during data analysis. It was necessary for this researcher to complete a thorough literature review in part to fulfill the requirements of the doctoral dissertation and to develop and defend a research proposal prior to conducting the study.

Constructivist grounded theory studies are emergent and rely upon the researcher as an instrument for uncovering and co-constructing participant meanings and experiences while emphasizing the need for reflexivity (Charmaz, 1996, 2014; Charmaz & Bryant, 2011; Creswell, 2013). As initially formulated by Glaser and Strauss, Charmaz (2014) maintains that data collection and data analysis must occur simultaneously. Often the researcher must revise the research questions in response to initial and subsequent findings (Charmaz, 1996; Charmaz & Bryant, 2011; Corbin & Strauss, 1990). Therefore, the initial research questions and the research design remain open to revision as data is collected and analyzed (Charmaz, 1996, 2014; Charmaz & Bryant, 2011; Corbin & Strauss, 1990; Creswell, 2013).

The methods of coding a constructivist grounded theory study are similar to the coding procedures outlined by Glaser and Strauss (Charmaz, 2014). While conducting a constructivist grounded study, the researcher codes the actions, processes, and meanings that surface from the data (Charmaz, 1996, 2014; Charmaz & Bryant, 2011; Creswell, 2013). These codes are further refined and elevated to categories that are related to the process being studied (Charmaz, 1996, 2014; Charmaz & Bryant, 2011; Creswell, 2013; Corbin & Strauss, 1990). The grounded theory investigator writes memos comparing and
contrasting the codes and categories, using the raw data gathered from each interview (participant stories, meanings, and actions) to build and support the emerging theory (Charmaz, 1996, 2014; Charmaz, & Bryant, 2011; Corbin & Strauss, 1990).

**Qualitative Inquiry**

Though grounded theory as it was conceived by Glaser and Strauss has positivist underpinnings and assumptions, it remains a qualitative approach, sharing characteristics of qualitative work (Charmaz, 2014; Creswell, 2013). The goal of qualitative research as stated by Creswell (2013) is that “the final written report or presentation includes the voices of participants, the reflexivity of the researcher, a complex description or interpretation of the problem, and its contribution to the literature or a call for change” (p. 44). The researcher may review documents, observe participants, and conduct interviews using open-ended questions in an effort to draw out participant experiences and meanings (Creswell, 2013). Creswell (2013) recommends that the grounded theory investigator “set aside, as much as possible, theoretical ideas or notions so that the analytic, substantive theory can emerge” (p. 89).

Built on a social constructivist framework that necessitates that the researcher’s bias, experiences, and values be acknowledged and made explicit, Charmaz (2014), also, calls for reflexivity. From the start to end of the research project, the researcher actively reflects upon how researcher’s bias may affect data analysis and data collection (Charmaz, 2014). By engaging in reflexivity, the researcher ensures that the data reflects the experiences, meanings, actions, and processes of the participants (Charmaz, 2014). Engaging in reflexivity assists the researcher with interpreting and analyzing the
data to account for the multiple perspectives of the research subjects, unclouded by the values and beliefs of the investigator.

It is hoped that the results generated will lay the groundwork for evaluating and transforming supervision, agency, and counselor practices to improve HCBC wellness and ultimately lead to better client outcomes. The ultimate goal of the study is to develop a theory of HCBC wellness, grounded from interviews with BHRS clinicians and supervisors, to inform stakeholders’ practices (supervisors, counselors, program directors, and insurance companies).

**Sample**

Large scale probability sampling is required of quantitative research in an effort to obtain data that *mathematically* reflects a subgroup of a population in order to quantify the characteristics of the population being sampled for the purpose of hypothesis testing (Berg, 2007; Maxwell, 2008). In contrast, sampling in qualitative research requires small, non-probability samples (Berg, 2007; Maxwell, 2008). Utilizing a smaller sample enables the qualitative researcher to explore in-depth the actions, processes, meanings, experiences, and perceptions of the research participants, and to gather rich data (Berg, 2007; Charmaz, 2014. Maxwell, 2008). A large sample would not yield the in-depth data garnered from participant interviews quintessential to qualitative research (Berg, 2007; Maxwell, 2008). Berg (2007) states, “the analysis of qualitative data allows researchers to discuss in detail the various social contours and processes human beings use to create and maintain their social realities” (p. 9).

At a grounded study’s onset, a purposive sample is identified to best answer the research question as it is initially proposed. Corbin and Strauss (1990) elaborate, “when
a project is begun, the researcher brings to it some idea of the phenomenon he or she wants to study, then based on this knowledge selects groups of individuals, an organization, or community most representative of that phenomenon” (p. 420). To conduct purposive sampling, a researcher selects a group of participants that reflects the population being studied, based upon the researcher’s expertise and knowledge about the subject being studied (Berg, 2007). To explore the systemic influences upon BHRS HCBC wellness, a small sample of BHRS HCBCs and supervisors was recruited to participate in individual interviews. In addition to purposive sampling, theoretical, and snowball sampling will be used in this inquiry. These additional methods of sampling are described in detail in the following sections.

**Purposive Sampling**

In this qualitative inquiry, a purposive sample of master’s-level BHRS counselors and supervisors were recruited to learn about the systemic process of maintaining wellness within the work of BHRS. A sample of willing participants was drawn from a population of BHRS master’s-level counselors and supervisors from available BHRS agencies in Pennsylvania. BHRS counselors and supervisors from several agencies were selected, in an effort to determine how BHRS counselors, supervisors, and agencies, as a whole, experience, perceive, and influence BHRS counselor wellness. The data from multiple participants, supervisors, and agencies was compared and contrasted to determine systemic factors perceived to be essential to BHRS HCBC wellness.

**Snowball Sampling**

If the researcher has difficulty recruiting via purposive sampling, snowball sampling may be utilized to obtain a larger sample (Berg, 2007). If needed, each
participant may identify potential BHRS HCBCs and/or supervisors to be interviewed, increasing the sample size through the use of snowball sampling (Berg, 2007). Snowball sampling was used and complemented the other sampling strategies.

**Theoretical Sampling**

Simultaneous data collection and data analysis were conducted in accordance with the tenets of grounded theory (Charmaz, 1996, 2014; Corbin & Strauss, 1990). Due to the emergent and iterative nature of a grounded theory study, the research question, interview questions, and sample itself were revised as needed (Charmaz, 1996, 2014). Gaps were revealed during the rigorous process of data collection and analysis, as categories were coded in the data (Charmaz, 2014). Thus, following purposive sampling, theoretical sampling was utilized to flesh out the categories thought to be part of the emerging theory (Charmaz, 1996; Charmaz, 2014; Corbin & Strauss, 1990). It is necessary to engage in theoretical sampling to further explicate these categories and further refine the theory. This investigation utilized theoretical sampling to sample additional BHRS HCBCs and supervisors. Additional interviews were conducted using interview questions that targeted expanding upon the categories, or exploring inconsistencies, similarities, or differences between participant interviews (Charmaz, 2014). Theoretical sampling included member-checking to ensure that the theoretical categories and theory developed from the data reflect the experiences and perceptions of participants (Charmaz, 2014). Sampling was no longer needed once the data were saturated. At the point of saturation, “fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories” (Charmaz, 2014, p. 213).
Selection Criteria. BHRS counselors were eligible for participation in the study if they had been employed by an agency for greater than one year and have a Master’s degree in counseling or a related field such as social work, marriage and family therapy, and psychology. Supervisors with at least one year of supervisory experience within each BHRS agency were eligible to participate in individual interviews.

Participant Selection. Permission was granted from Program Directors of three BHRS agencies to obtain a purposive sample BHRS master’s-level counselors and supervisors. A small purposive sample of BHRS supervisors and counselors from each agency was recruited for participation in individual interviews. The individual interviews explored the role of systemic factors in maintaining and enhancing BHRS HCBC wellbeing. Snowball sampling was used to attempt to recruit additional participants.

Recruitment occurred via a means preferred by the agency, including but not limited to an email and/or phone calls to potential participants, and a brief description given to potential participants at a staff meeting/supervision. The email or phone call description included the purpose of the study, criteria for participation, how confidentiality will be maintained and protected, and the activities and time commitment involved in participating in the study (see Appendix B). Upon agreeing to participate, a meeting was scheduled to obtain consent and complete the individual interview that lasted approximately 60-90 minutes. The participant reviewed and signed the Informed Consent for Interview (see Appendix C). The Informed Consent for Interview provided information about the purpose of the study, study procedures, voluntary nature of participation, risks and benefits of participation, how confidentiality will be maintained and protected, and the credentials and contact information of the investigator and the
dissertation chair. The consent form is further explained in the ethical considerations section of this chapter. After completing the Informed Consent for Interview, the subjects indicated whether or not they agree to participate in the research. Participants were asked if they were willing to participate in a follow-up interview and if they would like to be contacted with results from the study. If so, participants were asked to provide the investigator with an email address and telephone number.

**Sample Size.** The sample size needed to conduct a grounded theory study varies from study to study, depending on the nature of the inquiry (Charmaz, 2014). Often more sensitive topics require a greater number of interviews (Charmaz, 2014). However, the size of the sample of any given inquiry depends on what is uncovered during data collection and data analysis (Charmaz, 2014). Charmaz (2014) recommends continued sampling until enough information is gathered to reflect context, the background information provides rich, thick, detailed descriptions from participants, and the data evident in the data analysis and analytic categories are fully developed (Charmaz, 2014). Sampling continued until the data were saturated. Data were saturated after interviewing eight HCBCs and four HCBC supervisors.

**Data Collection**

Data were obtained from multiple sources, including individual interviews with BHRS HCBCs, individual interviews with BHRS supervisors, and a methodological journal maintained by this researcher. Collecting data from multiple sources, engaging in member checking to verify data analysis, and writing descriptions full of detail are recommended by Creswell (2013) and Charmaz (1996, 2014) to improve the validity of a study. In addition, gathering data from supervisors and HCBCs provided a means of
triangulating the data from multiple sources and thereby improved the credibility of the analysis (Denzin, 2009).

**Intensive Individual Interviews**

Charmaz and Bryant (2011) state, “interviews are, of course, retrospective accounts that often explain and justify behavior. Yet they may also be special social places in which research participants can reflect on the past and link it to the present and future in new ways” (p. 299). Charmaz (2014) recommends intensive interviewing as a means to gathering the rich data needed for the grounded analysis. Intensive interviewing involves using open-ended questions to interview a specific group of individuals familiar with the phenomenon under investigation to obtain detailed information about their experiences and perceptions (Charmaz, 2014). Often, unspoken, unstated ideas, and assumptions emerge when the investigator codes the data, and these must be revisited in future interviews. Intensive interviewing also includes a follow-up process to explore discrepancies, questions, and hunches (Charmaz, 2014).

**Semi-structured interview format.** Charmaz (2014) recommends that the novice researcher develop, in advance, a comprehensive interview guide that lists potential interview questions and areas to explore. The purpose of the interview guide is to help the interviewer adequately prepare for the interview, consider all the concepts that are under investigation, and carefully devise questions so as to not bias the data gathered. Charmaz (2014) explains, “‘the wrong questions result in forcing the data, but also how interviewers pose, emphasize, and pace their questions can force the data… Such questions may also foist the researcher’s concepts, concerns, and discourse upon the research participants’ reality” (p. 63). An interview guide also serves as a reminder of
the issues at hand and can be valuable checklist ensuring that the investigator remembers
to delve into all of the topics that need to be addressed. The interview guide was
comprised of initial open-ended questions, intermediate questions, and ending questions
(Charmaz, 2014). The initial open-ended questions allowed for rapport-building, and
eased the participant into the interview (Charmaz, 2014). During the initial questions, the
participant described experiences with the phenomena under study (Charmaz, 2014).
Intermediate questions were more difficult and explored more sensitive areas (Charmaz,
2014). Participants were given the space and time to describe their perceptions, thoughts,
and feelings (Charmaz, 2014). The ending questions wrapped up the interview and
facilitated concluding the interview on a positive note, helping the participant to make
sense of his or her experiences, and to derive meaning from them (Charmaz, 2014).

Despite the guide, the investigator followed the participant’s lead, co-constructing
the interview such that the participant is given the space to tell his or her story with little
interference from the investigator (Charmaz, 2014). During initial interviews, only a few
questions were asked in order to gather as much detailed information from the
participant, enabling the participant to fully share his or her story (Charmaz, 2014). As
the study progressed, interviews became more structured and involved using more
focused probes; however, the investigator remained flexible, adapting to the emergent
interview, asking questions to follow up on experiences, perceptions, and meanings
discussed during the interview (Charmaz & Bryant, 2011). In addition, the interview
guide continued to be modified as needed throughout the analysis to reflect the emerging
grounded theory and theoretical sampling (Charmaz, 1996, 2014).
The semi-structured guiding questions for the interviews included a list of potential prompts that were used to explore the role of systemic practices within HCBC counselor wellness (Appendix A). An interview guide was developed for the individual interviews with the HCBCs and the supervisors. The interview guide was scrutinized by the investigator and the dissertation committee to ensure that the questions did not force or shape participant responses (Charmaz, 2014). These prompts were subject to revision due to the emerging and iterative nature of grounded theory (Charmaz, 1996; Charmaz, 2014; Corbin & Strauss, 1990; Creswell, 2013). However, the research focus remained BHRS HCBC wellness and the prompts were related to this focus.

Observational Data

During and after the individual interviews and the focus group, the researcher recorded observations regarding the setting, participant behavior, and participant responses (Charmaz, 2014). This assisted the researcher with putting the interview and the responses in context and noting subtleties that may not be obvious during transcription (Berg, 2007). The observational data also included a review of how the participant responses and behaviors compare and contrast with one another. The researcher recorded hunches that might need further investigation.

Instrumentation

Researcher as Instrument

It is relevant to review the researcher’s interest in the area of self-care and BHRS, in particular to understand the researcher’s own values and biases regarding home and community based counseling, supervision, and self-care. This researcher’s past employment has included work as a BHRS counselor, a HCBC within an agency
contracted by the local child protective agency and juvenile justice, a Family Based Mental Health Professional, mental health counselor at a residential treatment facility for adolescents, and school-based counselor. This researcher is aware of the challenges inherent to the provision of in-home services having directly experienced them. This researcher clearly remembers the families encountered in the work and their pains and their triumphs. This researcher has had the privilege of working as a home-based counselor with both a large quantity and quality of supervision; however at times this researcher has received little to no supervision, instead relying upon self-supervision and peer and colleague support, obtaining supervision only in emergencies, or during scheduled monthly supervision. This researcher has experienced situations in which colleagues have provided a lot of support and has at other times felt very isolated and unsupported.

This researcher first became concerned with HCBC wellness while involved in both the researcher’s doctoral studies and the supervision of practicum students. During her doctoral internship, this researcher was able to obtain weekly supervision of BHRS work to fulfill requirements of a doctoral internship, whereas, BHRS master’s-level clinicians employed at the agency were only required to receive one hour per month of supervision. Because most BHRS positions do not require licensure, it is a viable position for recent graduates. However, the lack of supervision, given the complicated nature of the children and families receiving services, was concerning. This investigator was concerned for recent graduates working with multiply challenged children and families in a setting that can often obscure boundaries. To account for this researcher’s beliefs, experiences, and biases, this researcher had to continually revisit them when
designing the interview questions and while gathering and analyzing the data so as to prevent researcher bias. This researcher did not want her biases and values regarding HCBC wellness, the nature of the work, and the need for supervision to influence participant responses. This investigator wrote memos and maintained a methodological journal to describe how her biases and experiences may be affecting decisions within the study. Further, this researcher did not disclose her values regarding HCBC wellness, supervision, and agency practices to the participants.

**Ethical Considerations**

This study was submitted to the Institutional Review Board (IRB) at Duquesne University for review. The American Counseling Association Code of Ethics (ACA, 2014) was consulted during the design of the study. Potential ethical issues were considered and addressed in regards to the treatment of subject participants, nature of confidentiality, data storage and retention, and the report of findings.

**Treatment of Subject Participants**

The most pertinent ethical considerations when conducting research are to obtain voluntary participation and provide informed consent (Berg, 2007). The National Research Act of 1974 charged institutions with creating committees and institutional review boards (IRBs) to ensure that the investigator has considered and protected research participant's rights, the risks and benefits of the research, and will obtain informed consent (Berg, 2007). The study must also be deemed to have the potential to contribute to the research literature (Berg, 2007). The consent to participate in this investigation included the nature of the study, what is expected of participation, the anticipated length, and the credentials and contact information of the investigators. Informed consent outlined the risks and benefits of participation, and
participants were ensured that participation was voluntary, and as such, participation could be withdrawn at any time.

Individual interviews focused on wellness practices (individual, agency, and supervisory practices) and the nature of BHRS work, and the discussion of these topics placed participants and agencies at no apparent risk. These topics are often discussed in one’s work as a BHRS clinician within the confines of supervision, peer consultation, or conversations with friends and family. It was possible that the participants experienced negative emotions during the interview; however, these were not anticipated to be more than would be experienced during supervision or conversations with colleagues and confidants. Subjects were informed of this risk and reminded that participation may be withdrawn at any time and if needed debriefing would be provided. Though unlikely, if there was as participant who would benefit from additional counseling, referrals for counseling would have been provided. Subjects were informed that participation was voluntary and confidential and was in no way a function or requirement of employment at their respective agency. Participation, lack of participation, or withdrawing from the study, did not have negative ramifications on employment or supervision. Confidentiality was maintained such that agency supervisors and administrators did not know the identity of the BHRS clinicians or supervisors participating in the study. Participants were informed that they will not be compensated for participating in the study.

Potential risks and benefits of study participation were described during the informed consent process. Study participants were informed that they may or may not personally benefit from participation in the study. Following completion of the study,
participants may have developed their own informal plan for wellness having identified individual, supervisory, and agency practices necessary for wellness maintenance. Having identified the strategies deemed fruitful for wellness, participants may have been more likely to engage in these practices and seek agency and supervisory experiences beneficial to wellness. Participation may have served as a form of peer mentoring and a way to give back to the counseling field. HCBCs, agency administrators, counselor educators, and supervisors reading the research may improve their wellness practices. Agencies and supervisors may develop programs and interventions to address and support wellness. The results of the study have the potential to transform individual, agency, and supervisory practices in the area of home and community based counseling.

Confidentiality

Participants were informed that confidentiality would be maintained in accordance with the ACA Code of Ethics (2014), the Child Protective Service Law, and the IRB. The identity of the person and the agency remained confidential. Participants were reminded of the obligations of mandated reporting. As a mandated reporter, the investigator would have been required to report potential child abuse and neglect and intentions of harm to self or others to the appropriate authorities. Participants were aware that outside of these circumstances, information provided during individual interviews remained confidential. To prevent potential negative consequences from participation, agency administrators did not know the identity of participants and the identity of BHRS counselors participating were not be made known to supervisors. Participants were informed that the data and results obtained from the study were de-identified to protect
the identity of the agency and the participants. Individual interviews were recorded using audio recording and transcribed by this researcher. All information obtained on the audio recordings will be kept confidential. Any material that contains identifying information, including participant names or other information that would indicate the name of the agency or individual, was deleted from the transcription. Pseudonyms, for the purpose of explication of the data, were used to identify participants. Names were not used in the reporting of the information and the student investigator is the sole individual with access to the identifying information related to the data.

**Data Storage and Retention**

Subjects were informed that written materials, such as notes and informed consent documents, and audio recordings will be stored in a locked cabinet to which only the investigator has access. In addition, all electronic documents will be password protected. This includes but is not limited to the research memos and transcripts. Audio recordings will be destroyed at the completion of the research. Written documents, including memos, transcripts, and field notes, will be stored for five years after which time they will be destroyed.

**Report of Findings**

Participants were informed that all findings would be reported with identifiers removed. Names and identifiers were removed during transcription and pseudonyms were assigned. Participants had the opportunity to review a summary of the interview and a summary of the study’s results to verify accuracy of the analysis. Follow-up interviews with participants were utilized to verify data analysis.
Data Analysis

Data collection included individual semi-structured interviews with master’s-level clinicians of varying experience, as well as BHRS supervisors. A constant comparative method of grounded theory was used to code the actions, meanings, and processes that occur within and between the individual interviews, focus group, and documents (Charmaz, 1996; 2014; Corbin & Strauss, 1990). Grounded theory is rooted in the post-positivist belief that a theory can be generated through the rigorous scientific method of gathering data from qualitative interviews and systematically reviewing and coding the data for actions, meanings, and processes using Corbin and Strauss’s “constant comparative” approach to data analysis (Creswell, 2012). Grounded theory methods, including line-by-line coding, focused coding, memo writing, methodological journaling, were applied to analyze and collect the data obtained from the individual interviews, focus group(s), and agency documents (Charmaz, 2014). These methods will be described in depth in the subsequent sections.

Transcription

After each individual interview, a recording of the session was transcribed by the investigator. The investigator transcribed the data to remain close to the data during data analysis and coding. Each transcription was reviewed carefully by the investigator and coded as described below.

Initial Line-by-Line Coding

Transcripts and agency documents were reviewed line-by-line to code the actions and meanings evident in the data (Charmaz, 1996, 2014; Corbin & Strauss, 1990). The investigator made efforts to be open to phenomena that may emerge from the data and
quickly coded each transcript line-by-line for actions using succinct phrases and gerunds (Charmaz, 1996, 2014). For each line in the transcript, simple phrases were identified that reflect actions and meanings of the data. Strauss and Corbin (1990) refer to these units of analysis as *concepts* whereas, Charmaz (1996, 2014) refers to the units of analysis as actions and meanings initially, and later, broader categories that underscore the processes taking place.

The investigator coded the data line-by-line of each and every transcript and document in order to stay close to the data (Charmaz, 1996, 2014). All initial coding was completed by the investigator and revised according to committee member feedback. By conducting all of the coding as the sole-investigator, this researcher was thoroughly familiar with the data, and understood the perspectives of the participants, noting subtleties in the data (differences between interviews, unspoken assumptions/meanings, and gaps in the data) (Charmaz, 1996, 2014). Many researchers may leave the coding to a co-investigator, creating distance from the investigation, and possibly, impairing credibility and validity of the analysis (Charmaz, 2014).

**Focused Coding**

Focused coding began after the initial interviews were coded line-by-line for actions (Charmaz, 2014). The purpose of focused coding was to determine which codes are the most significant and stand out among other codes. The codes that stand out as being most significant to the phenomenon at hand were elevated to the status of a category. Categories described the main processes occurring in the data, and included several codes (Charmaz, 1996, 2014).
During focused coding, the investigator revisited initial coding, and re-coded the data using the categories identified to stand out in the data. Data were re-coded to identify the properties of each category, compare category to category, and determine the conditions and consequences of a category (Charmaz, 1996, 2014). When relevant, in-vivo codes, using participant words and meanings to code the data, were used during focused coding (Charmaz, 1996, 2014). In-vivo codes bring to the analysis meaningful metaphors that parallel the metaphors and symbolism that can occur during the counseling relationship. Using participants’ words and meanings, affirms their experiences (Charmaz, 2014). Often participants describe their experiences and perceptions using unique terms. These might reflect their individual experiences or the experiences of a group of participants. The participants may also have “insider shorthand terms reflecting a particular group’s perspective” (Charmaz, 2014, p. 134). The in-vivo codes bring participant words into the analysis, legitimizing their experiences (Charmaz, 2014).

**Memo-writing**

While gathering and analyzing data, memo writing is a crucial strategy for the grounded theorist (Charmaz, 2014). Memo writing, an unstructured process of free writing, can occur at any time during the research process (Charmaz, 2014). This strategy is instrumental to the process of data analysis, data collection, and theory formation and later describes the results and conclusions drawn from the investigation (Charmaz, 2014). “Memos give you a space and place for making comparisons between data and data, data and codes, codes of data and other codes, codes and category, category and concept and for articulating conjectures about these comparisons”
(Charmaz, 2014, p. 163). As the study unfolds, the goal of memo writing is to record the reasoning behind coding, in addition to the evidence gathered during data collection, coding, and theory development.

Memos were written in a spontaneous manner without worry about grammar and sentence structure and writing was refined at a later date (Charmaz, 2014). In this manner, early memos detailed data coding and provided evidence for codes and categories while the later memos were more analytic and thoroughly described the properties and conditions of a category, the consequences of a category, and compared categories to categories (Charmaz, 1996, 2014). Memos became lengthier as the study progressed and began to resemble the results and conclusions of the final draft of the study.

**Constant Comparative Approach**

One of the hallmarks of a grounded theory study is the constant comparative approach utilized throughout data collection and analysis (Charmaz, 1996, 2014; Corbin & Strauss, 1990). As data were gathered, data were compared with data, codes with data, codes with codes, codes with categories, categories with categories, incidents with incidents, incidents with categories, and categories with theory (Charmaz, 1996, 2014; Corbin and Strauss, 1990). Data were reviewed and re-reviewed systematically while making these comparisons. The investigator wrote about these comparisons in memos and the methodological journal. As the investigator interacted with the data and made comparisons, additional questions became evident (Charmaz, 1996, 2014; Corbin & Strauss, 1990). These comparisons uncovered gaps in the data that needed further investigation, and determined the direction of future data collection and analysis.
Methodological Journal

A methodological journal was maintained throughout the study to assist the investigator with managing preconceptions and to prevent these preconceptions with forcing and interfering with data collection and analysis (Charmaz, 2014). This strategy is recommended by Charmaz (2014) to track the research trajectory, specifically the dilemmas that ensue and their resolution. The methodological journal was a chronological account of the inquiry and analysis. It was useful for spurring future memo-writing that later needed to be incorporated into the results and conclusions of the research report. Thinking thoughtfully about research dilemmas, and how the investigator's preconceptions affect the study also serves to build credibility (Charmaz, 2014). This investigator maintained a methodological journal during the study and followed up as needed with memo-writing to address concerns that were uncovered during journaling.

Theoretical Saturation

Theoretical sampling was conducted to elaborate upon categories and refine the emerging theory (Charmaz, 1996, 2014; Corbin & Strauss, 1990). Theoretical sampling was complete when theoretical saturation was reached. Theoretical saturation occurred when “gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories” (Charmaz, 2014, p. 213). A fully saturated theory describes in detail the properties of each category and compares each category at length (Charmaz, 2014).
Summarization of the Interviews

The summary of the interviews included a discussion of the dominant codes and categories that were constructed during the analysis, and a proposed theory of maintaining BHRS counselor wellness (Charmaz, 2014). The interview participants were consulted via follow up emails and/or interviews to determine if the codes and categories constructed matched their experiences and whether the resultant theory resonated with them. Participants were given the opportunity to provide the investigator with additional information. Member checking helps improve the validity of the analysis (Charmaz, 2014; Creswell, 2013).

The Validity of the Inquiry

Many terms for validity exist within qualitative research literature, such as trustworthiness, authenticity, goodness, adequacy, verisimilitude, plausibility, validation, and credibility (Creswell & Miller, 2000). The validity of qualitative inquiries is defined as the extent to which a study accurately reflects the participant’s perceptions, experiences, and “realities of a social phenomena” (Creswell & Miller, 2000, p. 124). To demonstrate validity, the analysis must be credible to the participants (Creswell & Miller, 2000). To establish a credible and rigorous study, this investigator identified several validity procedures through the multiple lenses of the researcher, the participants, and those outside of the investigation (committee members, colleagues, and qualitative researchers) (Creswell & Miller, 2000). The following validity procedures were utilized to increase the credibility of the study: triangulation (Denzin, 2009), researcher reflexivity, member checking, rich and thick descriptions, consultation, and the rigorous procedures of grounded theory (i.e., line-by-line coding, memoing, theoretical sampling,

Triangulation

The limitations of the research methods and the influence of the investigator were mitigated using Denzin’s strategy of multiple triangulation (Denzin, 2009). To account for threats to credibility, Denzin (2009) recommends that the investigator use as many means of triangulation as possible in an effort to build a more rigorous study. Triangulation may include the use of multiple data, methods, theories, and/or investigators (Denzin, 2009). Data triangulation entails carefully considering and investigating data across persons, time, and space (Denzin, 2009). Person data analysis was most relevant to this study. Person analysis can occur across three levels, aggregate (studying individual subjects), interactive (considering interactions of a group of subjects in their natural setting or in a laboratory setting), and collective (investigating a group, society, or community) (Denzin, 2009). Aggregate and collective person analysis is to be utilized in this inquiry by conducting individual interviews with BHRS HCBCs and individual interviews with BHRS supervisors (Denzin, 2009). Data triangulation included following procedures for theoretical sampling in an effort to construct a theory fully grounded in evidence from the data (Charmaz, 1996, 2014; Charmaz & Bryant, 2011). Theoretical sampling included re-sampling additional BHRS HCBCs and supervisors in an effort to further expand and refine the developing theory.

In addition to data triangulation, method triangulation was employed by the investigator. Within and between method triangulation is used by researchers to improve study credibility and rigor (Denzin, 2009). Between method triangulation, the most
useful of the approaches, is described by Denzin (2009) as follows: “the rationale for this strategy is that the flaws of one method are often the strengths of another, and by combining methods, observers can achieve the best of each, while overcoming their unique deficiencies” (p. 308). Individual interviews with both the HCBCs and the supervisors were utilized to more broadly inform the research question and improve the credibility of the resultant grounded theory. Individual interviews provide the investigator with rich descriptions of participant actions, meanings, and processes, and perceptions of the phenomena under investigation (Charmaz, 2014).

Theory triangulation is pertinent throughout the study (Denzin, 2009). Multiple theories from the extant literature were utilized to carefully and systematically design, conduct, and interpret the study’s results. Existing theories were reviewed during the literature review and were consulted throughout data collection and analysis, and finally while drafting the final report. The theory developed was scrutinized against the existing research in the field of HCBC (Bowen & Caron, 2016; Snyder & McCollum, 1999; Macchi et al., 2014), counselor wellness (Bober & Regehr, 2006; Killian, 2008; Lawson, 2007; Lawson & Foster, 2005; Lawson & Myers, 2011) and theories regarding wellness supervision (Lenz & Smith 2010), burnout prevention (Skovholt et al., 2001), and counselor professional development (Loganbill, Hardy, & Delworth, 1982; Owens & Neale-McFall, 2014; Stoltenberg, 2005; Stoltenberg, McNeill, & Delworth, 1998). A thoughtful side-by-side comparison of the study’s results with multiple perspectives from the literature builds support for and pinpoints direction for future research, ultimately leading to a comprehensive theory of the systemic influences of HCBC wellness (Denzin, 2009).
**Researcher Reflexivity**

This investigator builds the study’s credibility by engaging in reflexivity throughout the study. While bracketing researcher values and biases at the beginning of the research is necessary (Creswell & Miller, 2000), the potential influence of the researcher must be made explicit throughout the study and accommodations must be made to minimize researcher influence (Charmaz, 2014). The study design, data collection, and data analysis are after all a social construction (Charmaz, 2014). As described in early sections, memo writing, a methodological journaling, and consultation with colleagues and the dissertation committee assisted the researcher in maintaining reflexivity throughout the study. Refer to the data analysis section of this chapter for more information regarding these methods of reflexivity.

**Member Checking**

Confirmation from participants was sought to determine whether the data analysis was valid and reflected the views, beliefs, experiences, and meanings of the participants. A summary of the interview, including the relevant codes and categories explicated, was returned to participants for review. Any error or inconsistency found will be corrected to ensure accuracy.

**Grounded Theory Procedures**

When the procedures recommended for grounded theory practice (e.g., line-by-line coding, coding using gerunds, theoretical sampling, methodological journaling, and simultaneous data collection and analysis) are diligently and systematically followed, the resulting analysis and findings are more credible (Charmaz, 1996, 2014; Charmaz & Bryant, 2011; Corbin & Strauss, 1990). The investigator followed the recommendations
provided by Charmaz (1996, 2014), Charmaz and Bryant (2011), and Corbin & Strauss (1990). These procedures were described in earlier sections of this chapter.

**Rich, Thick Descriptions**

The rich and thick descriptions garnered through qualitative inquiry contextualize the phenomena under investigation so that the reader can become immersed in participant experiences (Creswell, 2013; Creswell & Miller, 2000; Maxwell, 2008). Thick descriptions include providing as much of a description as possible of experiences, interactions, meanings, and feelings so that resultant analyses becomes more credible to the reader. When the reader is “transported” into the participant accounts, the reader begins to relate to the experiences of the participants, connecting the experiences with their own (Creswell & Miller, 2000, p. 129). In addition, with sufficient detail, the reader is able to make decisions regarding the transferability of the findings to other settings including their own (Creswell & Miller, 2000).

**Limitations of the Study**

With each and every inquiry, it is imperative for the investigator to be aware of the study’s limitations and share these limitations with the reader to assist with interpreting and understanding the results and implications of the research (Babbie, 2010). As a qualitative investigation, this study’s credibility may be limited by a small sample size, researcher bias, or reactivity. However, many of the limitations of qualitative research (Berg, 2007; Creswell, 2013; Creswell & Miller, 2000; Denzin, 2009) and more specifically constructivist grounded theory (Charmaz, 1996, 2014; Charmaz & Bryant, 2011) can be prevented by instituting and adhering to validity procedures and constructivist grounded theory procedures. Regardless, it is necessary to
take into account the limitations of a study when reporting results. The limitations of the study are addressed in the sections below.

**Generalizability**

In speaking of qualitative research, Lincoln and Guba (1985) state, "if there is a "true" generalization, it is that there can be no generalization" (p. 124). Unlike its quantitative counterpart that strives to generalize results, the aim of qualitative research is to explore the lived experiences of the participants, specifically the context, meanings, and processes, to learn more about an understudied topic, or generate theory (Maxwell, 2008). The power of the findings from a qualitative inquiry lie in the breadth of the data gathered and the possible extension of the theory generated to individuals in similar settings and contexts. This is referred to as analytic generalization by Maxwell (2008), and transferability by Lincoln and Guba (1985). Thick descriptions enable the reader to understand if the findings are relevant and applicable to his or her own situation (Lincoln & Guba, 1985; Creswell & Miller, 2000).

Because a small sample of clinicians and supervisors working within a few BHRS programs were interviewed, the findings from the study may only be cautiously generalized to home and community based counselors working within similar programs. The decision of the transferability of the study remains with each reader.

**Researcher Bias and Reactivity**

The strength of constructivist grounded theory, the approach’s emphasis on multiple realities, the researcher as an instrument, and research as a co-construction, can also become a liability, limiting the credibility of the results (Charmaz, 2008). Researcher bias is inevitable in qualitative inquiries (Maxwell, 2008). The researcher
cannot negate the influence of preconceptions, biases, values, and beliefs upon a study (Maxwell, 2008). It is possible that this researcher’s past experience working within BHRS and values and beliefs about BHRS, supervision, agency practices, and HCBC wellness may have affected data collection and analysis. A different researcher may have coded the data differently and may have developed an alternative theory from the data. Following grounded theory measures (Charmaz, 1996, 2014; Charmaz & Bryant, 2011, triangulating (Denzin, 2009), and developing rich descriptions (Maxwell, 2008), were employed to decrease the threat of researcher bias.

The study is also limited by reactivity, the process by which the researcher influences the participants to respond in a certain way (Maxwell, 2008). Reactivity is less likely to be a threat when conducting participant observation, but has the potential to influence the participant during interview studies (Maxwell, 2008). The wording of questions, pacing of the interview, and how the questions are asked can all influence participant response (Maxwell, 2008). It is possible that participant responses may have been influenced by social desirability and the need to appear competent as a HCBC or supervisor. Throughout data collection and analysis, reactivity was minimized by monitoring data collection and data analysis to avoid leading questions, maintain appropriate pacing, encourage participants to share his or her story, and refrain from sharing researcher views on the subject of the inquiry.

**Delimitations of the Study**

The delimitations of a study describe the scope of the study and provide boundaries around the study’s design (Fitzpatrick, Secrist, & Wright, 1998). The delimitations arise out the decisions that the researcher makes during the study, as the
researcher determines the focus of the study, the research questions, the sample, and methods of data collection and data analysis. To uncover the individual, organizational, and supervisory processes that support HCBC wellness, the researcher intentionally chose a home and community based program that does not have rigid requirements or standards for supervision. BHRS counselors, supervisors, and agencies were the subject of this inquiry. Because BHRS is not a team-delivered service and does not follow a manualized approach with additional oversight, supervision, and monitoring, there is a possibility that BHRS HCBCs may be more apt to experience isolation, burnout, and compassion fatigue, along with other challenges of the work. Delimiting the study to BHRS clinicians will facilitate determining what practices HCBCs identify as being essential to counselor wellness. This inquiry identifies the individual and organizational processes that assist BHRS HCBCs with thriving, despite the difficulties associated with the work and the setting. Even though supervision of BHRS may be limited, BHRS HCBCs will be able to illuminate the characteristics and practices of quality, wellness enhancing supervision that may create the “professional greenhouse” imagined by Skovholt et al. (2001, p. 274).

**Chapter Summary**

The aim of the study is to construct a model of HCBC wellness by examining HCBC and supervisor perceptions of systemic practices that sustain wellness. Though quantitative studies have tested the effects of supervision, self-care, experience, and perception of workload upon home-based therapist professional quality of life (Macchi et al., 2014), it remains unclear the specific strategies beneficial to HCBC wellness. Even when looking more broadly at the counseling literature, the results of quantitative studies
have been inconclusive, not yet pinpointing the practices that significantly affect wellness, growth, compassion satisfaction, and compassion fatigue among therapists (Brockhouse et al., 2011), clinicians treating sexual abuse (Killian, 2008), domestic violence counselors (Kulkarni et al., 2013), and mental health counselors (Thompson et al., 2014). Further, the models generated by these studies are limited by the variables entered into the analysis and the measures put to use, making cross-comparisons of the studies difficult, if not impossible (Brockhouse et al., 2011; Killian, 2008; Williams et al., 2012; Macchi et al., 2014).

Because there is scant research in the area of HCBC wellness, especially within the realm of BHRS where HCBCs have the potential to receive little oversight and supervision, qualitative research is most suitable for this line of inquiry (Creswell, 2013; Maxwell, 2008). A model of HCBC wellness has been advanced, grounded in data from individual interviews with BHRS HCBCs and supervisors. Study design, implementation, and analysis followed the procedures of constructivist grounded theory (Charmaz, 2014).

Participants were selected from BHRS agencies in an effort to obtain a purposeful sample (Charmaz, 1996; 2014; Charmaz & Bryant, 2011; Corbin & Strauss, 1990) of BHRS HCBCs and supervisors able to share their lived experiences working in HCBS, the impact of the work on their wellness, and the systemic processes involved in sustaining wellness. Theoretical sampling directed future recruitment to expand upon, compare, and contrast the categories extracted from data analysis, to ultimately build a comprehensive and rigorous theory of HCBC wellness. Methods of data collection include individual interviews with HCBCs and HCBC supervisors, a methodological
Grounded theory procedures followed include: simultaneous data collection and analysis, open coding using gerunds, focused coding, memo writing, theoretical sampling, and constant comparisons of data with data, data with categories, codes with codes, codes with categories, categories with categories, and data with categories (Charmaz, 1996, 2014; Charmaz & Bryant, 2011; Corbin & Strauss, 1990). The credibility of the data and the subsequent analyses were improved by using Denzin’s (2008) multiple methods of triangulation (data, method, theory, and investigator) and by carefully following the procedures of grounded theory (Charmaz, 1996, 2014; Charmaz & Bryant, 2011; Corbin & Strauss, 1990). The model of the systemic practices influencing HCBC wellness put forth will inform individual, supervisory, and agency practices for those working within contexts similar to the BHRS agencies under investigation. Chapter four illustrates the codes and categories constructed from analysis of the interviews. Rich descriptions and evidence for the significant codes and categories will be provided. Chapter five outlines the implications of the study, contributions to the literature, and limitations.
CHAPTER IV: RESEARCH FINDINGS

Introduction

The aim of this qualitative study was to uncover a theory of home and community based counselor (HCBC) wellness that is rooted in participant actions, meanings, and processes and unclouded by researcher bias (Charmaz, 1996; 2014; Charmaz & Bryant, 2011; Corbin & Strauss, 1990). While Macchi, Johnson, and Durtschi’s (2014) study identified that the frequency of self-care mediates the impact of workload on professional quality of life for a sample of home-based family therapists, specific self-care strategies utilized by the therapists were not explored. To date, little is known about how HCBCs manage their wellness while navigating the challenges of the work especially in home and community based settings that lack oversight and supervision. It is also unclear whether and how systemic practices may impact HCBC wellness.

Constructivist grounded theory methods (Charmaz, 1996; Charmaz & Bryant, 2011; Charmaz, 2014) were followed while conducting and analyzing individual interviews with HCBCs and supervisors. This chapter illustrates and details the recursive and reiterative nature of data collection and analysis and outlines the main categories uncovered. Eight home and community based counselors (HCBCs) and four supervisors were interviewed. This researcher conducted semi-structured interviews using the questions provided in Appendix A in order to uncover a theory of HCBC wellness and the systemic factors that support HCBC wellness. As explained in Chapter III, the participants were recruited from an agency that provides behavioral health and rehabilitation services (BHRS) in Western Pennsylvania. BHRS are home and community based counseling services that are provided to children diagnosed with a
mental health disorder according to the Diagnostic Statistical Manual-5 of Mental Health Disorders (DSM-V; American Psychiatric Association, 2013). Master’s-level counselors working as HCBCs were chosen for this study because they receive limited supervision and do not follow an agency prescribed model of evidence based treatment. Instead HCBCs deliver counseling that is individualized, child and family centered and therefore, have the freedom to determine therapeutic modality and interventions.

As described in Chapter III, this researcher analyzed data using a constant comparative approach, line-by-line coding, focused coding, and memo writing (Charmaz, 1996; 2014; Charmaz & Bryant, 2011; Corbin & Strauss, 1990). During a recursive process of data collection and analysis, the researcher strove to remain objective, acknowledging how the researcher’s values, beliefs, and experiences may influence the research process to ensure that the theory reflects the experiences of the participants (Charmaz, 2014; Creswell & Miller, 2000). To illustrate the process of data collection and analysis, Chapter IV provides a narrative of each of the individual interviews that were conducted with the home and community based counselors (HCBCs) and the supervisors. In these narratives, I describe the demographic characteristics of the participants and the prominent codes and categories that emerged from each interview. At the end of the chapter, a cross-case analysis demonstrates the categories and codes that emerged across interviews, in addition to thought provoking codes that were only uncovered in several interviews but point to areas of potential interest. Chapter IV provides a description of data explication and analysis that segues into the discussion, conclusions, and areas for future study outlined in Chapter V.
Demographic Information

There were 12 participants, eight home and community based counselors (HCBCs) and four supervisors, who participated in individual interviews. All of the participants were actively employed for over a year as either a master’s-level counselor or a clinical supervisor in an agency providing behavioral health and rehabilitation services (BHRS). BHRS is a service line developed to meet the mental health needs of children in the home, school, and community (Hodas, 2004). Children receiving BHRS have a diagnosable mental health disorder, need a higher level of care than outpatient counseling services, and are at risk for psychiatric hospitalization and/or placement outside of the home or school (Hodas, 2004).

Three different BHRS agencies were sampled to obtain the final pool of participants. In order to find participants who met the selection criteria, agency supervisors were contacted and this researcher requested to present information about the study at the beginning of group supervision. At each agency, flyers were posted with information about the study. Supervisors forwarded an email about the study to the HCBCs. HCBCs and supervisors interested in participating in the study provided this investigator with their contact information. There were three males and nine females, ranging in age from 27 to 68 years old, who participated in the study. In order to respect the confidentiality of the participants, each has been assigned a number and this descriptor will be used during the discussion of the findings.

The HCBCs’ years of experience ranged from several years to over 10 years working as a master’s-level HCBC. One HCBC was working at a BHRS agency part-time as a second job to supplement income. Each of the four supervisors interviewed
worked as HCBCs prior to becoming supervisors. Four HCBCs maintained a part-time schedule ranging from 6-18 billable hours per week, three HCBCs billed 25-34 hours per week, and one HCBC was working full time billing 32 hours per week. Table 2 provides a summary of the demographic information of the participants.
<table>
<thead>
<tr>
<th>Participant #</th>
<th>id #</th>
<th>Age</th>
<th>Gender</th>
<th>Years as HCBC or supervisor</th>
<th>Years in mental health</th>
<th>Degree and Licensure</th>
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<tr>
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<table>
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<td>SUPs=5.8</td>
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<td>Gender F=9</td>
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</tbody>
</table>
Individual Interviews

Individual semi-structured interviews were conducted with each of the participants. The interviews were digitally recorded in order to facilitate an accurate and verbatim transcription. During and after the interview, this investigator took careful notes of verbal and nonverbal behaviors, hunches of the prominent codes uncovered in the interview, and questions or areas to explore in future interviews. This investigator maintained a methodological journal throughout the study. This researcher recorded in her journal reflections before and after the interviews were conducted in an effort to reduce the possibility that values, biases, and experiences would impact the data gathered. While transcribing and coding the data, this investigator reflected upon how her questions and nonverbal behaviors may have influenced participants’ response. The data was cautiously coded so that the processes, meanings, and actions reflected those of the participants and not the researcher.

Initially, this investigator conducted two individual interviews with HCBCs to begin to gain an understanding of the systemic influences upon HCBC wellness. Then, the researcher interviewed a HCBC supervisor to draw out a supervisor’s perceptions of the phenomenon. An additional six individual interviews were conducted with HCBCs to begin to saturate the data. Finally, three more HCBC supervisors were interviewed. The interviews were conducted in a private location in the community, such as, the office of the participant or a private room in a library. The confidentiality of each participant was protected by finding locations with private rooms so that the interview could take place behind a closed door without interruptions.
Preconceptions

As the researcher, it is important to acknowledge the influence that the investigator has on the study. To do so, Charmaz (2014) recommends that the researcher engage in reflexivity, making values, beliefs, and experiences explicit at each decision point in the study to improve the validity of the resultant theory. While conducting the literature review and designing the study, this researcher identified her preconceptions and the beliefs regarding the area to be studied. This researcher needed to be able to recognize these preconceptions to allow herself to be sensitive to the emerging theory. Thus, the emerging theory is most likely to reflect the experiences and actions of the study’s participants (Charmaz, 2014).

As suggested by Charmaz (2014), a methodological journal was maintained throughout the duration of the study. In this journal, impressions, hunches, and thoughts that occurred during and after the interviews were recorded in order to acknowledge how the researcher’s experiences affected data collection and analysis. First, this investigator needed to recognize and acknowledge her experiences with HCBC wellness in order to be mindful of ways that the researcher may inadvertently influence the design and implementation of the study. This investigator has worked in various home and community based counseling programs including BHRS, family based mental health services (FBMHS), and an agency that provided in-home family counseling services to families referred by child welfare and juvenile justice. This researcher received supervision in both quality and quantity as a FBMHS HCBC. However, as a BHRS HCBC, this investigator vacillated from receiving individual supervision weekly to fulfill her doctoral and practicum internship requirements to receiving only monthly group
supervision. At the end of her work in BHRS, this investigator was feeling isolated, unsupported, and at times questioned her effectiveness as a counselor. Out of these experiences, the presuppositions arose that this investigator believes that supervision is vital to HCBC wellness, that HCBCs work with challenging children and families, that many HCBCs are lacking regular supervision and feel isolated, and that many HCBCs struggle to maintain wellness. This investigator was aware that there are many HCBCs that do the work well while maintaining wellness and was eager to find how they are able to do this.

Throughout the research process, the investigator treated these preconceptions as just that, beliefs about what the researcher might find the study was conducted. These beliefs were not held as truths. The investigator studied the HCBC wellness and supervision literature extensively to have a broad understanding of HCBC experiences outside of her own. The findings from the existing research were treated as sensitizing concepts, concepts that may or may not be pertinent to the study (Charmaz, 1996, 2008, 2014; Charmaz & Bryant, 2011). The investigator was sensitive to the need to be aware of HCBC isolation, lack of supervision, feelings of demoralization, while also being aware that it was important to be open to any concepts that may emerge from the interviews.

As found by Lawson and Foster (2005), Lawson and Myers (2011), and Bowen and Caron (2016), the researcher believed that she would find that HCBCs perceive themselves as not receiving adequate clinical supervision. In particular, the investigator expected to find that HCBCs believe that a lack of supervision is detrimental to wellness. Having worked in the BHRS field, this researcher has personally experienced limited
supervision and oversight. There were times that the investigator felt isolated and did not have a strong connection with her supervisor. However, while this researcher was receiving weekly supervision to fulfill the requirements of her doctoral practicum and internship, she felt connected with her supervisor and appreciated the opportunity to jointly conceptualize cases and develop interventions. This researcher believed that having supervision made her a stronger clinician and increased her self-confidence. The investigator chose to interview BHRS HCBCs, clinicians who work for a program that only requires one hour of group supervision per month because the researcher wanted to draw out the systemic influences that benefit HCBC wellness. Because this group of clinicians lacks regular individual supervision, it was believed to be even more important to acknowledge the aspects of supervision that are beneficial in addition to other individual HCBC and agency efforts that may enhance and detract from wellness.

While conducting the study, this researcher explored her biases and preconceptions by writing in a methodological journal and by speaking with colleagues and the dissertation chair. The research questions and interview prompts were designed with feedback from my dissertation committee. This investigator documented data collection and analysis. In the journal, this researcher explored her own biases, beliefs, and experiences, and provided an explanation for the decisions made during the study always trying to stay true to the experiences of the participants. During the interviews themselves, the investigator avoided asking leading questions or providing responses that might lead the response of the participants. The researcher continually referred back to the experiences of the HCBCs, allowing the theory to emerge from the data and the data to speak for itself. Each interview informed the next and the line of questioning was
modified to further explore concepts that arose and flesh out the emerging theory. Whenever the investigator would hear a participant use a term that may otherwise be taken for granted, participants were asked to share more about what the term meant to ensure the researcher obtained a clear understanding of the meaning and more importantly that the researcher was not making any assumptions about the participant’s experiences. This investigator was keenly aware of her own internal reactions during the interviews. The researcher refrained from discussing her own personal experiences and instead provided only reflections, summaries, and clarifying questions to draw out the actions, meanings, and processes of the participants. The researcher’s reactions to the interviews were documented in the methodological journal and memos.

For example, during the last HCBC interview, the researcher felt very frustrated that the participant did not directly answer my questions. This investigator found herself feeling discouraged that he was not providing me with more information, specifically that he was not answering the questions as expected. Instead of sharing this frustration with him, the investigator reminded herself of the challenges of home and community based work and the hectic schedule. The researcher appreciated that he was providing her with his time. The investigator let go of the urge to ask each question and instead focused on the areas that the participant was eager to share and drawing out those relevant experiences. This participant was very focused on sharing the difficulties and frustrations of the work. This researcher is the polar opposite and value finding a positive aspect in every situation and experience. However, the researcher was searching for the participant’s experience, therefore, every effort to avoid influencing his responses by showing a reaction. The researcher asked about both the practices that benefit and detract
from wellness just as was done in every other interview in an effort to uncover both aspects of the systemic process underlying HCBC wellness.

**Analysis of Interviews**

After the individual interviews were conducted, this investigator personally transcribed the recordings verbatim, recording each and every utterance accounting for pauses to provide an accurate account of the interview. The interviews were transcribed personally, instead of hiring a transcriptionist, so that the researcher could increase her proximity to and with the data. The researcher wanted to be as close to the data as possible to increase familiarity with each participant's experience and improve the validity of the analysis. During the transcription process, the investigator listened to each interview over and over to ensure accuracy. While transcribing, observations of verbal and nonverbal behaviors were noted. The investigator noted when the researcher may have influenced the participant's responses and when participant’s responses may need to be cautiously interpreted. There were times that the investigator chose not to code a participant’s response because the researcher may have influenced their response by the manner of questioning or with an utterance. Also, while transcribing, memos were written to document areas worth exploring further in subsequent interviews. The researcher was able to begin to identify the most salient participant meanings, actions, and processes and begin to make sense of the emerging theory.

After the interviews were transcribed, each interview was coded line-by-line using gerunds. Transcripts were coded as quickly as possible to draw out the actions and meanings of the participants and to avoid allowing the researcher’s biases to influence data analysis. Quick coding improves the validity of the analysis (Charmaz, 1996, 2014).
Following the line-by-line coding, each transcript was revisited and the researcher conducted focused coding to pull out the prominent codes from the data. Then, the investigator created a table to illustrate and compare the participant’s responses to each interview question using the corresponding codes. Some of the most prominent codes were then elevated to categories as memos were written. In these memos, this researcher used a method of constant comparison to compare code to code, category to code, and category to category by comparing participant responses. The investigator engaged in theoretical sampling to flesh out categories and codes conducting additional interviews. Theoretical saturation was reached when continued interviewing yielded similar codes. To discern the properties of each category, identify conditions in which the processes occur, and the consequences of each process, the researcher engaged in memo writing. The memos illustrated how the categories were identified and became concepts in the emergent theory of HCBC wellness. These memos were then sorted into a framework of concepts that illustrated the process of HCBC wellness.

**Summaries of Interviews**

In this section, the reader is provided with a summary of each interview, the initial codes derived from line-by-line coding, concepts constructed during focused coding, and the methodological directions taken as data was collected and analyzed in a reiterative nature. Each interview added new insight, sometimes confirming prior participant reports, other times sparking additional questions. These summaries function to illustrate the grounded theory methods followed, including theoretical sampling and saturation.

**Participant 1.** The first interview was conducted with a 47 year old male, HCBC-1, who had worked as a master’s-level BHRS counselor for four years. She
reported earning a Master’s degree in Marriage and Family Counseling and indicated that she had been employed in the mental health field in some capacity for 24 years. The interview was conducted at the local library in a private room where we were guaranteed to have a quiet and confidential space without any interruptions.

The researcher was very conscious of how nervous she was feeling as she began to interview HCBC-1. HCBC-1 was thanked her for her participation and the investigator began the interview by asking her to talk about her work as a HCBC. Throughout the interview, the researcher was careful not to lead HCBC-1’s responses, either with the way questions were phrased or with the researcher’s subsequent replies. HCBC-1 spoke confidently and maintained eye contact throughout the interview. She appeared very comfortable and open, readily sharing her experiences with me. The interview lasted approximately 90 minutes at which time, the interview questions were exhausted and the participant appeared to have shared all of the information that she wished to share. The investigator loosely followed the semi-structured interview guide (Appendix A), asking questions to determine the systemic factors that influence HCBC wellness. The researcher asked follow up questions to more fully explore HCBC-1’s experiences and the meaning that she attributes to them.

HCBC-1 described working long days from nine in the morning to eight thirty at night, generally billing 17-18 direct client hours weekly. HCBC-1 indicated that she values making a difference by leaving clients with the skills needed to better understand and process the difficulties that brought them into treatment. She acknowledged that the nature of the work can be a challenge. These challenges include working long days, completing paperwork on the evenings and weekends, and grappling with the reality that
clients do not always make progress. Further, HCBC-1 indicated that the long days, “back to back appointments”, and the isolation inherent in the work, can be detrimental to her wellness.

HCBC-1 defined wellness as the need to “look after yourself mentally, physically, emotionally, physically, just in all the areas… because if you don’t you are going to get run down. You are not going to be at your best.” HCBC-1 admitted to struggling at times to maintain wellness, feeling stressed and burned out. HCBC-1 did not identify any individual characteristics that impair her wellness but instead revisited the difficulty that she has finding time in her schedule to exercise and spend time with her friends. She mentioned that her wellness practices include: being aware of stress and the need to address wellness, praying, attending church, eating healthy, finding time to take a break from the work, balancing need to get work done with need to take time for herself, reading, taking vacations, tending to her own mental health, and spending time with her husband. HCBC-1 noted that by paying attention to and making efforts to improve wellness, she is “moving forward”. HCBC-1 reported setting boundaries with the work by not working weekends and monitoring the time that she spends on paperwork. HCBC-1 recommended that clinicians set boundaries with the work, “the time you are with your clients and the time that you are in your personal life.” In addition, HCBC-1 advised that HCBCs find someone that they can talk to when feeling tired or overwhelmed whether that is a supervisor, a colleague, or one’s own personal counselor. HCBC-1 wanted HCBCs to remember that they are doing admirable work and making efforts to help the client, even if the client does not appear to be making progress.
HCBC-1 spoke about the importance of supervisory and agency support and the role of supervision and agency practices in maintaining HCBC wellness. She receives one hour a month of supervision, during which she appreciates processing cases, “venting,” consulting, and getting ideas, looking for validation from her supervisor that she is on the right track. Additionally, HCBC-1 reminisced about beneficial aspects of LPC supervision where she was given the space to discuss professional development, licensure, goals for future work, how one’s own grief and loss may impact the work, and how developments in the field can impact wellness.

SUP-1 reported that supervisors are short staffed at her agency and very busy but are available if she needs support during a crisis or emergency. HCBC-1 suggested that supervisors focus more on talking to HCBCs about wellness by asking them, “What are you doing to take care of yourself?”, “How are you doing?”, and “How are you dealing with this?” Since she does not hear supervisors asking these questions, HCBC-1 reported that she gets “the sense that it’s not as important”. HCBC-1 cautioned that if supervisors do not address wellness burnout can result. HCBC-1 stated, “A burned out person who either stays in the field and is burned out or who leaves the field is… That’s not doing anybody any good.”

Because she admitted to feeling disconnected from the agency and spends little time in the office, it was more difficult for HCBC-1 to identify agency practices that support wellness. She stated that the agency supports wellness by adopting a model of trauma informed care and implementing trauma-informed practices. HCBC-1 described a perception of safety inherent in the agency and that employees are able to bring concerns to the agency’s attention. HCBC-1 viewed agency policies and expectations
around full-time employment as being detrimental to wellness. HCBC-1 stated that it is expected that full-time employees maintain 25 direct billable client hours each week, something she deemed “borderline doable” but “very draining”. Further, HCBC-1 described punitive practices that agencies enforce such as requiring HCBCs to work in the office completing administrative work if they do not maintain their expected billable hours, removing full-time status if expectations are consistently not met, and taking away vacation time to account for missed productivity. Due to these practices and the resultant stress experienced, HCBC-1 decided to change her status from full-time to part-time despite knowing she would lose her benefits and her vacation and sick time accrual rate would decrease.

HCBC-1 suggested that it would be helpful to offer HCBC support groups, not exclusively for BHRS HCBCs, but targeting HCBCs in general. She acknowledged how difficult it is to find someone to talk to who really understands and envisioned that the support groups would provide a milieu for obtaining and providing support and validation. In addition, she recommended that agencies support wellness not just in philosophy but through actions such as, asking about wellness in supervision and offering activities and programs that support wellness encouraging HCBCs to evaluate and monitor their wellness. HCBC-1 advised that agencies adjust expectations for productivity to allow for HCBCs to balance the workload with their personal life and maintain their wellness more effectively.

When this researcher asked HCBC-1 how her thoughts of wellness have changed since she began working in BHRS, HCBC-1 stated that it was not until she worked full-time that she realized how important it is to pay attention to wellness. When working
full-time, HCBC-1 said that she did not have time to think about managing stress. She reported, “I just kind of did the best that I could.” HCBC-1 described herself during this time as “losing my mind.” HCBC-1 stated that she is now more aware of how to address her own wellness and when she is “getting off track” but the time constraints of the work limit how much she is able to devote to her own wellness. Through the work, HCBC-1 reported that she has gained confidence and became more comfortable with delivering treatment interventions and writing treatment plans after receiving feedback that she is an effective clinician. HCBC-1 identified her strengths to be insight, flexibility, and awareness and viewed these strengths as facilitating wellness. See Table 3 for a list of some of the initial codes derived from the analysis of HCBC-1’s interview. Only the most prominent codes were included in this table.

Table 3

<table>
<thead>
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<th>Initial Coding of the Interview with HCBC-1</th>
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<tbody>
<tr>
<td>Making a difference</td>
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<tr>
<td>Working long days</td>
</tr>
<tr>
<td>Isolating</td>
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<tr>
<td>Struggling with wellness</td>
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<tr>
<td>Finding time</td>
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<tr>
<td>Gaining confidence</td>
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</table>

Participant 2. The second interview was conducted with a 38 year old male, HCBC-2, who had been working as a HCBC for 9 years and in the mental health field for 16 years. HCBC-2 maintains a behavior specialist license (BSL) and is qualified to work with children diagnosed with autism. HCBC-2 works part-time as a HCBC in the evenings while maintaining full-time employment as a supervisor at another mental health agency. Typically, HCBC-2 bills anywhere from six to 15 hours per week with clients. The interview for HCBC-2 was conducted in a similar manner as HCBC-1, again
using the semi-structured interview prompts in Appendix A.

HCBC-2 acknowledged that the biggest issue that he faces is encouraging parents to follow through with treatment interventions. HCBC-2 identified that he most values when he has success with clients, “when you see those changes occur, the little things occur over time and… build up to more… profound changes.” HCBC-2 went on to say that the successes keep HCBCs “moving forward”. Also, HCBC-2 valued the independence afforded to him as a BHRS HCBC, the independence to develop treatment plans and determine the direction of treatment. However, HCBC-2 admitted that dealing with the isolation out in the field, lack of the support in the moment, and the unstructured treatment setting can be problematic for the HCBC.

HCBC-2 defined wellness as self-care, “making sure that you are addressing your own needs… taking care of yourself and getting what you need so that you don’t burn out.” He often listens to heavy metal between sessions to get “an emotional release” and spends time with his husband outside of work, pursuing interests such as art and music. HCBC-2 indicated that engaging in self-care prevents him from “burning out” and resenting the work. In his experience HCBC-2 has noticed that HCBCs burnout, resent the work, and then leave the field. HCBC-2 incorporates practices that he teaches his clients into his own self-care protocol using mindfulness and grounding. As an “intellectual” with “an artistic side”, HCBC-2 explained he is able to plan his self-care using mindfulness and music.

HCBC-2 reported he has not found BHRS supervision to be adequate or effective. Instead, HCBC-2 developed his own “supervision network.” HCBC-2 identified that through this supervision network, he connects with colleagues who can listen and support
him in figuring out a direction for treatment. In these conversations, HCBC-2 finds it helpful to talk about difficult cases, those that “stick with you” and know that he is not alone, “not the only person out there.” The conversations provide a space for HCBC-2 to manage and work through secondary trauma to remain effective and move forward with clients and families. HCBC-2 cautioned that supervision should not be a place to “give them [the HCBC] all the answers… because they are not going to be able to stop and… intellectually view it and come up with a clinical way of approaching the barriers and cases they are working with.” Much like supervision, HCBC-2 was unable to identify any agency practices that support HCBC wellness. HCBC-2 stated, “I actually can’t think of one off the top of my head which is kind of sad when I think about it. Having done it for six years and sitting back and thinking about it…. It’s kind of surprising nothing sticks out for me.”

Without having immediate support, HCBC-2 indicated that managing difficult situations and challenging clients can be problematic, isolating, and negatively impact HCBC wellness. HCBC-2 did not want to fault or blame supervisors for not providing enough support to HCBCs; instead he explained that he believes that the fee-structure and the reality that the reimbursement rates for MT and BSC services have not increased in the past 20 years limit and prevent agencies from hiring full-time HCBCs. HCBC-2 reported agencies hire mostly part-time HCBCs so that the agency saves money and does not have to provide benefits to employees. The end result, HCBC-2 explained, is that there are more HCBCs to supervise. HCBC-2 reported that because supervisors are required to supervise so many part-time staff, supervisors do not have the time to provide quality clinical supervision to the HCBCs. According to HCBC-2, agency supervision is
mainly administrative supervision focused on “case reporting and billing versus clinical supervision and professional growth”.

HCBC-2 identified that supervision and agency practices can negatively impact HCBC wellness. HCBC-2 reported that supervisors often do not have direct home and community based counseling experience and lack an understanding of supervision theory and methods. HCBC-2 recommended that supervisors need to be equipped with an understanding of how to deliver supervision focusing on process instead of using case reporting to address session content in supervision. HCBC-2 perceives that his agency is only concerned with whether he has his “billing in” and does not communicate concern with how he as a counselor is doing. HCBC-2 recommended that agencies communicate that they are invested in and appreciate HCBCs.

When HCBC-2 began the work as a HCBC, he found that he needed to figure out how to treat clients and manage his wellness independent of agency supervision. Instead of using agency supervision for guidance, HCBC-2 relied on reading, his own research, and his own supervision network of colleagues for support. HCBC-2 reported that his wellness was shaped by working through the most difficult cases and learning how to “move forward” and continue to do the work, despite experiencing secondary trauma. HCBC-2 asserted that experiencing secondary trauma propelled him to realize that he needed to learn how to set boundaries with the work. HCBC-2 described moving forward as setting boundaries between the work and his personal life, negotiating the identities as a counselor and a person.

HCBC-2 acknowledged that he has grown from his work as a HCBC, and as a result of the work he has learned how to take responsibility for his own professional
growth. HCBC-2 viewed his strengths, “being independent and being inquisitive”, as facilitating wellness. HCBC-2 recommended that counselors maintain boundaries between their personal lives and the work and establish professional contacts for support and guidance to prevent burnout and remain effective with clients and families.

During the interview with HCBC-2, it became clear to this investigator that HCBC-2 perceived the work itself to be a systemic factor that influences wellness. HCBC-2 noted that the difficult situations encountered in the home and challenging clients coupled with the isolation that is inherent in the work can negatively impact counselor wellness. This researcher continued to explore the impact of the work on wellness in subsequent interviews. If HCBCs did not specifically talk about how BHRS work affects their wellness, the researcher probed them further. See Table 4 for a list of some of the initial codes that arose in the analysis of HCBC-2’s interview.

Table 4

<table>
<thead>
<tr>
<th>Initial Coding of the Interview with HCBC-2</th>
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<tbody>
<tr>
<td>Valuing success</td>
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<tr>
<td>Seeing progress</td>
</tr>
<tr>
<td>Managing chaos</td>
</tr>
<tr>
<td>Valuing intendance</td>
</tr>
<tr>
<td>Moving forward</td>
</tr>
<tr>
<td>Isolating work</td>
</tr>
<tr>
<td>Lacking support</td>
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<tr>
<td>Taking care of self</td>
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**Participant 3.** The first two interviews influenced the researcher’s line of questioning for subsequent interviews. HCBCs and supervisors began to be prompted to discuss more broad systemic factors such as the nature of the work, how the work may challenge or enhance wellness, and the investigator was aware that HCBC wellness may be affected more broadly by Medicaid regulations and the fee schedule that govern
BHRS service delivery. The next interview was conducted with a supervisor, SUP-1. This investigator chose interview supervisors in order to triangulate the data and buttress the credibility of the study. SUP-1 is a 41 year old female with 8 years of experience as a supervisor. SUP-1 worked as a HCBC prior to obtaining a position as a supervisor.

SUP-1 reported that as a supervisor, it is necessary for her to “juggle multiple responsibilities” that include managing payroll, supervising master’s and bachelor’s-level HCBCs, implementing trainings, maintaining a small caseload of clients, and processing referrals. Despite this, she reported she is making an impact as a supervisor and appreciates seeing growth of staff and hearing about client progress during supervision. As a supervisor, SUP-1 believed that she is making a greater impact because she is supervising staff and is in turn indirectly able to help more children and families. SUP-1 acknowledged that it can be difficult to appease and manage angry parents, staff, and insurance company representatives while handling “all of the… different supervisory responsibilities”.

As SUP-1 was interviewed, she compared her experiences at her current agency with those at a prior agency where she also worked as a supervisor. She described these experiences in detail, how an agency’s practices and policies, where she was previously employed negatively impacted her wellness and stand in stark contrast to the support that is embedded throughout her current agency, in supervision, in relation to supervisors, and in agency practices and policies. She defined wellness to be “taking care of yourself” and “making sure all aspects of your life are… what you want them to be.” For SUP-1, agency practices play a very important role in wellness. Without agency support, she reported she was unable to take care of herself when she worked at the past agency. She
felt defeated and was experiencing depressive symptoms. SUP-1 reported, “I had no time to take care of myself. I didn’t eat. I didn’t sleep. You know, I barely had time to go to the bathroom.”

SUP-1 stated that the punitive agency practices (e.g., focusing on mistakes and delivering directives) and impossible expectations for staff such as requiring supervisors to maintain 22 billable hours a week with clients on top of supervising HCBCs prevent HCBCs and supervisors from being able to take care of themselves. In addition, these punitive practices discourage HCBCs from asking for help. On the other hand, SUP-1 has discovered that when the agency policies and practices are positive, supportive, value HCBC and supervisor perspectives, the HCBCs and supervisors are able to take care of themselves. According to SUP-1, the agency support or lack thereof either spurred or disrupted her ability to manage her wellness.

At her current agency, SUP-1 pointed out that HCBCs, the agency, and the supervisors are all taking steps to improve HCBC wellness. The agency offers wellness fairs and programs, yoga, and specific trainings focused on self-care. She emphasized that supervisors create the space in supervision to ask if the HCBC needs help and discuss how the HCBC is taking care of him or herself. In addition, SUP-1 reported that she sees some HCBCs seeking out their supervisors for support and help when needed. She asserted that a willingness to ask for help is an important personal disposition that serves to improve HCBC wellness. SUP-1 has needed to encourage HCBCs to ask for help when needed because their experience at previous BHRS agencies was that it was not ok to ask for help.
SUP-1 reported that HCBCs engage in various activities outside of work and spend time with friends and family. SUP-1 noticed a difference between the HCBCs who actively spend time with friends and family and pursue interests and hobbies outside of work and those who do not. SUP-1 explained:

I’d say… your outgoing people are probably the ones that take care of themselves the best because they are seeking those friendships and seeking those relationships which help. So when I get somebody who is quieter or that you can tell is more introverted…. I’m typically working more on the self-help with them

While SUP-1 seemed to be asserting that the extroverted counselors were better at taking care of themselves than the introverted counselors, the observable differences that she described between the HCBCs were that the HCBCs who were well, were more engaged in supervision, and discussed time spent with friends and family or engaging in interests and activities outside of work. She continued to state, “You can see the difference usually… in their presence when they come in and the way they talk about things.”

SUP-1 identified several supervision and agency strategies that she has found to be beneficial to supporting HCBC wellness. According to SUP-1, HCBCs are only required to have one hour a month of supervision, which can include group supervision, and one hour a month of training for all HCBCs. She discussed the importance of supporting professional development and HCBC growth even if that means that the HCBC is looking for opportunities outside of BHRS. At the start of employment, SUP-1 and the HCBC develop the goals for HCBC growth and change and then continually revisit the goals to assess and revise them throughout the course of the supervisory relationship. In addition, SUP-1 provides space to “pause and reflect” and think about how the HCBC is feeling at the moment and what the HCBC needs from supervision. SUP-1 noted that this practice is helpful for her supervisees and for SUP-1 when she is
meeting with her supervisor. She stated, “I think a lot of us just do that. We don’t think about what we need and we just kind of continue on doing what we are supposed to be doing.” As a supervisor, she reported “it forces you to listen to other people and think about, ‘Oh, geez if they are feeling that way, wonder what’s going on and how can I help them in that… as a supervisor?’

Often SUP-1 reported that she also supports the HCBC in the home setting as well in order to model interventions for the HCBC, provide feedback, and help when treatment becomes stalled. SUP-1 spoke about the challenges inherent in the work and the difficulty that HCBCs can have maintaining professional roles with families in order to remain effective, conceptualize treatment, assess progress, and develop interventions. SUP-1 normalized the difficulty that HCBCs have establishing boundaries due to the nature of the work. She contended:

If you maintain too much of a professional boundary you are looking like you don’t care and they’re not going to be… as willing to accept the interventions from you…. Whereas if you kind of sit down with them and… are… caring and compassionate and trying to get… to what it is that is their barrier then they tend to… follow interventions.

SUP-1 schedules meetings with families if there is an issue in the home that jeopardizes the HCBC’s safety. In extreme cases, SUP-1 will “pull” HCBCs from the field until the issue is resolved.

SUP-1 stressed that she and other supervisors are always available to be help at any time and support the HCBC when they need to “vent” and at her agency there are not any negative repercussions after venting. Over the years, SUP-1 reported that her experience working for an unsupportive agency and conversely a supportive agency, allowed her to discover which practices work in supervision and which do not work. She
evaluates her supervision approach by asking herself whether a supervision method will “make somebody feel bad as opposed to good about themselves.” She has found that it is important to listen to the HCBC vent and then later try to relate her own experiences as a HCBC to the HCBC that she is supervising. SUP-1 reported that she promotes HCBC wellness by listening, empathizing, and then relating to HCBCs by sharing her own experiences in the field.

SUP-1 reported that HCBC wellness can be adversely affected by the nature of the work, specifically the travel involved and expectations for meeting productivity. In addition, SUP-1 explained that when HCBCs have difficulty maintaining professional boundaries, they can begin to personalize the work. SUP-1 explained that this leads to “more of an emotional clinician” who has difficulty seeing “outside of the issues” and instead is only “maintaining whatever… progress they have made with the client and not really seeing other ways to even improve more.” According to SUP-1’s accounts, individual characteristics can impair wellness. SUP-1 offered the following examples: pushing oneself to meet productivity, difficulty asking for help, difficulty accepting suggestions from supervisors, blurring professional boundaries, and personalizing the work. SUP-1 emphasized that it is important for HCBCs to set boundaries with the work by scheduling the sessions close together geographically and set boundaries with clients and families by maintaining a set schedule, not answering calls in the evening, “not friending on Facebook”, and sharing minimal to no personal information.

SUP-1 described supervisee behaviors, and agency and supervision practices and policies that can negatively impact wellness. SUP-1 identified that some HCBCs when they appear to be overwhelmed, will not admit to needing help, and do not accept
suggestions from supervisors. SUP-1 stated that these are the “I know, I know, I know clinicians.” She reported:

You… know that they are not taking care of themselves…. But they are not at a point to talk about it or listen to any suggestions…. So they go back out and they're… not really… as clinically good as they could be. I think that’s a big barrier.

In addition, the supervisory approach can be a barrier to HCBC wellness. SUP-1 explained that when the supervisor focuses on providing directives and reviewing productivity instead of listening to HCBC concerns, discussions of self-care are discouraged. She reflected that this approach “makes that person feel awful about themselves and… they get to the point where they can’t do a lot of self-care.” SUP-1 advised supervisors to start with letting the HCBC “vent” and talk about the concerns that they are having and the help that is needed and intersperse directives in the conversation as needed. SUP-1 believed that it was most important for the supervisor to first listen to the HCBCs concerns and needs.

After SUP-1’s interview, this investigator planned to continue to explore with supervisors HCBC characteristics and behaviors that might affect wellness and whether extroversion or introversion is a process that other supervisors believe impact wellness. SUP-1 very clearly outlined the role the work, supervisor, agency, and individual in maintaining HCBC wellness. This researcher was interested in learning whether other supervisors endorse the need to be involved with activities and interests outside of work and to spend time with friends and family. The investigator was also wondering if other supervisors encounter punitive practices at their agencies. The initial codes identified were all held as sensitizing concepts only earning their significance after repeatedly emerging in subsequent interviews. It was difficult to recruit supervisors to participate in
the study. Therefore, the next six interviews were conducted with HCBCs.

Subsequently, the remaining three supervisors agreed to participate in the study and were interviewed. See Table 5 for a list of some of the initial codes discovered during the initial analysis.

Table 5

<table>
<thead>
<tr>
<th>Initial Coding of the Interview with SUP-1</th>
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<tbody>
<tr>
<td>Juggling multiple responsibilities</td>
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<tr>
<td>Making a difference</td>
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<tr>
<td>Seeing progress</td>
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<tr>
<td>Taking care of self</td>
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<tr>
<td>Feeling defeated</td>
</tr>
<tr>
<td>Employing punitive practices</td>
</tr>
<tr>
<td>Expecting impossible</td>
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<tr>
<td>Focusing on mistakes</td>
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Participant 4. The next interview was conducted with a 27 year old male, HCBC-3, who has worked for three years as BHRS HCBC and in the mental health field for four years. By working as master’s and bachelor’s-level HCBC, HCBC-3 worked part-time, 25 hours billable hours per weekly, in order to receive health insurance.

HCBC-3 described the work stating, “Definitely no two cases are the same…. You have to be able to adapting to different kids, different situations, different family environments.” To do this, HCBC-3 stated he is constantly “compartmentalizing” the work to avoid letting the stress of one session impact the next session. He reported, “I kind of walk out of the house and start driving away. I’m able to leave that stuff there until I’ve got to go back there again”. Of the work, HCBC-3 reported that he values the income, times when he finds the work fulfilling, and having supportive relationships with coworkers. HCBC-3 indicated that the work is fulfilling when he is able to see progress.
and see improvements or “draining and very rough” when clients are not making progress or if a client is oppositional.

For HCBC-3, the most challenging aspects of the work have been keeping up with the 24 hour deadline for paperwork and managing initial contacts with family when he goes into the home for the first time, must build rapport, and develop treatment goals and interventions with the family. HCBC-3 defined HCBC wellness to be “being able to take care of yourself” and “perform enough self-care that you are not burned out”. HCBC-3 explained that counselors who are burned out are “less emotionally receptive”, likely to deliver “harsh judgements”, “run out of patience”, and consequently dread the work. HCBC-3 admitted that there are times when he does not enjoy going to work but is able to recover his “work stamina” quickly. HCBC-3 tries to set aside time at the end of the night to do things he enjoys, such as cooking and reading but in reality some nights he reported he works on paperwork late at night. Other nights he will delay completing case notes so that he can get his evenings to himself “to recharge from the day.” Instead of completing case notes in the evening, he will set aside time during the day to complete paperwork between sessions. HCBC-3 also spends time on the weekend swing dancing and doing karaoke and sets strict boundaries with work, not doing work or thinking about work on the weekends. HCBC-3 admitted that because he waits until the next day to complete his paperwork, he states that he is able to carve time for himself, recharge, and still manages to keep up with the paperwork.

HCBC-3 disregarded the role of supervision in improving HCBC wellness, stating, “You are able to talk about the cases, get feedback, get ideas… and that’s… generally how supervisions go. I am uncertain if I would see that as a wellness practice
exactly.” Also, HCBC-3 had difficulty identifying agency practices that benefit HCBC wellness. Per HCBC-3, the agency advocates for wellness in words but does not “push for any sort of thing.” Staff outings occur infrequently and the HCBCs are responsible for paying for themselves.

It was much easier for HCBC-3 to discuss systemic factors that challenge wellness. HCBC-3 suggested that the work itself negatively impact HCBC wellness. It can be stressful for the HCBC to work with challenging children and families and manage “emotionally charged situations” that can occur during sessions. Further, while HCBC-3 acknowledged that it is fulfilling to see improvements, he reported that there is stress inherent in the improvements because “the better they do, the less they need you, the less hours you get…. So that itself is kind of stressful. You do good. You lose time…. You gotta pick up another case… start the whole process over again.” In addition to the work, HCBC-3 stated that he “imagines” that he might not be getting enough sleep and this might impact his ability to stay well. He often lacks sleep, only gets five hours of sleep most nights but finds that he is able to function “well enough on that little amount of sleep.” HCBC-3 seemed unable to identify aspects of supervision that negatively impact wellness. If he is unable to attend supervision with his agency supervisor, HCBC-3 stated that he connects with and consults with coworkers. He noted that if needed his agency supervisor is available to meet for additional support.

HCBC-3 expressed frustration with agency practices and policies. He reported that the agency neglected to change his employment status and he in effect worked 6 months without accruing vacation or sick time. Even as a part-time regular employee HCBC-3 stated he is only accruing three hours a month of vacation time and has only
accumulated 20 hours vacation over the past 3 years. HCBC-3 reported that it is very difficult to meet the agency’s required productivity because the hours are unreliable, clients are either eventually discharged from services, their hours fade as they make improvements, or their services might lapse altogether. Finally, HCBC-3 maintained that requiring case notes to be completed in 24 hours poses a strain to HCBC wellness. While he keeps up with the work, HCBC-3 has noticed other counselors becoming overwhelmed when they let paperwork “snowball” until the work starts piling up.

Despite having studied burnout and self-care in graduate school, HCBC-3 stated that he did not realize how difficult it is to maintain wellness until he had worked as a HCBC at a BHRS agency. As HCBC-3 worked as a HCBC, he began to learn what worked and what would not work to support his wellness. He discovered that it is more beneficial for him to procrastinate and leave work for the next day so that he is able to have time to himself at the end of the night. HCBC-3 contended that the experience working in BHRS has shaped his wellness. He used the imagery of “a rock being a river and being worn down by water” to explain that:

You kind of learn to adapt to. Not really a specific experience that stands out. Just the work itself kind of forces you to figure out how to maintain wellness and not to maintain the work or you’ll leave the field or leave that job at least…. It either breaks you or it… wears you down so you are a lot more polished.

HCBC-3 maintained that the complexity of the work can trigger the HCBC to figure out how to both do the work and continue to take care of him or herself. HCBC-3 recognized that by working as a BHRS HCBC, he discovered that he is good at working with kids. Additionally, as he has been able to learn and successfully teach children and adolescent how to regulate their emotions and how to utilize various coping skills, he has been able to apply these same skills in his own daily life.
Many of the processes and experiences that HCBC-3 identified throughout the interview were repeated as HCBC-3 talked about his recommendations for HCBCs, supervisors, and agencies. HCBC-3 recommended that HCBCs “learn how to leave work at work” and build relationships with colleagues for support. HCBC-3 has created boundaries with the work by limiting the time he spends ruminating about it and by avoiding working evenings and weekends. HCBC-3 established relationships with other HCBCs so that he can turn to them for support when supervision is not available. He stated that his supervisor maintains a “casual,” “low stress” environment in the office that is “welcoming” and “very friendly”. She brings in tea and hot chocolate for staff to drink in the office. He reported appreciating that his supervisor is approachable and has a sense of humor. HCBC-3 recommended that agencies should increase HCBC pay to increase wellness and motivation among HCBCs.

HCBC-3’s experiences were similar to those of SUP-1 and HCBC-2 who identified that the nature of the work poses a significant challenge to HCBC wellness. At this point, the research questions were modified to include an additional research question in order to address how the nature of the work or other systemic factor may impact wellness: What are HCBCs’ and HCBC supervisors’ perceptions regarding the role of other systemic factors in maintaining and/or promoting counselor wellness? Up until this point, three HCBCs were interviewed, two counselors, HCBC-1 and HCBC-3 working part-time approximately 18-25 hours per week and HCBC-2 working 5-10 hours per week. The investigator began to make efforts to recruit and conduct interviews with HCBC who work full-time to make sure that the investigator was considering a range of
HCBC experiences. See Table 6 for a list of most prominent of the initial codes derived from the analysis of the interview with HCBC-3.

### Table 6

*Initial Coding of the Interview with HCBC-3*

<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
<th>Code</th>
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<tbody>
<tr>
<td>Adapting to work</td>
<td>Pursuing interests</td>
<td>Managing paperwork</td>
</tr>
<tr>
<td>Seeing progress</td>
<td>Finding time</td>
<td>Consulting with co-workers</td>
</tr>
<tr>
<td>Draining work</td>
<td>Setting boundaries</td>
<td>Moving forward</td>
</tr>
<tr>
<td>Valuing income</td>
<td>Supervision not supporting wellness</td>
<td>Practicing what you preach</td>
</tr>
<tr>
<td>Gaining experience</td>
<td>Working with multiply challenged families</td>
<td>Supervisors sense of humor</td>
</tr>
<tr>
<td>Developing relationships with colleagues</td>
<td>Supervisors advocating for HCBCs</td>
<td>Being disconnected from agency</td>
</tr>
<tr>
<td>Taking care of self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burning out</td>
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**Participant 5.** HCBC-4 was the fifth participant interviewed. She was 36 years old at the time of the interview and has been working in the field of BHRS for two and a half years. Currently, HCBC-4 is working part-time at a BHRS agency as a BSC, maintains a behavior specialist license (BSL), and works with children diagnosed with autism. Prior to working in the field of BHRS, she was employed as a special education teacher in mixed disability classrooms. HCBC-4 typically works with three to four families, billing about eight to 12 hours per week. She indicated that she most values that she is “helping kids and their families”. The most difficult aspects of the work identified by HCBC-4 are that she does not have “ready access” to colleagues and supervisors and that she frequently finds herself “second guessing” her work, especially when clients are not making progress.

HCBC-4 defined wellness as “anything that you can do that keeps you from waking up in the middle of the night stressed out about your job. So whether it’s your mindset, or… talking to somebody, or whatever. Keeping busy with other things.”
HCBC-4 manages her own wellness by “keeping balance” in her life between work and “other interests, other activities, other parts of… life.” She reported that she limits the time that she spends on the work, encourages herself with positive self-talk, and is sure to “see the sun… getting outside and walking and spending time with my daughter”. On some occasions, HCBC-4 reported that she will have a drink at the end of the night. She stated that this goes on for a few days after which she redirects herself “back to other strategies” of maintaining wellness. HCBC-4 advised that HCBCs have regular “dialogue with other clinicians and supervisors” to combat the isolation in the field and prioritize their own wellness. She stated that new HCBCs should start off “slow” when working with families for the first time, focus on developing rapport and building relationships, and remember colleagues and supervisors can provide guidance.

Over the course of the interview, HCBC-4 discussed individual characteristics and traits that either lend themselves to or diminish wellness. HCBC-4 indicated that she is an optimistic person and that makes it easier for her to “see the positives”. She will remind herself of the progress that the child has made and the benefits of her services. However, the propensity to second guess her own work can become problematic leading HCBC-4 to experience additional stress. In addition, there are times that HCBC-4 admitted that she finds herself “taking on the stress of the situations and the families” and has difficulty maintaining boundaries. She reflected upon the difficulty of working with a mother:

[The] most important thing… right now isn’t about their autistic kid learning to match pictures, it’s about protecting them from the abusive husband… even though the insurance company says that I can only work with the kid. So it’s about trying to help and find what role I am able to help in.
In these situations, HCBC-4 must try find a way to help the family and the child while adhering to the insurance company’s requirements so that the interventions provided meet the criteria of a billable service.

HCBC-4 identified that aspects of the work can cause her to experience additional stress. HCBC-4 spoke about the difficulty “entering into other people’s spaces” whether that is the home or school setting. She explained that she must figure “out the rhythm”, determine the boundaries of parents and develop the routine, schedule, and expectations for treatment. HCBC-4 reported that there are times that she must confront parents to encourage them to try different methods of parenting. These situations were reported to be very uncomfortable for HCBC-4.

HCBC-4 acknowledged that she has experienced supervision to be at times beneficial and at other times harmful to HCBC wellness. HCBC-4 identified beneficial supervisor dispositions and practices and recounted qualities and aspects of supervision and supervisory practice that can be detrimental to wellness. At a previous agency, HCBC-4 was receiving two hours of individual supervision per month, one hour of autism specific supervision. In this hour, HCBC-4 recalled that she and her supervisor talked about the “ins and outs” of every case and her supervisor provided recommendations. She found this time with her supervisor to be very helpful. At her current agency, HCBC-4 is only receiving one hour of group supervision a month, sometimes with a group of 20 other HCBCs. She maintained that it would be helpful to have individual supervision as well. Despite infrequent supervision, HCBC-4 described her interactions with her current supervisor as positive and supportive. HCBC-4 reported that supervisors provide support, positive feedback, and suggestions for areas of
improvement and that supervision does not focus on “all the things you are doing wrong.” This feedback and support from supervisors has helped to shape HCBC-4’s wellness. She asserted that “getting good feedback, getting… good recommendations… from my supervisors… that helps me know that I’m doing good work… so that helps reassure me when I start thinking about what could be better.”

HCBC-4 stated that supervision needs to maintain a “positive culture… making sure to acknowledge accomplishments, and progress, and thanking people for the work that they are doing”. She acknowledged the limitations of supervisors that they “are just loaded down with so much work” and “they have all these things that they want to accomplish when they first start but they have zero time to get to them all.” She called on the agencies to hire more supervisors so that they have more time to work with HCBCs, providing more individual supervision.

HCBC-4 asserted that not having regular individual supervision and punitive approaches in supervision are detrimental to HCBC wellness. HCBC-4 shared that at a previous agency, it “was very punitive… everything. They just piled on stuff for and yelled at your for. I mean, it was a crazy environment”. She explained that it was “a culture of the person above you yelling at the person below you just on and on down the chain.” Even though her supervisor was supportive of her work, her supervisor was required to deliver messages from the agency directors that reinforced punitive practices. As a consequence of experiencing this constant pressure and working in an environment that she described as “inconsistent” and “insecure”, HCBC-4 almost left the field.

HCBC-4 described the current climate in her agency as supportive, “respectful”, and “understanding”. The agency directors, supervisors, and HCBCs are trained to
provide trauma-informed care. As a result, wellness is emphasized on an agency level, in supervisions, and in trainings. HCBC-4 explained that wellness “is always on the forefront of everything that… [the agency] does”. The agency requires the HCBCs to create their own crisis plan that identifies potential triggers and steps to take for self-care. HCBC-4 stated, “I just like that idea. That it’s like recognizing that everyone has triggers and… everyone needs to take care of themselves and that is recognized and supported.” The only thing that HCBC-4 identified in her current agency that is detrimental to HCBC wellness is that the copier, laminator, and printer at the office often do not work. HCBC-4 suggested that supervisors organize materials, books, programs, and paperwork to make them easily accessible to prevent HCBCs from wasting time on “busy work” that they will not get paid for.

HCBC-4 identified practices and policies that she found to be detrimental at the previous agency. She stated that the agency continuously expected the HCBCs to complete more and more paperwork. Weekly hours were tracked in a spreadsheet and if HCBCs did not meet the weekly expectation this was noted in their file. HCBC-4 also mentioned that supervisors were “constantly shifting”. Over a period of nine months, HCBC-4 remembered having six different supervisors. The atmosphere of the agency was “very corporate, very for profit, money driven”, pushing HCBCs to get “every single cent out of the insurance companies.” HCBC-4 recalled feeling tension in the office and stated, “like, they would show up in the office and… fire someone and escort them out of the building.”

HCBC-4 advised agencies to adopt an agency-wide “climate of support, incentive, not punitive” that puts HCBCs first. If clinicians are put first, HCBC-4 predicted that
turnover would decrease. HCBC-4 recommended that agencies offer additional individual supervision or “paid working groups” for HCBCs. She envisioned that during these working groups three or four clinicians could meet once or twice a month to discuss problems, share successes, and review new interventions, programs, and therapies.

HCBC-4 also reflected that while she has a close relationship with her direct supervisor and other TSS and BSCs, she has little contact with the agency and upper management something that she acknowledged she appreciates given how often she was exposed to the punitive climate of the previous agency. In her experience, HCBC-4 reported that she answers more to the insurance company and less to the agency, “So you can be doing one thing with one care manager and then the other one wants something different.” HCBC-4 suggested that the insurance company would better serve HCBCs if they created a document that clearly describes their expectations for HCBCs.

As she has worked as a HCBC, HCBC-4 reported that she has discovered how important it is to find balance, “balance between work, family, friendships, and other volunteer things.” Over time as a HCBC, she stated she gained wisdom, perspective, and gratitude, confidence, and a bigger “toolbox” of interventions. As a result of her BHRS work, HCBC-4 described becoming a stronger clinician and is now better able to function as a consultant, talking as an expert, and is more comfortable confronting new situations, and new families while working in the home and school settings.

HCBC-4 was the first participant to discuss at length how the insurance company’s regulations and practices influenced her wellness as a HCBC. The investigator was aware of the need look even more broadly at the systemic factors that influence counselor wellness. Further, this researcher was aware of the need to probe
HCBCs in this area to determine if other HCBC had similar experiences. Sampling was extended to include more full-time HCBCs. Table 7 describes the most prominent initial codes derived from the initial analysis.

Table 7

<table>
<thead>
<tr>
<th>Initial Coding of the Interview with HCBC-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making a difference</td>
</tr>
<tr>
<td>Second guessing</td>
</tr>
<tr>
<td>Feeling frustration</td>
</tr>
<tr>
<td>Not following through with interventions</td>
</tr>
<tr>
<td>Being on own</td>
</tr>
<tr>
<td>Keeping up with best practices</td>
</tr>
<tr>
<td>Taking care of self</td>
</tr>
<tr>
<td>Adopting positive mindset</td>
</tr>
<tr>
<td>Keeping balance</td>
</tr>
<tr>
<td>Pursuing interests</td>
</tr>
<tr>
<td>Seeing the sun</td>
</tr>
<tr>
<td>Spending time with family</td>
</tr>
<tr>
<td>Drinking to relax</td>
</tr>
<tr>
<td>Consulting with colleagues</td>
</tr>
<tr>
<td>Setting boundaries</td>
</tr>
<tr>
<td>Feeling constrained by</td>
</tr>
<tr>
<td>insurance company</td>
</tr>
<tr>
<td>Finding rhythm</td>
</tr>
<tr>
<td>Creating treatment space</td>
</tr>
<tr>
<td>Confronting</td>
</tr>
<tr>
<td>clients/families</td>
</tr>
<tr>
<td>Needing autism specific supervision</td>
</tr>
<tr>
<td>Perceiving supervisors as busy</td>
</tr>
<tr>
<td>Wanting more supervision</td>
</tr>
<tr>
<td>Maintaining positive culture</td>
</tr>
<tr>
<td>Acknowledging</td>
</tr>
<tr>
<td>Employing punitive practices</td>
</tr>
<tr>
<td>Making resources</td>
</tr>
<tr>
<td>Suggesting paid working groups</td>
</tr>
<tr>
<td>Answering to insurance</td>
</tr>
<tr>
<td>Growing toolbox</td>
</tr>
<tr>
<td>Gaining confidence</td>
</tr>
</tbody>
</table>

**Participant 6.** The next interview was conducted with HCBC-5, a HCBC who had been working in the mental health field for five years. For two of those years, she has been working as a master’s-level HCBC in a BHRS agency. She typically provides 28-30 hours direct service with clients each week. At the time of the interview, she reported that she was slated to bill 34.5 hours for the week. At other agencies this would be considered a full-time caseload. At her current agency, she would need to be billing 32 hours per week for at least six weeks before they would promote her to full-time status. Taking into consideration time spent traveling and completing paperwork, HCBC-5 was working at least 40 hours per week.

Several observations were noted about HCBC-5’s appearance and behavior. When HCBC-5 arrived for the interview, she appeared to be hurried and out of breath.
She was observed yawning throughout the interview even though the interview was conducted on a Monday at 1pm. HCBC-5 nails appeared to be bitten down. She appeared to be well organized sharing with me her planner and notes that she writes to herself to manage and track all of her responsibilities. The investigator tried to be respectful of her time and move through the interview quickly to gather enough information while remaining respectful of her need to get to her next appointment.

HCBC-5 described her position as “overworked and underpaid” and “stressful.” She reported she works “long hours.” HCBC-5 appreciates the flexibility inherent in the position and the ability to make her own schedule. She values that she is becoming more experienced working with children and adolescents. For HCBC-5, the most difficult aspects of the work are due to the nature of the work itself, the extensive travel, frequent cancellations and no shows, and difficulty juggling meetings and trainings in the schedule.

HCBC-5 reported counselor wellness is “doing things to make sure that their mental health and their happiness is also stable and well…. Just overall making sure that you can practice what you preach to your clients.” She reported practicing what you preach includes taking time for yourself, using coping skills, doing things you enjoy, and finding time for exercise and meditation. HCBC-5 distinguished between what she believed wellness should be and the reality of wellness for her. For HCBC-5, she reported that struggles to maintain wellness. She acknowledging coming home at the end of the night and finding herself complaining, not wanting to work out, eating quickly because she is so hungry, not having time to sit down, and instead spending time finishing progress notes, and then showering and going to bed. She stated, “to do it all
again the next day” and concluded “that’s what you need to have a decent paycheck. Like you need to have all of those hours.” In an ideal world, HCBC-5 reported that counselor wellness would be taking time off without needing to make up missed hours and “taking time, if you need it, to make yourself happy. Making sure that you have time at the end of the night when you don't feel so exhausted.”

HCBC-5 stated that she manages her wellness by having a few drinks to relax, painting, and talking to family and coworkers. However, the pressures of the work often prevent HCBC-5 from being able to take time for herself. Trying to take care of herself becomes “counterproductive” because HCBC-5 falls behind in the work. HCBC-5 reported that as a part time regular employee she is only accruing three hours per month and even if she wanted to take time off, she does not have the vacation time to do so. HCBC-5 offered that she tries as much as possible to be positive and remind herself that she will not be working in BHRS in the long term and that she is gaining “good experience” while she is working to earn her professional counselor license.

HCBC-5 noted that while she might be considered a “hypocrite”, she recommended that counselors set aside time for themselves at any point in the day, even if it is just 20 minutes. She also suggested that it is helpful to communicate with supervisors and coworkers to get extra support. HCBC-5 reported that if she has time in the office, she will eat with coworkers, work on case notes, and talk. During this time, HCBC-5 has found that it is helpful to “vent” and listen to one another. She reported that venting is talking with one another “about client’s parents who are kind of being ridiculous or being jerks” and then “giving suggestions or receiving suggestions on how to… deal with certain things that come up.” HCBC-5 emphasized that she appreciates
having a close relationship with some coworkers. HCBC-5 offered the following advice for newly hired HCBCs: “don’t be afraid to ask for help”, and “learn how to balance like your own life, and happiness along with your workload”. HCBC-5 acknowledged that it is difficult to find time for yourself given that “there is always something that needs to be done.”

HCBC-5 reported that she only receives a half hour of supervision with her agency supervisor each month and that supervision can take time away from HCBC-5’s time that she has to meet with clients. HCBC-5 indicated that she does not feel supported in agency supervision. She stated, “Especially with our agency now, they are cutting so many positions and people that… it’s hard to feel fully supported when the supervisor has all their stuff they have to do plus the supervisor role”. Overall in supervision, HCBC-5 reported that her supervisor “understands and helps when she can” but that her supervisor is so busy that HCBC-5 often does not want to “bother her” even if she has a question or a need. She appreciates that she does not get “yelled at” or “scolded”. HCBC-5 also receives LPC supervision twice a week, individual and group supervision. During this supervision, HCBC-5 stated that she feels supported, finds it a “good outlet”, and receives validation, feedback, and advice, learning new strategies and interventions. HCBC-5 could not identify any practices in supervision that are detrimental to her wellness. HCBC-5 recommended that supervisors provide HCBCs with “reassurance” that the supervisor is available if any help is needed. HCBC-5 remembered that her supervisor sends out emails each week and provides “shout outs” to HCBCs, expressing thanks for their hard work.
In contrast to supervision, HCBC-5 reported that, “as a whole our agency is not very supportive…. I don’t agree with how they do certain things.” In fact, HCBC-5 was not able to identify any agency practices that support HCBC wellness but she identified several practices that undermined her wellness. HCBC-5 recounted that one of her supervisors was “fired” without warning. The HCBCs lost a supervisor and the other supervisor assumed the responsibilities of the fired supervisor while continuing to supervise all of the HCBCs. HCBC-5 was left feeling less supported and she reported other HCBCs also indicated that they felt the same way. The agency did not communicate with HCBCs why staffing changes were occurring. In addition to losing supervisors, HCBC-5 also expressed that she has difficulty accessing trainings and professional development. She reported that it is unclear where to go and how to sign up for different trainings. To cope with these stressors, HCBC-5 stated that she has tried to keep herself busy, avoids the office, and has developed a “chip on my shoulder” toward upper management. She described this chip on her shoulder as “an attitude”.

HCBC-5 reported that she would feel better supported if there was more than one supervisor available at her agency. HCBC-5 stated that the agency does offer staff appreciation events typically twice per year, but the agency requires the HCBCs to provide some of the food. HCBC-5 recommended that it would be beneficial if the agency showed “appreciation to the staff that keep this company running” suggesting that upper management could send out emails and show up at the office to thank people for hard work. She surmised that HCBCs need positive reinforcement from the agency much in the same way that children need and benefit from positive reinforcement from their parents and teachers.
HCBC-5 suggested that agencies pay HCBCs more. HCBC-5 described spending time traveling, preparing materials, and writing progress notes, and noted that she works so much but it “doesn’t show” in her paycheck. Because she relies on only her own income, HCBC-5 feels pressured to work as many hours as possible to increase her income. HCBC-5 imagined that if she had a significant other and a two income household she would be able to reduce her hours and therefore reduce pressure and stress.

HCBC-5 did not realize how difficult wellness is to attain until she actually started working full-time as a BHRS HCBC. Since she has been a HCBC, HCBC-5 admitted that she has been probably drinking to relax more often and has had less motivation to exercise after work. HCBC-5 reported that she has been working more hours in order to be able to afford rent and other living expenses and as a result, has less time to spend on exercising and taking care of herself. HCBC-5 admitted that she is stressed daily. However, HCBC-5 reported that since she began working as a HCBC and has experienced different households, she has gained an appreciation for her own upbringing and privileges. HCBC-5 has also become more patient both with clients and families and applies this patience to her own life. In addition, HCBC-5 stated she has more developed more skills and interventions to use with clients and this has led her to be more comfortable and confident in her role as a HCBC. She asserted that she is more organized and manages her time more efficiently. To do this, HCBC-5 schedules clients with only a small amount of time between sessions, allows thirty minutes of time between some clients to work on documentation, and writes herself reminders and to do lists so that she is as productive as possible when she is in the office. HCBC-5 has also
learned to vary her caseload on any given day so that she does not have all of her most challenging clients on the same day.

Based upon the prior data collected and analyzed from earlier interviews, the investigator probed HCBC-5 for additional systemic factors, such as insurance company practices and policies that might affect HCBC wellness. HCBC-5 explained that it can be difficult to meet parents’ expectations for treatment and satisfy the insurance company’s requirements. Parents can become angry at HCBC-5 when the insurance company does not approve additional treatment hours. It can take several weeks to collect the data to justify additional services, obtain the prescription from the psychiatrist and finally receive the insurance company’s approval or denial of services. During this time, HCBC-5 stated, “the whole time the kid needs the extra support but they aren’t getting it”. See Table 8 for a listing of the initial codes derived from the initial analysis. This researcher planned to continue to sample full-time HCBCs to be able to determine a process of HCBC wellness that is true for HCBCs regardless of employment status.

Table 8

<table>
<thead>
<tr>
<th>Initial Coding of the Interview with HCBC-5</th>
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<tbody>
<tr>
<td>Working long hours</td>
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<tr>
<td>Appreciating flexibility</td>
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<tr>
<td>Gaining experience</td>
</tr>
<tr>
<td>Juggling the schedule</td>
</tr>
<tr>
<td>Taking care of self</td>
</tr>
<tr>
<td>Practicing what you preach</td>
</tr>
<tr>
<td>Pursuing interests</td>
</tr>
<tr>
<td>Finding time</td>
</tr>
<tr>
<td>Staying positive</td>
</tr>
<tr>
<td>Developing friendships</td>
</tr>
<tr>
<td>Consulting with colleagues and supervisors</td>
</tr>
<tr>
<td>Vventing</td>
</tr>
<tr>
<td>Giving and receiving</td>
</tr>
<tr>
<td>Asking for help</td>
</tr>
<tr>
<td>Finding balance</td>
</tr>
<tr>
<td>Not feeling supported by agency</td>
</tr>
<tr>
<td>Perceiving supervisor as busy</td>
</tr>
<tr>
<td>Showing appreciation</td>
</tr>
<tr>
<td>Employing punitive practices</td>
</tr>
<tr>
<td>Lacking training</td>
</tr>
<tr>
<td>Needing more supervisors</td>
</tr>
<tr>
<td>Needing positive reinforcement</td>
</tr>
<tr>
<td>Lacking compensation</td>
</tr>
<tr>
<td>Drinking to relax</td>
</tr>
<tr>
<td>Increasing confidence</td>
</tr>
<tr>
<td>Setting boundaries</td>
</tr>
<tr>
<td>Feeling gratitude</td>
</tr>
<tr>
<td>Growing toolbox</td>
</tr>
<tr>
<td>Justifying work to insurance</td>
</tr>
<tr>
<td>Lacking training</td>
</tr>
<tr>
<td>Needing more supervisors</td>
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<tr>
<td>Needing positive reinforcement</td>
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<td>Lacking compensation</td>
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<td>Feeling gratitude</td>
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<td>Growing toolbox</td>
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<tr>
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<td>Lacking training</td>
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<td>Lacking compensation</td>
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<td>Increasing confidence</td>
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<td>Setting boundaries</td>
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<tr>
<td>Feeling gratitude</td>
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<tr>
<td>Growing toolbox</td>
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<tr>
<td>Justifying work to insurance</td>
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</table>
**Participant 7.** The seventh interview was conducted with HCBC-6, a 42 year old female who has worked in the BHRS field for 10 years. HCBC-6 is a licensed practitioner and works with 13 clients, billing 25-30 hours per week. At HCBC-6’s agency, 37.5 hours per week is considered full-time status. While HCBC-6 is not a full-time employee, taking in consideration travel time and documentation, she is working 40 hours per week. HCBC-6 “values the progress that the kids make”, finds the work gratifying, and knows that she has “made a difference” when she sees progress. HCBC-6 reported that it can be difficult keeping up with the paperwork given that HCBC-6’s agency does not have electronic records. Also, HCBC-6 stated that it is difficult to “convey your suggestion to a parent… tactfully” especially when needing to discuss “their child’s negative behavior” or address a parent who is not participating in treatment.

HCBC-6 defined counselor wellness as “making sure that you are happy with what you are doing” and having “a good family support system in place.” HCBC-6 emphasized the need to engage in healthy activities, exercise, and spend time with family and friends. HCBC-6 enjoys taking walks, breathing fresh air, spending time with extended family, going to the hairdresser, getting a spa treatment, and exercising. HCBC-6 practices several daily rituals such as having a cup of tea before bed, spending time on her iPad, eating dinner with her husband, and talking to family. Though it can be a challenge to find time to do so, HCBC-6 reported that she and her husband eat together three or four times out of the five work days. HCBC-6 stated that for her it is very important to have other things in her life to focus time and energy outside of work.

HCBC-6 noted that she believes that working as a mental health counselor helps the HCBC apply their work to their own lives. HCBC-6 called it, “a practice what you
preach approach” and stated, “I’m telling clients all the time…. This is how you can maintain a better mental health status…. I think just being in the field and knowing how important it is to maintain… your own well-being.” HCBC-6 reported that being “on the positive side” and “staying positive” probably also help to keep her well. Through the work, HCBC-6 discovered the following strengths that contribute to her wellness: strong communication skills and the ability to communicate tactfully with parents, listen to the concerns and provide them with positive feedback about their child.

HCBC-6 identified that both the work and her own tendency to overthink things can challenge her wellness. She stated that managing disagreements with parents, dealing with a lack of progress, and addressing when parents are not following through with interventions can be stressful aspects of her work. In some cases, HCBC-6 reported that HCBCs can have difficulty functioning in their role due to “hygiene issues”, such as lice, cockroaches, or unsanitary living conditions. Also, HCBC-6 indicated that there is frequent turnover amongst TSS workers and the turnover can negatively affect HCBCs. When a new clinician must be trained, the child and family must build rapport the new clinician and treatment progress can be stalled. HCBC-6 admitted to having a tendency to “overanalyze” and ruminate about the situation and that can cause her to experience additional stress.

To let go and move forward, HCBC-6 stated that she will “move on with her daily routine” in order to stop thinking about the day. HCBC-6 will reassure herself that “tomorrow is another day and that… we can just move forward.” She explained that moving forward is “accepting that that situation happened… and that I’m not upset about it anymore and that I am just moving on with the rest of my work routine or daily
routine.” HCBC-6 recommended that HCBCs be careful not to personalize the work and to recognize the need to let go and move forward after having a difficult day. HCBC-6 provided the following advice, “Not every… parent… may agree with our recommendation even if it’s… research or evidence based as effective and that’s ok. You just have to figure out a way… to make that situation work.” In addition, she advised that HCBCs engage in activities that they enjoy outside of work.

HCBCs at HCBC-6’s agency are required to attend one hour a month of group supervision at the agency. The particular supervision group that HCBC-6 attends is small and is regularly attended by a group of experienced HCBCs. HCBC-6 stated that she appreciates talking to colleagues about cases so that she can hear different points of view and receive validation. According to HCBC-6, her supervisor recognizes that the work is difficult and stressful and therefore, brings humor into supervision encouraging HCBCs to “joke around” and laugh together in order to reduce stress. HCBC-6 appreciates being able to “vent about whatever is happening”, “being able to talk about it... in a[n]... environment that isn’t going to… affect your client in any way… because you can’t really say certain things when you are with the client.” HCBC-6 does not have to worry about being tactful in supervision and can instead be “blunt” and speak openly. HCBC-6 recommended that supervisors provide positive feedback to HCBCs and develop an incentive program, such as a gym membership, for HCBCs who have been in the field for over five years. In addition, HCBC-6 advised that supervisors “computerize” paperwork so that HCBCs only need to email progress notes once a week instead of having to drive into the office.
HCBC-6 did not identify any aspects of supervision or supervision practices that challenge wellness. Even when HCBC-6 was asked what advice she would provide to a program director newly hired at an agency, she responded that she could not think of anything and did not have “a whole lot of complaints.” After thinking about it for a moment, HCBC-6 reported it might be helpful to have an onsite gym but quickly acknowledged that most HCBCs are off site most of the time and would probably not take advantage of gym equipment at the office. HCBC-6 reported that the paperwork can be challenging to wellness but the paperwork policies at the agency are based on insurance company’s requirements. The insurance company care managers send emails that detail requirements for documentation. HCBC-6 reported that an insurance company audit can be a stressful experience for a HCBC because the progress note and other treatment documentation must reflect the same treatment goals and interventions as written in the treatment plan. In addition, the HCBC is responsible for justifying clinical necessity for treatment. As long as sufficient justification is provided, treatment is usually approved. To help HCBCs meet the criteria of the insurance company, HCBC-6 reported that the agency has set up a “thorough check and balance system” to catch mistakes before an audit.

HCBC-6 had difficulty identifying agency practices that benefit HCBC wellness because she spends so little time at the office. The agency frequently has office dinners, potlucks, birthday parties, and baby and wedding showers that HCBCs can attend. Even though HCBC-6 reported that she does not attend many of these dinners, she knows colleagues who have attended and have a good time. HCBC-6 commented that the
agency may offer additional activities and programs to support wellness of which she is unaware. HCBC-6 did not identify any agency practices that are a detriment to wellness.

HCBC-6 admitted that she did not think much about counselor wellness when she first began working in BHRS. As a HCBC, HCBC-6 realized the importance of taking care of herself. She suggested that maybe her caseload became more complex spurring the need to focus on taking care of herself or possibly she just “gained that knowledge with time.” Over time, HCBC-6 acknowledged that she began to spend more time exercising and began to focus on incorporating healthier coping skills. HCBC-6 reported that working with clients affected by trauma has led her to be more grateful for her own life circumstances. As a result of her work in BHRS, HCBC-6 reported that she has become a more tactful and effective communicator, has learned how to be more organized and manage all of various responsibilities that accompany the role of a HCBC. HCBC-6 uses a planner and has an ongoing list of things that need to be completed. Without this list, HCBC-6 stated she would not remember to do the work.

Unlike HCBC-5, HCBC-6 reported that she felt supported by her agency and her supervisor. Outside of paperwork that is required to fulfill the expectations of the insurance company, HCBC-6 did not identify any agency or supervision practices that negatively impact her wellness. HCBC-6 did not identify that the pay was inadequate and she expressed that she was happy working as a HCBC at her agency. HCBC-6 did indicate that aspects of the work itself can pose a challenge to wellness, mainly the paperwork, confronting parents, and coping with a lack of progress. HCBC-6’s reports support data gathered from earlier interviews and other HCBCs perspectives that broader systemic factors impact HCBC wellness. Many of the same concepts were continuing to
be repeated, e.g., practicing what you preach, moving forward, and taking care of 
yourself. The investigator continued to look for new concepts in subsequent interviews.
This researcher planned to stop sampling when all of the concepts and categories are 
clearly compared, contrasted, and defined and no new concepts arise. Table 9 lists the 
prominent initial codes that arose during the analysis of HCBC-6’s interview.

Table 9

*Initial Coding of the Interview with HCBC-6*

<table>
<thead>
<tr>
<th>Seeing progress</th>
<th>Staying positive</th>
<th>Receiving validation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gratifying work</td>
<td>Providing clients with positive feedback</td>
<td>Venting</td>
</tr>
<tr>
<td>Making a difference</td>
<td>Confronting parents</td>
<td>Appreciating supervisor’s sense of humor</td>
</tr>
<tr>
<td>Keeping up with paperwork</td>
<td>Dealing with turnover</td>
<td>Needing incentives</td>
</tr>
<tr>
<td>Being tactful</td>
<td>Second guessing</td>
<td>Computerizing paperwork</td>
</tr>
<tr>
<td>Pursuing interests</td>
<td>Moving forward</td>
<td>Justifying to insurance</td>
</tr>
<tr>
<td>Spending time with family and friends</td>
<td>Letting go</td>
<td>Feeling disconnected from agency</td>
</tr>
<tr>
<td>Practicing what you preach</td>
<td>Having daily routine</td>
<td>Increasing gratitude</td>
</tr>
<tr>
<td></td>
<td>Consulting with colleagues</td>
<td>Being organized</td>
</tr>
</tbody>
</table>

**Participant 8.** The eighth interview was conducted with HCBC-7, 31 year old 
female, an LPC and BSL, who has worked as a master’s-level HCBC for three and a half 
years and in the mental health field for six years. The interview lasted approximately one 
hour. The following notes were recorded following the interview: “HCBC-7 appeared to 
be in a rush. She answered questions quickly, efficiently, and in a focused manner. We 
needed to move quickly through the interview because she did not have much time.”

HCBC-7 described her work as a HCBC is “hectic at times”. In order to obtain 
32 billable hours each week, HCBC-7 has 10 clients and works four 12 hour days 
Monday through Thursday and a shorter day on Friday. HCBC-7 values seeing children 
make progress in treatment and having the opportunity to use her counseling skills with 
children and families. The most difficult aspects the work for HCBC-7 were reported to
be maintaining boundaries with families and “fitting” all of her billable hours into short weeks when there are holidays. When able, HCBC-7 will try to conduct data analysis, complete assessments, or write treatment plan updates to make up for lost direct time. HCBC-7 defined counselor wellness as, “making sure I am getting enough rest. Making sure to manage the administrative parts of it without like letting it creep up on you.” If the HCBC lets the paperwork creep up on them, HCBC-7 reported that “they tend to get behind on their notes or indirect services, getting signatures…. Once you let it pile up, it’s hard to dig yourself out of that hole.”

While it is important for HCBC-7 to keep up with the paperwork, she also spends time with family and friends, avoids working on the weekends, and tries to remain present during sessions. When HCBC-7 did work on the weekends, she reported that she was “feeling really stressed” and found that she did not have the time that she needed with family and friends. HCBC-7 indicated that she tries to take care of herself by “being very present in all situations so that I don’t feel like… So I don’t get that burnt out feeling.” She reflected that, “it’s hard to turn that around sometimes if you are not aware of it.” HCBC-7 went on to explain that being “burnt out” means “being tired all the time, being behind on the administrative things and not having enough time to do the things that I really enjoy.” In an effort to stay present, HCBC-7 states that she focuses on clients when she is in her sessions instead of worrying about being behind on paperwork.

Additionally, HCBC-7 takes care of herself physically by attending any needed medical appointments and having a back massage and emotionally by spending time with friends, family, and pets, a dog and cat. HCBC-7 commented that it is difficult to find time for these appointments because of frequent last minute schedule changes to
accommodate families. For HCBC-7, daily rituals such as a coffee and breakfast to go every morning are also essential. HCBC-7 takes breaks during the day so that she can work on paperwork. HCBC-7 reported that she tries to stay attuned to her own health needs, monitoring the need to eat and drink so that she can avoid a headache. She makes it a point to take a vacation once or twice a year. HCBC-7 admitted that she pushes herself to meet productivity and bill 32 hours per week as much as possible and this pressure can hamper her wellness.

HCBC-7 reported that in the past she was receiving LPC supervision. During LPC supervision, HCBC-7 asserted that her supervisors frequently talked about self-care and these discussions influenced HCBC-7 to be “aware about taking time for self-care”. After completing a self-care assessment, HCBC-7 realized that working weekends was emotionally draining. HCBC-7 explained that it was not until she was “burned out” that she realized that she needed to make changes. HCBC-7 reported that at this point, HCBC-7 began taking more time to take care of herself. HCBC-7 indicated that she is no longer receiving LPC supervision and is only receiving individual supervision with her clinical supervisor one hour monthly. HCBC-7 was not able to identify any aspects of individual supervision that benefit her wellness and instead repeated that her “own knowledge about self-care” is an asset to her but she does not get that from supervision.

It was much easier for HCBC-7 to identify how supervision is detrimental to her wellness. HCBC-7 stated that there are high expectations for productivity and HCBCs are not receiving additional autism specific supervision. HCBC-7 appreciated receiving additional autism supervision in the past and lamented that working with children with autism can be more “complex” than strictly working with children diagnosed with other
mental health disorders, implying an even greater need for supervision. HCBC-7 also indicated that it can be difficult to coordinate supervision due to her busy schedule.

HCBC-7 acknowledged that several agency policies negatively affect her wellness. HCBC-7 identified the 24 hour expectation for documentation, punitive practices, such as tracking incomplete documentation and removing HCBCs from the field when behind in documentation, and expecting full time employees to maintain 32 billable hours weekly as problematic practices. I asked HCBC-7 how she is able to do the work despite these challenges and what keeps her in the field. HCBC-7 commented that she manages the work by staying organizing and using a calendar to track scheduled sessions. She stated that she enjoys building rapport with the kids and that seeing her clients make progress keeps her doing the work.

HCBC-7 admitted that at times the work can sustain wellness and at other times the work can be a detriment to wellness. HCBC-7 indicated that sometimes she will see clients in the community after they have been discharged. She appreciates when she sees them in the community “being successful”. In contrast, the long days can be a strain for HCBC-7. Her day may start at 8:00 a.m. if she is working as a BSC in the school and may end at 7:45 p.m. if she is conducting mobile therapy sessions. HCBC-7 indicated that families can be “rigid” about session times and scheduling with families can be difficult.

As with other HCBCs, during HCBC-7’s interview, this investigator inquired whether insurance company practices and policies influence HCBC wellness. HCBC-7 identified that parents sometimes do not schedule their psychological evaluation within the timeframe needed or they might not complete the necessary paperwork to have their
medical assistance renewed. As a result, services lapse until the insurance company receives all the necessary paperwork to approve them or until medical assistance is reinstated. If there is a lapse in services, HCBC-7 has to figure out other ways to earn those billable hours and in some instances may need to substitute for another HCBC. In addition, HCBCs have to prepare for insurance company audits. Feedback from the insurance company can vary from care manager to care manager and the HCBC has to adjust their practices to match the expectations of the care manager.

HCBC-7 reflected upon her work as a HCBC and stated that her wellness has been shaped by attending professional development opportunities and trainings and establishing and enforcing boundaries with families and the work. She sought out training in Discrete Trial methods and the Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), autism specific approaches, so that she could insure that she was provided the best treatment to her clients. HCBC-7 reported that she consults with other colleagues who are more experienced with working with children with autism. Because HCBC-7 seeks consultation and training when needed, she reported: “[I have] become more confident in my skills…. Being able to make… good recommendations for services… taking planning time for sessions… resources to use in sessions.”

As she started her career as a HCBC, HCBC-7 quickly found that parents can challenge HCBC professional boundaries. Parents attempted to text HCBC-7 between sessions or call and text after hours during crisis situations. These occurrences forced HCBC-7 to set boundaries with parents. She made it clear with parents that concerns needed to be addressed during counseling sessions and that BHRS is not a crisis service;
therefore the crisis hotline needed to be contacted after hours. HCBC-7 clarifies her roles and responsibilities as a BSC or MT with parents because past HCBCs have not maintained clear boundaries. For instance, HCBC-7 does not provide tutoring or homework assistance and will not provide services during a birthday or family party. HCBC-7 sets boundaries with the work when she gets home at the end of the night. In addition, she is careful not to let the work “follow” her home. If HCBC-7 is too tired to complete additional paperwork, she reported, “I leave it for the next day” and if there are openings in her day due to a cancellation, she will complete any paperwork then. HCBC-7 also sets boundaries with the work in supervision. HCBC-7 reported that she requests to work with clients within a particular geographical area to reduce travel time. HCBC-7 discovered that as she set boundaries with the work and with families her wellness improved.

HCBC-7 recommended that HCBCs have “boundaries of when work is done, work is done”, set boundaries with clients, and keep up with administrative tasks. She advised that supervisors assist HCBCs with managing the work by monitoring their caseload so that the HCBC does not have too many evening cases. HCBC-7 also recommended that supervisors attempt to match client need with clinician ability.

After the transcript from the interview with HCBC-7 was coded, the codes derived from her interview were compared with previous codes in earlier interviews. Similar concepts are being repeated across interviews including but not limited to: taking care of self, maintaining boundaries, and seeing progress. This investigator had one more interview to conduct with HCBC-8 and planned to discontinue sampling HCBCs as long as no new concepts arose in HCBC-8s interview that would require additional sampling.
Table 10 provides a list of the prominent initial codes derived from the interview with HCBC-7.

Table 10

<table>
<thead>
<tr>
<th>Initial Coding of the Interview with HCBC-7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working long days</td>
</tr>
<tr>
<td>Setting boundaries</td>
</tr>
<tr>
<td>Getting rest</td>
</tr>
<tr>
<td>Keeping up with paperwork</td>
</tr>
<tr>
<td>Employing punitive practices</td>
</tr>
<tr>
<td>Taking care of self</td>
</tr>
<tr>
<td>Spending time with family and friends</td>
</tr>
<tr>
<td>Being present</td>
</tr>
<tr>
<td>Avoiding burnout</td>
</tr>
<tr>
<td>Following daily rituals</td>
</tr>
<tr>
<td>Being aware</td>
</tr>
<tr>
<td>Taking vacation</td>
</tr>
<tr>
<td>Meeting productivity</td>
</tr>
<tr>
<td>Needing autism supervision</td>
</tr>
<tr>
<td>Difficulty scheduling supervision</td>
</tr>
<tr>
<td>Lacking quality supervision</td>
</tr>
<tr>
<td>Seeing progress</td>
</tr>
<tr>
<td>Preparing for audits</td>
</tr>
<tr>
<td>Receiving conflicting feedback</td>
</tr>
<tr>
<td>Completing notes in session</td>
</tr>
<tr>
<td>Gaining confidence</td>
</tr>
<tr>
<td>Consulting with colleagues</td>
</tr>
<tr>
<td>Needing specialized supervision and training</td>
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**Participant 9.** The final HCBC interview was conducted with a 68 year old male, HCBC-8, who has worked as a BSC and MT for 14 years. HCBC-8 works part-time, has six clients, and bills approximately twelve hours per week. The interview lasted about an hour. HCBC-8 indicated that he values the flexibility inherent in working part-time. In his position, HCBC-8 stated that he can choose to “reject cases” in order to keep all of his clients in the same geographical area. HCBC-8 also appreciates “helping kids get along better” and being able to see the client wherever they are having problems, whether in the home, the school, or the community.

HCBC-8 identified many difficulties associated with BHRS work. According to HCBC-8, full-time HCBCs struggle and end up going back to part-time work because “they are made to drive all over the place and take cases that they don’t want to take.” In addition to traveling extensively, HCBC-8 reported that much of the work of the HCBC is unpaid. The insurance company determines and therefore limits which activities are reimbursable according to medical assistance regulations and guidelines. HCBC-8 stated
he has “resigned myself to the fact that I’m not going to get paid for this. I’m not going to get paid for that”. Finally, HCBC-8 stated that the clients and families have complex needs that may be complicated by the parent’s physical and/or mental health issues.

According to HCBC-8, many HCBCs have difficulty maintaining professionalism. He asserted that many HCBCs work two jobs and have difficulty maintaining a professional relationship with clients as a result. HCBC-8 asserted that if BHRS work paid more, HCBCs would not need to work two jobs and there would be less turnover. HCBC-8 reported that he does not think that many HCBCs take the work seriously and when young HCBCs enter the work, they often “leave right away. They don’t see the benefit.” HCBC-8 went on to say that there are “hardly any… old timers” and that most HCBCs are recent graduates. HCBC-8 claimed that the younger HCBCs do not have the “maturity” or “life experience” needed for the position and some families have difficulty working with a younger clinician who is not a parent, themselves, or is not married.

HCBC-8 defined HCBC wellness as, not working harder than the client, taking care of oneself, and having financial security. HCBC-8 reported, “Whenever you find that you are doing more work than your client, then… you’re doing too much.” When this starts to happen, HCBC-8 stated that the HCBC needs to “take a break, go relax, do something. Maybe get rid of a case.” The challenge, HCBC-8 identified, is that it is difficult to make money working BHRS and this puts additional stress on HCBCs. Of full-time HCBCs, HCBC-8 reflected, “They get very disgruntled. They get worn down and when you talk to them, they’re all… very negative. There are so many complaints…. You can actually see it on their face how things are going.”
HCBC-8 maintains his own wellness by trying to “keep a positive attitude”, reminding himself that if families do not comply with services, he can discharge them from treatment and get a new case. Again, HCBC-8 reverted to talking about the difficulties of the work, reporting that much of the job involves trying to convince adults to “do what they are supposed to do.” However, the caregivers or parents, according to HCBC-8 will say, “Oh, no, no it’s not about me. Just fix him or her.” Being able to “walk away” from this at any time, “takes some pressure off, some stress off because you don’t have to push this.” HCBC-8 mentioned that he enjoys spending time with family, especially his grandson, and going to the gym. HCBC-8 reported that his sense of humor, love of gardening, and healthy habits, eating healthy and exercising keep him well. HCBC-8 recommended that HCBCs have other interests outside of work, a “hobby” or “maybe having another job.”

Initially, HCBC-8 was unable to identify any aspects of supervision that are beneficial to HCBC wellness. In fact, while acknowledging that he appreciates talking with someone who has experience, he noted that in his experience, most supervisors do not have a lot of experience. HCBC-8 went on to say that as long as he has been in the field, working in several different agencies, he has not found supervision to be adequate because supervision is almost solely focused on administrative issues and not clinical concerns. HCBC-8 did not have any recommendations and he acknowledged the barriers that supervisors face that prevent them from being able to provide quality supervision. He stated, “They are doing what they are doing. They have all kind of other…. Most of their responsibilities are administrative and they can’t. It’s hard for them to really focus on the therapeutic issues of their… supervisees.” Because supervisors have so many
administrative responsibilities, HCBC-8 asserts that they are unable to provide HCBC with clinical supervision.

Of the supervisors, HCBC-8 stated, “I’m never reluctant to approach them….
There’s many times [I] don’t even make the call because I just don’t think that they are going to be able to provide me with any insight.” HCBC-8 explained, “You try that and then you find out what you get and if you don’t think it’s… going to be helpful, in the future, you just don’t do it anymore.” HCBC-8 went on to say, “They have so much… stuff to do. It’s just overwhelming. I understand that so if I don’t think, if I don’t have any serious issues, I’m not going to bother somebody.”

HCBC-8 spontaneously discussed some positive experiences that he had with one supervisor in the past. He reported that this supervisor, despite being younger than HCBC-8, was viewed by HCBC-8 to be one of the “best therapists” that he had encountered. HCBC-8 stated he, “had good suggestions”, was “always ready to talk”, provided resources about interventions, and even provided wooden airplanes that HCBC-8 could use as a reward with the client. HCBC-8 also indicated that this supervisor always had advice and was willing to provide support. HCBC-8 suggested that agencies need to hire more experienced supervisors.

HCBC-8 described agency practices and policies that are beneficial to wellness by comparing experiences that he has had working at several different agencies. HCBC-8 stated that his current agency practices trauma-informed care and “pushes” this approach onto HCBCs. HCBC-8 reported that while he does not “buy into” it, he reported that perhaps if he “dug deeper into maybe it would be helpful.” HCBC-8 reported that having electronic notes has improved his ability to effectively document treatment. In addition,
his current agency has consistent and clear expectations for HCBC and these are communicated consistently regardless of supervisor. He indicated that the agency is “hands off”, as long as paperwork is complete and submitted weekly, “no one really bothers you.” While working another agency, HCBC-8 had an altogether different experience. He remembered being asked to revise all of his progress notes written over a six month period.

During the course of the interview, HCBC-8 had identified several instances of situations in which the insurance company limited HCBC-8’s ability to do his work. HCBC-8 explained that the insurance company restricts which activities are considered billable services. HCBC-8 reported that when he is working as a BSC, he is not supposed to have individual sessions with clients but that he should be meeting with teachers and parents, instead. However, he insisted that there are times when it is beneficial to meet individually with clients. The insurance company also limits the amount of time spent on billable activities. HCBC-8 recalled that HCBCs could take four hours to write an initial treatment plan in the past. Currently, the HCBC will only be reimbursed for two hours spent on the treatment plan and only one hour for an interagency meeting. HCBC-8 reflected that the care managers from the insurance company have been providing consistent feedback and this makes it easier for HCBCs to provide documentation that meets their expectations. As long as HCBCs adequately justify the services that they provide in their case note, HCBC-8 reported that the insurance company generally will approve the service.

When HCBC-8 was asked how his thoughts of wellness have changed since he began the work, HCBC-8 replied that he has realized that he is “only going to be paid so
much money” and “there’s a lot of stuff you have to do for free.” HCBC-8 reported that his wellness practices as a HCBC have not changed over the years. HCBC-8 instead talked about how his mindset has changed over the years and stated, “I just tried to be… to keep… to take things with a grain of salt and understand that this, everybody can’t be helped… and… [I’m] coming to that conclusion a lot more recently than earlier.”

HCBC-8 stated that he has learned not to “reinvent the wheel” when he starts to work with a client who has received BHRS in the past. Consulting with past therapists has helped HCBC-8 learn how to approach treatment with the client.

HCBC-8 marks the last interview with HCBCs. The analysis of HCBC-8’s interview yielded similar concepts as earlier interview; however, HCBC-8 provided a different perspective. HCBC-8 was not fighting to maintain a full-time caseload in order to earn a living. He did not rely on the income and therefore was able to turn down clients if needed. HCBC-8 went so far as to suggest that the inadequate pay that results from the unpredictable nature of the work and the difficulty obtaining billable hours due to frequent cancellations, negatively affects HCBC wellness. Other important concepts mentioned by HCBC-8 that were seen in earlier interviews include: maintaining professional boundaries, pursuing interests, and taking care of self. Table 11 provides a list of the prominent initial codes identified in the analysis of HCBC-8’s interview.
Table 11

*Initial Coding of the Interview with HCBC-8*

<table>
<thead>
<tr>
<th>Appreciating flexibility</th>
<th>Lacking experience as HCBCs</th>
<th>Receiving administrative supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting boundaries</td>
<td>Keeping positive attitude</td>
<td>Perceiving supervisor as busy</td>
</tr>
<tr>
<td>Traveling extensively</td>
<td>Pursuing interests</td>
<td>Providing resources and support</td>
</tr>
<tr>
<td>Making a difference</td>
<td>Spending time with family</td>
<td>Being available</td>
</tr>
<tr>
<td>Needing more compensation</td>
<td>Having sense of humor</td>
<td>Receiving consistent feedback from insurance</td>
</tr>
<tr>
<td>Working with multiply challenged families</td>
<td>Supervisors lacking experience</td>
<td>Justifying to insurance</td>
</tr>
<tr>
<td>Lacking professionalism</td>
<td>Perceiving supervision as inadequate</td>
<td>Limiting billable activities</td>
</tr>
<tr>
<td>Taking care of self</td>
<td>Needing clinical supervision</td>
<td>Consulting with other clinicians</td>
</tr>
<tr>
<td>Experiencing turnover</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having financial security</td>
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**Participant 10.** The tenth interview was conducted with a 34 year old female, SUP-2, who has been a supervisor for two years and has worked in the mental health field for 12 years. Currently, SUP-2 is working part-time at a BHRS agency and has prior experience working as a BHRS HCBC. SUP-2 indicated that there are about 50 master’s-level HCBCs employed at her agency, 20 of whom are full time HCBCs.

SUP-2 reported that she is responsible for clinical and administrative oversight of HCBCs. Her responsibilities include providing supervision, developing and providing trainings, and participating in employee reviews. In addition, she is available to meet with HCBCs when requested and there are times that SUP-2 will require a HCBC to attend individual supervisions. SUP-2 values helping children and is grateful that as a supervisor she is able to indirectly help exponentially more by overseeing the treatment of all of the clients of the HCBCs she supervises. Also, SUP-2 values being involved with developing trainings and agency policies and procedures. Since beginning as a supervisor, SUP-2 stated the agency has been adding more “structure” to service delivery
by requiring that treatment plans are individualized and evidence-based, ensuring that HCBCs attend monthly supervision, and providing additional documentation training.

SUP-2 reflected, “It’s hard in a community based service because it’s easy for people to kind of go out and do their thing and then we don’t see them much.” SUP-2 stated, “I definitely hate not knowing exactly what is going on…. I have clinicians who can report to me what they are doing but… I still think sometimes even what they are reporting is skewed from what’s actually happening.” To deal with this problem, SUP-2 indicated that she is offering more supervisions and is following up with HCBCs, trying “to get people in here as often as I can so that I know them.”

SUP-2 discussed differences between counselors who manage their wellness and HCBCs that struggle to manage the stress of the work. SUP-2 emphasized that she notices when HCBCs are not “handling the stress of their job.” SUP-2 reported these HCBCs present in supervisions as “anxious about having conversations with parents that shouldn’t be difficult.” Unlike SUP-1, SUP-2 did not perceive introverts as having more difficulty managing wellness than extroverts. In fact, SUP-2 reported that “I have a lot of people who are extroverted but are just still so anxious.” SUP-2 acknowledged that some HCBCs come into the agency “anxious already and then it gets worse and they quit”, other HCBCs continue to do the work but the anxiety does not go away and SUP-2 questions whether these HCBCs are able to be effective counselors. SUP-2 has found that HCBCs manage this anxiety by avoiding situations that cause additional anxiety. SUP-2 reported noticing that the anxious counselors “perseverate” about difficulties that they are having with treatment and avoid confronting parents if they are not complying with treatment. Sometimes it becomes so problematic that the HCBC becomes the
barrier to the client making progress to treatment. In these instances, if the HCBC continues to be employed with the agency, SUP-2 will require individual supervisions to monitor HCBC progress. In addition, she recognizes that all HCBCs have strengths and weaknesses and she tries to match HCBCs with clients that compliment that HCBCs strengths and do not exploit weaknesses.

SUP-2 encourages HCBCs to have the difficult conversations with parents, to address barriers, in order to provide the necessary consultative services. SUP-2 encourages the HCBC to “let go” in order to “move forward and look at what we can do for this child”. When HCBCs are moving forward, they are able to continue to provide child centered treatment without letting their emotions interfere with their ability to provide counseling as opposed to “dwelling on things that have happened or collecting injustices.”

In contrast to the anxious HCBCs who avoid difficult conversations, SUP-2 asserted that HCBCs who do the work well, manage the stress of the work, “are even keeled about things”, “good about handling problems”, and “they can stay calm and focused and rational and logical about what is going on and can kind of see what goal they need to reach.” The HCBCs create boundaries between work and their personal lives, do not let emotions interfere with the work, and set boundaries with clients (e.g., not ruminating about work at night, not answering late not calls, and not working weekends). During supervision, SUP-2 reminds counselors that after leaving a session, they need to “shut it off” and suggests that the HCBC contact SUP-2 if supervision is needed. SUP-2 is concerned that the HCBC who has difficulty “shutting it off” will “get burnt out”. SUP-2 stated that she normalizes the difficulty of the work and the benefit of
processing the work with someone. She reminds newer HCBCs to contact her if needed. SUP-2 clarified that she either sees HCBCs learning to leave work at work, learning to avoid the work, or quitting BHRS work altogether. SUP-2 tries to prevent turnover by providing initial support to HCBCs. She reminds HCBCS that “This is a hard service. You are going to need support and you’re going to have to… figure things out so call me, email me, whatever you need to do is fine.”

SUP-2 identified that those who seem to be better at managing the stress of the work are also “better at managing their schedules. They are better at managing how they use their billable hours.” She went on to explain, “Because as a BSC you can do some hours onsite and some offsite. Usually the people who are…. They’ve learned how to have a balance of that… they are not doing all of their hours onsite. They do some offsite.” SUP-2 reiterated that HCBCs who manage the stress of the work better, typically, are also “laid back” and “flexible” and if there are cancellations, they try to accommodate the family if able. If they cannot, they set boundaries with the parents and explain that it will not work. By being overly accommodating to families, SUP-2 reported that HCBCs can bring additional stress onto themselves, rearranging their schedule constantly. SUP-2 recommended that HCBCs be patient and listen to clients. SUP-2 has found that when she is patient, listens, and shows that she cares, that it does help SUP-2 to “connect with people better”. For HCBCs that are just starting to work in BHRS, SUP-2 suggests to the HCBC that it is important to set boundaries with families and with the work. These boundaries may include: not moving schedule around for the family, not receiving calls after a certain time, referring family to a crisis service.
SUP-2 asserted that the agency tries to create a culture of support and supervisors reassure counselors that they are available if needed. Again, SUP-2 emphasized that it is very important for her to remind HCBCs that the supervisors are available as a resource for the HCBCs. In SUP-2’s experience when HCBCs do not utilize the supervisors, they typically end up leaving the agency. SUP-2 reassures the HCBCS that she is there to answer questions as often as needed. HCBCs have provided SUP-2 with feedback that they appreciate the reassurance and support and that they feel better after talking to SUP-2.

SUP-2 provided several examples of how supervision and agency practices serve to support HCBC wellness and offered suggestions for supervisors of HCBCs. SUP-2 reported that the HCBCs attending group supervisions have become a close-knit group “cohort” and they support one another during supervision. SUP-2 stated, “I want people to… vent a little bit because I know it’s tough but that also can’t be what supervision is for.” SUP-2 wants HCBCs to “keep moving forward.” SUP-2 indicates that supervisors and program managers are considering organizing employee appreciation days to try to encourage the HCBCs to spend more time together and hopefully instill the idea that they are not “out there with no support.” SUP-2 advised that supervisors be “patient” and “supportive” and guide HCBCs to learn the “roles and limitations of the service” so that the HCBCs are “more equipped to do the job and do it right and feel good about doing it.”

SUP-2 reported that venting in supervision can become problematic and interfere with HCBC wellness if it is not managed by supervisors. In the past group supervisions were more of a “venting session” where HCBCs would just complain. Past supervisors
allowed the venting to happen and even encouraged and “instigated” HCBCs and centered supervision on venting. Current supervisors manage the venting that occurs in supervision so that “things don’t kind of go to a dark place”. SUP-2 explained that it’s easy for the HCBCs to get together and complain about TSS turnover, lack of parent follow through, and the difficulty of managing paperwork. Since SUP-2 has become a supervisor she has learned how to better managing supervisions to curtail venting. First, SUP-2 listens to the HCBC say their “complainy piece” and then directs the conversation to discuss ways that the HCBC can address and overcome the difficulty. In the past, SUP-2 had noticed that spending too much time on venting was having a negative effect on the HCBCs and they would leave supervision more annoyed with the work.

Because there are a lot of different skill sets involved in the work, SUP-2 reported it is difficult to do all of those things well and many of the tasks involved in the work are inherently stressful. SUP-2 stated, “master’s-level clinicians have to wear a lot of different hats and they have to be. If you want to be a good BSC you have to have a good understanding of all… of the different hats you have to wear.” Managing all of these responsibilities can become a challenge especially if one part of the job becomes overwhelming for the HCBC. For instance, SUP-2 recounted having “really good therapists” who struggled to keep up with their paperwork. SUP-2 described their paperwork as “just horrendous” and stated, “So it’s too bad and then that piece of things makes people really stressed out and not like the job too.”

SUP-2 did not identify any agencies practices that challenge HCBC wellness. SUP-2 stated that the agency hires supervisors who are positive and able to stay focused. In addition, the agency is family-focused and supports HCBCs and supervisors when they
need to take off to care for their own family. SUP-2 reported that she passes this message onto her supervisees. She explained, “But we want to tell people like you’re not just bodies going out and… making us money. So we definitely try to have a good culture here too which I really think we do.” SUP-2 stated that there has been a shift in agency practices regarding the role of the supervisor in supporting the HCBC. Now, supervisors inform HCBCs that they are available whenever needed. SUP-2 reflected that this change has improved HCBC wellness. SUP-2 reported that she has observed that she “can just see people look relieved.”

SUP-2 reported that since she has begun supervising, she has developed “a lot more sympathy for people now”. She stated, “I just think I’m more sympathetic and understanding at this point because I know what they have to do… and I… try to do the best that I can to help them.” Her experience as a HCBC helps her to understand and relate to HCBCs and she sees this as benefiting HCBC wellness. SUP-2 stated she will remind herself that she has had “10 years to practice difficult conversations with parents” and this experience helps her to realize that the conversations are not “a big deal” but initially, she remembers them being “tough.” SUP-2 uses her own experience to normalize the difficulties and fears that HCBCs have. As I analyzed this portion of the interview, it struck me that SUP-2 is not only empathizing with supervisees, she is also modeling these difficult conversations for them by challenging HCBCs to confront parents when needed. SUP-2 stated that she motivates HCBCs to have the difficult conversations by reminding them of why they entered the field in the first place, to make a difference.
As a supervisor, SUP-2 reflected that she has grown to be more tactful and can have the difficult conversations with supervisees in a way that is supportive, open, and honest so that the HCBCs do not feel threatened. In addition, SUP-2 has found that her strengths as a supervisor are that she always wants to help and is tactful when having the more difficult conversations with HCBCs. Because of these strengths, SUP-2 reported that HCBCs trust her and will confide in her when needed.

Many of the same concepts arose in the SUP-2’s interview, such as, making a difference, setting boundaries, moving forward, and being available to HCBCs. Like SUP-1, SUP-2 used her past experience as a HCBC to relate to her supervisees. However, SUP-2 introduced the idea that some HCBCs experience significant anxiety that can impair them from doing their work, increase stress, and negatively affect their wellness. Two more supervisors were interviewed to discover whether anxiety is viewed by other supervisors to be affecting HCBC wellness and if there are additional factors that may have yet to be uncovered. The prominent initial codes found when analyzing SUP-2’s interview are listed in Table 12.
### Table 12

**Initial Coding of the Interview with SUP-2**

<table>
<thead>
<tr>
<th>Juggling responsibilities</th>
<th>Providing support</th>
<th>Working with HCBC strengths</th>
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</thead>
<tbody>
<tr>
<td>Making a difference</td>
<td>Managing time</td>
<td>Matching HCBC with clients</td>
</tr>
<tr>
<td>Overseeing treatment</td>
<td>Being flexible</td>
<td>Managing venting</td>
</tr>
<tr>
<td>Observing anxious HCBCs</td>
<td>Creating positive culture</td>
<td>Hiring positive supervisors</td>
</tr>
<tr>
<td>HCBCs not confronting</td>
<td>Being available</td>
<td></td>
</tr>
<tr>
<td>parents</td>
<td>Reassuring HCBCs</td>
<td></td>
</tr>
<tr>
<td>Avoiding</td>
<td>Becoming a cohort</td>
<td>Keeping up with</td>
</tr>
<tr>
<td>Letting go</td>
<td>Venting</td>
<td></td>
</tr>
<tr>
<td>Moving forward</td>
<td>Supporting one another</td>
<td>Increasing empathy</td>
</tr>
<tr>
<td>Personalizing the work</td>
<td>Organizing employee</td>
<td>Motivating HCBCs</td>
</tr>
<tr>
<td>Setting boundaries</td>
<td>appreciation days</td>
<td>Reminding why in field</td>
</tr>
<tr>
<td>Burning out</td>
<td>Needing to be patient and supportive</td>
<td>Modeling difficult conversations</td>
</tr>
<tr>
<td>Normalizing difficulty of work</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Participant 11.** The eleventh interview was conducted with SUP-3, a 41 year old female, who has worked in BHRS as a supervisor for two years and in the area of mental health for 17 years. The interview lasted an hour and 20 minutes. The following observations were made about SUP-3 during the interview, “She seemed to be such a positive person…. She took clear steps to make sure she could focus 100% on our discussion and not be interrupted. She turned off her computer so she would not be distracted.”

SUP-3 entered into the counseling field to help minority inner-city children. Raised in the city of Pittsburgh, SUP-3 stated, “I saw youth…. I think that was the time that it was like gang violence and a lot of that going on so… it inspired me to just try and figure out what’s going on with these kids.” At SUP-3’s agency, supervisors have both clinical and administrative responsibilities. Supervisors conduct performance reviews, remind HCBCs to schedule psychological evaluations, meetings, and submit treatment plans, manage payroll, conduct quality checks with clients, train HCBCs, and process
referrals, in addition to providing supervision and maintaining a small caseload. SUP-3 reported that she meets with staff with “a lot of problems” weekly for individual supervision. These are HCBCs that have difficulty turning in paperwork or are working with families who have made complaints. If HCBCs have over 20 hours of direct client hours, SUP-3 sees the HCBC for monthly individual supervision. She recommends that HCBCs with a smaller caseload attend monthly group supervision. HCBCs can request individual supervision with SUP-3. In supervision, SUP-3 addresses any concerns that the HCBC may have, reviews cases and upcoming paperwork, and recognizes HCBC successes.

SUP-3 values the flexibility of her current position, the transparency of the agency, and the opportunity to learn how to work with HCBCs with “different personalities.” In her supervisory position, SUP-3 enjoys the consistent hours and a typical 8am to 5pm workday as opposed to the long hours that she worked as HCBC. In an effort to achieve work-life balance, SUP-3 learned “to set my own boundaries as far as what I will take and what I will not take with things.” In addition to the flexibility, SUP-3 stated that she appreciates that the agency is transparent with the HCBCs, supervisors, and other staff and no one is “left in the dark”. She went on to say, “We know what’s going on. It eliminates all that other stuff which I’ve experienced before at other places where people gossip.”

Also, SUP-3 appreciates “learning how to deal with staff and their different personalities.” She explained that each HCBC has different ways of writing and turning in paperwork and for some HCBCs this can be problematic and needs to be addressed by SUP-3. SUP-3 helps HCBCs improve in areas that they are struggling. She discussed
the difference between “strong staff” who are able to challenge parents, are not “afraid of confrontation”, and are not anxious about going into homes in the “inner city”, as opposed to other HCBCs that are “afraid of confrontation” and have difficulty holding parents accountable. SUP-3 notices that the stronger clinicians are more focused on treatment but also do not have as many “things going on” as other clinicians. SUP-3 stated, “Other clinicians who, they just have too many things on and… the quality of their work goes down. Maybe they are going to school. Maybe they have this [other] job. Maybe they have some personal family issues going on.” SUP-3 stated that she can tell if HCBC is struggling based upon the quality of their paperwork. When she sees the paperwork deteriorating, she knows to step in. SUP-3 discussed the difference between supervising male and female HCBCs and reflected that the male HCBCs frequently need more reminders than the female HCBCs. She stated:

Sometimes I wonder if they, you know, think a female in a leadership role such as thing or a supervisor role…. I don’t want to say they look down on it but I just, I don’t quite figured that out yet. But I just feel like… if I was a man, it’d probably be different. The response would be different.

SUP-3 wondered if perhaps the male HCBCs “just become dependent on being reminded” much like she ends up reminding her husband to take out the trash or other things around the house.

SUP-3 is most rewarded by seeing the growth of staff or the growth of families. She appreciates “seeing” HCBCs use the interventions provided in supervision, apply them to treatment, and ultimately discharge clients successfully. Even if the HCBC needs to discharge the client to higher level of care, SUP-3 recognizes that the HCBC is helping the family find the most appropriate service for the client. SUP-3 defined counselor wellness as “being heard”, knowing that your supervisor is listening and willing to help
when needed, and “being respectful of people’s time and family.” SUP-3 worked for an agency in the past that did not respect their employees’ time and instead were focused on “how much money” HCBCs were going to bring in. SUP-3 reported that her current agency has a wellness committee, and administers wellness surveys and wellness initiatives. Supervisors organize potlucks on days that HCBCs have supervision and training to thank HCBCs for the work that they are doing and help them have a space to relax. The HCBCs have informed SUP-3 that they appreciate the potlucks because many of them do not get home until eight or nine o’clock at night. Some of the trainings are focused on “self-care and how to stay balanced and how not to be an enabler to your families…. That type of stuff just to keep people on track.” SUP-3 described how her supervisor listens to her concerns and assists SUP-3 with finding solutions to any problems that she might be experiencing. Outside of supervisions, SUP-3 stated that her supervisor stops by her office to ask how SUP-3 is doing and also, will ask about her children and family.

In SUP-3’s experience, HCBCs manage their wellness by setting boundaries and knowing when “to say no.” SUP-3 provided an example of a HCBC that approached SUP-3 and requested to be taken off of case. She told SUP-3 that after working with the family and trying to be patient, the mother continued to be very disrespectful to the HCBC. SUP-3 reported that HCBCs may say, “I don’t want this case anymore. I can’t do it anymore.” SUP-3 stated that this is one way that HCBCs try to “keep that balance” and try to promote their own mental health. SUP-3 encourages HCBCs to confront parents when they are being disrespectful to the HCBC and will support the HCBC by discussing the concerns with parents.
SUP-3 stated that she also notices that the HCBCs that stay well are also adept at managing their time. In particular SUP-3 stated, “When I see staff manage their time better, they are not as stressed out.” Some of the relatively simple things that she sees HCBCs doing are printing out paperwork before meetings, and sending out the invitations beforehand. For the HCBCs that have difficulty managing their time, SUP-3 reported that there are checklists available that the HCBC can use to improve organization. SUP-3 follows up with HCBCs during supervision to ask about weekend plans and what HCBCs are doing to take care of themselves outside of work. HCBCs report that they go to yoga, exercise, and talk to other coworkers. SUP-3 recommends that HCBCs be organized, set limits with the work, and seek out supervisors when they need assistance. SUP-3 becomes concerned when she sees HCBCs working weekends and often wonders when they have time off to themselves.

SUP-3 identified several ways that supervisors and the agency support HCBC wellness. Supervisors recognize HCBCs achievements either via email or at supervisions. Supervisors identify and brag about the work of the HCBCs (i.e., give “brags”) and also ask staff if they have any brags to add and HCBCs will recognize the successes of other staff or clients. The agency organizes a yearly wellness fair for HCBCs and other agency employees. During the wellness fair, employees can receive massages, have their blood pressure checked, and meet with health coaches. Full-time staff are able to meet with health coaches regularly to discuss nutrition, weight management, and exercise. The agency also provides employees with access to an employee assistance program (EAP). Frequently, supervisors will refer HCBCs to the EAP if the HCBC is having difficulties that are beyond the scope of supervision.
SUP-3 reported that HCBCs face multiple challenges in their role that can diminish their wellness. Some HCBCs working at SUP-3’s agency travel extensively and work in “dangerous” parts of the city. The HCBC may arrive to the client’s home and encounter additional people at the home, drug deals going on in the neighborhood or even at the home. Supervisors directly address these concerns in learning initiatives and advise HCBCs “if you suspect something. Don’t even go.” Supervisors report to their HCBCs that, “We’re not trying to jeopardize your life. You have to take care of yourself.” Despite receiving this advice, SUP-3 reflected that some HCBCs do not reach out to supervisors and do not “speak up” when they are encountering a safety concern or other treatment barrier. SUP-3 might not know about the difficulties that the HCBC is facing until she reads the progress note or until she notices that treatment is taking place in the school instead of in the home. According to SUP-3, HCBCs have encountered mice infestations, a lack of space in the home due to hoarding behavior, and bedbugs. SUP-3 reported that it is important for supervisors to be aware of the challenges that HCBCs are facing so that supervisors can assist HCBCs with providing the families with resources needed to address the concerns to keep staff safe physically and mentally.

SUP-3 did not identify anything about supervision that can pose a challenge to HCBC wellness but acknowledged that she could be doing more to support wellness in supervision. SUP-3 would like to spend more time in supervision checking in to see how HCBCs are doing to determine if they are feeling “overwhelmed” or “burned out”. SUP-3 supports HCBC professional development giving HCBCs time in supervision to reflect on career goals and then SUP-3 offers advice and assistance, even if that means exploring employment outside of BHRS. It is difficult for SUP-3 to find the time to focus on
wellness and professional development due to needing to review cases and problem solve any issues that the HCBC is confronting.

SUP-3 reported that the agency has been affected by high turnover. Despite the recent turnover, SUP-3 reported that a majority of the staff stay with the agency. Per SUP-3, turnover most often affects the supervisors and not the HCBCs out in the field. SUP-3 stated she makes efforts to “try not to really… worry staff about that stuff. We don’t want to stress them out.” SUP-3 did not identify any specific agency practices or policies that contribute to depleting HCBC wellness.

The interview with SUP-3 provided additional information about how HCBCs maintain wellness. Earlier concepts that arose in HCBC and supervisor interviews also appeared in SUP-3’s interview, making a difference, seeing progress, setting and maintaining boundaries with the work and families, and experiencing anxiety. It is interesting that SUP-1 identified needing to work with the “I know, I know, I know” HCBC, SUP-2 mentioned dealing with the “Yeah, Yeah, Yeah” HCBC, and SUP-3 reported that often she must confront the HCBC that does not speak up and ask for help. Each of them identified ways that HCBCs may pose a barrier to the supervision process. To be sure that the data is saturated, one more interview was conducted with a supervisor. Refer to Table 13 below for a list of the prominent codes uncovered during the analysis of SUP-3’s interview.
### Table 13

**Initial Coding of the Interview with SUP-3**

<table>
<thead>
<tr>
<th>Setting boundaries</th>
<th>Keeping up with paperwork</th>
<th>Talking with coworkers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making a difference</td>
<td>Being heard</td>
<td>Taking care of self</td>
</tr>
<tr>
<td>Juggling responsibilities</td>
<td>Respecting time and family</td>
<td>Seeking supervision</td>
</tr>
<tr>
<td>Overseeing treatment</td>
<td>Providing wellness</td>
<td>Keeping staff safe</td>
</tr>
<tr>
<td>Showing appreciation</td>
<td>initiatives</td>
<td>Traveling extensively</td>
</tr>
<tr>
<td>Appreciating flexibility</td>
<td>Organizing potlucks</td>
<td>Working in unsafe settings</td>
</tr>
<tr>
<td>Finding work-life balance</td>
<td>Listening</td>
<td>Asking about wellness</td>
</tr>
<tr>
<td>Dealing with different personalities</td>
<td>Managing time</td>
<td>Supporting professional goals</td>
</tr>
<tr>
<td>HCBCs holding parents accountable</td>
<td>Pursuing interests</td>
<td></td>
</tr>
</tbody>
</table>

### Participant 12.

The last interview was conducted with SUP-4, a 36 year old female, with two years of experience as a BHRS supervisor and 15 years of experience working in the mental health field. Like all of the other supervisors, SUP-4 also has experience working as a BHRS HCBC. SUP-4 supervises approximately 15 master’s-level clinicians and 12 bachelor’s-level TSS workers. SUP-4’s responsibilities include both administrative and clinical tasks such as, reviewing treatment plans, providing supervision, tracking dates and timelines, reviewing plans of care, sending treatment packets to the insurance company, and providing training. HCBCs are required to attend one hour of individual supervision with SUP-4 monthly.

SUP-4 values “the progress that consumers make” and “seeing staff grow.” The most difficult aspect of the work for SUP-4 is dealing with “the leadership” above her. SUP-4 stated, “Because it kind of trickles down.” SUP-4 explained that her supervisor does not have mental health experience. When directives come down from her supervisor, SUP-4 reflected it is difficult to “pass that information to staff when I know it is impossible when I actually did work in the field.” In addition, SUP-4 receives pressure from her supervisor to explain why HCBCs are not making their utilization, the expected
billable hours each week. Oftentimes, SUP-4 reported that families are on vacation or families cancel sessions. SUP-4 must manage the tension that exists between meeting her supervisor’s expectations and her own expectations to support the HCBCs that she supervises. SUP-4 informs the upper management when expectations are unreasonable and will not be able to be implemented. SUP-4 reported that her supervisor usually wants an explanation as to why something cannot be implemented or why billable hours are not being met.

SUP-4 asserted that it is very difficult if not impossible for HCBCs to manage the stress of the work. She stated, “I think that they struggle with figuring out… how to schedule themselves, how to spend time with their family, and how to keep work from personal stuff.” SUP-4 has noticed that HCBCs will work long hours, feel “burnt out” and then struggle to maintain their documentation that is due within 24 hours of the session. SUP-4 suggests to HCBCs that they complete their notes in sessions to minimize work at the end of the day. SUP-4 normalized the difficulty of the work, reporting, “I think it’s really hard to do that because I know when I was out in the field, I was doing it like crazy. Like notes, answering phone calls at 7 o’clock, 8 o’clock at night.” SUP-4 recognized that frequently boundaries become “skewed” because HCBCs are working in the client’s home and the danger is that the HCBC becomes more of friends with family instead of acting in the role of counselor. SUP-4 suggested that HCBCs set boundaries and expectations with families at the start of treatment.

SUP-4 reported that punitive measures are used by the agency to motivate HCBCs but that these measures increase HCBC anxiety and stress. For example, the agency tracks whether or not progress notes are completed and signatures are submitted. A total
count of missing documentation serves as a visual reminder to the HCBC daily when they log into the program to complete their case notes. SUP-4 reported that HCBCs perceive this reminder as “a visual reminder of how bad things are.” SUP-4 stated that as a supervisor, she is also “held accountable” for missing documentation. If the HCBC has more than seven items missing, they are pulled from the field until the paperwork is completed. For this work, the HCBCs only earn minimum wage and therefore miss out on a significant amount of income that would have been earned if they were able to meet with clients. The agency also communicates expectations to HCBCs in emails and will threaten disciplinary action if the expectations are not met.

In addition to paperwork, HCBC can also be challenged by the work itself and have difficulty working with parents and caregivers. SUP-4 reported that there are some caregivers who do not follow through with treatment interventions. Other caregivers may be following through with interventions, the client is progressing in treatment, and yet, the family wants additional treatment hours. The HCBC can find themselves in a difficult situation needing to communicate to the caregivers that additional treatment hours will not be approved by the insurance company because the client is making progress.

According to SUP-4, HCBCs pressure themselves to take on as many cases as possible to earn a reasonable income and this can cause HCBCs to experience additional stress. SUP-4 indicated that HCBCs may take on “more cases than they can handle because they are looking to make money.” The HCBCs then have difficulty “meeting… the consumer’s needs when they take on more than they can chew.” She explained that HCBCs will try to have a “buffer case or two” just in case they have cancellations but it
can be difficult to meet the clinical needs of the client and family and keep up with paperwork.

SUP-4 reported that the part-time HCBCs appear better able to manage the work and maintain their wellness. Per SUP-4, “they have families of their own, have kids, have a person at home supporting them and they are just doing this because this is what they enjoy to do.” On the contrary, the full-time staff, SUP-4 described as “running ragged” trying to meet the requirement to obtain 32 billable hours a week. SUP-4 went on to say, “They are killing themselves here… to get their billable hours. So they are working from the time they get up to pretty much like 8 o’clock at night to get their billables in….” Further, SUP-4 stated that if the full-time and part-time regular staff do not complete the necessary hours expected, they will lose their employee benefits and their employment status would be reduced. SUP-4 also hypothesized for HCBCs working strictly with mental health diagnoses like depression, anxiety, and ADHD, that it might be easier to manage their responsibilities at work and still maintain wellness, than HCBCs working with children with autism. According to SUP-4, there is more paperwork involved and more oversight for HCBCs working with clients with autism, including more assessments and data collection.

SUP-4 encourages HCBCs to approach SUP-4 if they have any questions or need support. SUP-4 maintains an open door policy and rarely closes her door. If SUP-4 is busy and the door is shut, she asks the HCBCs to knock. SUP-4 is also available via email during the day or text. SUP-4 requests that if there is an emergency HCBCs call or text her. SUP-4 has noticed that some of HCBCs are reluctant to go to SUP-4 for support because their previous supervisor had “told them if the door was shut don’t walk in and
don’t knock.” SUP-4 suggested that because past supervisors were not available to the HCBCs, the HCBCs began to form close friendships to support one another. SUP-4 indicated that HCBCs seek peer support when “they are feeling frustrated or… thinking that’s impossible.” In addition to having close relationship with colleagues, SUP-4 stated that some HCBCs manage the stress of the work by receiving additional LPC supervision and spending time with friends and family. Though the agency offers a company picnic, SUP-4 reported that not many HCBCs attend, “A lot of them just see this. Like, this is their job. This is what they need to do and that’s kind of it.”

SUP-4 discussed several supervision practices that she perceived as beneficial to HCBC wellness. In supervision, she provides HCBCs with an opportunity to “vent for like the first couple of minutes of supervision about any issues that are going on… and what they need help with.” In addition, SUP-4 provides resources, feedback, and assessments. SUP-4 acknowledged that much of supervision focuses on recent treatment plan audits, paperwork deadlines, ways to improve, and providing feedback. SUP-4 stated that treatment plans are reviewed by the upper management to determine if treatment plans include evidence based interventions and assessments and whether the client is making progress. SUP-4 reflected that HCBCs “stress out and overthink things” when they receive a lower score and worry about whether they are effective counselors.

SUP-4 reflected that because she has been “in their [the HCBCs’] shoes” she has become more aware of what is possible and impossible to do in their role. Because of this, she has modified her expectations of HCBCs. She stated, “I mean I don’t demand a lot of things from them. Like I have more leeway.” SUP-4 acknowledged that she has learned which staff she can afford to provide more leeway. SUP-4 reported that she has
some staff who cannot be given leeway because they are already behind on the work. SUP-4 explained that she gives “leeway” by giving them extra time to complete their documentation and meeting their expected billable hours.

At this point in her supervisory career, SUP-4 reported she is now more focused on providing a learning experience in supervision instead of focusing on the “negatives” and the mistakes. SUP-4 encourages HCBCs to read and be familiar with the psychological evaluations. SUP-4 has questions prepared to ask the HCBCs about each case so she can gain an understanding of what they know and how they are approaching treatment. She stated, “It kind of lets me see where they are too and what they know… so then I can kind of guide them as well. ‘This is what, you know, you need to do and how we can move forward.’” SUP-4 clarified that she does not tell the HCBCs what they need to do per se, but asks questions such as, “What do you think you could do?” and “How do you think it could work?” SUP-4 also gives HCBCs homework and follows up each supervision. SUP-4 will recommend that HCBCs seek consultation from the psychologist or the upper management that specializes in autism treatment but HCBCs are reluctant to seek additional support. SUP-4 stated, the HCBCs are “more fearful of… what they may ask and they may not know…. Their chart reviews are not nice…. They typically make staff either angry or cry.”

SUP-4 was unable to identify any experiences at her current agency that she has noticed have shaped HCBC wellness. When working for a different agency, SUP-04 shared that the agency practices and policies emphasized wellness and self-care. She reflected, “The focus was more on self-care and things like that. Was a bigger push there than it is here… And… there was always that focus on what you can do each month….
Here… that doesn’t exist.” SUP-4 discussed the importance of attending trainings and pursuing professional development. Currently, SUP-4 seeks out training whenever possible, frequently attending provider trainings offered by the insurance company. SUP-4 reported that she has learned a lot from the HCBCs, as well, “everybody does things different and everybody has their own little toolbox so it's always interesting to kind of learn from the staff that you are working with.” SUP-4 noted that as a supervisor she has learned to delegate and this has become one of her strengths. Delegating for SUP-4 means to “take on what… you can handle and then kind of passing off the rest.” This was difficult for SUP-4 to do at first. SUP-4 has also discovered how to be supportive and understanding of HCBCs while also maintaining boundaries that communicate that SUP-4 is not there to be their friend but their supervisor. SUP-4 does not friend employees on Facebook or snapchat, and will not go to lunch with HCBCs. In addition, SUP-4 does not check her email after 5pm. SUP-4 reinforces these boundaries when talking to other staff, requesting that she only be contacted after hours in an emergency via text or with a phone call. Since setting these boundaries, SUP-4 indicated that the work has been less stressful.

SUP-4 advised that counselors “leave work at work” but recognized that this is “the most impossible thing to do.” She also recommended that HCBCs set up consistent hours and establish boundaries with families to not answer calls in the evenings or work on weekends. SUP-4 stated that some HCBCs might take off Fridays so that they can work Saturdays but that she wants to be sure that they are taking time for themselves. SUP-4 tries to avoid asking HCBCs to work weekends and therefore does not accept cases that need weekend sessions. SUP-4 encouraged supervisors to set boundaries with
the work and refrain from working weekends, including checking emails evenings and weekends. SUP-4 suggested that supervisors ask for help if they feel overwhelmed. SUP-4 reported that she will reach out to other supervisors at her agency if she needs assistance or has a problem. SUP-4 did not hesitate in recommending that agencies start paying HCBCs more. SUP-4 noted that clinicians are “not making any money here and they are killing themselves.” She predicted that if the agency started compensating HCBCs more, there would be less turnover.

This was the final interview conducted. Similar concepts were repeated some of which included: seeing progress, taking care of themselves, setting boundaries, not compensating HCBCs enough, moving forward, being available, venting, and providing support and resources. The concepts that arose in SUP-4’s interview added to the existing data by confirming concepts already uncovered. At this point, the data was saturated and additional sampling was not necessary. See Table 14 for a list of the prominent initial codes identified when analyzing SUP-4’s interview.

Table 14

<table>
<thead>
<tr>
<th>Initial Coding of the Interview with SUP-4</th>
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<tbody>
<tr>
<td>Juggling multiple responsibilities</td>
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<tr>
<td>Seeing staff grow</td>
</tr>
<tr>
<td>Dealing with upper management</td>
</tr>
<tr>
<td>Expecting the impossible</td>
</tr>
<tr>
<td>Monitoring productivity</td>
</tr>
<tr>
<td>Advocating for staff</td>
</tr>
<tr>
<td>Managing schedule</td>
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<tr>
<td>Spending time with family</td>
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</table>
Theory of HCBC Wellness

After the initial process of line by line coding, this researcher engaged in focused coding and elevated the most salient codes to categories. The properties of each category were identified by defining the concepts subsumed within and comparing participant experiences across interviews. Helping others, confronting the realities of the work, taking care of yourself, finding support, striving for work-life balance, and moving forward were concepts that appeared repeatedly in the data and earned their significance and place in the theory of HCBC wellness that unfolded during data analysis. In Table 15, I list each category and indicate whether the HCBCs and supervisors endorsed the concept. Each category is described in detail in the remainder of Chapter IV. First, I provide a broad overview of the theory derived from the data.

Table 15

Cross Case Analysis

<table>
<thead>
<tr>
<th>Categories</th>
<th>Home and Community Based Counselors</th>
<th>Supervisors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>H1</td>
<td>H2</td>
</tr>
<tr>
<td>Helping others</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Confronting the realities of the work</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Taking care of yourself</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Finding support</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Striving for work-life balance</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Moving forward</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

HCBCs and HCBC supervisors enter the field to help others. Seeing progress and growth in clients and HCBCs is proof for the HCBCs and supervisors that they are making a difference in the lives of children, families, and HCBCs. In their role as a
HCBC, they confront and grapple with many challenges. The HCBCs reported facing isolation, high expectations for productivity, extensive travel, considerable paperwork, inadequate pay, and lack of supervision, while treating multiply challenged children and families. Some of the HCBCs enjoyed greater flexibility and independence in their unique role in the home and community.

The HCBCs and supervisors defined wellness to be “taking care of yourself” and further identified that HCBCs are responsible for seeing to their emotional, physical, social, financial, and occupational wellness. In an effort to find support, HCBCs relied on friends, family, colleagues, and coworkers. Due to limitations inherent in the BHRS treatment model, namely, namely, inadequate supervision, and the limited resources of the agencies, many of the HCBCs sought out their own training and developed their own supervision networks.

HCBCs struggled to find work-life balance. While HCBCs identified that it is important to find time to take care of themselves, they also acknowledged that it was difficult, if not impossible, to do. HCBCs attempted to achieve work-life balance by setting boundaries with clients and the work, pursuing their interests, adopting a positive mindset, and managing the work. HCBCs reported that these efforts helped them move forward as counselors so that they can effectively meet clients’ needs and find work-life balance.

HCBCs and supervisors described the negative impact that a negative agency culture can have on HCBC wellness. When agencies implement punitive work practices and unrealistic expectations, HCBC wellness and client outcomes can suffer. When the
agency is supportive of HCBC wellness and adopts a positive workplace culture, HCBCs are better poised to take care of themselves and work effectively with clients.

Helping Others

Over and over again, the HCBCs and the supervisors interviewed acknowledged that they value helping children and families, “making an impact”, and facilitating HCBC growth. The concept, helping others, was elevated to a category and defined it was defined to be the experiences and processes related to helping children and helping HCBCs. As seen in Table 16, both the HCBCs and supervisors discussed the importance of making a difference in the lives of children and families and seeing the progress made by clients and HCBCs, all experiences that fall under the umbrella of helping others. Knowing they were helping others motivated HCBCs to enter the field and also served to continue to motivate them to persist with the work despite the difficulties associated with it.

Table 16

<table>
<thead>
<tr>
<th>Categories</th>
<th>Home and Community Based Counselors</th>
<th>Supervisors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>H1</td>
<td>H2</td>
</tr>
<tr>
<td>Making a difference</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Seeing Progress</td>
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<td>x</td>
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Making a difference. This investigator first identified the process, making a difference, while interviewing HCBC-1. HCBC-1 stated:

I think the ability to go in and work with families and kids and know that what I am doing is at least making either somewhat of a difference or a... maybe a little bit more, you know, larger difference.
After qualifying that the clients and families "have to do the work too", HCBC-1 went on to explain that making a difference is, "leaving them with more skills, more understanding of the issues.... The ability to process that stuff. So feeling for the most part, I am leaving them better off than when they came in."

Using HCBC-1’s words, the process that she described was named, ‘making a difference’, and this investigator began to sift through the other interviews to code passages that alluded to the same process. Making a difference also was discussed by HCBC-4. HCBC-4 spent her career working with children and adults with disabilities initially working in a residential treatment facility for adults with disabilities and later as a special education teacher before pursuing her behavior specialist license to become a HCBC. Without hesitation, HCBC-4 identified that as a HCBC she values making a difference, stating, “I think [what] I value most about the job would be that it is something that is helping kids and their families.”

In a similar manner, HCBC-6 spoke to making a difference recounting the following:

I value the progress that the kids make…. It's very... gratifying when you work a client and you can see the progress that they've made and… you know that you've made a difference. That would be my number one. It doesn't happen on every case but when it does… you know that you've done your job to the best of your ability and you know that you've made a difference.

HCBC-7 did not overtly mention that making a difference is a valuable aspect of the work but she did indicate that she values working with families and teaching parents and caregivers how to better manage “times when their child is really just out of sorts emotionally.” It is evident from this statement that HCBC-7 values helping to improve and strengthen family relationships and assisting clients with making progress in
treatment, actions that equate to making a difference. HCBC-8, the last HCBC interviewed, reported that he values, “helping the kids get along better”. HCBC-8 continued:

So many families are so dysfunctional. They don’t really understand… education, the educational system, how to get along in that environment with teachers because many of them have… had bad experiences themselves so they really don’t…. Plus, they’ve got their own health issues, mental health issues. I mean it’s all pretty hard.

HCBCs valued that they are able to impact the lives of children and families in a meaningful way. Several of the supervisors interviewed also noted the role that making a difference played in their past work as a HCBC and how making a difference continues to be relevant as a supervisor. SUP-1 has worked both, as a supervisor and as a program manager. She shared that she had to adjust her perception of making a difference, something she referred to as “making an impact”. She acknowledged that while she is not directly working children and families, she can make a difference in the lives of HCBCs and continues to indirectly affect growth and change in children and families. By seeing and hearing about the growth of clients and HCBCs, she stated that she knows she is “making an impact”. She recounted:

So I have had to try to find a different favorite part because I am coming more out of that clinical role. So my favorite part now has been watching the growth of the employees… and hearing the suggestions that I make to them, them implementing them, and them working or the problem solving involved in that…. I am really making an impact, I am making a greater impact because of the more people I am supervising.

SUP-2 also indicated that she is motivated by the need to make a difference and recognized that this same need inspires the HCBCs that she supervises. SUP-2 shared that as she has been promoted from bachelor’s-level counselor, to master’s-level
counselor, to supervisor, she has been able to help exponentially more children. SUP-2 stated the following:

I mean I like that I get to help kids. I mean it's definitely the thing that I value the most. I think in my position I am lucky that, you know, especially in having done fieldwork, where it was like as a TSS I get to help one or two kids at a time, as a BSC I was able to help ten. But in then on the administrative side of things we have 350 BHRS clients right now. So I feel like I can help all of those kids.

During supervision, knowing that HCBCs are motivated to make a difference, SUP-2 reminds HCBCs why they are in the field:

Because you could really make a difference in a child's life so I try to, try to help remind them of those things too. I mean, why at their core they got into this service in the beginning or in this field, was to help kids.

Like SUP-1 and SUP-2, SUP-3 also reported that she entered the field to make a difference. She stated, “So that's probably the biggest because again I came into this field to try to help families make change.”

**Seeing Progress.** For HCBCs, another aspect of helping others was the experience of seeing progress. HCBC-2 was the first HCBC to identify the importance of seeing and bearing witness to the progress that children and families make during the course of counseling. HCBC-2 indicated that he finds it "heartening to see [emphasis added] where... [the client] started and where... [the client] is at." HCBC-2 described noticing and observing changes:

I think it's when you have success. I think that's the.. the thing that I value most about it. When you see [emphasis added] those, you see [emphasis added] those changes occur, the little things that occur over time and... build up to more... profound changes for some of these children.

Sifting through the interviews, the investigator found that repeatedly HCBCs mentioned the importance of being able to see client progress.
HCBC-3 indicated that seeing progress was necessary for the work to be fulfilling, stating he finds the work, “fulfilling if things are going well. If you are working with a kid and you are able to establish that, like working relationship and they’re receptive to the things you say. It can be fulfilling to see [emphasis added] them improve.” This investigator found that continued data analysis supported that HCBCs endorse the importance of seeing progress. HCBC-6 stated, “I value the progress that kids make…. It’s very… gratifying when you work with a client and you can see [emphasis added] the progress that they’ve made and… you know that you've made a difference.” HCBC-7’s statements echoed the sentiments of HCBC-2, HCBC-3, and HCBC-6. HCBC-7 stated:

I would say that I value seeing the progress that a child makes within our services…. That may look like, you know, a child who is really physically aggressive and struggling to use emotion regulation skills. They are able to use those skills to prevent the physical aggression.

Later in the interview, HCBC-7 revisited the importance of seeing progress as she discussed how the nature of the work as a HCBC in the field of BHRS, may serve to improve wellness. HCBC-7 explained:

Once you have discharged a family sometimes you may see them out in the community, and seeing [emphasis added] them being successful in the community that’s a good feeling. I recently saw a client that I had three years ago. I recognized them in school but they did not recognize me and I saw them being successful in that setting.

When asked what keeps her working as a HCBC in BHRS, again, HCBC-7 reiterated the importance of seeing progress and stated, “It’s honestly been being able to see [emphasis added] the progress with the kids.”

Supervisors also recognized that seeing progress is a valuable aspect of their work; however, acknowledged that this process, as a supervisor, is different. Many of the
supervisors interviewed maintained a small caseload and therefore at times continued to work as HCBCs while supervising. SUP-1 described seeing progress as a very tangible process that includes witnessing, sometimes first hand as a HCBC, and other times as a supervisor, second hand through HCBC accounts, the growth of clients. SUP-1 appreciated and valued observing and hearing about both client and HCBC growth and change. This is articulated by SUP-1 in the following account:

I really like being able to see… the growth of everybody around me whether it be staff or kids…. My favorite part is when I can go out with the younger kids with autism and… they are severely autistic and they can't speak or anything and you start to slowly see them…. They pay attention when you come, they give you a smile when you come. Before they had no awareness of anybody and then they start… making sounds, making words, and spontaneously saying things. That's my favorite part…. So I have had to try to find a different favorite part because I am coming more out of that clinical role. So my favorite part now has been watching the growth of the employees… and hearing the suggestions that I make to them, them implementing them, and them working, or the problem solving involved in that.

SUP-1 went on to describe how seeing progress is different now as opposed to when she was a HCBC. She explained, “I can't see the direct impact usually. I can hear about it but I can't see it. So it's been different.”

Similarly, SUP-3 described the value of seeing growth in staff:

when I see [emphasis added] growth in staff… and then I can slowly step back, kind of get out of the way…. When I see a staff who maybe needed an employee performance improvement plan and I see the growth in that and I see the change…. So seeing staff being able to use your interventions and use the strategies that you discussed in supervision and apply the… theory or the model.

SUP-3 indicated that she values seeing client’s progress as well:

When I see [emphasis added] the staff successfully discharge families and that's whether they are increasing in services or decreasing…. I feel like the staff recognized the service is not the most appropriate any more as far as BHRS and they recognize that this child needs something else…. But also on the other end, of them discharging where they may need a lower level of service or no service at all and they've, you know, pretty much met their goals or um… you know, just
need to move on to another, you know, level or just get involved in after school activity.

SUP-4 made similar statements during her interview indicating that she appreciated seeing progress and witnessing growth of both the clients and the HCBCs:

To see I think the progress that the consumer's make. So it's always good to hear when staff come in and say, you know, they try these different things and just like the little things that the consumer is making progress in is beneficial and I, like, that's the best part of it or seeing the staff grow.

SUP-4 acknowledged that, similarly to SUP-1, she relied on HCBCs’ reports to know that the clients and the HCBCs, themselves, are making progress.

**Confronting the Realities of the Work**

HCBCs and supervisors discussed the most challenging aspects of the work, how they contend with these difficulties and move forward as a HCBC. Specifically, the HCBCs and supervisors discussed how the nature of the work itself can wear on HCBC wellness and how facing and learning from these experiences can improve one’s counseling skills and increase one’s appreciation and gratitude for one’s own circumstances. As HCBC-3 poignantly explained, the work, it either “breaks you or it… wears you down so you are a lot more polished.” The category, confronting the realities of the work, was created. Confronting the realities of the work encompasses all of the experiences encountered in the work that can influence HCBC wellness. HCBCs wrestle with these challenges sometimes on a daily basis and the challenges that they face are a byproduct of the service itself. As can be seen in Table 17, HCBCs and supervisors discussed how dealing with isolation, trying to meet productivity, keeping up with paperwork, receiving inadequate compensation, and working with multiply challenged
children and families without adequate training and supervision can affect HCBC wellness. Each of these concepts will be described.

Table 17

Cross Case Analysis of Confronting Realities of the Work

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<th>Categories</th>
<th>Home and Community Based Counselors</th>
<th>Supervisors</th>
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<td>H1 H2 H3 H4 H5 H6 H7 H8 S1 S2 S3 S4</td>
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<tr>
<td>Isolation</td>
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<tr>
<td>High Expectations for Productivity</td>
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<tr>
<td>Keeping up with Paperwork</td>
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<td>Difficulty earning a living</td>
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<td>Multiply challenged children and families</td>
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<td>x x x x x x</td>
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<tr>
<td>Infrequent supervision</td>
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<tr>
<td>Insufficient supervision</td>
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<tr>
<td>Perceiving supervisors as busy</td>
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Isolation. Four out of eight of the HCBCs experienced the work as isolating and described being isolated from other HCBCs, the supervisors, and/or the agency. The HCBCs described how they experienced varying degrees of isolation and how that isolation impacted their wellness. All of the HCBCs interviewed work independently in the home and community settings and typically receive monthly group or individual supervision.

Several of the HCBCs reported that working independently in the community can lead to isolation because the counselors lack regular contact with supervisors, coworkers, or other HCBCs. HCBC-1 admitted that she has a close relationship with her supervisor...
and the administrative staff at the agency but does not know the other HCBCs very well. HCBC-1 indicated that “the job can be very isolating.” She explained, “When you are with clients that is obviously different than being with coworkers or friends.” She continued to state:

When we get together for um, our monthly training and case review um like I know people. There's very few people that I know consistently, to talk and touch base with… but I just forget people’s names because I hardly see them.

HCBC-4 echoed this sentiment stating, “Not having ready access to... colleagues, to supervision…. It's very, you are sort of on your own.” Later in the interview, HCBC-4 cautioned other HCBCs that “it can be such an isolating job. In that you're not working with colleagues really at all.” Like HCBC-1, HCBC-2 did not have close relationships with other HCBCs. He reported, “I walk into the office some days and I couldn’t tell you who most of the people are.” HCBC-2 acknowledged the value of the independence associated with the work; however, he cautioned that “at the same time you are also out there by yourself.”

Some of the HCBCs indicated that they felt “disconnected” from the agency. HCBC-2 reported that this disconnection negatively impacts his wellness. He stated, “You’re just a number and people don’t know… don’t even know your name if you will and if you left tomorrow, it wouldn’t make a difference.” HCBC-2 was unable to identify any agency policies or practices that support HCBCs. In HCBC-2’s experience, the agency has been more concerned with whether his “billing is in” and less concerned with how he is doing or how he is managing the stress of the work. HCBC-1 reported that she does not spend much time in the office and that she feels “a disconnect from the agency”. HCBC-3 admitted that he did not interact much with upper management in his
agency and described the agency as “invisible in general”. HCBC-2 asserted that the isolation is the most difficult aspect of the work. He stated:

You don't have the, any support, or anyone for support in that moment when things kind of go awry and you leave the house and you think, ‘What the hell. What the hell just happened.’ You know, you don't have that support in the moment. I think that's probably the biggest issue that sticks out to me.

Similarly, HCBC-3 stated, “Going into a home by yourself where you don't know anyone is a bit daunting but. I've done it enough that it's not so scary anymore. But it's still… something to work through.”

**High expectations for productivity.** HCBCs and supervisors asserted that HCBCs are expected and pressured to meet their productivity each week. The required expectation for weekly productivity for full time HCBCs varied by agency and ranged from 25 to 32 completed billable hours. At one agency, part-time HCBCs were able to receive medical benefits and some time off if they maintained 25 hours each week. At another agency full time employees were required to bill 32 hours per week. Regardless of whether the requirement was 25 or 32 hours, HCBCs reported that the expectation was difficult to meet. Billable hours include time spent conducting individual and family counseling sessions, completing data analysis, consulting with family, school staff, and other providers, and time spent documenting treatment, such as writing treatment plans and summaries. Several HCBCs reported that HCBCs have difficulty meeting productivity expectations, the expectations should be reduced, and that the pressure to do so can impact the HCBC’s wellness negatively. Several supervisors interviewed agreed that trying to meet productivity requirements can negatively impact HCBC wellness.

Many HCBCs interviewed reported working long days either to meet productivity or to earn a reasonable paycheck. Despite working only part-time, HCBC-1 reported that
she often works daily from 9am in the morning to 8:30pm at night in order to complete 17
to 18 hours weekly. HCBC-3 works part-time typically billing 25 hours per week so that
he can receive benefits from the agency. To be able to attain these hours, HCBC-3 stated
that he also works long days and there are some nights when he is up until midnight
completing paperwork. Despite only working part-time and acknowledging that the
agencies requires part-time employees bill 25 hours per week, HCBC-5 admitted that she
pushes herself to try to bill as many hours as possible in order to earn a “decent
paycheck.” Typically, HCBC-5 is billing 28-30 hours per week. As a result, HCBC-5 is
working “long hours.” HCBC-5 reported:

Well by the time I get home at the end of the night. I mean there's not really
anything else to do besides catch up on notes or print and laminate and cut out
things for the next day for clients that you need…. It can be really tough to do
work at home after a long day and on the weekends when all you want to do is
take time for yourself but there is always something that needs to be done.

She reported that trying to see as many clients as possible leaves her for little time to take
of herself. HCBC-5 shared her experience:

Usually by the time I get home, um I don't even want to do a home workout. I
usually just make my dinner and usually eat it at the counter because I am so
hungry by then. I don't sit down. I have finish my progress notes then I shower
and go to bed. To do it all again the next day.

In order to meet the agency’s expectation of 32 hours per week, HCBC-7 indicated that it
is necessary for her to work four 12 hour days and a shorter Friday.

Several HCBCs experienced additional stress trying to keep up with the agencies’
expectations for full-time employment. HCBC-1 and HCBC-5 both reported working
full-time in the past but both were unable to maintain enough billable hours each week to
continue full-time. HCBC-1 reported that she changed her working status from full-time
to part-time because she could not meet the expectation. She stated:
They really wanted us to have 25 hours per week of direct service, which is, that's a lot and um, even if it's doable which it's I think kind of borderline doable as far as logistics and scheduling. Um it's very draining…. I just think it's, the expectation is too high…. I made the decision to say look let's just, I'll go back to part-time, you know, I may not carry, I might carry 20 hours, I might carry 21 whatever I feel like I am capable of though I might make less money and I feel like my stress has gone down.

HCBC-1 found that when working full-time, she did not have time to think about her own self-care or wellness. She stated, “Especially when my caseloads were like the highest, I felt like there wasn't a lot of time that I could spend thinking about how can I manage my stress, how can I take care of all of these things.”

HCBC-5 reported that she had also worked as a full-time HCBC but was unable to meet the requirement consistently. She explained that there were times when she did not have the caseload needed to bill enough hours. HCBC-5 reported that other times, families canceled sessions or went on vacation, preventing her from meeting her expectation. This was a stressful time for HCBC-5 because she reported that supervisors were contacting HCBC-5 weekly to question her hours and ask why she was not meeting her expected billable hours. HCBC-3 stated that he perceives that it is too difficult to maintain enough billable hours to work full-time because the hours in general are unreliable and are constantly changing. According to HCBC-3, if a client is discharged, services are reduced, services lapse, or clients cancel appointments, HCBCs lose hours and have even more difficulty meeting productivity. HCBC-7 reported that she is able to work full-time and meet the productivity expectations but doing so as often as possible can be a detriment to her wellness.

HCBC-2, HCBC-4, HCBC-5, SUP-1, and SUP-4 indicated that supervisors are often responsible for monitoring whether the HCBC has completed their expected
billable hours. HCBC-2 reported that agencies in his experience are typically only concerned with whether the HCBC is getting his or her billing in. HCBC-4 shared that at a past agency, she needed to complete extra paperwork to show that she was meeting her productivity. She explained that the agency as a whole was “very corporate, very for profit, money driven. We need to make sure we are getting every single cent out of the insurance companies.” SUP-1 had a similar experience working as a supervisor at another agency and indicated that productivity often became the focus in supervision. SUP-4 explained that she is questioned by her own supervisor and asked to explain when HCBCs are not meeting productivity. According to SUP-4, HCBCs become “frustrated because they're like, ‘What more can I tell you. Like, they are not here so I can't get the hours in’.” HCBC-1, HCBC-4, and HCBC-5 experienced this oversight and monitoring of billable hours as stressful and reported that it added additional pressure. SUP-1 and SUP-4 both reported that they believe that trying to meet productivity has negative repercussions for the HCBC’s wellness. SUP-4 reported that the HCBCs are “running ragged” and are “killing themselves” to make productivity.

**Keeping up with paperwork.** Several HCBCs stated that they had difficulty keeping up with the paperwork. HCBC-1, HCBC-3, and HCBC-4 indicated that the paperwork is the most difficult aspect the work. Due to the paperwork demands, HCBC-3 stated he is often “not quite so thrilled” with working. HCBC-6 reported, “We do have a lot of paperwork. It um... does take a lot of time and um.. Sometimes… I think… to be more efficient some of it could be… more computerized at this day and age.” HCBC-6 has to make special trips to her agency once a week to submit her paperwork.
HCBC-1, HCBC-3, and HCBC-4 reported that they complete their notes electronically but still had difficulty keeping up with paperwork demands. HCBC-1 indicated that, to keep up with paperwork demands, she often works weekends and evenings. HCBC-3 reported that it takes him a long time to complete his paperwork. HCBC-3 stated:

I am terrible at paperwork. I don't have the attention span for it. It's very boring and tedious but I have to do like an hour of paperwork for all of my cases each day. An hour what it should be, takes me about twice that because sometimes I will zone out while writing and just stare at the screen for a little bit until I snap back and remember that I am supposed to be writing or figuring out what I have to write or making it sound clinical.

HCBC-3 continued to explain that he writes detailed notes though he is unsure if that is necessary. Further, HCBC-3 asserted that completing the paperwork within the expected 24 hour deadline is difficult and can challenge his ability to stay well. HCBC-4 reported that while working at another agency in the past, HCBCs were required in to complete excessive paperwork. Often the agency would add additional paperwork with little notice or explanation. She explained that there was “a lot of extra paperwork to do” and “they kept adding more and more.” HCBC-7 stated that it is important for HCBCs to stay ahead paperwork reporting, “Once you let it pile up, it's hard to dig yourself out of that hole.”

Several supervisors acknowledged the difficulty that some HCBCs have completing paperwork in a timely manner. SUP-2 and SUP-3 have noticed that it is very difficult for HCBCs to manage all of the aspects of their work well. According to SUP-2:

So you could be a really good therapist but be terrible at communicating with families and which is too bad but it happens. Or we've had people who were really good therapists but could not get their paperwork under control. Their paperwork was just horrendous so it's too bad and then that piece of things makes people really stressed out and not like the job too.
SUP-3 recounted that some HCBCs have difficulty submitting their paperwork on time. SUP-3 stated, “I have some staff that are very strong clinicians. Paperwork is in. They are like very into the interventions. Like, I can clearly; I clearly know what direction they are going in with their families.” On the other hand, SUP-3 also works with clinicians who are “strong clinicians and then they don't do well with paperwork and then I have some that do well with paperwork but then they are not strong clinicians.” If SUP-3 notices paperwork deteriorating in quality, she stated that this is often an indication that the HCBC is struggling with the work and taking care of him or herself. SUP-4 reported that HCBCs find the paperwork “challenging and stressful” because HCBCs are required to complete paperwork within 24 hours.

**Difficulty earning a living.** Several HCBCs and supervisors acknowledged the difficulty HCBCs have making enough of an income to support themselves financially. HCBC-8 was the first to overtly mention financial security as an important aspect of counselor wellness. The processes associated with HCBC’s reports of wanting to be adequately compensated with pay, vacation time, and insurance benefits were coded as difficulty earning a living. HCBC-8 was the first to overtly mention that having financial security is important to HCBC wellness. HCBC-8 identified that colleagues, hoping to have greater financial stability, are often motivated to work more hours to “make more money” and “get insurance.” HCBC-5 admitted that she feels pressure to work as much as possible to make enough money to support herself. She stated, “But that's what you need to have a decent paycheck. Like you need to have all those hours.”

HCBC-3, HCBC-4, HCBC-5, HCBC-8, and SUP-4 reported that HCBCs are not making enough money to support themselves. HCBC-8 referred to himself as a “highly
paid volunteer” and stated, “I’ve kind of resigned myself to the fact that… I’m only going
to get paid so much money…. There’s a lot of stuff you have to do for free.” When
HCBC-5 was asked to describe her work as a HCBC, she quickly responded “overworked
and underpaid.” HCBC-5 works part time as a HCBC but maintains close to a full-time
caseload billing between 28 to 30 hours per week with clients. She explained, “If you
don’t see a client, you don’t get paid…. But now if someone cancels and you can't fit it
in then you just miss out on those hour and half or two hours whatever.” Outside of the
28 to 30 hours spent working with clients, HCBC-5 reported that HCBCs are only paid a
minimal amount for travel and documentation. HCBC-5 reported she often does not
request to be paid for administrative time for completing notes because they are supposed
to be completed during the session. HCBC-5 stated:

But if you bill too much documentation per week then you get an email saying,
‘You billed too much for that. You should be finishing these in session.’ It's hard
to finish them in session... with certain cases, so then you do it at home. But then
you get… if you bill too much admin time or too much office time then you get
notified so then a lot of work that you do goes unbilled. Sometimes it's just easier
to not put it in the system then to get like scolded and said you put too much time
into it.

HCBC-4, worked in a different agency than HCBC-5, but similarly found that there are
activities for which she is not reimbursed including preparing materials for counseling
sessions, “researching new programs” and “new methods”. The danger, HCBC-4 has
found, is that “You bill two hours with a child and then you can take eight hours of
unbilled time, uncompensated time of thinking about it, strategizing about it, whatever
else.”

HCBC-5 expressed frustration that her paychecks do not reflect how hard she is
working and admitted thinking, “Well, why am I even in this type of job when I work this
much and it doesn’t show.” HCBC-3’s experiences were similar to those of HCBC-5 and HCBC-8. HCBC-3 stated that the agency could increase HCBC pay given that “mental health work is… underpaid for what we do.”

In addition to pay, many HCBCs expressed frustration with the lack of benefits such as vacation and sick time. Despite working close to a full-time schedule, HCBC-5 reported that she only earns three hours of paid time off a month. This equates to only four and a half days off a year. HCBC-3, a HCBC working for the same agency as HCBC-5, reported that he has only taken one day of vacation over the past three years.

HCBC-3 talked about witnessing colleagues going on vacation:

The staff that did have full time status and had accrued a decent amount of vacation time, I have seen them go on vacation for a week and then here I am stuck with like 20 hours and working on finally getting to take a vacation.

In HCBC-8’s experience, he noted that either HCBCs worked full-time, working as many billable hours as possible to have an adequate pay check; HCBCs worked BHRS as a second job to supplement their income; or HCBCs worked part-time to complement a partner’s income. SUP-4 also noted the same phenomenon. SUP-4 acknowledged:

So I feel like the staff that we have that are part-time are much better off than our full-time staff. The part-time staff typically have families of their own, have kids, have a person at home supporting them…. and they are just doing this because this is what they enjoy to do. So they are much better off and you know, they are not doing it for money.

In contrast, she has noticed that the full-time staff are “running ragged” and “are killing themselves… to get their billable hours. So they are working from the time they get up to pretty much like 8 o’clock at night to get their billables in.” HCBC-8 admitted that he did not rely on the income through his HCBC work to support his family, his income supplemented his spouse’s income. HCBC-5, on the other hand, acknowledged that she
did rely on her income to pay all of her expenses, including rent. She lamented, “So I think if I had a two income household, I would be able to cut back on my hours which would make it not as bad. But since I have to maintain all of these hours to be able to survive on my own. It sucks.”

HCBC-8 went as far to say that having financial security is essential to wellness. He explained:

I'm not in this boat, but a measure of counselor wellness would certainly be financial. There is nothing more stressful in life than finding yourself with not enough money and it's very difficult in this business to make money especially starting out. I think if you got your own practice, had a little reputation, you did a good job…. You could do ok but if you want to be working in BHRS, you aren't going to ever… be, you know, financially well off and that's a stress.

Further, HCBC-8 contended, the lack of financial security inherent in BHRS leads to turnover and HCBCs leaving the field. He stated:

Plus if the job paid more money people wouldn't…. I find... people don't stay in BHRS very long because it doesn't pay enough.... It's a struggle to make ends meet because you… can only work a certain amount… you can only get a certain number of hours... so people move on. They get a BHRS job and then they start looking around to find something else.

HCBC-8 also maintained that in his experience, full-time work leads HCBCs to become disgruntled. He stated, “They get worn down and when you talk to them, they're all... they are very negative. There are so many complaints…. You can actually see it on their face.” After working full-time to gain more financial stability, HCBC-8 has found that “colleagues... quit and go back to being part-time because they are made to drive all over the place and take cases that they don't want to take.” HCBC-3 also pointed to a connection between having more financial security and wellness. HCBC-3 recommended that if agencies pay counselors more, it might spur improvements in wellness.
HCBC-2 asserted that agencies make decisions based on fiscal needs and pressures and these fiscal pressures limit the agency’s ability to provide insurance and adequately pay HCBCs. According to HCBC-2 pursuing financial security is a relevant process that affects agencies as well as HCBCs. Fiscal pressures can create limitations that affect the financial security of their employees and therefore, the ability to retain employees. HCBC-2 explained,

Looking at the big picture…. you know, like the rates haven't increased for 20 years. Since the 90s… so it becomes like a situation where you can't even really bring on full-time staff and give them a caseload because the rates are so low. You know because all the, since the last 20 years, overheads went up. Insurances went up. Everything has went up but the rate. So it's harder for agencies… to manage a service where they keep requesting more and more for that out of that service and they're working with less and less and less…. I think that's probably the biggest issue… I think it becomes a fiscal issue and then the fiscal issue drives… the service line unfortunately. So, then they have to rely on 200 part-time people to meet the needs of these kids as opposed to 50 full-time people.

Due to the financial limitations of agencies, they are unable to compensate employees adequately and are only able to offer insurance to a small number of full-time staff.

**Multiply challenged children and families.** In their work, the HCBCs and supervisors interviewed reported encountering families affected by suicide, domestic violence, trauma, gun violence, child abuse or neglect, and poverty. In addition to their child’s mental health needs which brought them to treatment, the families’ problems were multiple, layered, and complex. Six out of eight of the HCBCs indicated in their interviews that they have worked with families and children that facing multiple challenges such as child abuse, mental health or physical health difficulties, legal issues, and/or domestic violence. The supervisors’ reports supported that of the HCBCs.

Additionally, three of four of the supervisors identified that families face multiple
challenges, such as, a family history of mental health and addiction, living in unsafe neighborhoods, and/or living in conditions of poverty.

The HCBCs provided vivid descriptions of their work with multiply challenged families. HCBC-1 remembered a particular day when she had to report three different incidents of child abuse. In addition, she recounted her work with a family, who was receiving additional services outside of BHRS, including case coordination services, and was having legal troubles. In this situation, HCBC-1 had to sort out her role as a BSC/MT from her urge to help the family by solving their problems for them. She stated:

I think that I just felt like that I had to like help solve the problem and then between the time that I actually met with the supervisor and the time that I had the session, I realized that you are working too hard here. You are. You just need to let them deal with it, however they try to deal with [it]. Let the chips fall where they may basically.

HCBC-2 described working with a child whose mother had attempted suicide in front of her son. HCBC-2 explained the importance of working through the HCBC’s own secondary trauma as follows:

Being able to.. being able to just express, you know, almost like, your, you know your secondary trauma that you experience. Try to, you know, get that in the open and… discuss what that's like to try work through that for yourself knowing that you have to go back into that environment and work with those, the kids that are really struggling with witnessing it first hand.

HCBC-3 reported that working with children and families can be stressful. He stated, “Just because of the nature of, a sort of stressful environment, where you are working with a variety of children with their own challenges and their families with their own challenges and oftentimes getting involved in emotionally charged situations.”
HCBC-4 mentioned the difficulty of trying to work in her BSC role and still support the parent in a violent relationship. She explained:

Each family has their own thing. So there's a lot of situations that, you know, are very stressful for the families and trying to figure out how to support them or support their kids through this time when it's not really, the most important thing to them right now isn't about their autistic kid learning to match pictures. It's about protecting them from the abusive husband or something like that and even though the insurance company says that I can only work with the kid. So it's about trying to help and find what role I am able to help in.

HCBC-6 reported that she has worked with families and children affected by trauma. HCBC-8 noted that many of the families “are so dysfunctional. They don't really understand… how to get along in that environment with teachers because many of them have… had bad experiences themselves…. They've got their own health issues, mental health issues…. It's all pretty hard.”

The supervisors recognized that HCBCs sometimes work in unsafe neighborhoods, with challenging parents, and with clients with complicated mental health needs and these struggles can negatively affect HCBC wellness. SUP-3 reported that HCBCs may work in unsafe neighborhoods and there may be many people in the home including drug dealers. These situations can cause the HCBC to understandably experience more stress. SUP-2 identified how difficult it can be for HCBCs to manage their anxiety when working with parents. In her experience, the most anxious HCBCs have difficulty confronting parents when they are not involved in or following through with treatment recommendations. SUP-1 remembered working with a HCBC whose client was “continually suicidal.” SUP-1 described one difficult session that a HCBC was having with the client as follows:

One day she called me and she was in a professional role and she was really trying to maintain that role but the kid had to be, you know, taken by the cops,
and you know, all kinds of stuff happened, and she [the HCBC] called me sobbing, and she’s like, ‘I can’t do this.’ Um. So she had moved from the professional role into the personal role and she couldn’t get out of it.

**Infrequent supervision.** Due to the structure of BHRS service delivery and minimal regulations surrounding supervision, the HCBCs interviewed were receiving infrequent agency supervision. The supervisors reported that at least one hour of supervision, either individual or group, is required each month to fulfill the requirements outlined by the Department of Public Welfare regulations. At one agency, the supervisors meet individually with each HCBCs once per month. At the other two agencies, the HCBCs were only required to attend group supervision monthly.

SUP-2 and SUP-3 had their own guidelines for determining whether to meet with a HCBC individually or recommend that they attend group supervision. SUP-3 requires individual supervision for HCBCs who have difficulty completing documentation requirements, HCBCs who are having difficulty working with clients/families, or HCBCs are new to the agency and need extra support. SUP-3 described the following guidelines for ongoing supervision:

If I have staff that has over 20 hours of client time, I will have them come in for supervision [individually] once a month and then they have the option to do the group supervision. Those are usually staff who are like, they only have like 9 hours or 6 hours like low man hours, and they can just do group supervision unless they request individual.

SUP-2 indicated that she will also require some HCBCs to come into the office for additional individual supervisions if necessary outside of the monthly one hour of group supervision. She stated she will request to meet with HCBCs after they have completed their initial training if they still need support and if “there is an issue that needs to be dealt with one on one and it’s going to take longer than a couple minutes to... talk
SUP-3 also reported that meeting with HCBCs individually allows her to monitor and oversee treatment:

> I try to get people in here as often as I can so that I know them and I can just kind of even if it's just for a couple minutes just touch base with them and see kind of what is going on. It gives me a better idea about the treatment that they are providing onsite which again is just hard to determine otherwise.

The HCBCs described meeting with their supervisors infrequently. HCBC-4, HCBC-6, and HCBC-8 reported only attending group supervision monthly. HCBC-2 reported he does not utilize agency supervision as he has not found it helpful in the past. HCBC-1, HCBC-3, and HCBC-7 stated that they receive individual supervision once a month with their supervisors. HCBC-5 reported meeting with her supervisor individually once a month for “maybe… a half hour as long as you need it.”

_Formal agency supervision insufficient._ The HCBCs indicated in their accounts of supervision that they perceived supervision to be inadequate. Supervisors were often busy managing so many responsibilities that there were times that the HCBCs did not seek supervision. HCBCs reported a need for additional clinical supervision, as agency supervision was mainly focused on administrative tasks such as paperwork, caseload management, and productivity.

HCBC-2 imagined an effective support system in his agency to be, “having supportive supervision on a regular basis that you find productive.” HCBC-2 stated he did not find agency supervision to be helpful and therefore he did not attend agency supervision. HCBC-4 also viewed supervision as being insufficient and lacking in frequency. She stated, “Now at [this agency]... there is only once a month group supervision with like 20 people…. So that’s all we get for supervision. So there’s not that time.” Previously when working for a different agency, HCBC-4 was receiving
autism specific individual supervision once a month and was able to receive feedback and recommendations for each case. HCBC-4 met for one hour individually with the autism director and one hour individually with her supervisor each month. She appreciated having the additional support.

Like HCBC-4, HCBC-5 reported that she used to receive supervision with an autism director at her agency, until the agency removed the position. HCBC-5 reported, “There’s just been a lot of changes that have made myself and other employees, just from talking, feel under supported.” Later in the interview, she revisited these concerns, stating, “The fact that all these different positions are being taken away and kind of, not screwing us over, but making things a lot difficult for us. That kind of sucks.” HCBC-7 also appreciated receiving individual supervision with an autism director. She reported that this supervision was “helpful…. She was able to hook me up with those things and talk about those, in our supervisions, interventions to use.” HCBC-4, HCBC-5, and HCBC-7 all reported that at the time of the interview, this specialized monthly individual supervision was not being offered at their respective agencies.

Several of the HCBCs reported a need for additional supervision. HCBC-4 stated, “I feel like it would be useful for BSCs to have once a week supervision or something like that.” She emphasized that “more supervisions for clinicians is big.” To offer more supervisions, HCBC-4 and HCBC-5 recommended that agencies start hiring more supervisors. HCBC-2 also suggested that agencies offer more frequent clinical supervision.

**Perceiving supervisors as busy.** HCBC-1, HCBC-2, HCBC-4, HCBC-5, and HCBC-8 stated during the interview that supervisors are very busy and this can interfere
with their ability to support HCBCs sufficiently. HCBC-1 reflected that the supervisors at her agency are very busy and hiring additional supervisors would be beneficial. HCBC-2 questioned whether the supervisors are able to meet all the needs of HCBCs and the clients, given the amount of HCBCs supervised. HCBC-2 reported, “It's tough but I think supervisors trying to find ways to connect with their staff somehow even though I think the system kind of works against that sometimes. Because it is hard, how do you connect with 200 people? I mean let's be honest…” He continued to state, “When you have got 200 people different work schedules, seeing folks at different times of the day…. It's just… it's tough. It's a tough place to be.” Given the frequency of turnover, HCBC-2 wondered, “How do you do the supervision, you know, and provide it if you have 200 people always revolving in and out the door?” HCBC-2 also stated:

I’ll be honest. I don’t even think you’d be able to find them with everything that they have to manage, the one person has to manage…. I think about even just calling and asking questions about something or sending an email and it might be days before you get a response.

HCBC-4 noted, “If there's a crisis, we can call our supervisor. We can request. But they're... super busy… so they don't have time to sit with everyone one on one.” HCBC-4 went on to say later in the interview that she thinks supervisors are “just loaded down with so much work that they can’t. They have all these things that they want to accomplish when they first start but they have zero time to get to them all.” HCBC-5 also indicated that she believes that supervisors are very busy and her agency is “cutting so many positions and people that… it’s hard to feel fully supported when the supervisor has all their stuff they have to do plus the supervisor role.” HCBC-5 admitted that there are times that when she has questions, she is hesitant to reach out to the supervisor. She
stated, “If I have questions… I almost feel bad bothering the supervisor now because I know she is so busy.”

HCBC-8 acknowledged that supervisors as “doing just the best they can do” and reported that “they are doing what they are doing. They have all kinds of other…. Most of their responsibilities are administrative…. It’s hard for them to really focus on the therapeutic issues of their supervisees.” He emphasized that “they have so much… stuff they have to do it’s just overwhelming.” Knowing that supervisors are very busy, both HCBC-5 and HCBC-8 were reluctant to approach their supervisors at times. HCBC-8 reported, “I understand that so if I don’t think, if I don’t have any serious issues, I’m not going to bother somebody.” HCBC-5 recommended that supervisors provide “reassurance to their employees that ‘I know everything is busy and crazy but I’m… here if you need any help.’”

“Taking Care of Yourself”

After comparing the transcripts of each interview to identify prominent, recurring concepts, this researcher found that HCBCs and the supervisors defined wellness as taking care of yourself, emotionally, physically, socially, occupationally and financially. Several HCBCs identified either the consequences of not taking care of yourself as a clinician or conversely the payoff for engaging in self-care. Other accounts were provided by HCBCs and supervisors that supported the importance of taking care of yourself to wellness. In the next few paragraphs, the phrases of significance that support the concept, taking care of yourself, are provided. This researcher describes, as identified by the HCBCs and the supervisors, the consequences of poor self-care and the payoffs of cultivating one’s wellness.
First emerging in HCBC-1’s interview, the concept, taking care of yourself, was mentioned by all of the HCBC and several supervisors. HCBC-1 explained that HCBC wellness is, “the need to look after yourself mentally, physically, emotionally, just in all of the areas.” HCBC-2 echoed HCBC-1’s comments, reporting, “I probably go to self-care when I think of counselor wellness.” He continued to reflect, “It's an issue across the field as far as self-care, making sure that you are addressing your own needs, making sure your taking care of yourself [emphasis added] and getting what you need.” HCBC-3 also viewed HCBC wellness similarly. According to HCBC-3, wellness is, “being able to take care of yourself [emphasis added] so that you are not burned out.” HCBC-4’s stated that wellness is “anything that you can do that keeps you from waking up in the middle of the night stressed out about your job…. Whether it's your mindset… talking to somebody, or whatever. Keeping busy with other things. Whatever that is.” HCBC-5 declared, “I would think it would be the counselor themselves doing things to make sure that their mental health and their happiness is also stable and well.”

HCBC-6’s definition of wellness captured the importance of loving the work and then taking steps to actively maintain one’s wellness. HCBC-6 stated:

I would say that… my definition of maintaining counselor wellness is… making sure that you are happy with what you are doing because if you are not happy then you are not going to be… a positive person and you're not going…. I just think it trickles down to everything else. My first thing is you have to make sure you are happy with what you are doing and then in order to maintain that happiness there are other key aspects, you know, that go along with that. It's important to have… a good family support system in place. Um… It's good to have your own healthy things that, activities that you engage in… as a counselor um, to maintain your own wellness. Like exercise and… meeting with family, meeting with friends.

HCBC-6’s definition includes taking care of one’s occupational, social, emotional, and physical aspects of wellness. HCBC-7 referred to her own experiences with the work
when she described counselor wellness, reporting that both getting enough rest and spending time with family are important to her wellness. HCBC-7 gave a detailed description of a time in the course of her work when she was having difficulty taking care of herself because the work was all-consuming:

Because I used to when I first started being full-time, work Monday through Friday and half day on Saturday. And eventually I found it, to not take a whole day off on Saturday, it was too much. Like, I would feel really stressed on the weekend because I never felt like I had enough time to spend with family and friends or get things done that I didn't finish during the day.

For HCBC-7, taking care of herself, included managing her social, occupational, and physical wellness.

HCBC-8 remembered difficulties that he confronted when he was first in the field, the need to work really hard, “making sure that everybody… got better. Everybody was happy.” HCBC-8 stated:

I struggled a lot more… with that and then… there’s that whole… that saying in therapy, ‘whenever you find out you are doing more work than your client then… you’re doing too much’ and frequently I think thinking about that is… a good thing to do on a regular basis because if you feel like you are pushing a client more than you should then it’s time to well… take a breath, go relax, do something. Maybe get rid of a case.

HCBC-8 also reported that pressures to earn a living can also affect wellness. He stated, “But if you want to be working in BHRS you aren't going to ever, you're not ever going to be, you know, financially well off and that's a stress.” All of the counselors defined wellness as the need to take care of oneself as a HCBC and that may include taking active steps to manage emotional, physical, occupational, financial, and social wellness.
The supervisors also defined counselor wellness to be taking care of yourself.

SUP-1 offered a broad definition of wellness, stating:

I look at that as taking care of yourself and making sure as much as possible that you are taking, that you are making sure all aspects of your life are… what you want them to be. I guess. Because… I've been in a position where um, I have not been happy with the job and that really affects your wellness.

Her definition also included the importance of finding happiness in the work, like HCBC-6’s account. SUP-2 had difficulty defining HCBC wellness. Instead of offering an outright definition, she discussed the differences between HCBCs who are well and those who are unwell. SUP-2 stated:

I'm trying to think the people who are good what I always say about them. They're just. They are very even keeled about things. They are good about handling problems. It doesn't make them anxious. They can stay calm and focused and rational and logical about what is going on and can kind of see what goal they need to reach and don't get flustered with trying to get there even if it is a difficult situation um, and they are not grumpy. They are happy.

The HCBCs that are taking care of themselves in her experience are those that manage their emotions and remain focused on the work, no matter the circumstance.

SUP-4 reported that she did not think that wellness exists in the field of BHRS. She stated:

I don't really think it exists to be completely honest with you. I think that they struggle with figuring out like how to schedule themselves, how to spend time with their family, and how to keep work from personal stuff. That seems to be the biggest issue is that they will work all hours of the night and then they get burnout and then they are not doing the concurrent documentation.

SUP-4 questioned the HCBCs’ ability to take care of themselves and find a work-life balance. SUP-1, SUP-2, and SUP-4’s accounts support the HCBCs reports that wellness is taking care of yourself. The supervisors highlighted the importance of managing one’s emotions, the work, and spending time with family- social, emotional, and occupational aspects of wellness.
Several HCBCs addressed either the consequences of engaging or conversely not engaging in self-care. The consequences of not tending to self-care were first described by HCBC-1. She explained that the reasons for managing self-care are as follows, “because if you don't, you are going to get run down. You are not going to be able to at your best.” HCBC-2 also cautioned that self-care was necessary “so that you don't burn out.” HCBC-3 acknowledged the frequency of burnout stating, “I think that’s the main thing. Being able to perform enough self-care that you are not burning yourself out because that happens a lot.” In the definition of wellness described earlier in this section, HCBC-4 suggested engaging in self-care to prevent excessive rumination about the work that occurs when you are not able to sleep at night due to preoccupation with the stress of the work. SUP-2 spoke at length about HCBCs that do not manage the work and their wellness. SUP-2 stated:

I can't tell you how anxious they are. Um... Like I said sometimes they are crying all the time, overwhelmed, flustered, stressed out. I mean.... I always say they perseverate about things. Like they want to talk about things over and over and having a hard time.... I will say that ‘you have to let that go and we have to move forward and look at what we have to do for this child.’ Um, they avoid things. I see a lot of people who've just they've learned how to deal with this service throughout the years by just avoiding things. So it doesn't matter how many times I say you have to do that for the benefit of the child. They are kind of like well, I'd rather just acquiesce to the parents.

Several HCBCs and supervisors identified the benefits of taking care of yourself. HCBC-2 stated by engaging in self-care “you remain effective for these families that we serve.” Again, HCBC-2 is repeating HCBC-1’s assertion that counselors need to manage their own wellness to work effectively with clients. Later in her interview, HCBC-1 referred back to the importance of taking care of oneself. She stated, “I need to take care of myself or I’m not going to be able to take care of other people.” While talking about
supervision with a HCBC, SUP-1 reported that the agency supports counselor wellness and the idea that, “it’s about taking care of yourself so that you can take care of others.” HCBC-5 recommended engaging in self-care to improve HCBC mental health and happiness. According to SUP-2, counselors who manage the stress of the work, “are very even keeled about things. They are good about handling problems. It doesn't make them anxious. They can stay calm and focused and rational and logical.” SUP-2’s account of HCBC wellness points to the importance of tolerating distress within the work and managing emotions. HCBC’s taking care of themselves exhibit the ability to modulate their emotions and manage stress and remain effective counselors.

Finding Support

The category, finding support, was created to capture the experience of HCBCs and supervisors trying to find the support of supervisors, colleagues, and family members. Thoughts about agency supervision varied amongst the HCBCs and supervisors interviewed. Responses indicated that all of the HCBCs and supervisors value the utility of supervision, in general.

The HCBCs interviewed perceived agency supervision differently. HCBC-1 stated, “I really value supervision a great deal… and right now I get supervision from my boss, my supervisor once a month and…. With that I really feel like, it gives me a chance to talk about cases, process, kind of just like emotionally, just let go of something, of the stuff, by just processing”. HCBC-4 also reportedly valued receiving supervision at her agency but has been disappointed that supervision is not offered more frequently and the supervision that is provided is group supervision. HCBC-5 stated that when she has received supervision she does find it “positive and helpful”. For HCBC-6, supervision is
valued as a time to be able to “talk with clinicians”, “get some different viewpoints”, and “bounce those ideas off of other clinicians”. Several HCBCs, including HCBC-1, HCBC-5, and HCBC-7, indicated appreciating licensed professional counselor (LPC) supervision. HCBC-1 reported receiving LPC supervision from two supervisors weekly. HCBC-5 stated, “I’m kind of lucky that I do have my LPC supervision twice a week and we have group every Friday so that’s a good outlet.”

Some HCBCs had difficulty identifying aspects of supervision that were beneficial to HCBC wellness. For example, HCBC-2 reported, “I haven’t found it particularly effective for the agency that I work for.” HCBC-2 contended that the supervisors at his agency have not traditionally had a lot of experience. HCBC-2 claimed supervisors “don’t really understand the whole process of supervision and the benefit to staff and how to handle it and how to… utilize it.” HCBC-8 also reported that agency supervision is not beneficial for supporting HCBC wellness for some of the same reasons as HCBC-2. HCBC-8 repeated the concern that supervisors often lack experience and also maintained that most of supervision is administrative and focuses on maintaining documentation and paperwork. HCBC-8 reported, “I have not been anywhere in any agency where… I have felt there was adequate supervision.” Referring to the supervisors, HCBC-8 stated, “The next step after taking… after going from BHRS part time to BHRS… full-time BHRS is moving into a managerial position…. And they haven’t lasted long in BHRS either so many of them don’t have a lot of experience.” HCBC-8 maintained that “in some cases the… supervisors are just administrators and they are not really clinicians.” Further, HCBC-8 indicated he does not approach the supervisors because he doubts that they will be able to “provide insight…. You try that
and then you find out what you get and if you don’t think it’s going to be helpful in the future you just don’t do it anymore.”

While he did not view supervision as harshly as HCBC-8, HCBC-3 was reluctant to qualify supervision as a wellness practice. He stated, “You are able to talk about the cases, get feedback, get ideas… that's, I mean that's generally how the supervisions go…. I am uncertain if I would see that as wellness practice exactly.” HCBC-3 viewed supervision as helpful if he obtains a new idea or intervention to try with a client or family. Like HCBC-3, HCBC-7 did not view supervision to be a benefit to wellness. She stated, “I really… I feel like I benefit from my knowledge about self-care. I don’t get that in supervision.”

Illustrated in Table 18, the category, finding support, includes the concepts feeling valued, developing a supervision network, needing ideas and resources, and being there. HCBCs described the ways that they found support from families, colleagues, and supervisors. Because they were not receiving enough support in supervision, several HCBCs reported that they created their own supervision networks that included coworkers and colleagues outside of BHRS. The HCBCs relied on these contacts to fill perceived gaps in supervision at the agency level. HCBCs and supervisors expressed that through agency supervision or the supervision networks that the HCBCs established, the HCBCs were hoping to obtain ideas, resources, support, appreciation, and professional development. In agency supervision, supervisors reported listening to HCBCs concerns and supporting their professional development by discussing professional goals. Several supervisors drew from their own personal experiences as HCBCs to provide support and recommendations in supervision. Some of the HCBCs and several of the supervisors
described punitive supervision and agency practices that had the potential to be
detrimental to HCBC wellness. The concepts feeling valued, developing a supervision
network, needing ideas, feedback, and resources, and being there are described in detail
below.

Table 18

Cross Case Analysis of Finding Support

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<tr>
<th>Categories</th>
<th>Home and Community Based Counselors</th>
<th>Supervisors</th>
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<td>H1 H2 H3 H4 H5 H6 H7 S1 S2 S3 S4</td>
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<tr>
<td>Feeling valued</td>
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<tr>
<td>Developing supervision network</td>
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<tr>
<td>Needing ideas, feedback, resources</td>
<td>x x x x x x x x x x</td>
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<tr>
<td>Being there</td>
<td>x x x x x x x x x x</td>
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<tr>
<td>Supporting and investing in staff</td>
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<tr>
<td>Showing appreciation</td>
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<td>Supporting professional development</td>
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<td>Drawing from personal experiences</td>
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<td>Employing punitive practices</td>
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**Feeling valued.** HCBC-2, HCBC-4, SUP-1, and SUP-3 alike, acknowledged the
profound effect that feeling or not feeling valued can have upon wellness. When asked
how agency practices impact wellness, HCBC-2 indicated that “disconnection from the
agencies” negatively affects wellness. He stated that he did not feel valued by
supervisors or the agency where he works. HCBC-2 explained that, “You're just a
number and people don't know... your name, if you will. And if you left tomorrow it wouldn't really make a difference. That's kind of the... impersonal nature of it.” HCBC-2 admitted feeling frustrated that, in his observation, the agency does not notice his hard work and instead seem to be most concerned about “getting billing in” and less concerned with how HCBC-2 or other HCBCs are doing. The process, feeling valued, was identified from this portion of the interview with HCBC-2. SUP-1 and SUP-3 also spoke about the process, feeling valued, and its importance to wellness. SUP-3 worked in previous agencies where she also did not glean a sense of appreciation or value from supervisors or the agency. She discussed her experience in this other agency when I asked her to define her own view of counselor wellness. She stated:

Being heard… That's my biggest thing… being respectful of people's time and family…. Because I have been in job's where… they had a mission but they didn't necessarily follow that mission… and it was all about the money. How much money are you going to bring in? And that was the feeling that I got.

SUP-1 compared and contrasted her experiences at her current agency with those at a past agency. At the past agency, SUP-1 remembered that, “it was like you could never be good enough for what they wanted”. It was clear from her account that she did not feel valued in her role as a supervisor. She stated:

And no matter how hard you tried and I have always been a hard worker and I have always tried to meet what everybody wants. It was just really frustrating and really… just defeating. I just kept feeling defeated over and over again… because I couldn't meet what they wanted and it just wasn't realistic what they wanted.

Like SUP-3 and HCBC-2, SUP-1 concluded that the agency cared more about making money and a profit as opposed to being concerned about HCBCs, supervisors, and clients. SUP-1 described her experience as follows, “when they went to a for-profit
agency from non-profit it was all about the money and nothing about the clients. They did not care about the clients or the staff.” SUP-1 acknowledged that working at her current agency is “totally different”. She reported that she loves “this type of environment because this is where people thrive.” HCBC-2, SUP-3, SUP-1 provided similar descriptions of experiences of the need to feel valued while working for three different agencies.

**Developing a supervision network.** To get past the barriers to wellness that exist due to the demands of the work, isolation, and infrequent supervision, HCBC-2 suggested that HCBCs need to establish their own supervision network. HCBC-2’s words were used to name this concept, developing a supervision network, and reviewed the other HCBC and supervisor interviews to identify other instances of the same process. The importance of creating a supervision network was repeatedly mentioned in the data, supporting its significance as a concept.

HCBC-, HCBC-3, HCBC-4, HCBC-5, HCBC-6, HCBC-7, SUP-2, SUP-3, and SUP-4 discussed ways that HCBCs create their own supervision network to build a support system in an environment that can be isolating. HCBC-2 advocated that this supervision network would include: a network of people at work that “you bounce ideas off of”, “discuss difficult cases with”, and discuss those issues that you might be personally “struggling with as… a counselor”. Overtime, HCBC-2 developed his own professional contacts that included coworkers and colleagues outside of BHRS, with whom he was able to consult after finding supervision at his agency to be unhelpful. HCBC-3 also recommended that HCBCs new to the field, rely on colleagues as a resource, stating, “They have the resource of everyone, all the other staff that they could
reach out to and talk with about… whatever cases they end up on.” HCBC-3 indicated that he has found collaborating with coworkers to be extremely valuable. Per HCBC-3, “If we are on the same case or they are able to provide information or insight into issues…. It’s very valuable to kind of have a source of support.” HCBC-3 acknowledged relying on co-workers for supervision if he misses the agency’s supervision.

The value of having a support network was endorsed by HCBC-4, as well. HCBC-4 recommended that HCBCs have “dialogue with other clinicians and supervisors regularly.” The “key” HCBC-4 stated is, “to just have that community and have that feedback and be able to one, give your knowledge and expertise to someone else and two, receive that.” Often, HCBC-4 admitted that she is the one giving the recommendations because she frequently supervises the TSS workers. Since often there is not adequate supervision at her agency, HCBC-5 also suggested that HCBCs communicate with co-workers and one’s supervisor in order to get “any extra support that you can”. HCBC-5 follows her own advice and if she has time when at the office she will “mingle with people in the staff room” and will “listen to them vent”, she “vents”, and then colleagues offer support in turn by listening. She explained that the “little, small interactions help”. HCBC-5 recommended that HCBCs new to the field reach out to colleagues or supervisors for help if needed. She stated, “I would advise them…. Even if you think you might be bothering people…. Don’t hesitate to ask for help on things…. In the beginning of working this job, it’s really overwhelming…. So don’t be afraid to ask for help.” HCBC-5 finds by talking with other employees she discovers often other HCBCs feel the same way, “stressed out… under supported at times.” After the agency eliminated a position and no longer offered supervision specifically geared toward
working with children with autism, HCBC-7 began to seek out contacts with colleagues and other staff at the agency who have more experience with autism. HCBC-7 explained, “Our supervisors have their skills but sometimes I may need to go to another… staff that has a lot of experience in autism. Like, there’s another staff that is a BCBA so I may go to her.”

Some HCBCs were able to develop their support network within the existing supervision that is offered at the agency. HCBC-6 described attending monthly supervisions with a small group of colleagues. HCBC-6 reported that attending the group is beneficial especially when she is able to receive feedback and has time to process difficulties that she is having with clients and families. Even though other supervision groups are offered, HCBC-6 attends the same group supervision consulting with the same group of colleagues and supervisor each month. Two of the supervisors, SUP-2 also noticed this phenomenon. SUP-2 stated, “our group supervisions- it seems like there's kind of been… we've kind of developed these cohorts and it seem like the clinicians are really good about supporting each other now…. They’ve developed some good relationships.” SUP-3 has found that having group supervisions monthly gives HCBCs the opportunity to meet one another and share their experiences. She surmised that “some of them… don’t even know each other until we have the monthly meeting.” SUP-4 also noticed that HCBCs, “seek a lot of peer support”. She stated, “I think that helps them when they are feeling frustrating or… thinking that it’s impossible. They do reach out and they do have their own little… bonds and their relationships that they seek for support.” SUP-4 believed that the HCBCs developed these bonds because in the past they did not have support from their supervisor.
**Needing ideas, feedback, and resources.** HCBCs reported that they looked to supervision, and consultation with colleagues and coworkers for ideas and resources to support their treatment with clients. Supervision was often the first stop for HCBCs to find support. HCBC-1 reflected that it helps her to “go in [to supervision] and process and get ideas and just um, I guess just basically vent too.” HCBC-1 spoke to the need for ideas and clinical direction when she is stuck and unsure how to proceed with clients. HCBC-3 reported that supervision is a place for him to “talk about the cases, get feedback, get ideas.” HCBC-4 wished she had more opportunities to collaborate with colleagues and supervisors, a “community… and… that feedback and be able to one-give your knowledge and expertise to someone else and two- receive that.” In addition, HCBC-4 suggested that HCBCs would benefit from having resources and paperwork more easily accessible to reduce time HCBCs spent on unbillable activities. In LPC supervision, HCBC-5 reported that she is learning a lot of different strategies, techniques, and activities to do with my clients and that makes me feel more competent and able so that I guess helps with my overall wellness. From HCBC-8’s recollection, his most memorable, supportive, and helpful supervisor provided resources and shared ideas at each supervision.

HCBCs also looked for additional resources, ideas, and feedback from colleagues and coworkers. HCBC-2 reported that he consults with colleagues to “bounce ideas off of” them. Outside of supervision, HCBC-5 gives and receives feedback when collaborating with other HCBCs. HCBC-6 stated that she appreciates consulting with other HCBCs in group supervision especially to obtain validation that she is using an effective approach or gather other perspectives of how she could approach a case.
Regardless of whether they approached a supervisor or a colleague/coworker, HCBCs sought support in order to gain fresh ideas, interventions, and perspectives in order to improve their clinical skills.

Being there. The supervisors’ reports aligned with HCBCs’ perceptions that supervisors assume various administrative duties in addition to the responsibilities of supervising HCBCs. Supervisors were responsible for reviewing treatment plans and progress notes, completing payroll, coordinating trainings, and managing complaints. Three out of four of the supervisors indicated that they also maintain a small caseload of clients. However despite trying to keep up with these additional responsibilities, each supervisor mentioned the importance of being available to HCBCs, a concept that was coded, being there. Supervisors did not report that these additional responsibilities prevent them from supervising HCBCs adequately.

SUP-1 commented that “all of the supervisors are willing to help everybody.” She continued to state:

They are very open... and you can get a hold of any of the supervisors any time that you need them…. I think that that helps a lot as far as feeling comfortable in your role and feeling like you, you're being more confident in your role.

SUP-2, SUP-3, and SUP-4’s statements echoed those of SUP-1. As an agency practice, SUP-4 meets individually with each HCBC one time per month. SUP-2 and SUP-3 indicated that there are times that it is necessary to conduct individual supervisions in addition to the one hour per month of group supervision. In addition, outside of these supervisions, all of the supervisors reported that they are open and available to meeting HCBCs for additional supervision as needed. At the beginning of the interview, SUP-2 described the provision of supervision in her agency and added that supervisors are “also
open to anybody at any point requesting an individual supervision.” She emphasized supervisor availability several more times during the interview. SUP-2 stated, “Initially I tell people to call me. This is normal to feel in this service…. It can be difficult. It's helpful to process with people.” Later she reflected on the value of being available and the danger of either an unavailable supervisor or of a HCBC who does not utilize the supervisor:

Just telling people that we are always available when they need us has helped. We had somebody here… a while ago and people did not like going to that person. They said they did not feel like if they had questions or they needed help like they got like that person was very receptive to that. So it was important to me to tell people like at the office, like, ‘We are here to support the field staff and it's an important part of our job.’ I just always wanted to make sure that people knew that. Not only that we were available but that they had to use us as a resource… because I have seen it happen where people don't use us as a resource and they leave.

She continued to describe how, as a supervisor, she has helped HCBCs and that HCBCs appreciate being able to email quick questions or to call SUP-2 to discuss questions or concerns regarding a case.

SUP-4 reported that the supervisor before her did not make him or herself available to HCBCs. SUP-4 reflected that because of this, HCBCs were not always willing to go to SUP-4 with questions or concerns. She stated, “I think that's a struggle for a lot of them too because they are just like used to the old ways of things…. They had a supervisor before that told them if the door was shut don't walk in and don't knock.” She contrasted this with her approach which is to have an “open door policy”.

Further, SUP-4 reported:

I also have on my door…. I switch it when I’m in a meeting or when I’m busy I ask them to know but typically my door is never closed. It’s always open for them and they’ll text me or call me at night if they have a question. I don’t have a problem with any of that.”
SUP-3 had a similar approach to supervision and advised that whenever HCBCs needed that they seek out their supervisors for assistance. She stated that:

I think that's a biggie too because this is a job where you do need to be independent but we always want to make sure staff know that they can call us for anything... email us.

HCBC-2, HCBC-5, and SUP-1 discussed how HCBC’s benefit from receiving support from their supervisor and the agency. According to HCBC-2’s account, by investing in staff, HCBCs experience an increased sense of value and worth (i.e., feeling valued) and this in turn buttresses wellness. SUP-1 speculated that it is necessary to have support at work in order to be able to take care of yourself, stating, “If you don’t have that support and you have somebody constantly, negatively… saying everything that you are doing is wrong, continually…. You can’t take care of yourself in that situation.” HCBC-5 also imagined that if she had an unsupportive supervisor who was constantly questioning her decisions, it would negatively impact her wellness.

In their accounts, HCBCs and supervisors described supervisors as being there for HCBCs in various ways. These included supporting and investing in staff, showing appreciation, supporting professional development, and drawing from their personal experience. All of these actions comprised ways that supervisors are or could be being there and supporting the HCBCs. Conversely, several supervisors and HCBCs talked about the effect of employing punitive practices on HCBC wellness. All of these concepts are described in detail in the following section and statements supporting the concepts are provided.

**Supporting and investing in staff.** HCBC-2, HCBC-4, SUP-1, SUP-2, and SUP-3 acknowledged how important it is for the agency to create policies and practices that
communicate system-wide support of HCBCs. HCBC-2 advised agencies to make efforts to connect with HCBCs and show that “they are invested in their staff”. He stated, “I think that goes a long ways towards BHRS folks feeling that they are appreciated and that the work that they are doing is important.” This concept, supporting and investing in staff, was mentioned by many other HCBCs and supervisors. HCBC-4 worked for an agency in the past that did not provide support to HCBCs. She understood firsthand the difficulties associated with working for an agency focused more on making money and also recommended that agencies adopt a “climate of support”. HCBC-4 noted that the current agency, where she is employed, practices “trauma-informed care for not just our clients but within the agency as well so… it's an environment that's very respectful and understanding.” While HCBC-4 described it as a “climate of support”, SUP-2 reported that her agency maintains a “good culture” and that “we want to tell people like, ‘You’re not just bodies going out and… making us money’”. She spoke positively about her agency and said:

I feel like I’m very blessed to work for this company. Like, they are very child-centered. They are very family focused…. I am allowed to make up my own schedule and do whatever I have to do and if my kids are sick then I’m allowed to go home whenever I need to and I think that, you know, mentality definitely goes to the field staff too. We tell people… ‘We want to be supportive of you.’

While SUP-1 works for a different agency than SUP-2, SUP-1 also indicated that she perceives her agency as a whole is “very… invested in making sure employees take care of… themselves.” She stated that the agency has established programming and outreach activities that encourage employees to place their wellness at the forefront. These outreach activities include wellness fairs, yoga, and wellness counseling offered by the insurance company through employment benefits. SUP-1 further reported that in the
past a supervisor at her agency offered a spiritual care group for HCBCs and supervisors to attend as a way to engage in faith practices with one another to assist each other with managing the stress of the work. SUP-3 identified additional supportive practices offered at her agency, including wellness fairs, wellness surveys with opportunity to win gift cards, massages, blood pressure clinics, and health coaches. SUP-3 admitted that she did not realize how much the agency offers until she began to name examples. She stated that compared to other agencies, her current agency, “does a lot more as far as trying to help their staff just to stay focused on then take care of themselves.”

HCBC-2, HCBC-3, HCBC-5, and HCBC-7 on the other hand did not perceive their respective agencies to be supportive. HCBC-2, HCBC-3, HCBC-5 and HCBC-7 were unable to identify any agency practices that they perceive as supporting their wellness. HCBC-2 was surprised that he was unable to think of anything:

You know what I actually can't think of one off the top of my head... which is kind of sad when I think about it.... Having done it for 6 years and sitting back and thinking about it. Yeah, it's kind of surprising that nothing really sticks out for me.

HCBC-3 as well did not identify any particular practices that improve wellness. He mentioned that the agency “advocates” practicing self-care in order to avoid burnout by posting information on the walls in the office, however, HCBC-3 reported that the agency does not “push for any sort of thing.” HCBC-5 stated that she perceives that “as a whole our agency is not very supportive.” HCBC-5 described several practices that have been instituted by the agency that resulted in HCBCs feeling less supported, such as, downsizing supervisors and eliminating a position that provided specialized training and supervision for working with children with autism. HCBC-7 also reported that agency policies and procedures do not support HCBCs. HCBC-7 reported that it is difficult to
meet the expected billable hours to maintain full time employment and benefits as families often cancel sessions due to illness or vacations.

Several of the HCBCs and supervisors interviewed indicated that their supervisors have been supportive. HCBC-1 reported being able to process concerns in supervision and receive validation that her treatment approach is acceptable or ideas of other interventions or approaches. HCBC-3 stated that his supervisor works to create a supportive environment in the office, bringing in tea, hot chocolate, and coffee for the HCBCs. At her current agency, HCBC-4 stated that the supervisors “are very supportive…. whereas the other agency, it was just a culture of the person above you yelling at the person below you just on and on down the chain.” Even though HCBC-5 has found the agency overall to be unsupportive of HCBCs, she has been able to rely on her supervisor for support and help. She reported appreciating that she won’t get “scolded or yelled at” by her supervisor, an experience that she shared a friend at a different office frequently endures. HCBC-5 added that, “I think if I had that type of supervisor it would not be good for my mental wellness.” HCBC-6 appreciated group supervision and the support provided by the supervisor. HCBC-6 described her supervisor’s sense of humor as follows:

He realizes that we all... work very hard and some days may be stressful for us. So he knows how…. He knows the older employees pretty well now. You know, the ones that have been around for a few years. So he knows what will make us laugh and he does do that with us. He will joke around and try to make us laugh which is nice.

HCBC-8 recounted a previous supervisor who provided support by suggesting interventions and providing resources.
SUP-1 spoke of the support that she receives from supervisors at her current agency. She stated:

Here it’s much more laid back. Like you can actually say, ‘You know, I’m really struggling here. I can't get these hours right now’ and if you… talk to them about it, they are usually like, ‘Ok. Take care of yourself. Make sure you are doing what you can do for yourself and then we will figure this out and then we will come up with a plan together’ which is very helpful and it…makes you feel empowered… because now you had a way of stating your feelings and expressing yourself and you are not just being squashed back down and you are not kind of like, ‘no you need to do this.’

Because the agency values wellness, SUP-1 reported that the importance of wellness “trickles down” and influences her practices as a supervisor. She explained that:

They do all kinds of different things and a lot of our meetings and stuff… in our supervision is, ‘How are you taking care of yourself? You are doing all this work…. Do you need help with anything?’ So it's all about that and it trickles down… So that's what I'm doing in my supervisions with my behavioral specialists and the TSS. I'm like, ‘Ok well what do you need help with? Let's talk about this. How are you taking care of yourself?’

SUP-3 had a similar experience at her agency and stated, “I will say since I have been a supervisor here there have been constant changes but constant support as well….,” She also noticed that support begins to “trickles down” into her provision of supervision. SUP-3 likened this to a “domino effect”, stating, “If they’re supporting me then I feel like I can support my staff”.

**Showing appreciation.** HCBC-3, HCBC-5, HCBC-6, and SUP3 described ways that supervisors show appreciation toward HCBCs. Some of the tokens of appreciation are small gestures as mentioned by HCBC-3, tea and hot chocolate in the break room, and others are words of thanks offered in weekly emails, exemplified by HCBC-5 and SUP-4’s accounts. HCBC-5 noted that her supervisor sends out emails and provides “shout outs” or thank you notes in the weekly updates that describe “when employees…
step up”. HCBC-5 was especially appreciative when her supervisor gave her a “shout out” for taking on a high-need case when another HCBC left the company. HCBC-5 described that the shout out provides “validation” and “makes you feel good.” HCBC-5 recommended that agencies would benefit from providing the same validation toward staff, “it would be nice to show the appreciation to staff that keep this company running.” She advised that it would be worthwhile for the agency to “send out emails…. Show up at the office… Thank people, you know, ‘You’re doing a great job’, just the validation piece.” SUP-3 mentioned that she makes it a point to recognize staff for their accomplishments. In one instance, she recognized staff at their yearly performance evaluation by commending the HCBC for completing and submitting paperwork in a timely manner. She explained, “I’ll definitely try to brag about, if people do their progress notes well…. when people turn their paperwork on time” by sending an email. SUP-3 stated:

But we are trying to implement more… recognizing staff more for… the good things they are doing in the community. We usually do that at our monthly meetings or we’ll… shoot them an email. So we always start off our meetings with a community meeting and then… we usually do brags.

After the supervisor takes the time to pay tribute to staff accomplishments, she provides staff with an opportunity to recognize other HCBCs or clients.

In addition, SUP-3 reported that satellite offices will provide care packages for other offices as a means of expressing gratitude and supervisors organize potlucks during supervision. According to SUP-3, the potluck was organized to help HCBCs relax during supervision while supervisors thank HCBCs. HCBC-5 acknowledged that at her agency, the agency plans a staff appreciation picnic each year, however, required that staff provide the side dishes. HCBC-5 expressed frustration that the HCBCs are required to
spend time and money to make food for their own appreciation picnic. HCBC-6 stated that her agency organizes holiday potlucks and baby showers. While HCBC-6 reported that she often does not attend events, because she has difficulty finding the time, she did mention that many HCBCs at her agency attend and enjoy themselves. HCBC-4 acknowledged that while both her supervisor and the agency support and promote HCBC wellness, she recommended that agencies as a whole would benefit from a “positive culture in interactions of making sure to acknowledge people’s accomplishments and progress.”

Another form of appreciation mentioned by HCBCs and supervisors, was positive feedback. HCBC-1 reported appreciating this feedback, “it has really helped that I have gotten feedback from the people in my agency right now that… they feel like I am a good clinician and… meeting their expectations, like getting things done in time, meeting the clients”. HCBC-4 stated she received much of this feedback from her autism supervisor and indicated that “it was great to get feedback either knowing you’re on the right track or getting suggestions.” She noted that she receives positive feedback from her supervisors after an insurance audit, something that she did not receive from her past employer. With the current employer, HCBC-4 commented that the supervisors comment first on “the positives and this is where you are doing great” and followed that with recommendations for improvements, whereas the past employer outlined a “list of all the things you’re doing wrong”. HCBC-4 reported that the positive feedback has influenced and shaped her wellness as a HCBC:

I think that the thing that comes to mind is getting positive feedback, getting… good recommendations and… from my supervisors… that helps me know that I'm doing good work… so that helps to reassure me when I start thinking about what could be better.
When asked what supervisory strategies enhance wellness, HCBC-6 quickly identified the important role of providing feedback. She stated, “I would say positive feedback for the clinicians. Maybe… just saying like, ‘Hey great job on this… with this client’ or… something like that. That goes a long a way.”

SUP-1 and SUP-3’s responses also supported the importance of providing positive feedback. SUP-1 not only noted that she as a supervisor provides positive reinforcement, she receives this positive reinforcement from her own supervisor. SUP-1 reported, “My supervisors will point out… ‘You did this great…’ and it's a lot of positive reinforcement over and over and so it makes me feel like I want to do my job well.” SUP-1 identified that a key part of the supervision process is “positively reinforcing” HCBC “for what they have done.” Many of SUP-3’s supervision practices described above as showing appreciation, could also be considered ways of providing positive feedback. SUP-3 mentioned recognizing and acknowledging achievements as equally as important as providing suggestions for improvement.

Supporting professional development. A few HCBCs and all of the supervisors mentioned that supporting professional development is vital to being there for HCBCs. HCBC-7 stated that she appreciated when supervisors supported her professional development by connecting them with appropriate trainings. Prior to receiving these trainings, HCBC-7 stated that she lacked the confidence to work with children with severe autism. HCBC-7 received VB-MAPP and discrete trial training. She stated, “I felt that that autism director was very helpful…. Yeah she was able to hook me up with those things [trainings] and talk about those, in our supervisions interventions to use.” HCBC-2 and HCBC-5 reported that their supervisors did not provide them with
professional development support. HCBC-2 mentioned that he needed to conduct his own research and seek out and attend trainings. HCBC-5 stated that she was unsure how to access and sign up for trainings at her agency.

While the HCBCs’ accounts indicated that HCBCs receive mixed support for professional development and training, all of the supervisors discussed the importance of supporting professional growth. SUP-1, SUP-2, and SUP4 mentioned establishing and mandating trainings for the HCBCs. SUP-1 stated that all of the HCBCs are mandated to attend 1 hour of training each month. She reported that an important aspect of this training is learning how to establish and maintain professional boundaries. SUP-2 indicated that she, others supervisors, and agency administrators developed trainings to support the delivery of autism services, including providing ABA trainings to improve service delivery. When SUP-4 began to work at her agency, she reported, as one of her first changes, she created and mandated monthly trainings for the HCBCs. While these trainings were initially not popular among the HCBCs, SUP-4 mentioned that now, the HCBCs look forward to the trainings and request that trainings address specific topics.

SUP-1 and SUP-3 stated that they support the professional growth of their supervisees by establishing goals and monitoring their growth toward the goals at each supervision. SUP-1 reported:

So we… set goals with, for staff. We talk to them about, ok, well, you know, ‘What are you doing now? What would you like to be doing?’ And each time that we do supervision, we follow up with it…. I will say to people our growth and change means that um. You coming into the company means that we are gonna to work with you to grow in any way that you want. So that means if you tell me that you want to be in a totally different company as a different position that's where I am gonna help you go. I'm not here to make you stay with us. I'm going to help you achieve those goals and we are going to talk about those goals each supervision and they can be any type of goals.
SUP-3 stated that she aspires to support her supervisees’ professional goals. To do so, she indicated that she might need to support a HCBC that is looking for work in another department of the agency. She explained:

I want to be able to just kind of be able to tap in more with staff to see what their goals are professionally. Because some of them want to achieve getting their license um. You know, we have resources for that here. Just trying to find out more of how I can help them out more professionally which I think is part of their self-care. Because I don't want anyone feeling like they are stuck in wraparound. Just let them know there's other options here a [the agency].

Both supervisors recognized that it is important to support the professional growth of their employees even if that means that they will leave BHRS.

**Drawing from personal experiences.** All of the supervisors reportedly had prior experience as HCBCs before working as a supervisor. At least three of the supervisors, SUP-1, SUP-3, and SUP-4 continue as supervisors to maintain a small caseload of their own clients. Each supervisor discussed how they bring these experiences into their work as a supervisor to support the HCBC. This process was coded, drawing from personal experiences.

SUP-1 identified that her supervision approach is informed by her experiences with supervision as a supervisee and her counseling experience as a HCBC. SUP-1 recounted how her approach to supervision developed over the years:

I don’t think I really ever thought about um, how to approach somebody in supervision and I think over the years in being in different agencies. I’ve gotten a little bit of everything…. This isn’t going to work. This is going to make somebody feel bad as opposed to good about themselves.

More specifically, she remembered how difficult it was for her to support the HCBCs that she supervised when she had to focus on productivity and addressing mistakes. She learned, while being supervised, that focusing on mistakes and leading supervision with
concerns and productivity can cause the HCBC to feel defeated, depressed, and possibly burned out. SUP-1 stated that she had difficulty maintaining her own self-care in this situation. She reflected that if “you don't have that support and you have somebody constantly just kind of like negatively um... saying everything that you are doing is wrong. It’s just, uh, really difficult and you can't take care of yourself in that situation.” SUP-1 is now working for an agency where she receives support from her supervisor and the agency emphasizes self-care and she is able to better support the HCBCs. SUP-1 stated, “especially with my um, clinicians that I know are doing a lot of hours and I know it's tough because I've been there.” To support these clinicians, SUP-1 asks how they are doing and how they are taking care of themselves. SUP-1 does not lead supervision with discussions of productivity but instead begins supervisions asking HCBCs how they are doing and how she can help.

SUP-1 reflected that she shares her experiences as a HCBC with her supervisees. She stated:

Other times I go back and relate to my experiences because, you know, starting out as a young professional. I was in that role…. So I related to my experiences and what happened when I was in that role. That usually works. If I can relate back to them in some way…. I'll be listening to whatever they are saying and then somehow relate it back to me as a young professional, what I did and what happened and um try to get them to think more.

Because she worked as both a bachelor’s and master’s-level HCBC, SUP-1 stated that she is able to empathize with and understand the struggles of her supervisee. She continued to state, “I can empathize and I can actually, you know, give stories about, you know, what happened when and they often relate to what somebody else is saying.” SUP-2 also drew upon her own experiences as a HCBC to help her supervisees learn how to have difficult conversations with parents and caregivers. With her supervisees, SUP-2
normalizes that it is difficult to confront parents about treatment barriers. SUP-2 explained:

I know it can tough and sometimes I have to remind myself of that. Like, I've had 10 years to practice difficult conversations with parents and now I realize they are no big deal but the first time you have them, they are tough. So I try to tell people like I know it seems like you are being confrontative and I know it seems like you are gonna, you know, tell them something that. But I even tell people, if you get yelled at, it's also not the worst thing in the world. I've been yelled out lots of times and it's a good learning experience and it helps you as a clinician and so I don't know. I think it is good that I can and I think they probably see that with me too that I'm trying to be patient and understanding.

SUP-4 stated that she draws on her past experience as a HCBC to understand what is and what is not feasible for HCBC practice. SUP-4 stated:

I think just being more aware because I was in... Like in their shoes so just kind of knowing um, what is… what can and can't be done when they are out in the field has been a big, you know, a big change so, you know, I wouldn't push a lot of things on staff because I know what it's been like or... My expectations aren't as....like someone who's never done it. I think I would have different expectations of staff then. Um, because I've, I've lived it.

In regards to her supervisor and the upper management at her agency, SUP-4 stated, “They don't have firsthand experience as to what it is so it's hard for me to pass that information to staff when I know it's impossible when I actually did the field work.”

When she is able, SUP-4 stated that she challenges these impossible expectations and informs her supervisor when the practices or policies are unrealistic for HCBCs to implement. SUP-4 will then modify her expectations of HCBCs to provide them with leeway when she is able because SUP-4 remembered how difficult the work as a HCBC can be. SUP-4 stated, “I mean I don't demand a lot of things from them. Little. Like, I have more leeway. Like I'm not going to write someone up the minute they have red x's [missing paperwork] and things like that because I was a procrastinator too.” If HCBCs
are making every effort to submit paperwork on time, SUP-4 reported that “Whereas I am more laid back and get it. As long as you get it done, I'm not going to stress about it.”

**Employing Punitive Practices.** Several of the HCBCs and supervisors identified agency practices that are detrimental toward HCBC wellness. HCBC-1, HCBC-4, HCBC-5, HCBC-7, SUP-1, and SUP-4 described practices that they found to punish and be a detriment to HCBCs. Initially, HCBC-1 worked in a full-time capacity at her agency. She described the pressure that she experienced trying to maintain the expected billable hours and the consequences that occurred when she did not. The agency would offer for the HCBC to make up the lost billable hours by working in the office completing administrative work. If the HCBC was unable to make up the lost hours, HCBC-1 stated:

> The one thing that the agency I worked for and this one did was, which I thought was very… detrimental to wellness, was that if you didn't make up, or if you didn't hit, the other agency it was 26 hours, they would do your like time off time. They would take away vacation time and I think that… I was never full time there, so I don't know how it worked out for people. But I think it came to the point where, like, how are you going to take care of yourself and get away if you don't have time to take because you're always using it to make up? And I know for me and I think the other people that worked full time in my agency, it was just very difficult to get to those 25 hours.

If the HCBC consistently was unable to meet the expected billable hours, HCBC-1 reported that the agency would demote the HCBC to part-time. According to HCBC-1 this reduced the HCBC’s pay and time off accrual rate. Because of the pressure inherent in trying to maintain 25 billable hours, HCBC-1 eventually made the decision to revert to part-time as she began to experience the work as “draining”. HCBC-7 discussed similar practices at her agency. At HCBC-7’s agency, it is expected that as a full-time employee, she maintain 32 hours per week billable hours.
The agency monitors this expectation as follows:

Right now it's 6 out of 10 weeks that you need to make, you need to hit those hours…. They track it for 10 weeks to see if you've made productivity for 6 out of 10 of those weeks. You can be off the hook for 4 of those but if you are consistently not at, you know, 6 out of those 10 weeks, they can bump you down to the next…. They change your employee status. I think that is really punishing you as a clinician.

While full-time, HCBC-5 also appreciated the paycheck but reported that she was also unable to maintain the expected billable hours and was subsequently “bumped” from salary to hourly. She stated:

I had to maintain 32 hours per week which… I was unable to due to cancellations or just not even having those clients hours…. And so it was getting to be every week, I was getting contacted by my supervisors, you know, ‘You didn’t meet 32 billable hours.’ I’m like, ‘I don’t even have 32 hours on my caseload!’

After being reduced to part-time and being paid an hourly rate, HCBC-5 stated that her paychecks suffered and she was reimbursed less for travel.

At a previous agency, HCBC-4 remembered having to report and account for every hour in her schedule and explain when and why paperwork was unable to be completed in a 24 hour timeframe. She compared and contrasted her past agency with the current agency stating, “And you had to have your schedule set and emailed by like Sunday night or something for the next week, and at this agency, you don't have to show your schedule to anybody.” Like HCBC-5 and HCBC-7, HCBC-4 viewed agency practices as “punitive”. She stated:

It was just a culture of the person above you yelling at the person below you just on and on down the chain…. They just piled on stuff for and yelled at you for. I mean it was a very crazy environment.

SUP-1 recounted her work as a supervisor with another agency remembering that the agency was “very punitive. So even if they told us exactly what to do and I did exactly
what they asked us to do, it was still wrong.” According to SUP-1, the agency required “employees to do what's not possible to do” and when employees could not uphold expectations the agency responded by being “continually punitive”. SUP-1 began to experience symptoms of depression due to the constant negativity she was receiving from her supervisors and the administrators at the agency. She reported “after getting so many punitive things. I was at a place where I just couldn't do my job anymore I was just so depressed.” Further, SUP-1 explained that supervision revolved around “productivity” and she perceived as a supervisor that this practice blocked any discussion of self-care or HCBC wellness.

SUP-4 provided other examples of punitive practices that are being enforced at her current agency. SUP-4 stated that agency administrators will send out last minute notifications to all staff and the expectation is that they take effect immediately even if they were impossible expectations. On one occasion, SUP-4 reported that the administration threatened “disciplinary action” if the new procedure was not followed. SUP-4 also reported that administrators frequently contact the supervisors questioning HCBCs productivity and asking for explanations as to why the billable hours were not met, calling for the supervisors to develop an “action plan” to address the concerns and improve productivity. SUP-4 expressed her frustration in the following statement:

It's not always going to be, you know, we're going to get these three hours a week every week…. They always want to see why that is happening and then an action plan for the why and you know… some of those things just aren't realistic and it gets staff frustrated because they're like, ‘What more can I tell you like, they are not here so I can't get the hours in’ or if the family cancels.

HCBC-4, HCBC-5, SUP-1, and SUP-4 described in detail the effects of the negative and punitive agency practices on their wellness. The punitive agency practices
affected their work performance as counselors, mental health, ability to continue working at the agency, and/or willingness to continue to work in the BHRS field. In response to dealing with an “inconsistent and insecure” workplace marked with last minute changes in procedures that led to additional paperwork, promises that were not kept, and the firing employees for making those promises, HCBC-4 indicated that she was ready to “quit the field in general because it just wasn’t worth it.” HCBC-4 reported she left the agency due to the negative practices. HCBC-4 reiterated this point when asked what recommendations she would make to agencies to better support HCBC wellness. She stated, “Put clinicians first…. If you aren’t supporting them… you won’t be supporting your clients and you’ll have a higher turnover rate.”

Due to a perceived lack of support from the agency stemming from the removal of several supervisor positions, and the agency’s lack of communication with employees, HCBC-5 expressed that she now has “a little attitude” and “a little chip” on her shoulder toward the agency. HCBC-5 reported that she is planning to look for a different position when she obtains her LPC credential. SUP-1 left an agency, where she worked as a supervisor, before finding a supervisory position at her current agency. She was willing to take a pay cut to work for an agency that provided their HCBCs and supervisors with support, an agency that provided an environment in which employees could “thrive”.

SUP-1 and SUP-4 described how punitive practices can affect the HCBC. SUP-1 asserted that negative agency and supervisory practices such as, “somebody constantly just kind of like negatively... saying everything that you are doing is wrong”, prevent the HCBC from being able to take care of themselves. I asked her to talk more about what
happens when the HCBC is not able to take care of themselves in that situation and SUP-1 replied:

Well, what ends up happening is it's very evident in your work. Because usually it leads to depressive symptoms. It leads to… just you not taking pride in your work and when you don't take pride in your work or care about your work, the clients really suffer. And your job really suffers because… you just don't care anymore and actually everything in your life suffers.

SUP-1 provided a vivid explanation of how the difficult working conditions negatively affected her mental health and her quality of life overall. She reported:

In the last agency that I worked for…. It was a job where we were required to have… 22 billable hours plus we were supposed to be a clinical supervisor on top of it, which is nearly impossible to do.. So I was working literally 70 to 80 hours per week. I was very rarely seeing my son… and I had no time to take care of myself. I didn't eat. I didn't sleep. You know, I barely had time to go to the bathroom.

Later in the interview, she concluded, “I was at a place where I just couldn't do my job anymore I was just so depressed.” SUP-4 reported that the agency delivers last minute directives that can be unrealistic and impossible for HCBCs to implement and these directives increase HCBC frustration and anxiety.

**Striving for Work-Life Balance**

HCBCs identified many different ways of staying well as a HCBC. As shown in Table 19, these different codes were organized under the category, striving for work-life balance. The most frequently endorsed means for achieving work-life balance included: pursuing interests outside of work, setting boundaries, finding time, being aware, adopting a positive mindset, and managing the work. First, the investigator will provide the HCBC and supervisors statements and experiences that define that category, striving for work-life balance. Second, I describe the phrases of significance that support
pursuing interests, setting boundaries, finding time, being aware, adopting a positive mindset, and managing the work.

Table 19

Cross Case Analysis of Striving for Work-Life Balance

<table>
<thead>
<tr>
<th>Categories</th>
<th>Home and Community Based Counselors</th>
<th>Supervisors</th>
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<tbody>
<tr>
<td></td>
<td>H1  H2  H3  H4  H5  H6  H7  H8  S1  S2  S3  S4</td>
<td></td>
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<tr>
<td>Pursuing interests</td>
<td>x    x    x    x    x    x    x    x    x    x</td>
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<tr>
<td>Setting boundaries</td>
<td>x    x    x    x    x    x    x    x    x    x</td>
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</tr>
<tr>
<td>Finding time</td>
<td>x    x    x    x    x    x    x    x    x    x</td>
<td></td>
</tr>
<tr>
<td>Being aware</td>
<td>x    x    x    x    x    x    x    x    x    x</td>
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</tr>
<tr>
<td>Adopting a positive Mindset</td>
<td>x    x    x    x    x    x    x    x    x    x</td>
<td></td>
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<tr>
<td>Managing the work</td>
<td>x    x    x    x    x    x    x    x    x    x</td>
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The HCBCs and supervisors discussed trying to balance their personal life with the demands of the work. HCBC-1 reported that she tries to “balance everything out.” She stated, “There’s nights when I get home… I want to get these notes done tonight so they are not stacking up on me. There’s other nights where I decide that I’m just going to let this late night go.” When she lets the “late night go”, she takes time away from the responsibilities of work, and instead, she spends time with her husband, watches TV, or reads. HCBC-2 reported that HCBCs need to balance taking care of themselves with taking care of their clients. He stated, “When you are not taking care of yourself and you are just giving, and giving, and giving and not focusing on, at all on yourself, you start burning out.” HCBC-3 reported that he takes time away from work at the end of the day so that he can have time for himself. HCBC-4 stated that she manages her wellness by “keeping balance in my life with other interests, other activities, other parts of my life.”
HCBC-4 reported that makes sure that she has time to “see the sun” and spend time with her family. HCBC-5 admitted that it is very difficult for her to balance work and life outside of work. However, she recognized the importance of work-life balance and advised HCBCs to “learn how to balance like your own life and happiness along with your workload.” HCBC-6 explained her own work-life balance as follows:

I like to know that um, there are other things important in my life as well and work is very important. I take it very seriously and I give forth a lot of effort, you know. I try to when I'm there um, or when I'm working on something at home but I also try to make time for the other parts of my life. So I think that it's important for me to know that it's not 24-7 work related.

SUP-2 did not explicitly use the words work-life balance during the interview but her statements matched the experiences of HCBCs who described finding work-life balance. She has found that HCBCs that manage the work well, separate work from their personal lives and they do not take work home with them or answer calls late at night. SUP-2 reflected that she and her husband have been working for BHRS for 15 years and have learned:

you have to when you leave the office you have to be done with the job. So, I think people who have learned to maintain some sanity within this service have learned to put up the right boundaries so that they are not taking it all home with them and thinking about it all night or answering phone calls from parents whenever or going out to cases on the weekends like.

SUP-3 mentioned the idea of finding balance throughout her interview. She referred to the need for HCBCs to find balance in their caseload and not always try to accept every case to get additional hours. She reported that HCBCs find balance when they acknowledge and take care of their own mental health needs. For example, SUP-3 reported HCBCs will recognize their limits when working with families and may request to be taken off of a case when a parent is being verbally abusive. In addition, SUP-3
stated that HCBCs build relationships with other HCBCs and pursue activities outside of work in order to find balance. In her experience, SUP-4 has noticed it is extremely difficult for HCBCs “keep work from personal stuff.” SUP-4 notices that HCBCs have difficulty parting with the work at the end of the day. They continue to ruminate about issues and concerns related to clients, answer phone calls late at night, and work on progress notes late into the night. SUP-4 stated:

I think that they struggle with figuring out like how to schedule themselves, how to spend time with their family and how to keep work from personal stuff. That seems to be the biggest issue is that they will work all hours of the night and then they get burnout and then they are not doing the concurrent documentation.

As they described the importance of work-life balance, supervisors and HCBCs identified the means by which HCBCs achieve balance. They discussed how HCBCs and supervisors pursue interests outside of work and set boundaries with the work and with clients. Finding time, being aware, adopting a positive mindset, and managing the work were other concepts that HCBCs and supervisors identified to be important to finding work-life balance. I describe each of these concepts in the following sections providing supportive statements from the interviews.

**Pursuing interests outside of work.** Each HCBC reported that they manage their wellness by taking time outside of work to do things that they enjoy. Some HCBCs carve out time during the day to take a break while others find time during the evenings or weekends. HCBC-1 and HCBC-3 both reported that they take books with them to work and if there is time, they may read. HCBC-1 reported that she may go shopping before she returns home at the end of the day. HCBC-2 enjoys listening to music during the day and likes attend art and music events with his husband. HCBC-3 indicated that he never works weekends. On the weekends, he likes to swing dance and karaoke.
HCBC-4 stated that she enjoys spending time outside, walking and seeing the sun when she is able. HCBC-4 and HCBC-5 both reported having a few drinks at the end of the day to relax on particularly stressful days. Both reported that they believe that drinking is not a healthy way to manage the stress. HCBC-5 stated that she enjoys painting but has a difficult time finding the time to paint. HCBC-6 has built rituals into her day, such as, having a cup of tea at the end of the day and going on walks. HCBC-7 reported that it is important that she has coffee and breakfast every morning and spends time with her pets. HCBC-7 also enjoys pampering herself with a massage from time to time. HCBC-8 likes to garden and go to the gym.

SUP-1 and SUP-3’s accounts supported those of the HCBCs. Both SUP-1 and SUP-3 reported that they will ask how their supervisees are taking care of themselves and what their plans are for the weekend. SUP-1 indicated that HCBCs have reported that they attend church, practice yoga, and exercise. SUP-1 also reported that some HCBCs seek out classes and activities that they enjoy. SUP-3 stated that some HCBCs attend yoga and exercise.

**Setting boundaries.** All of the HCBCs but HCBC-5 and HCBC-6, talked about ways that they set boundaries with the work, the agency, and with their clients. The HCBCs discussed setting boundaries with clients and the work, advised other HCBCs to do so, and provided examples of how they set boundaries.

HCBC-1 described how she set boundaries with the work. She stated:

Usually I'm not in the field on the weekends because that's part of I think my wellness too, come to think of it. I don't do clients on the weekend…. I don't know, it just does something to my head. I feel like first of all I have enough work to do and then second of all, I feel like I need that, my personality is such that I can spend so much time with people but I need time away, to myself or with my husband.
HCBC-2 stated that he believes that establishing healthy boundaries with the work helps prevent burnout and be more effective with families. HCBC-2 reported that he sets boundaries between, “myself as the counselor and myself as the person, HCBC-2. And that there has to be a certain. There has to be a certain, at times rigid, boundary so that I don't carry that back with me.” HCBC-2 stated that one way that he sets boundaries with the work is by leaving his bag locked in the trunk at night. This physical separation from the work helps HCBC-2 leave work at work and focus on spending time with family.

HCBC-3 reported separating himself from the work, or setting boundaries with the work, by “compartmentalizing.” HCBC-3 explained:

I don’t want to be like carrying around with me. So um, and like thinking about it when I’m trying to relax at the end of the day. Basically, I mean it's either you are going to section it off and leave it behind and that's it. Um. At least, that's how I kind of see it.

HCBC-3 compartmentalizes the work to prevent bringing “the stress of one client with you as you go see another one.” HCBC-7 also identified that she sets boundaries with the work. She will wait and complete paperwork the next day if she is too tired at the end of the night.

HCBC-4 identified that it can be difficult to maintain boundaries with clients. According to HCBC-4:

Because when you are in someone's house weekly biweekly, once every a week, um and you are there as a, as a support. Um. It's very easy for families to quickly want you for more than you actually are there for. Maintaining those boundaries um is also sort of an area where it is difficult.

HCBC-4 sets boundaries with families at the first few sessions. HCBC-4 reported that with the help of the family, she develops a session routine, discusses expectations, and creates a weekly schedule. Working as a HCBC, HCBC-7 has encountered families that
have invited her to dinner, called her in the evening, contacted her in crisis situations, requested homework assistance, and invited her to birthday parties. HCBC-7 reported that she responded to these situations by setting boundaries with families, declining dinner and birthday party invitations, not answering the phone in the evening, and referring families to crisis service. HCBC-7 only assists with homework if the client’s behavior is affecting homework completion. Like HCBC-7, HCBC-8 sets boundaries with families and with agencies. HCBC-8 reported that he requires that families actively participate in services. If families are not participating and parents are not involved in treatment, HCBC-8 will move to discharge them from treatment. HCBC-8 reported that he sets boundaries with the agency by only accepting cases and working with clients within a certain geographic area. This helps reduce the time HCBC-8 spends driving.

HCBC-1 recommended that HCBCs draw boundaries “between the time you are with your clients and the time you are in your personal life” and further to “be careful with boundaries and be careful of what you are taking home.” HCBC-3 suggested that HCBCs “learn how to leave work at work.” HCBC-7 stressed that it is important for HCBC to set boundaries with the work that “when work is done, it is done” and set boundaries with clients around communication (e.g., referring to crisis service if needed, not accepting calls after hours, and not accepting text messages). SUP-1 also reported “you need to really maintain your professional boundaries. Um. That’s really important because once you start taking on… vicarious… traumas and everything else that is happening in somebody’s life, it starts impacting you greatly.”

SUP-1 and SUP-4 admitted that it can be extremely difficult for HCBCs to set boundaries with families given how closely they work with families. SUP-4 reported
“boundaries get skewed a lot when they are in the homes too. So they become more friends than they do therapists with families.” SUP-1 stated that HCBCs need “to keep those professional roles but it's still very difficult to… maintain that when you are hanging out with the family…. You become kind of a part of their family even though you are trying not to be because you are helping so much.” SUP-2 and SUP-3 shared that they have seen some HCBCs successfully set and maintain boundaries with families. SUP-2 stated that the HCBCs who are able to “maintain some sanity within this service” have set boundaries with the work and with families and are therefore not “taking it all home with them and thinking about it all night or answering phone calls… or going out on cases on the weekends.” In addition, these HCBCs are not rearranging their schedule for families. SUP-3 has noticed that some of the HCBCs will request to be taken off of a case if a parent continues to be verbally abusive. SUP-1 suggested that HCBCs share minimal information about themselves with families and are not friending families on Facebook. SUP-3 recommended that HCBCs do not answer late night calls and instead set boundaries and expectations with families “up front.”

SUP-3 and SUP-4 appeared to lead by example, establishing their own boundaries with supervisees and with the work. When I met with SUP-3, she turned off her computer so that she could focus solely on answering my questions. She mentioned she has learned to set her own boundaries and appreciates her current work schedule that allows her to be present for her children’s activities after work. SUP-4 indicated that she established clear boundaries with her supervisees when she began working for the current agency. She does not access email on her phone, does not friend coworkers or supervisees on Facebook or snapchat, and will not go out for lunch with supervisees.
Finding time. As the HCBCs and supervisors shared their experiences with work-life balance, it was clear that finding time to pursue interests and spend time with family members was a struggle for them, especially for full-time HCBCs. All of these experiences were coded, finding time. HCBC-1 stated that when she was working full-time and her caseload was the highest “there wasn’t a lot of time” to think about how to manage stress. As a full-time HCBC, HCBC-1 stated she was “losing my mind. This was just too much.” Even as a part-time HCBC, HCBC-1 continues to have difficulty finding time to spend with her husband and friends or exercise. HCBC-3 reported that he often gets home late at night and after he takes care of chores around the house, there is little time left. HCBC-3 reported that this is time for himself or to complete paperwork. HCBC-5 worked a full-time schedule and had difficulty finding any time for herself even though she valued and understood how important taking time for yourself can be. She reflected that counselor wellness is “Taking time, if you need it, to make yourself happy. Making sure that you have time at the end of the night where you don’t feel so exhausted to relax.”

In reality, at the end of day HCBC-5 had little to no time for herself. By the time she would come home and eat and finish paperwork, it was already time to go to bed and she had no energy or motivation to work out or paint, things she normally enjoys. Unfortunately, HCBC-5 shared that if she did take time to paint, she would then be behind on paperwork and this would increase her stress.

SUP-3 and SUP-4 were concerned that HCBCs were not finding time to take care of themselves. SUP-4 reported that HCBCs who work full-time are “killing themselves” to try to obtain enough billable hours to earn a sufficient paycheck. She sees HCBCs
working late nights, answering phone calls, and completing paperwork late at night. As a result, they are not finding time for themselves outside of work. SUP-3 reflected that she checks in with staff to see how they are finding time to take care of themselves. She is most concerned about the HCBCs that are working two jobs or HCBCs who are trying to bill as many hours as possible. She stated:

Like I said they work Saturday, Sundays, um... Their choice but I think. I mean I look at their timesheets and I'm like, ‘when do you get a break? You are working Saturday until seven, Sunday until.’ Um, We can't make them but maybe setting some boundaries as far as how long you are going to see clients so that you can have that time to yourself.

**Being aware.** When asked how HCBCs manage their wellness, HCBC-1, HCBC-2, HCBC-4, HCBC-6, HCBC-7, and SUP-3 spoke of the importance of awareness. Awareness was the first step that the HCBCs needed to take in order to facilitate wellness. Without awareness, HCBCs were unable to recognize the need to start taking time for themselves. HCBC-1, HCBC-2, HCBC-4, HCBC-6, and HCBC-7 discussed how awareness is a part of their work-life balance as HCBCs. HCBC-1 reported that counselor wellness is:

I think paying attention to the times that you are struggling like when there is more stress and the need to um say ok maybe I need to eat better. I need to get more sleep or I need to figure out how to deal with stress…. I really try my best to at least be aware.

HCBC-2 stated, “I am able to plan my self-care. I think a lot easier than some other people do at times. I can make connections maybe that other people struggle with when it comes to what they need.” HCBC-4 suggested that HCBCs remember and be “aware of what, that no one can do good work if their wellness isn’t at the forefront um, so making sure that is the case.” HCBC-4 provided an example of how she monitors her use of alcohol in response to a stressful day at work. When having a stressful week at work,
HCBC-4 reported that she may have a drink each night to relax. After several days, HCBC-4 realizes that this might not be the healthiest response to stress, and she seeks out other strategies to cope. HCBC-6 downplayed the role of agency practices in supporting wellness saying, “I don’t really know how much of a need I have for that but that’s also because I do things to maintain my own wellness. I’m really aware that that needs to happen.” She emphasized her own awareness and her ability to take steps to maintain her wellness.

HCBC-7 also relies on her own awareness as the crucial first step to taking care of herself. She indicated:

I manage it by attempting to, you know, be very present in all situations so that I don’t feel like burnt. So I don’t get that burnt out feeling. It’s hard to turn that around sometimes if you are not aware of it.

She explained that being aware improves her ability to manage her wellness. Over time, HCBC-7 asserted that she is “more aware of taking time for wellness.” Initially, as a HCBC, HCBC-7 was working 6 days a week. She discovered that she was tired all of the time, became behind on paperwork, and did not have time for family and friends. Once she was aware that this was occurring, she realized she could no longer work Saturdays. Now, HCBC-7 has more time to herself and can spend time with family and friends.

Through her supervisory work, SUP-3 has noticed that HCBCs that are aware of their workload and their reaction to it, are better able to manage their wellness. She stated that some clinicians “take on way too much.” SUP-3 reported:

The strong clinicians they just know how to have that balance. And other clinicians they just take on way too much. They think they can do it and they don't realize they are going downhill until you tell them though. They think it's all great until you say something.
The HCBCs’ and SUP-3’s reports point to the importance of awareness and the role of the HCBC and the supervisor in facilitating the awareness so that the HCBC can manage their wellness and find work-life balance.

**Adopting a positive mindset.** HCBC-4, HCBC-5, HCBC-6, HCBC-8 identified that they try to maintain a positive attitude. This was easier for some HCBCs than others. HCBC-4 and HCBC-6 both referred to their optimism as an individual characteristic that facilitates their wellness. HCBC-4 indicated that she because she is “more optimistic. It’s a bit easier to see the positive things.” HCBC-6 stated, “I think I’m probably a little, just a little bit on the positive side anyway…. We do have to keep practicing that, you know, staying positive.” HCBC-6’s positivity translated into a positive approach with clients her clients. HCBC-6 identifies her client’s strengths and progress and reflects this to parents before providing additional suggestions or interventions. HCBC-5 admitted she can be pessimistic at times but really tries to “think positively”. When HCBC-5 finds herself thinking negatively, she stated, “I try to remember that… it’s not all bad. Like I can make my own schedule and it's flexible. I try to remember those good things.”

HCBC-8 reported that he maintains his wellness by keeping “a positive attitude” and reflected, “and know that I, I don’t have to, you know, I don’t have to do this if I don’t want to.”

SUP-2, HCBC-4, HCBC-5 went even further and asserted that a positive culture within the agency and supervision benefits HCBCs. At one point in time, SUP-2 reported that there were supervisors in her agency that encouraged negativity and venting in supervision. SUP-2 noticed that HCBCs left supervision feeling disgruntled with the agency and the work. This supervisor is no longer with SUP-2’s agency and instead
SUP-2 reported that the agency hires supervisors “who are positive and who are good at um, staying focused so that things in the agency aren’t. There isn’t a lot of people. There aren’t a lot of people who are unhappy, disgruntled with like agency practices.” HCBC-5 stated that when she receives her supervisor’s support in supervision, she is more likely to have a “positive mindset”. Additionally, HCBC-6 indicated that her current supervisors focus on “positives” and “where you are doing great”. According to HCBC-6, when supervisors adopt a “positive culture in interactions of making sure to acknowledge people’s accomplishments and progress” improves HCBC wellness.

Managing the work. As the HCBCs and supervisors discussed how HCBCs are able to find work-life balance, they identified the importance organization and time management. These concepts were coded as managing the work. All of the supervisors indicated that it is important for HCBCs to be able to manage their time wisely. Many of the HCBCs offered how difficult it is to manage the schedule amid cancellations and last minute pleas to reschedule. Several of the HCBCs discussed ways that they manage their schedule and stay organized.

SUP-1, SUP-2, SUP-3, and SUP-4 reported that some HCBCs struggle to figure out how, as SUP-4 put it, “to schedule themselves, how to spend time with family, and how to keep work from personal stuff.” SUP-4 noted that some HCBCs are spending late nights working on notes and end up working all hours, day and night, but are still unable to keep up with paperwork. SUP-3’s statements echoed SUP-4’s. SUP-3 indicated that that she frequently checks in with her “problem children”, the HCBCs that have difficulty meeting deadlines and completing paperwork in a timely manner. According to SUP-3, in her experience, the HCBCs that have the most going on, personally and professionally,
have difficulty keeping up with the paperwork. She noted that the HCBCs that manage their time better and are more organized are not as “stressed out” and furthermore, she notices they are more prepared for meetings and their paperwork submitted on time with fewer mistakes. SUP-3 identified time management as an aspect of self-care. SUP-4 stated that some HCBCs manage the work by taking off a Friday in order to work a Saturday. SUP-1 and SUP-2 recommended that HCBCs need to be flexible on one hand without leading clients to believe that they will constantly change their schedule last minute to adapt families. SUP-2 stated:

Like if there is a change in their schedule they make it work or they tell a parent ‘I'm sorry I can't make that work. Here's what I can do.’ And if they can't do it they are like, ‘Ok, I will just do what I can.’ They just don't get so anxious about everything. They've learned how to just kind of go with the flow, I guess. Learned how to just be flexible with things.

SUP-1 suggested that HCBCs chunk their billable sessions into sessions lasting a couple hours to make the most use of their time, instead of scheduling two one hour sessions during the week. SUP-4 advisees her supervisees to complete notes at the end of the session to minimize paperwork at the end of the day.

Several of the HCBCs interviewed discussed the difficulty that HCBCs have managing their schedule. HCBC-1, HCBC-3, HCBC-5, and HCBC-7, described working very busy schedules and having limited time. By their accounts, their schedules were consumed by work and they had difficulty finding time for friends, family, and leisure activities. The HCBCs reported that there were many days when they spent their evenings completing paperwork at home.

HCBC-1, HCBC-3, HCBC-5, HCBC-6, and HCBC-7 offered suggestions for improving time management based on their own practices. HCBC-1 reported that she
tries to find time in the middle of the day to take a break and indicated that she “will take that time for myself if I am out somewhere in between appointments…. And maybe I will get on my phone and I will mess around or go grab something to eat.” HCBC-3 reported that he also takes advantage of breaks in the middle of the day either to complete progress notes. HCBC-7 also endorsed taking breaks during the day to get caught up on paperwork and giving clients a break during the session to complete the progress note. While HCBC-5 understood the benefit to completing notes at the end of a session while still in the home, she reported it was very difficult to do. Both HCBC-6 and HCBC-7 indicated that they are flexible in the face of cancellations and will use the free time to complete other billable activities like writing treatment plans, conducting data analysis, or completing assessments or work on progress notes.

According to HCBC-4 and HCBC-5, time management included thoughtfully scheduling clients and deciding how much time to devote to the work. HCBC-5 reported that she avoids scheduling several “intense” clients on the same day to prevent her schedule from being overwhelming and sessions from running late. HCBC-5 tries to schedule clients close to one another to reduce time spent traveling. Time management for HCBC-4 is trying to “balance sort of the amount that I am getting paid with the amount that I put forth into it outside of the hours that I am working.”

HCBC-5, HCBC-6, and HCBC-7 reported that they make use of calendars and lists to stay organized. HCBC-5 maintains a task list along with her schedule to be sure to complete requirements on time. HCBC-6 also keeps a task list with her schedule to track when evaluations, revisions to treatment plans, meetings, and initial treatment plans are due for her clients. HCBC-6 asserted, “I have become more organized because if you
are not organized in the BHRS field, I really honestly don’t know how you could do it.” She went on to say without organization, “it’s not going to be a productive career path for you.”

“Moving forward”

Data analysis of the interviews with HCBCs and their supervisors yielded the process, “moving forward”, shown in Table 20. This process was coded using the words of the participants themselves. This process was discussed by four counselors and two of the supervisors. HCBC-1, HCBC-2, HCBC-3, and HCBC-6 described moving forward as the process by which they stay well, in spite of the challenging work, and continue to work effectively with clients. In his discussion of moving forward, HCBC-2 also identified that HCBCs must assist families with moving forward. Supervisors identified that they are responsible for assisting HCBCs with moving forward as counselors.

Table 20

Cross Case Analysis of “Moving Forward”

<table>
<thead>
<tr>
<th>Categories</th>
<th>Home and Community Based Counselors</th>
<th>Supervisors</th>
</tr>
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<tbody>
<tr>
<td>Moving forward as counselor</td>
<td>H1 x H2 x H3 x H4 H5 H6 H7</td>
<td>S1 x S2 x S3 S4</td>
</tr>
<tr>
<td>Helping clients move forward</td>
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<td>x x</td>
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</tbody>
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Moving forward as a counselor. Many of the HCBCs brought up the process, moving forward, during the course of their interview. Each HCBC described the experience of moving forward a little differently. To understand how HCBC-1 defined moving forward, it is necessary to provide context and include the statements leading up
to the point when she stated, “It’s moving forward.” First, HCBC-1 spoke to the importance of being able to identify when she is negatively affected by the work:

When you come into a session… I know with some jobs… maybe you can afford to be a little tired or just a little bit off your day but when you are coming into to do counseling with someone you pretty much need to be you know, present with a client… and I think paying attention to the times that you are struggling. Like when there is more stress and the need to um say, ‘Ok maybe I need to eat better, I need to get more sleep, or I need to figure out how to deal with stress.

HCBC-1 admitted that she had been experiencing more stress recently and she explained, “I've been doing this for four years and I'm just kind of getting to the point where I am feeling a little bit burned out.” Interestingly, HCBC-1 was very aware of behaviors that seem to take her further away from wellness and those that move her toward wellness.

She distinguished between these two contrasting phenomenon when she stated:

But at the same time… I’ve been kind of getting into some bad habits, as far as, I'm a stress eater. So sometimes, I tend to go that route… and I like to stay up late and just have time for myself to read or do whatever because a lot of my day is doing things that I have to do even at home…. I'm at the point now where… I've been aware of this for a little while. I need to make at least some small changes to get back on track.

Having an awareness of her own state of well-being became a precursor for taking the small changes needed to move forward. These are the small changes that HCBC-1 described as moving forward. She continued to explain:

I really try to… say, ‘ok… you need to cut back on sugar, you need to eat a little bit healthier.’ And my husband is going to school full-time. He's almost done. But right now so we are both under a lot of like stress and time constraints so,… I think we try to do the best we can but I really try to think about eating healthy. Unfortunately, I feel like I really don't have a lot of time to exercise…. I'm a Christian so I attend church. I pray a lot and I... I really try to pay attention and say, ‘ok maybe I can't do like make this great big overhaul, like I probably need to make but at least if I can change a few little things.’ It's moving forward."

HCBC-1 identified that she moves forward by making small changes to better cope with stress, improve wellness, and function optimally at home and at work.
HCBC-2 mentioned the concept, moving forward several times during the interview. When he first introduced the idea of moving forward, he stated that success and progress in treatment are the catalyst for moving forward despite the chaotic, unstructured, and challenging experiences encountered in the home. HCBC-2 explained:

Because we do go into homes. We do go in and kind of see the family in their natural environment, for good and bad. You know, it's good to see the patterns of interaction but it can also be tough when there is chaos and things going on in the environment and you're trying to work with the family to accomplish some goals.... But I do. I think it's those successes they really, you know, keep you moving forward as a community therapist.

Later in the interview, HCBC-2 maintained that support from others in the field is necessary for processing difficult sessions:

Having someone that you can kind of discuss your difficult cases with. Like anything else in this field, you do have those cases that stick with you or you have those things that happen on those cases where you are just kind of floored by the whole thing 'cause you're human.... I can think of one case in particular where I worked with a young... man whose mother tried to commit suicide in front of him by drinking Drano.... being able to just express, you know, almost like, your, you know your secondary trauma that you experience.

When HCBC-2 was asked what it is about conversations with colleagues that can be helpful, HCBC-2 discussed the importance of being present with a client, something noted by HCBC-1 to be important. During these conversations, HCBC-2 suggested that it is important for the HCBC to, "try to work through that for yourself knowing that you have to go back into that environment and work with those, the kids that are really struggling with witnessing it firsthand." Though this was not specifically identified by HCBC-2 as moving forward, it was coded as such because it seemed to reflect another aspect of ‘moving forward’, moving forward as a counselor, processing secondary trauma, so that the HCBC can work effectively in their role.
Again, HCBC-2 brought up the role of moving forward and reiterated the need to focus your work as a HCBC, this investigator asked about the experiences that stand out as shaping his wellness. HCBC-2 spoke about the first suicide attempt encountered in his work. He explained, "I think you struggle with how do you move forward [emphasis added] with one your, your own trauma and also not being afraid to do your job as well." HCBC-3 mentioned a similar process when he reflected the following, “I’ve heard of some pretty horrible cases. I haven’t had many of those but I imagine the kind of dread you feel when you have to go back there. You kind of have to learn how to deal with that a certain way so that you can keep on with the treatment”. HCBC-2 also spoke about assisting clients and families with moving forward. In reference to assisting parents with moving forward, HCBC-2 stated, "It's great to have the independence to go out in the community and do what you need to do and work with the families and help them move forward [emphasis added]...." HCBC-2 and HCBC-3 describe moving forward as the ability to function effectively as a HCBC despite the ongoing challenges of the work.

Because HCBC-2 continued to revisit the idea of moving forward, I asked him specifically what moving forward looks like for him. HCBC-2 identified how he is able to move forward as a HCBC. He went on to explain, "Being able to draw healthy boundaries between myself as the counselor and myself as HCBC-2. And that there has to be a certain... at times rigid boundary so that I don't carry that back home with me." HCBC-2 described another dimension of moving forward, creating boundaries between work and one’s personal life.
HCBC-6 defined moving forward as the means in which she manages her own disappointment and frustration with the work through acceptance and letting go. HCBC-6 stated:

I have to learn to let the situation go if something, you know, didn't work out or maybe I made a mistake…. I have to learn that that's ok… tomorrow is another day and that… we can just move forward…. It's really hard because you are dealing with children…. You don't want things to affect them… or their families and you are always there to provide… a service but maybe one day I'm having a bad day and I might not have been as professional as I should be. So then I will come home and I will say, ‘You know what. That wasn't really good I should have been more professional’…. Things like that. I just need to be able to let them go…. Moving forward means that… I’m accepting that that situation happened… and that I am not upset about it anymore and that I am just moving on with the rest of my work routine or daily routine.

During the course of the interview, HCBC-6 offered advice to other HCBCs suggesting:

I would say number one make sure… that they are not taking things too personally…. Things can happen… on cases and we just have to make the best of it and move forward [emphasis added]… and not every… parent… may agree with your recommendation even if it's… research or evidence based as effective and that's ok. You just have to figure out a way… to make that situation work and I would definitely also recommend… that they have activities outside of work that they can find joy in and engage in.

**Helping HCBCs move forward.** SUP-2 reported noticing that some HCBCs have difficulty moving forward. She noticed that these HCBCs tend to be anxious. SUP-2 reported:

They are crying all the time, overwhelmed, flustered, stressed out…. They perseverate about things…. They want to talk about things over and over and having a hard time…. I will say that, ‘you have to let that go and we have to move forward and look at what we have to do for this child.’

SUP-2 shared that in her experience moving forward is keeping “treatment child centered”, and “not letting their emotions or a parent’s emotions play into what we have to do for that child.” SUP-2 notices that some HCBCs, “perseverate about things…. They want to talk about things over and over and having a hard time…. I will say that
you have to *let that go* [emphasis added] and we have to figure out how to move forward."

SUP-2 assists HCBCs with moving forward by reminding the HCBC to focus on the child’s needs and remember to keep bringing the focus of treatment back to the child’s goals for treatment and how to help the child reach those goals. SUP-2 explained, “We have to do what we have to do to move forward with the child…. let’s look at treatment…. Where we’re at and what do we need to do for the child to… get the child stable.” SUP-2 cautioned that the HCBC can become focused on “dwelling on things that have happened or collecting injustices” instead of moving forward. According to SUP-2, the HCBCs that are able to remain goal-oriented, “don’t get flustered with trying to get there even if it is a difficult situation.” Further, SUP-2 has found that these HCBCs are “very even keeled about things. They are good about handling problems. It doesn’t make them anxious. They can stay calm and focused and rational and logical.” SUP-2’s emphasis on letting go as a function of moving forward lends further support to the importance of letting go as described by HCBC-6.

SUP-4’s experiences in supervision with HCBCs resembled SUP-2. SUP-4 recounted that she assists HCBCs with moving forward with treatment. Supervision becomes an opportunity for her to ask HCBCs questions about treatment and help them come up with solutions to their own problems. SUP-4 divulged that this approach:

kind of lets me see where they are too and what they know… so then I can kind of guide them well, ‘this is what you need to do and how we can move forward.’ So it’s interesting because a lot of them don’t do those things. They are waiting for somebody to tell them, like, this is what you need to do and I’m not going to do that. So, I… let them tell me what they need to do.
SUP-2 and SUP-4 both view the process of moving forward to be essential to keeping treatment goal oriented and see supervision as the supportive environment to facilitate this. From the interviews with the HCBCs and the supervisors, I determined that moving forward as a HCBC is a process through which HCBCs set boundaries with the work, take steps to improve wellness (e.g., taking time for self, eating healthier, exercising, spending time with friends and family, consulting with colleagues, and accepting and letting go of the situation) in order to optimize their functioning at personally and professionally.

Chapter Summary

Eight home and community based counselors (HCBCs) and four HCBC supervisors participated in this qualitative study. The aim of the study was to develop a theory of HCBC wellness built upon the systemic processes that influence HCBC wellness and grounded in the experiences of supervisors and HCBCs working in the home and community setting. This researcher conducted semi-structured individual interviews with each participant using the interview schedules found in Appendix A.

From the process of focused coding and memo writing, this researcher identified the following categories: helping others, confronting the realities of the work, taking care of yourself, finding support, striving for work-life balance, and moving forward. HCBCs acknowledged that they value helping children and families and “making an impact.” The supervisors also indicated they wanted to make a difference in the lives of clients and facilitate the growth of HCBCs. Both the HCBCs and supervisors looked for evidence that they were making a difference, either in seeing and witnessing client progress, or hearing about HCBC progress and growth in supervision. The HCBCs faced many
different challenges due to the nature of the work, itself. When confronting the realities of the work, HCBCs experienced isolation and had to contend with high expectations for productivity, extensive paperwork, insufficient pay, and a lack of supervision while working with multiply challenged families. While the supervisors perceived themselves to be readily available to HCBCs, the HCBC experienced supervisors and supervision differently. Many HCBCs indicated that either, they were not receiving adequate clinical supervision or they were reluctant to seek supervision because they perceived their supervisors as being too busy.

The HCBCs and supervisors interviewed defined wellness as “taking care of yourself”, emotionally, physically, socially, occupationally, and financially. Some of the HCBCs and supervisors likened wellness to self-care, the things that the HCBCs do to stay well, such as, spending time with friends and family, consulting with colleagues, seeking supervision, pursuing interests outside of work, and getting rest. Finding support and striving for work-life balance were two processes identified by the HCBCs and the supervisors, to be important to HCBC wellness. The category, finding support, included feeling valued, developing a supervision network, needing ideas, feedback, and resources in supervision, and being there. When the HCBCs did not find support and the needed resources in agency supervision, the HCBCs turned to friends and family, colleagues, and LPC supervision for additional assistance (i.e., developing a supervision network). The HCBCs and supervisors discussed the importance of the agency culture to HCBC wellness. When present, a supportive agency culture was evident throughout the agency, in interactions with upper management, between supervisors and HCBCs, and between
HCBCs and their clients. Punitive agency practices negatively affected HCBC wellness and the HCBCs ability to take care of themselves and work effectively with clients.

The HCBCs strove for work-life balance by pursuing activities outside of work, setting boundaries with the work, clients, and the agency, finding time, adopting a positive mindset, and managing the work through organization and time management. Again, HCBC and supervisors shared that agency practices and policies could potentially stymie or set work-life balance into motion. When the agency and the supervisor provided encouragement, appreciation, and support, the HCBCs were better able to find work-life balance and move forward as a counselor. The HCBCs defined moving forward to be managing wellness so that the HCBC can focus on clinical work and function effectively as a counselor. Moving forward means that the HCBC is processing the HCBC’s reaction to the client or family’s trauma or the HCBC’s reaction to a difficult and challenging counseling session. HCBCs also described moving forward to be setting boundaries with the work so that the HCBC does not “carry that back home.” SUP-2 and SUP-4 reported that supervisors can assist HCBCs with moving forward with treatment by encouraging them to stay focused on treatment goals and how the HCBC can continue to help the family.

In the upcoming Chapter V, this researcher reviews how the findings answer the research questions and the implications. The limitations of the study will be described and future research directions will be suggested.
CHAPTER V: DISCUSSION

Introduction

Over the past several decades, home and community based counseling services have become instrumental to the treatment of children and adolescents struggling with mental illness (Cornett, 2011; Snyder & McCollum, 1999). These services were designed to reduce barriers to treatment, prevent hospitalizations, and keep children with their families (Cornett, 2011; Mann & Hyde, 2013; Snyder & McCollum, 1999). However, home and community based counselors working in these systems of care face significant challenges in this unique setting (Lawson, 2005; Macchi & O’Conner, 2010; Snyder & McCollum, 1999).

In addition to the mental health diagnosis required for treatment, children and families that access home and community based counseling may be affected by a family history of mental illness, poverty, domestic violence, and addiction (Lawson, 2005). Also, home and community based counselors (HCBCs) often contend with a chaotic treatment setting as they try to set boundaries with the family and create a viable space for counseling (Adams & Maynard, 2000; Lawson, 2005; Macchi & O’Conner, 2010). Most HCBCs face these challenges as recent graduates, not having adequate preparation for the home setting, and receive little supervision (Lawson & Foster, 2005; Stinchfield, 2004; Worth & Blow, 2010). Not surprisingly, HCBCs have reported feeling isolated and unsupported and question their effectiveness as counselors (Bowen & Caron, 2016; Macchi & O’Conner, 2010; Zarski, Sand-Pringle, Greenbank, & Cibik, 1991).

The research literature has begun to address the challenges of home and community based work (Cortes, 2004; Macchi & O’Conner, 2010), identify HCBC
competencies (Hammond & Czyszczon, 2014, Tate, Lopez, Fox, Love, & McKinney, 2014), and the need for ongoing training and supervision (Hammond & Czyszczon, 2014; Lawson, 2005; Macchi & O’Conner, 2010; Stinchfield, 2004). Macchi, Johnson, and Durtschi (2014) found that work experience and workload predicted the professional quality of life of a sample of home-based family therapists. Greater work experience and the perception of a more manageable workload were associated with an enhanced professional quality of life (Macchi et al., 2014). Further, in Macchi et al.’s (2014) study, the frequency of supervision mediated the association between experience and workload on professional quality of life, while the frequency of self-care practices mediated the association of workload on professional quality of life. Macchi et al.’s (2014) results point to the importance of self-care to HCBC wellness, especially when the HCBC is lacking supervision.

Macchi et al.’s (2014) investigation is the only one to date that examines the wellness of HCBCs. While Macchi et al. (2014) suggest that self-care and supervision are important to HCBC wellness, we are unable to discern from the study which self-care strategies may benefit the HCBC. It is also unclear how systemic factors may affect HCBC wellness.

This researcher conducted a broad review of the literature and discovered that studies examining the individual and organizational factors that may influence counselor wellness have yielded inconclusive results. Because the area of research pertaining to HCBC wellness is limited, qualitative studies are needed to identify the unique individual, agency, and supervisory practices that may play an important role in HCBC wellness. The aim of this qualitative study was to learn more about HCBC wellness,
specifically how systemic factors influence HCBC wellness. Eight HCBCs and four HCBC supervisors were interviewed individually to answer the research question, “How do systemic influences affect the well-being of HCBCs?” Out of the grounded analysis, six concepts were identified: helping others, confronting the realities of the work, taking care of yourself, finding support, striving for work-life balance, and moving forward. Within each of these concepts, participants identified what individual, supervisory, and agency factors can impact HCBC wellness and how this process occurs. The experiences shared by the HCBCs and supervisors make it clear that it is not just the individual practices that matter, organizational and supervision practices impact wellness as well.

The HCBCs and supervisors interviewed reported that they entered and continue to work in the field because they want to make a difference. They want to make an impact on the lives of children and families. Seeing progress and success served as indication that they were in fact helping others. The HCBCs and supervisors defined wellness to be taking care of yourself. Taking care of yourself included managing all aspects of wellness, the emotional, physical, social, occupational, and spiritual.

The HCBCs’ and supervisors’ narratives illustrated that in finding support, they want to feel valued by the agency, supervisors, and colleagues. The HCBCs’ perceptions toward supervision as a support were mixed. In an effort to find support, HCBCs and supervisors reported that HCBCs create their own supervision network. Through this supervision network, HCBCs look to receive ideas, feedback, and resources. By being there, supervisors reported that they support and invest in staff, show their appreciation,
and support professional development, often drawing upon and sharing their own experiences as a HCBC.

The HCBCs and supervisors described the negative impact that workplace culture can have upon HCBC wellness. Workplace culture has the potential to have an effect on supervision, HCBC wellness, and the HCBC’s effectiveness with clients. The HCBCs and supervisors achieve work-life balance by pursuing interests outside of work, setting boundaries, finding time, adopting a positive mindset, and managing the work using organization and time management skills. The HCBCs and supervisors discussed the need for HCBCs to move forward, to process reactions to difficult sessions or client trauma, be aware of and address their own HCBC wellness, and continue to remain goal oriented in treatment.

This Chapter provides a discussion of the dominant categories that were identified from focused coding. This researcher will identify how the findings inform each research question, the implications thereof, and recommendations for HCBCs, supervisors, agencies, and counselor educators. Finally, the limitations of the study will be described along with questions generated by the study and directions for future research.

**Discussion of the Findings**

Semi-structured individual interviews were conducted with each participant using interview schedules as a guide (Appendix A). The following section provides a discussion of each of the research questions and the concepts that were identified through data analysis. As the findings of the study are outlined, the concepts that arose are connected to each research question. The implications of the study on HCBC wellness, supervision, and HCBC agency practices are addressed.
Research Question #1

A constructivist grounded theory methodology (Charmaz, 1996; Charmaz, 2008; Charmaz, 2014) informed the design and analysis of this study. Using this methodology, this researcher sought to answer the question, “How do HCBCs and supervisors define wellness as a HCBC?” From the responses the category, taking care of yourself was identified.

Taking care of yourself. The HCBCs and supervisors interviewed defined HCBC wellness as the process of taking care of yourself. In this definition, the HCBCs and supervisors discussed the actions that the HCBC must take to stay well. Responses from HCBCs indicated that the HCBCs needed to “look after” themselves emotionally, physically, and socially, practice self-care, “take care of yourself” to prevent burnout, take action to prevent “waking up in the middle of the night stressed out about your job,” and do “things to make sure that mental health and their happiness is also stable and well.” All of their responses placed HCBC wellness squarely on the HCBC.

The supervisors’ responses further supported the HCBC’s experience of wellness as taking care of oneself. However, the supervisors’ responses also identified the impact that workplace culture, supervision, and the nature of the work, itself, can have on HCBC wellness. SUP-1 suggested that without agency and supervisory support, the HCBC is unable to take care of themselves. SUP-2 had difficulty defining wellness but was able to compare and contrast the HCBCs that she conceptualizes as well with those HCBCs that are unwell. She explained that the HCBCs that struggle the most are “overwhelmed, flustered, stressed out.” The HCBCs who manage their emotions and remain focused on the work are “even keeled about things” and “can stay calm.” SUP-2 acknowledged her
own role in supporting the struggling HCBCs in supervision. SUP-4 had difficulty defining wellness, claiming, “I don’t really think it exists.” She identified that HCBCs have difficulty taking care of themselves and “struggle with figuring out like how to schedule themselves, how to spend time with their family, and how to keep work from personal stuff.” Again, these responses point to the importance of tending to the emotional, social, and occupational aspects of wellness. The systemic factors that influence the HCBCs ability to take care of themselves will be addressed more fully as this researcher expounds upon the findings in relation to other research questions. It appears as though the supervisors conceptualized wellness as an all or nothing concept, something that either “exists” or does not exist, as opposed to viewing wellness on a continuum.

**Implications.** The results from this study further support definitions of wellness that exist in the literature (Roscoe, 2009; Myers, 1991) and the directives provided by the ACA Code of Ethics (2014). Roscoe (2009) reported that the dimensions most often included in conceptualizations of wellness are social, emotional, physical, intellectual, spiritual, psychological, occupational, and environmental wellness. The ACA Code of Ethics reminds counselors to “engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being” (ACA, 2014, p.8). The dimensions of wellness identified to be important to the HCBCs interviewed included the physical, emotional, mental, social, occupational, and financial aspects of wellness. The dimensions identified by participants can be found in Roscoe (2009) and the ACA Code of Ethics (2014). Myers (1991) suggested that as counselors we must model wellness for our clients by adopting “wellness lifestyles in ourselves and our families” and the ACA
Code of Ethics directs counselors to “engage in self-care activities.” Like Myers (1991) and the ACA (2014), the HCBCs and supervisors recommended that HCBCs actively take steps to be aware of and actuate their own wellness.

The HCBCs readily defined HCBC wellness to be the actions that HCBCs take to manage their wellness. The idea that wellness as a concept that is the responsibility of the counselor, is also perpetuated in the conceptual literature that advises counselors to be aware of and manage their self-care (Figley, 2002; Lawson & Vernart, 2005; McCann & Pearlman, 1995). The findings from this study lend further support to the quantitative research that has found that practicing self-care can impact professional quality of life (Macchi et al., 2014). This study’s findings also add to the body of literature that suggests that counselors believe practicing self-care matters and makes a difference to HCBC wellness (Killian, 2008; Lawson, 2007). Killian’s study found that clinicians identified self-care practices to be beneficial to coping with working with survivors of trauma. Lawson (2007)’s participants with higher scores of compassion satisfaction and lower scores of burnout endorsed the following self-care strategies as being beneficial: time with friends and family, a sense of humor, self-awareness, work-life balance, spirituality, and quiet leisure.

Interestingly, this study’s findings suggest that the HCBCs and supervisors may view wellness as an all or nothing concept, instead of acknowledging that wellness can exist on a continuum. Roscoe (2009) and Antonovsky (1996) view wellness and health, respectively, on a continuum. Roscoe (2009) and Antonovsky’s (1996) approach to wellness and health promotion recognize the efforts of the individual. Viewing HCBC as
all or nothing may serve to negate or even worse undermine the efforts and inherent strengths of the HCBC.

**Research question #2**

The interviews with the participants also sought to answer the question, “What do HCBCs do to stay well?” The purpose of this question was to determine how HCBCs stay well in their line of work. Self-care practices have been identified in the conceptual literature (Figley, 2002; Lawson & Vernart, 2005; McCann & Pearlman, 1990; Skhovolt, Grier, & Hanson, 2001) but research has not yet identified what strategies counselors working in the home and community may implement to stay well. The categories identified from the data that most pertinently answer this research question are striving for work-life balance and finding support. As the HCBCs and supervisors talked about HCBC wellness, it became evident that the HCBCs struggled to find work-life balance and “move forward” as a counselor, yet aspired to regardless.

**Striving for work-life balance.** The HCBCs identified many different ways of staying well. All of the concepts that they identified were grouped under the category, striving for work-life balance. HCBCs and supervisors indicated that it was important for the HCBCs to try to “balance everything out” and keep “balance” in their lives with “interests, other activities, other parts of life”. The most endorsed actions taken by HCBCs included pursuing interests outside of work, setting boundaries, and managing the work.

**Pursuing interests.** Each HCBC indicated that they manage their wellness by taking time outside of work to do things that they enjoy. The activities identified by the HCBCs include reading, attending church, shopping, listening to music, attending art and
music events, enjoying swing dancing or karaoke, spending time outside, gardening, exercising, going for walks, and painting. A few of the HCBCs talked about how they have built in and observe rituals each day as a way to take care of themselves, such as taking coffee and breakfast to go each morning, going for a walk at the end of the day, or drinking a cup of tea at the end of the night. The supervisors’ responses supported the HCBCs’ reports. The supervisors indicated that HCBCs report that they attend church, practice yoga, and exercise.

**Setting boundaries.** Many of the HCBCs and supervisors identified that they set boundaries with the work, clients, and the agency. In order to set boundaries with the work, many of the HCBCs did not work weekends. HCBC-2 physically separated himself from the work by leaving his work bag locked in the trunk at night. HCBC-3 described mentally separating himself from the work by “compartmentalizing” the work and leaving the “work behind”. One of the supervisors identified that she has noticed HCBCs setting boundaries with work, limiting the amount of work that they take home at night. The HCBCs interviewed varied in their ability to set boundaries with the work. Some of the counselors shared that there is always work to do and that necessitates working on documentation late into the night. Other HCBCs shared that they limit the amount of time that they spend on paperwork so that they can have time to themselves or with friends and family in the evenings or on the weekends.

The HCBCs and supervisors recognized that it can be very difficult to set boundaries with families because the home setting can be chaotic and unstructured by nature. HCBC-4 set boundaries with families during the first few sessions by developing a session routine, discussing expectations, and creating a weekly schedule. HCBC-7
reported that she refuses to help the client with homework unless indicated by treatment, declines dinner and party invitations from families, does not answer the phone in the evening, and refers families to a crisis hotline for crisis support. Several of the supervisors shared that they have seen HCBCs successfully set and maintain boundaries with families by not answering phone calls at night and refusing to rearrange their schedule last minute. The supervisors were observed setting boundaries during the interview or discussed how they set boundaries with the HCBCs that they supervise. For instance, one supervisor shut off her computer to give me her undivided attention. The other supervisor talked about how she does not friend the HCBCs on Facebook or snapchat, will not go to lunch with supervisees, and does not access work email on her phone.

**Managing the work.** All of the supervisors indicated that it is important for HCBCs to be able to be organized and manage their time wisely. They noted that many HCBCs have difficulty figuring out how to keep up with paperwork and manage the schedule. SUP-3 asserted that time management is an essential self-care tool. She has noticed that the HCBCs that are struggling have difficulty completing paperwork correctly and on time, while the HCBCs who manage their time better and are organized are more prepared for meetings and submit paperwork in a timely manner. To make better use of one’s time, a supervisor recommended to schedule sessions for several hours instead of scheduling two one hour sessions. Another supervisor advises HCBCs to complete their progress notes during the session to minimize paperwork later.

Several HCBCs provided their strategies for time management and organization, skills that they believed were essential to functioning in the field. These HCBCs were
creative with their time. They would take breaks in the middle of the day to complete
progress notes, give clients a break during sessions to complete paperwork, and make use
of free time in the event of a cancellation. During this free time, HCBCs stated that they
complete other billable activities (e.g., treatment plans, data analysis, and assessments) or
progress notes. HCBCs indicated that they thoughtfully schedule clients both to avoid
having too many intense clients on the same day and prevent excessive travel. Some
HCBCs monitored the time and effort that they put forth in the work realizing that
overworking does not benefit the HCBC or the client. Organizational methods used by
HCBCs included, maintaining a calendar and keeping task lists to track deadlines and
important dates.

Finding support. The HCBCs and supervisors reported that HCBCs seek
support from friends, family, colleagues, and supervisors. HCBCs indicated that they
created their own supervision networks that may include colleagues or coworkers.
HCBC-2 advocated for HCBCs to create their own supervision network to “bounce ideas
off of” and “discuss difficult cases with.” HCBC-3 relied on consultations with
colleagues when he was unable to schedule supervision. HCBC-4 and HCBC-5
recommended that HCBCs reach out to other HCBCs for support when needed. HCBC-7
stated that she consults with other HCBCs who have experience working with children
diagnosed with an autism spectrum disorder. HCBC-4 and HCBC-5 remembered a time
when they had a supervisor who was trained to work with children with autism. Both
HCBCs appreciated the additional supervision and support. HCBC-6 finds support by
attending group supervision that is regularly frequented by the same small group of
colleagues. The reports from the supervisors corroborated the experiences of the
HCBCs. The supervisors indicated that the HCBCs tend to form close bonds with one another and rely on one another for support.

Implications. The HCBCs and supervisors described in detail ways that HCBCs manage their wellness. All of these concepts were grouped into the categories, striving for work-life balance and finding support. In order to try to achieve work-life balance, HCBCs made efforts to set boundaries with the work, clients, and the agency, pursue interests outside of work, and manage the work with organization and time management strategies. All of the HCBCs admitted that it is difficult to attain work-life balance due to the demands of the work and expectations of the agency. Some HCBCs were so consumed with work, working late into the night, and they still had difficulty keeping up with the paperwork. One HCBC was aware that her work-life balance was out of kilter, knew what she needed to do, but had difficulty finding the time to pursue interests that might reduce stress and improve her wellbeing. The HCBCs quickly recommended that other HCBCs need to be sure to find time to themselves and spend time with friends and family but implementing their own advice was difficult.

The HCBCs and the supervisors reported that they find work-life balance by pursuing interests outside of work, setting boundaries with clients and the work, and managing the work. It was clearly important to the HCBCs to find enjoyment in their life outside of work. The ACA Code of Ethics reminds counselors to engage in activities that support “their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities.” Figley (2002) recommended that when compassion fatigue is evident, counselors seek therapy and engage in self-care. However, the HCBCs in this study reported that it is important to consistently find time for activities that serve to
sustain them. Most of the activities described by the HCBCs could be categorized as quiet leisure, a career sustaining behavior endorsed by counselors in Lawson’s (2007) study who had lower levels of burnout and greater compassion satisfaction. HCBCs reported that they enjoy attending church, painting, going for walks, gardening, listening to music, attending art and music events, and drinking a cup of coffee or tea.

It has been clearly established in the literature that it is extremely difficult in the home setting to establish boundaries with families in order to create a space for therapy to successfully occur (Adams & Maynard, 2000; Lawson, 2005; Macchi & O’Connor, 2010; Snyder & McCollum, 1999). The HCBCs interviewed by Bowen and Caron (2016) and Lauka et al. (2013) described several instances when professional boundaries were frequently challenged in the home setting, including being invited to birthday parties, offering HCBCs food or drink, and giving HCBCs gifts. The HCBCs and supervisors in this study had similar experiences. HCBCs described situations in which families invite the counselor to birthday parties, text HCBCs between sessions, calls after business hours, and demand crisis support. The HCBCs reported that they set boundaries in each of these situations and their response shaped the therapeutic and professional relationship. The experiences of the HCBCs in this study add to and extend the body of literature that has identified ways that boundaries can be tested in the home and community settings (Bowen & Caron, 2016; Lauka et al., 2013; Worth & Blow, 2010).

The HCBCs in this study identified how they organize and manage their time as a way to maintain work-life balance. Like the participants in Bowen and Caron’s (2016) study, the HCBCs in this study had difficulty keeping up with paperwork. The suggestions provided by HCBCs and supervisors may benefit HCBCs working in similar
system of care as BHRS HCBCs. One of the supervisor’s interviewed in this study recommended that HCBCs schedule sessions in longer blocks of time to minimize travel throughout the week. The counselors-in-training in Snyder and McCollum’s (1999) study found that most often sessions needed to be lengthened in the home and often averaged 90 minutes as opposed to the 50 minute sessions hour often indicative of a clinic setting.

Other strategies endorsed by the HCBCs interviewed in this study include: be prepared for meetings, complete progress notes at the end of the counseling session when able, make use of breaks at the end of the day, make use of cancellations to complete other billable activities, and maintain a calendar and task lists to manage important tasks. Outside of Bowen and Caron’s (2016) study and past outdated studies (Adams & Maynard, 2000; Lawson & Foster, 2005; Snyder & McCollum, 1999; Stinchfield, 2004), there is a dearth of literature investigating the experiences of home and community based counselors. This study offers realistic recommendations for HCBCs working in systems of care similar to BHRS that necessitate working in isolation without weekly supervision.

Macchi and O’Conner (2010) state that the framework for home based family therapy training should include “opportunities for ongoing support and collegial relationships” and “encourage therapist collaboration and consultation” (Mission and Objectives Session, para 1). Lawson (2005) recommended that HCBCs be provided with regular group supervision in addition to individual supervision, shadowing, and field supervision. The HCBCs in training in Snyder and McCollum’s (1999) study were able to share ideas and collaborate during weekly group supervision. Like the clinicians interviewed by Bowen and Caron (2016), the HCBCs and supervisors in this study
indicated that they value collaborating and consulting with colleagues and coworkers. The HCBCs participating in this study were only required to attend one hour of supervision per month and for three out of four of the agencies, group supervision was offered. The HCBCs participating in this study relied on support from their colleagues especially when they did not have a supervisor readily available or if they were not receiving sufficient clinical supervision. HCBCs suggested that the agency offers paid working groups or support groups for HCBCs to encourage consultation with colleagues. These findings confirm those of Lawson and Myers (2011) and Stevanovic and Rupert (2004) that counselors and psychologists, respectively, endorse case consultation as a career sustaining behavior.

**Research question #3**

The interviews with the HCBCs and supervisors sought to answer the question “What do HCBCs and supervisors perceive to be the role of individual wellness practices (cognitions, affect, and behaviors) in maintaining counselor wellness?” The HCBCs and supervisors discussed how striving for work life balance and seeking support can influence HCBC wellness. In addition, based upon the reports and experiences of the HCBCs and supervisors, this researcher identified the process, moving forward, in which HCBCs set boundaries, persist through challenges, and seek support from colleagues in order to process vicarious trauma and improve wellness.

**Striving for work life balance.** The HCBCs and supervisors tried to attain work-life balance by pursuing interests, managing the work, and setting boundaries. During their interviews, the HCBCs and the supervisors described the role of these concepts in maintaining HCBC wellness. To achieve work-life balance, the HCBCs recommended
that HCBCs do things that they enjoy (i.e., pursue interests outside of work) and set boundaries. The HCBC-3 asserted that wellness is performing enough self-care to prevent burnout. HCBC-4 also suggested that the counselor must do “things to make sure that their mental health and their happiness is also stable and well.” When HCBCs do not have time for themselves, HCBCs reported that they were more likely to feel “burned out” or “stressed.” Several supervisors noted that the HCBCs that manage time and their schedule more effectively keep up with documentation and are calmer, less anxious when working with families. SUP-3 viewed time management as a self-care tool.

The HCBCs recognized the difficulty of establishing and maintaining boundaries; however, the HCBCs interviewed connected setting boundaries to counselor wellness. The HCBCs identified that setting boundaries with clients and the work is necessary to stay well personally and professionally. HCBC-2 stated that he believes that establishing healthy boundaries with the work helps prevent burnout and be more effective with families. SUP-1 warned that if the HCBCs do not maintain professional boundaries, it may lead to “taking on… vicarious… traumas and everything else that is happening in somebody’s life, it starts impacting you greatly.” SUP-2 recognized that the HCBCs who better manage the stress of the work, set boundaries with the families, so that they are not taking the work home with them at night. SUP-2 reported that they do not answer calls late at night. They do not work weekends and they will only accommodate schedule changes if it is feasible and practical. SUP-3 and SUP-4 identified that some HCBCs take on too much, are overworked, and as SUP-4 stated, are “killing themselves.”
Moving forward. Many of the HCBCs and supervisors brought up the concept, moving forward, during the course of the interview. The HCBCs and supervisors who endorsed the process, described moving forward in one of four ways, as the ability to be aware of and respond to stress, to continue with the work despite challenges confronted, to set boundaries with clients, or to process one’s reactions to difficult sessions so that treatment can continue to be effective. HCBC-1 was very aware of the behaviors that move her toward and away from wellness. She stated, “I really try to pay attention and say, ‘Ok, maybe I can’t do, like, make this great big overhaul, like I probably need to make. But at least if I can change a few little things. It’s moving forward.” HCBC-2 maintained that success with clients keep HCBCs “moving forward.” HCBC-2 also identified the importance of setting boundaries between the work and his personal life and relying on support either in supervision or from colleagues. HCBC-6 moves forward by accepting and letting go when “things didn’t work out” or if she made a mistake. She moves on with her daily routine whether that is her routine at home or at work. SUP-2 and SUP-4 defined moving forward as remaining child focused and goal oriented regardless of the stressors confronted.

Implications. The HCBCs identified that it can be difficult to obtain work-life balance, yet also emphasized the importance of work-life balance on wellness. These finding supports the results from prior studies conducted by Killian (2008), Lawson (2007), and Kulkarni, Bell, Hartman, and Hermann-Smith’s (2013). The clinicians interviewed in Killian’s inquiry identified workaholism, and lack of self-awareness as risk factors for burnout. SUP-3 refers to workaholism, a trap that many HCBC fall into, as she discusses her experiences with HCBCs:
The strong clinicians they just know how to have that balance. And other clinicians they just take on way too much. They think they can do it and they don't realize they are going downhill until you tell them though. They think it's all great until you say something.

Killian (2008) conducted a quantitative analysis using multiple regression and found that work drain explained some of the variance of burnout and compassion fatigue and work hours and an internal locus of control explained some of the variance of compassion satisfaction. Many of the HCBCs and supervisors reported that HCBCs frequently have difficulty keeping up with the demands of the work. SUP-4 described the HCBCs as “killing themselves” and HCBC-5 stated that “there is always something that needs to be done.” Many of the HCBCs recounted times when they needed to work evenings and weekends to treat clients or complete paperwork. Clinicians working with survivors of domestic violence were surveyed by Kulkarni et al. (2013) to determine the impact that their perceptions of organizational factors such as, workload, control, reward, community, fairness, and values had upon compassion satisfaction, burnout, and secondary stress. Kulkarni et al. (2013) found that workload was positively related to secondary traumatic stress and burnout. According to HCBCs and the supervisors, when a HCBC had difficulty managing and keeping up with the workload, they also struggled with feelings of burnout, depression, and anxiety.

This investigation corroborates research suggesting that engaging in self-care can positively influence home and community based counselor wellness (Macchi et al., 2014) and more generally, counselor wellness (Killian, 2008). The self-care behaviors described by clinicians to be important to maintaining well-being included: debriefing or processing, exercise, and spirituality (Killian, 2008, p. 36). The HCBCs readily identified things that they do to stay well (e.g., listening to music, going for walks,
drinking coffee and tea, attending church, and reading). It was clear that when they had more time to devote to their interests outside of work, they were less overwhelmed. Bober and Regher’s (2005) and Killian (2008)’s studies contradict these findings. Bober and Regher (2005) contend that “there is no evidence that using recommended coping strategies is protective against acute symptoms of distress” (p. 7). Coping style and self-care strategies as measured by Killian (2008) were not found to predict compassion satisfaction, compassion fatigue, and burnout. However, “proactive” coping strategies, such as, supervision, social support, and reducing workload, were positively associated with reduced work stress (Killian, 2008, p. 40).

The HCBCs studied by Christensen (1995), Bowen and Caron (2016); and Lauka et al. (2013) acknowledged the importance of maintaining boundaries with the work and with clients. This investigation extends the body of research regarding the importance of boundaries upon HCBC wellness. Not only did the HCBCs and supervisors mention the need for maintaining boundaries, the HCBCs and supervisors connected these boundaries to HCBC wellness purporting that establishing health boundaries prevents burnout, reduces vicarious trauma, and improves one’s ability to manage stress. No studies to date have linked setting boundaries to HCBC wellness.

The HCBCs and supervisors interviewed endorsed the process moving forward. They depicted moving forward to be the way in which they were aware of and responded to stress, continued to work even in the most challenging circumstances, and how they processed their thoughts and feelings following difficult sessions. Moving forward was not simply carrying on or persisting with the work. They described moving forward to be fueled by their awareness and intentionality, an intention to continue to
provide therapy that was child-centered and goal oriented. Snyder and McCollum (1999) described a process of learning to do in-home therapy that is similar to the process of moving forward identified in this study. In Snyder and McCollum’s (1999) study, family therapy trainees working out of home and community based University clinic, had difficulty learning how to provide counseling in the home setting. The trainees’ anxiety increased as they realized that the counseling approach that they had developed working in an outpatient setting was not going to be effective in the home and community. The trainees were not stalled by their anxiety. Instead, they worked through their anxiety in supervision and consultation and through reflective journaling to develop a more effective approach to working with clients and families.

**Research question #4**

This investigation also seeks to answer the question, “What do HCBCs and supervisors perceive to be counselor characteristics (i.e., personal characteristics or personal practices) that contribute to counselor wellness?” This question is slightly different than research question #3 that inquired about the role of individual practices upon HCBC wellness. Research question #3 seeks to understand how individual wellness practices affect wellness, whereas research question #4 aims to address what HCBC characteristics that may improve wellness.

**Being aware.** HCBCs indicated that awareness was the first step that HCBCs needed to take in order to facilitate wellness. Without awareness, HCBCs were unable to recognize the need to start doing anything differently. The HCBCs described awareness to be, “paying attention”, making “connections” to determine what you need, keeping wellness “at the forefront”, and being “very present in all situations.” The awareness
spurred the HCBCs to recognize when they may need to modify eating and sleeping habits, plan self-care, find work-life balance, and monitor coping strategies to ensure that they are using the healthy, adaptive coping mechanisms. As HCBC-7 explained, “It’s hard to turn that around if you are not aware of it.” Several of the supervisors reported that some HCBCs are often unaware that their workload is too much or that they are feeling overwhelmed. SUP-3 stated, “They think they can do it and they don’t realize that they are going downhill until you tell them though. They think it’s all great until you say something.”

**A positive mindset.** Several HCBCs shared that adopting a positive mindset has facilitated and served to improve their wellness. HCBC-4 described herself as “optimistic” and able to see the “positive side”. HCBC-6 maintained positivity as a personal practice and then translated this approach to her work with clients. HCBC-5 tries to maintain positively but admits it can be difficult and something that she struggles with at times. HCBC-8 also indicated he maintains his wellness by keeping a positive attitude.

**Feeling valued.** Several HCBCs and supervisors detailed the profound effect that feeling valued or alternatively, not feeling valued, can have upon HCBC wellness. HCBCs and supervisors indicated that they value making a difference in the lives of children and families. HCBCs and supervisors were aware that they were making a difference when they saw their clients or supervisees making progress. The HCBCs reported, “I value the progress that kids make”, “It’s very… gratifying”, it’s “heartening to see”, and it’s “fulfilling if things are going well.” HCBC-7 indicated that seeing progress keeps her in the field. HCBC-2 commented that seeing clients make
progress moves him forward as a HCBC. The supervisors, as well, reported that they appreciate helping kids and find as supervisors that they can help “exponentially” more children.

While HCBCs found value in helping children, some of the HCBCs shared their experiences of not feeling valued by the agency or supervisors. HCBC-2 recounted feeling like he was “just a number and people don’t know your name.” He went on to lament, “if you left tomorrow, it wouldn’t really make a difference.” HCBC-2, HCBC-4, SUP-1, and SUP-3 described their tenure at different agencies that valued making money over clients and employees. SUP-1 stated that she “could never be good enough for what they wanted” and as a result, she felt “defeated over and over again” because she could not meet their unrealistic expectations. As she continued to try to meet the agencies expectations and failed, SUP-1 reported that she became depressed. On the other hand, SUP-1 reported that once a HCBC feels valued by the agency or a supervisor, the HCBC can “thrive.”

Implications. It was important to the HCBCs investigated in this study to be aware of and assess their wellness in order to determine how to reduce stress and the likelihood of burnout and compassion fatigue. HCBC-1 described monitoring her eating, sleeping, and exercise habits and SUP-3 cautioned HCBCs to be aware of their caseload and how the workload is impacting their wellness. HCBC-7 reported that she is aware of the need to recognize the first signs of burnout because she stated, “it’s hard to turn that around sometimes if you are not aware of it.” SUP-3 monitored her supervisees’ documentation in order to stay aware of the challenges that she faced in homes. With this extra step, SUP-3 was able to help her supervisees confront these challenges and maintain
physical and emotional safety. Without self-awareness, the HCBC and the supervisor would not be able to identify the need for additional self-care, to set boundaries, to modify workload, or to ask for help in supervision.

These findings lend further support to the results obtained by Lawson (2007) and Killian’s (2008) studies and conceptual literature that point to the importance of self-awareness as a protective factor that can reduce burnout and improve wellness (Figley, 1995; Lawson & Vernart, 2005; Merriman, 2015). Lawson (2007) found that counselors who had lower scores of burnout and higher levels of compassion satisfaction endorsed self-awareness as a career sustaining behavior. Killian (2008) found that compassion fatigue was partially explained by a lack of self-awareness. Lawson and Vernart (2005) call on counselors to “demonstrate the same level of commitment to self-awareness, self-care and balance for ourselves as we have for clients.”

Some of the HCBCs reported that they are “more optimistic”, “a little bit on the positive side anyway” while others consciously tried to “think positively” and keep a “positive attitude.” Having a positive attitude functioned to buffer some of the HCBCs from stress or was a direct response to the stress of the work. Bowen and Caron (2016) conducted a qualitative study exploring the experiences of rural HCBCs and found that each participant emphasized the importance of having a positive attitude. The professional behaviors endorsed by Bowen and Caron’s (2016) sample of rural HCBCs included positivity, authenticity, and the right attitude. Tate, Lopez, Fox, Love, and McKinney (2014) examined the counseling competencies of HCBCs working with young children living in poverty. Tate et al.’s (2014) analysis identified professional dispositions and attributes conducive to successful work with families living in poverty;
these dispositions include thinking positively about families and having a strengths based focus and respect for other cultures and beliefs. While Bowen and Caron (2016) and Tate et al. (2014) do not allude to how positivity may affect HCBC wellness, this study supports the usefulness of a positive mindset to the work and wellness of HCBCs.

The HCBCs and supervisors in this study yearned to feel valued, whether that meant being valued by the agency and their supervisor or feeling valued because they are helping others and making a difference. When feeling valued because they were able to affect change within the lives of children and families, HCBCs were able to continue to persist with the work, focusing on treatment goals and finding time to take care of themselves, while achieving some semblance of work-life balance. When their value as HCBCs was not emphasized and nurtured by the agency or the supervisors, the HCBCs shared that they had difficulty taking care of themselves, and did not have work-life balance. HCBCs can question their effectiveness to help children and families who are faced with complicated, multilayered challenges (Adams & Maynard, 2000; Christensen, 1995; Snyder & McCollum, 1999). In this study, however, the supervisors were aware that HCBCs want and need to feel valued because the supervisors interviewed also had experience working as a HCBC. The aspects of supervision that can impart a sense of value onto HCBCs will be discussed when reviewing the findings that relate to research question #5.

**Research question #5**

This researcher was interested in learning how other systemic factors may affect HCBC wellness, including supervision and agency practices. This inquiry also answers the question, “What are HCBCs’ and supervisors’ perceptions regarding the role of
supervision in maintaining and/or promoting counselor wellness?” The concepts, finding support, being there, supporting and investing in staff, showing appreciation, supporting professional development, and drawing from personal experiences were extracted from the analysis of participant interviews. These concepts reflect how HCBCs and supervisor’s perceive supervision practices impact HCBC wellness.

**Finding support.** The perception that supervisors were too busy to provide support when needed prevented many HCBCs from seeking supervision or consultation with their agency supervisor. In fact, HCBC-1, HCBC-2, HCBC-4, HCBC-5, and HCBC-8 stated during the interview that supervisors are very busy and this can interfere with their ability to support HCBCs sufficiently. HCBC-2 and HCBC-8 asserted that supervisors provide mainly administrative supervision and are not able to provide the level of clinical supervision needed. HCBC-5 stated, “If I have questions… I almost feel bad bothering the supervisor now because I know she is so busy.” HCBC-1 and HCBC-4 suggested that agencies need to hire more supervisors so that supervisors can offer more clinical supervision to HCBCs. HCBC-5 suggested that supervisors reassure HCBCs that they are available to provide HCBCs with support and assistance when needed.

Interestingly, the perceptions of the supervisors did not match HCBCs’ perceptions. All of the supervisors indicated that they are willing and able to meet with and provide support to HCBCs when needed. SUP-4 described maintaining an open door policy and providing after hours support if needed. SUP-1 stated, “All supervisors are willing to help everybody.” SUP-2 encourages HCBCs to contact her if they are having difficulty, especially when they first begin to work as a HCBC. SUP-3 also shared that she suggests that HCBCs call or email if they have concerns.
HCBC perceptions of supervision influenced whether HCBCs utilized supervision as a means for clinical and emotional support. Many HCBCs appreciated agency supervision despite having supervision only once per month. HCBCs described supportive supervision as “a chance to talk about cases”, an opportunity to “emotionally, just let go of something”, “getting good feedback, getting… good recommendations, “positive and helpful”, “talk with other clinicians”, “get some different viewpoints”, and “bounce those ideas off of other clinicians.” HCBC-6 appreciates the support she receives regularly from colleagues in group supervision. Several HCBCs reported that they valued receiving additional supervision as they pursued their professional counseling license (LPC).

The HCBCs that did not find agency supervision to be supportive to their wellness described supervision as not “particularly effective”, focused on administrative vs. clinical responsibilities, and helpful for obtaining ideas and recommendations but not beneficial to HCBC wellness. Several HCBCs and supervisors recounted ways that supervision that they had received had been detrimental to their wellness. In these instances, supervision focused on mistakes and whether the HCBC was making productivity. One supervisor remembered feeling depressed and defeated because she never felt “good enough for what they wanted.”

**Being there.** Despite the reality that the supervisors’ responsibilities include various administrative duties in addition to clinical supervision, each supervisor emphasized the importance of being available to HCBCs, a concept that was coded as being there. While some HCBCs reported that they are reluctant to seek supervisory support at times because supervisors are so busy, supervisors indicated that they are
available to HCBCs. Supervisors made the following comments about supervision: “all of the supervisors are willing to help everybody”, “you can get a hold of any of the supervisors any time”, and supervisors are “open to anybody at any point requesting an individual supervision.” One supervisor reported meeting with her supervisees for individual supervision once per month and the other three supervisors provided group supervision monthly. Two out of the four supervisors reported that they meet with some HCBCs individually if they are maintaining a large caseload, there is an issue that is best addressed one on one, or if a HCBC is new to the agency and has not had prior experience in the home or community. The supervisors reflected that they tell HCBCs that they are available and encourage HCBCs to come to them with questions or concerns. Supervisors indicated that they “make sure staff know that they can call us for anything… email us”, are “telling people that we are always available”, and they maintain an “open door policy”.

Several of the HCBCs and supervisors described how being there for HCBCs can affect HCBC wellness. ‘Being there’ as supervisors, served to buttress HCBC wellness. SUP-1 reported that without support “you can’t take care of yourself in that situation.” Without immediate support and supervision, HCBC-2 reported that managing challenging clients can become difficult and the work can be isolating, negatively impacting HCBC wellness. Because he did not attend individual or group supervision at his agency, HCBC-2 relied on contact with his colleagues to process the difficult cases, those that “stick with you” and work through secondary trauma so that he could continue to work effectively with clients and families. HCBC-5 reported that an unsupportive
supervisor, constantly questioning the HCBCs decisions, could negatively impact HCBC wellness.

**Supporting and investing in staff.** Many of the HCBCs and supervisors interviewed shared experiences of the support that they have received from their supervisors. HCBCs appreciated being able to process concerns in supervision and receive validation. One HCBC reported that his supervisor provides tea, hot chocolate, and coffee for the HCBCs at the office. Other HCBCs appreciated their supervisors’ sense of humor, resources and interventions, and positive feedback and suggestions for areas of improvement. The supervisors commented upon the impact that the support that they were receiving from their supervisors had upon their ability to support HCBCs. SUP-1 reported that she can talk with her supervisor when she is struggling and her supervisor encourages her to take care of herself. Similarly, SUP-1 supports the HCBCs, asking them what help is needed and how the HCBCs are taking care of themselves. SUP-3 shared that if her supervisor is supportive, then she can support the HCBCs.

**Showing appreciation.** HCBCs and supervisors reports indicate that it is important for supervisors to show appreciation to HCBCs and that appreciation and positive feedback can improve HCBC wellness. HCBCs reported that supervisors provide small tokens of appreciation such as tea, hot chocolate, and coffee in the break room and arranging for potlucks at supervision, and will highlight in emails and meetings HCBC successes, accomplishments, and ways HCBCs “step up.” SUP-3 reported that she will “definitely try to brag about, if people do their progress notes well…, when people turn their paperwork in time.” Additionally during meetings, after recognizing
HCBCs, SUP-3 asks HCBCs to identify and recognize the successes of clients or other HCBCs. According to the HCBCs, receiving the positive feedback “makes you feel good”, helps the HCBC to know “you’re on the right track”, and “helps me to know that I’m doing good work”, and “makes me feel like I want to do my job well”.

**Supporting professional development.** A few HCBCs and all of the supervisors mentioned the importance of supporting professional development. When HCBC-7 first began working with children with autism, her supervisor arranged for her to attend specialized trainings to improve her skills. HCBC-7 appreciated that her supervisor connected her to these trainings and then continued to provide suggestions for interventions to use when working with children diagnosed with an autism spectrum disorder. HCBC-2 and HCBC-5 did not receive assistance with professional development in supervision. Instead, HCBC-2 conducted research and sought out his own training and continuing education opportunities. While only a few HCBCs identified the importance of professional development, all of the supervisors discussed ways that they support the professional growth of HCBCs either in supervision or through additional training. Several of the supervisors established and mandated trainings for their HCBCs that included topics, such as maintaining professional boundaries and using applied behavior analysis to work with children diagnosed with autism. Two of the supervisors reported supporting professional growth in supervision by establishing goals with supervisees and monitoring their progress toward the goals at each supervision.

**Drawing from personal experiences.** All of the supervisors reported that they have direct experience working as a HCBC. Three out of four of the supervisors
continued to maintain a small caseload of clients while supervising. The supervisors’
own experiences as HCBCs and with supervision informed their own supervision
practices. The supervisors adjusted their own behaviors in supervision based upon their
own experiences being supervised or as a HCBC. Without adequate support in
supervision, SUP-1 had difficulty staying well emotionally and it was through this
experience that she learned that focusing on mistakes and productivity caused her to feel
depressed, defeated, and burned out. SUP-1 discovered that this type of supervision
approach does not work, it is “going to make somebody feel bad as opposed to good
about themselves.” SUP-1 now tailors supervision to the needs of the HCBC asking
them first how they are doing and how she can help. SUP-4 explained that because she
understands home and community based counseling work, she is able to manage her
expectations of the HCBC and provide leeway if needed by giving the HCBC extensions
on completing paperwork. In addition, she advises her supervisor when the agency’s
expectations are unreasonable.

The supervisors shared their own experiences working as a HCBC with their
supervisees as a way to empathize with the HCBC, normalize the difficulties of the work,
and provide guidance. SUP-2 reported, “I know it can be tough and sometimes I have to
remind myself of that. Like I’ve had 10 years to practice difficult conversations with
parents”. SUP-1 shared, “I can empathize and I can actually, you know, give stories
about, you know, what happened when and they often relate to what somebody else is
saying.” SUP-4 explained, “I mean I don’t demand a lot of things from them. Little.
Like, I have more leeway. Like, I’m not going to write someone up the minute they have
[missing paperwork] and things like that because I was a procrastinator too.”
Implications. More than half of the HCBCs participating in this study stated that they believe supervisors are too busy to provide adequate clinical supervision. The HCBCs craved the opportunity to meet with supervisors to discuss their clinical work and obtain feedback. HCBC-5 and HCBC-8 avoided seeking supervision because they believed the supervisors were too busy. HCBC-2 and HCBC-8 did not believe that agency supervision is useful and reported that frequently supervisors do not have HCBC experience. HCBCs perceived supervision to be inadequate because it was infrequent and maintained an administrative focus as opposed to offering clinical direction. These findings are in line with Bowen and Caron’s (2016) and Lauka et al.’s (2013) results. The rural HCBCs interviewed by Bowen and Caron (2016) expressed frustration that group supervision mainly addressed administrative issues and Lauka et al.’s (2013) participants indicated that quality supervision for HCBCs is lacking, posing a significant ethical concern for the field. While some of the HCBCs perceived supervisors as lacking experience, a concern also noted by Lauka et al. (2013), the supervisors participating in this study had worked as HCBCs for years prior to beginning their supervisory positions. Many of the supervisors continued to work with clients and families and maintained their own caseload of clients.

Supervisors were unaware that the HCBCs were reluctant to seek supervision because they perceive supervisors as being too busy. In fact, supervisors emphasized, without prompting on the part of the researcher, that supervisors are available and make themselves available to support HCBCs by offering supervision, maintaining an open door policy, and being available via email and phone. Given that supervision has the potential to mediate the association between experience and workload on professional
quality of life of HCBCs, it is concerning that HCBCs may be reluctant to seek supervision when needed. These findings lend credence to the concern that supervisors are at times unaware of the experiences and perceptions of HCBCs whom they supervise (Adams & Maynard, 2000).

The Home Based Family Therapy (HBFT) Partnership developed a training program for home based family therapists. The HBFT partnership guides home-based training to prioritize supervision as vital given the isolation inherent in the work and the difficulty working with multiply challenged clients and families (Macchi & O’Conner, 2010). The HCBCs in this study were only receiving one hour per month of supervision. This finding supports the mounting evidence that HCBCs receive infrequent supervision (Lawson, 2005; Lawson & Foster, 2005; Macchi & O’Conner, 2010) and that HCBCs are receiving group supervision that is mainly focused on administrative issues (Bowen & Caron, 2016). While the HCBCs in this study received infrequent supervision, most of the HCBCs believed that the supervision was beneficial to their wellbeing. Other HCBCs recounted negative supervision experiences that were detrimental to HCBC wellness and caused one HCBC to experience depressive symptoms and another HCBC to consider leaving the field altogether. These results validate the Macchi et al.’s (2014) findings that supervision serves to improve professional quality of life of HCBCs especially amongst HCBCs who are less experienced and have a challenging workload and make it clear that supervision can also negatively affect HCBC wellness.

While Macchi et al. (2014) discovered that supervision can mediate the impact of workload on professional quality of life of HCBCs, specific aspects of supervision that can be beneficial to HCBC wellness were not gleaned from Macchi et al.’s study.
The HCBCs appreciated being able to process difficult cases in supervision, work through their own emotional reactions to challenging situations, and receive resources and interventions. Further, HCBCs valued when supervisors actively recognized the HCBCs hard work and successes with clients. Also, supervisors shared how they used their own experiences as HCBCs to manage their expectations of HCBCs, to empathize with the difficulties HCBCs face, to offer recommendations and suggestions, and to understand how to deliver supervision in a way that supports the HCBC. All of the supervisors asserted that they support the professional development of HCBCs by offering training as needed that addresses autism, establishing boundaries, and maintaining safety in the home and community. While supervisors stated that they emphasize professional development, some HCBCs shared experiences of needing to seek out their own training. Concerns have been noted in previous studies that HCBCs are unprepared and have not received HCBC training (Bowen & Caron, 2016; Lawson, 2005; Stinchfield, 2004; Worth & Blow, 2010). The HCBCs’ reports support the findings of past research, while the supervisors’ reports suggest that agencies are beginning to implement some training for HCBCs to address the gaps in HCBCs’ skillsets.

Research question #6

Little is known about how agency practices and policies may influence HCBC wellness. This investigation examines the question, “What are HCBCs’ and supervisors’ perceptions regarding the role of the agency in maintaining and/or promoting wellness?” From the participants’ experiences and stories, this researcher uncovered the following concepts that were identified by the HCBCs and supervisors as influencing
HCBC wellness: high expectations for productivity, difficulty earning a living, employing punitive practices, and supporting and investing in staff.

**Confronting the realities of the work.** During the course of the interviews, the HCBCs and supervisors shared aspects of work that can challenge their wellness. From these discussions, high expectations for productivity and difficulty earning a living emerged as two concepts that HCBCs and supervisors perceive to affect HCBC wellness. Both of these experiences, encountering high expectations for productivity and difficulty earning a living are the products of the practices and policies enacted by the agency.

**High Expectations for productivity.** Each agency maintains different expectations for productivity (the amount of billable hours per week) depending on whether the HCBC is working part-time or full-time and whether the HCBC is receiving benefits from the agency. The required productivity for full-time employment ranged from 25 to 32 billable hours per week. Productivity is only comprised of the billable hours with clients (counseling sessions, treatment plans, assessments, and data analysis) and does not include the time spent traveling to the clients home, writing progress notes, or researching interventions.

Regardless of whether the expectation for productivity was 25 or 32 hours per week, HCBCs reported that the expectation was too difficult to meet and they often worked long days and spent evenings completing paperwork. In addition to pressuring themselves to bill as many client hours as possible, HCBCs reported that supervisors monitored whether HCBCs were meeting their productivity weekly. At one agency supervisors were questioned frequently by upper management and called to explain and
account for why HCBCs are not meeting their productivity. The HCBCs experienced this oversight and monitoring of billable hours as stressful and reported that it added additional pressure.

Many of the HCBCs and supervisors reported that trying to meet this expectation negatively affects HCBC wellness. Supervisors stated that HCBCs are “doing too much” and “killing themselves”, trying to earn as many billable hours as possible in order to keep their benefits and earn a “decent paycheck.” HCBC-5 admitted that pushing herself to bill as many hours as possible, typically between 28 and 30 hours per week, leaves HCBC-5 with little time for herself. HCBC-1 had a similar experience when she worked full-time. She stated that when “caseloads were... the highest... there wasn’t a lot of time” to spend “thinking about how can I manage my stress?” HCBCs recommended that agencies reduce the expectations for productivity.

**Difficulty earning a living.** HCBCs reported struggling to earn a living in the field of BHRS. Agency policies governed compensation, vacation time, and insurance benefits. HCBC-8 and HCBC-3 recognized the importance of earning a living, HCBC-3 reported he valued the income and HCBC-8 was the first to overtly mention the importance of being financially secure. The HCBCs and supervisors reported that HCBCs are not making enough money to support themselves. Two HCBCs referred to themselves as a “highly paid volunteer” and “overworked and underpaid”. Another HCBC explained the predicament as follows, “You bill two hours with a child and then you can take 8 hours of unbilled time, uncompensated time of thinking about it, strategizing about it.” HCBC-3 suggested that the agency could increase pay for HCBC and stated that “mental health work is... underpaid for what we do.”
HCBCs also expressed frustration with the lack of benefits and limited vacation and sick time. At one agency, the part-time employees that were billing 25 hours per week were only earning 3 hours of paid time off per month equating to only four and a half days off per year. Part-time employees who did not earn the required billable hours did not earn time off and were required to take unpaid vacations and sick days. As a result, supervisors noted that HCBCs are “running ragged,” “killing themselves,” and “take on way too much.” HCBC-8 has noticed that HCBCs who work full-time become disgruntled, “they get worn down and when you talk to them, they’re all negative. There are so many complaints.” HCBC-2 assessed that the unchanging reimbursement rates create fiscal pressure on agencies and limit the agency’s ability to adequately compensate staff. Therefore, agencies hire mainly part-time staff because agencies would not stay afloat if they had to pay and provide benefits for full-time staff.

**Employing punitive practices.** HCBCs and supervisors indicated that some of the agencies implemented punitive measures that HCBC believed to be detrimental to their wellness. Typically, when HCBCs do not meet their productivity, it is because clients cancel sessions or services lapse, both situations that are out of the HCBC’s control. Despite this, HCBCs at one agency were required to make up missed productivity by working in the office and if they continually did not meet the expected billable hours, the HCBC was demoted to part-time, losing their salaried status and their time off accrual rate. Another HCBC explained that she lost vacation time when she did not meet her productivity. She had to take vacation time to make up for the hours that she did not meet with clients. The HCBCs had already believed that they were not receiving adequate time off. Penalizing them further by requiring them to use their
vacation time, could have detrimental effects on their wellbeing. HCBC-1 reported that this practice was detrimental to HCBCs and wondered, “How are you going to take care of yourself and get away if you don't have time to take because you're always using it to make up?”

Several of the HCBCs worked for agencies or had worked for agencies that they described as adopting a punitive workplace culture. HCBCs reported that the agencies were “continually punitive” and even when doing what was asked, it was still not enough. These agencies expected the impossible and would provide last minute directives threatening disciplinary action if not implemented. Supervision revolved around productivity. One HCBC described the agency atmosphere as “just a culture of the person above you yelling at the person below you just on and on down the chain.” In this contentious and unsupportive work environment, HCBCs had difficulty coping with the constant negativity. According to one supervisor, supervisions focused on productivity, blocking any discussion about wellness. HCBCs and supervisors asserted that the punitive workplace culture can lead HCBCs to experience depressive symptoms, anxiety, preventing the HCBC from taking care of him or herself, and the HCBC may consider leaving the field altogether.

**Supporting and investing in staff.** When agencies adopted a “climate of support”, there were positive repercussions for HCBC wellness. For the HCBCs and supervisors, this climate of support consists of an “environment that’s very respectful and understanding” that is “supportive” of HCBCs, emphasizes the HCBCs as “not just bodies going out and… making us money,” and is “invested in making sure employees take care of… themselves.” Supervisors also noted that when agencies support the
supervisor, this support trickles down to supervision and the supervisor is likewise supportive of the HCBC. SUP-3 stated, “If they’re supporting me then I feel like I can support my staff.” One agency offers programming and outreach (e.g., wellness fairs, yoga, wellness coaching, and spiritual care groups) that encourages employees to prioritize their wellness. However, about half of the HCBCs reported that they could not identify agency practices that support wellness. HCBC-5 and HCBC-7 reported that the agency downsized and removed a supervisor who provided specialized autism training and supervision. When this position was eliminated, the HCBCs were left feeling unsupported.

**Implications.** The HCBCs and supervisors identified agency practices and policies that threaten HCBC wellness. These include: high expectations for productivity, difficulty earning a living due to inadequate pay and compensation, and the use of punitive practices. Both HCBCs and their supervisors reported that HCBCs work long days and evenings to bill enough hours to meet productivity. Supervisors were pressuring HCBCs weekly to determine whether HCBCs were meeting their hours. This level of overworking left little time for HCBCs to spend time with family and friends or pursue interests outside of work. HCBCs and supervisors reported that attempting to meet productivity was negatively affecting HCBC wellness. These findings lend further support to studies concluding that workload (Kulkarni et al., 2013; Macchi et al., 2014), work hours (Killian, 2008), and work drain (Killian, 2008) can negatively impact counselor wellness.

This study contradicts the findings that have not found an association between perceived organizational support (Brockhouse et al., 2012) or workload and
organizational culture (Williams et al., 2012), and counselor wellness. This is the first investigation to date that addresses the implications that an inadequate pay and compensation can have on HCBC wellness. Because HCBCs were working long days, evenings, and in some cases weekends in order to earn an adequate pay check, they had little time to spend with families, friends, or doing activities that they enjoy. Even more concerning, the punitive practices in place at several agencies limited the HCBCs ability to use their vacation and sick days. In addition, participants described how a punitive culture within the agency has diminished HCBC wellness and for some HCBCs led to depression, anxiety, and feeling defeated. While research has not found an association between taking vacations and counselor wellness (Lawson, 2007; Bober & Regehr, 2005), HCBCs reported overworking as they pressured themselves to meet the agency’s expectations for productivity. Workload (Killian, 2008; Kulkarni et al., 2013; Macchi et al., 2014), work hours (Killian, 2008), workaholism, and work-life balance (Lawson, 2007) have been found to impact counselor wellness.

**Research question #7**

As this researcher began to conduct interviews and the concurrent data analysis, it became evident that HCBCs were identifying other systemic factors that impact their wellness, namely due to the work itself. Given the recursive nature of qualitative research, it is common to reify research questions after beginning data collection (Berg, 2007). To this end, this investigation answers the research question, “What are the HCBCs’ perceptions regarding the role other systemic factors in maintaining and/or promoting wellness?” From the grounded analysis of participant interviews, this researcher identified the following categories that answer the research question: finding
time and confronting the realities of the work (isolation, keeping up with the paperwork, and working with multiply challenged children and families).

Finding time. HCBCs devoted much of their time to seeing clients and completing paperwork and as a result, they struggled to find time in their day to spend with family, friends, or engaging in activities that they enjoy. One HCBC shared that if she takes time for herself, she finds herself behind with work, and becomes even more overwhelmed and anxious. However, this same HCBC recognized the benefits of taking time and reflected that counselor wellness is, “taking time, if you need it, to make yourself happy. Making sure that you have time at the end of the night where you don’t feel so exhausted to relax.” Other HCBCs reported that full time work prevented them from finding time to spend time with family, friends, pets, or pursue interests. The nature of the work itself, prevented HCBCs from taking the time that they needed at the end of the day.

Confronting the realities of the work. The category, confronting the realities of the work was embedded in the experiences and stories shared by the participants. The HCBCs and the supervisors navigated the isolation, paperwork, and complex cases inherent to HCBC work. In their accounts, they shared the impact of these challenges upon their own wellness.

Isolation. Four out of eight of the HCBCs recounted experiencing isolation from other HCBCs, supervisors, and/or the agency and described the work as “isolating”, “not having ready access to… colleagues, to supervision”, and being “very much on your own.” One HCBC reported, “I walk into the office some days and I couldn’t tell you who most of the people are.” While the HCBCs valued the independence of the work,
they understood that there was a cost to this independence. The HCBCs were left feeling disconnected from the agency questioning whether the agency was at all concerned with how the HCBCs were managing the stress of the work. From the HCBC’s vantage point, the agency seemed most concerned with whether the HCBC’s “billing is in.” The HCBCs asserted that isolation can negatively impact HCBC wellness when the HCBC does not have support in the moment when “things kind of go awry.”

**Keeping up with the paperwork.** The HCBCs admitted having difficulty completing and staying ahead of the paperwork. The paperwork was described by some HCBCs to be the most difficult aspect of the work. The HCBCs struggled to complete the paperwork efficiently and realized that there were times that too much time and energy was devoted to completing detailed progress notes. In some cases, HCBCs spent evenings and weekends completing progress notes. Supervisors reported that for some HCBCs the paperwork is “horrendous” and may be a reflection that the HCBCs are struggling with managing the work and maintaining their wellness.

**Multiply challenged children and families.** The HCBCs and supervisors provided vivid accounts of the children and families encountered in home and community based worked. They shared experiences working with families affected directly by suicide and depression, domestic violence, gun violence, child abuse and neglect, and poverty. Families were confronted with complex multi-layered problems and were involved in other systems, such as child protective services, case management, and the legal system. The HCBCs and supervisors acknowledged that at times the HCBCs struggled to process their own emotional reactions to their work with clients and families, the “emotionally charged” sessions, learning about a mother’s suicide attempt in front of
her child, multiple suicide attempts by a client, witnessing police involvement with a client, and making multiple reports to child protective services in one day. These incidents wore on the HCBCs and necessitated that they processed the “secondary trauma” experienced. HCBC-2 recommended that HCBCs “get that in the open and discuss what that’s like to try to work through that for yourself knowing that you have to go back into that environment and work with those kids.”

**Implications.** During their interviews, the HCBCs and the supervisors discussed how aspects of the work impacted their wellness. Because HCBCs were so busy completing paperwork and meeting with clients, they had difficulty finding time to spend with friends and family and to pursue activities that interested them. They experienced isolation, had difficulty keeping up with the paperwork, and faced significant challenges working with the complex needs of children and families. The HCBCs acknowledged that they did not always find time for themselves outside of the work. Given that supervision and self-care have been found to play a role in HCBC wellness (Macchi et al., 2014), it is concerning that many HCBCs are only supervised for an hour a month and are overworked, lacking work-life balance.

**Limitations of the Study**

Eight HCBCs and four HCBC supervisors participated in this qualitative study. These participants were recruited from three BHRS agencies in Pennsylvania. A purposeful sample was obtained from BHRS agencies because the HCBCs employed by these agencies are only required to receive one hour of supervision per month. HCBCs and HCBC supervisors, working in an agency with limited supervision, were best suited to answer the overarching research question, “How do systemic influences affect the
wellbeing of HCBCs?” Participants were eligible to participate in the study if they had
greater than a year of BHRS master’s-level counseling experience or greater than a year
working as a supervisor. A purposeful sample of HCBCs was selected with experience
that ranged from 2 years to 14 years as master’s-level counselors. The supervisors had
worked as supervisors for two to 11 years and all had HCBC experience. It is possible
that the theory of HCBC wellness obtained from participant interviews may represent the
experiences of HCBCs who were experiencing less stress. The purposeful sampling did
not obtain the experiences of HCBC that did not participate in the study. There may be a
subset of HCBCs that were feeling too overwhelmed with the work to find time to
participate in the study.

The study’s findings are not generalizable to all HCBCs and may not reflect the
experiences of HCBCs working at other BHRS agencies. This researcher attended group
supervision meetings in order to recruit as diverse a sample as possible. However, most
of the participants in the study were Caucasian females. Only three out of 12 of the
participants were male and only one participant was African American. Therefore, the
study’s findings should be cautiously generalized to HCBCs of color. While the agencies
were located both in urban and suburban settings, the experiences of the HCBCs
interviewed may differ from HCBCs working in rural settings. The detailed
methodology and participant demographic information will assist the reader with
identifying whether the results might be applicable to their practice as a counselor,
supervisor, or agency administrator.

While this investigator attempted to bracket out her own presuppositions and
biases, it is possible that the researcher may have influenced data collection and analysis
(Charmaz, 2014). The investigator had experience working as a HCBC in various settings including BHRS and family based mental health services (FBMHS) and has been working as therapist for 14 years. This experience was not shared with participants before or during the interview. As this investigator conducted the literature review, constructed the research questions, interviewed participants, and analyzed data, the researcher reflected upon her own experiences and biases and how these may affect the study. Regardless, it is still possible that the researcher’s presuppositions and biases affected the study’s findings in ways that were not recognized.

The researcher may also have influenced the participants in the study. Participants may have provided answers that were more socially desirable or in a way that is more favorable, that shows that they are “good” counselors. The participants may have been concerned that their participation might affect employment; although it was made clear that results would be de-identified and reported in aggregate. Enough identifying information was removed to prevent other HCBCs from figuring out who participated in the study. All recruitment was coordinated by this researcher so that agency supervisors were unaware of which HCBCs participated in the study.

**Implications for Future Research**

Several areas of further research were identified from this study. The participants identified ways that they are able to improve their wellness by pursuing interests, setting boundaries, and being aware. The study provides anecdotal support for the benefits of individual, supervisory, and agency practices upon HCBC wellness. It would be interesting to learn if practicing self-care, having work-life balance, being self-aware,
monitoring workload, maintaining boundaries, and perceived agency support affect HCBC wellness.

The participants discussed concerns regarding how the work and agency practices can negatively affect supervision. Even though the nature of the work cannot be changed, agencies and supervisors can modify their practices to better support HCBC wellness. Further research into the practices of HCBC agencies and supervisors would be beneficial. It would be interesting to conduct a focus group with HCBC supervisors sharing the research findings and discussing possible implications for agencies and supervision.

From these findings, additional research could be conducted to determine if quantitative studies indicate that these factors are associated with improved HCBC wellness and better treatment outcomes. A HCBC wellness survey could be developed from these findings and administrated to HCBCs along with the professional quality of life scale (ProQOL; Stamm, 2010) to determine whether systemic factors predict HCBC wellness. This HCBC wellness scale could also be used in supervision to monitor HCBC wellness and develop improvement plans.

**Questions Generated by the Research**

Many questions were generated from this qualitative inquiry.

- How do the challenges faced by rural HCBCs differ from that of urban and suburban HCBCs? How do systemic factors influence rural HCBCs wellness?
- Would a similar theory of HCBC wellness be uncovered if additional agencies were sampled or if a more heterogeneous group of HCBCs were sampled?
• How do HCBCs working in other systems of care, such as family based mental health services (FBMHS) maintain their wellness? How would systemic factors impact the wellness of FBMHS HCBCs?
• How do systemic factors influence the wellness of HCBCs of color?
• How do supervisors working for agencies that adopt a punitive workplace culture mitigate the effects of the workplace culture on HCBC wellness?
• What are additional ways that agencies support HCBC wellness?
• Do strong peer relationships improve the wellness among HCBCs?
• Is there association between workload and HCBC wellness?
• What systemic factors are associated with HCBC wellness?

**Conclusions and Recommendations**

The purpose of the investigation was to develop a theory of HCBC wellness and discover how systemic factors impact HCBC wellness, grounded in the experiences of HCBCs and supervisors working within BHRS, a system of care that requires little oversight and supervision. The participants described ways that they manage their wellness, through the things that they do, and how agency, supervision and the work affect wellness. Eight HCBCs and four HCBC supervisors were pooled from three different BHRS agencies and interviewed individually following constructivist grounded theory procedures.

The grounded analysis yielded six categories: *helping others* (making a difference, seeing progress), *confronting the realities of the work* (isolation, high expectations for productivity, keeping up with paperwork, difficulty earning a living, treating multiply challenged children and families, infrequent supervision), *taking care of*
yourself, finding support (feeling valued, developing a supervision network, needing ideas, feedback, and resources, and being there), striving for work-life balance (pursuing interests outside of work, setting boundaries, finding time, being aware, adopting a positive mindset, and manage the work), and moving forward. By being there, supervisors support and invest in HCBCs, regularly show appreciation, and use their own HCBC experience intentionally in supervision and training. Punitive agency practices were reflective of the agency climate and were reported to negatively impact HCBC wellness. A positive agency culture was reported by HCBCs and supervisors to be associated with supportive supervision and agency practices (wellness fairs, spiritual groups, wellness coach, and yoga) that improved HCBC wellness.

The HCBCs and supervisors believed that the individual practices of HCBCs were important to HCBC wellness. The HCBCs and supervisors identified ways that supervision, the agency, and the work impact wellness. Interestingly, the supervisors and HCBCs had differing perceptions of the availability of supervisors. While all of the supervisors reported that they extend themselves to HCBCs, encouraging HCBCs to seek out consultation and supervision when needed, HCBCs believed that supervisors were too busy to provide the needed supervision, outside of the one hour a month requirement. HCBCs indicated that supervision was mainly administrative and some HCBCs were concerned that supervisors often do not have HCBC experience. The study’s findings indicate however, that all of the supervisors interviewed from three different agencies had direct HCBC experience working in the BHRS field.

Supervisors would benefit from further encouraging HCBCs to seek supervision using supervision as a space for the HCBC speak openly about wellness and for the
supervisor to assess the HCBC’s ability to manage the work, set boundaries, find support, and take care of themselves. Supervisors need to also assess whether the HCBC is feeling valued and appreciated. Given that several of the HCBCs doubted their supervisor’s experience, sharing their own HCBC experiences may improve the supervisory relationship and increase the likelihood that HCBCs seek support from the supervisor.

This investigation points to the importance of agency practices and policies that support and do not overwork the HCBC. The HCBCs described in vivid detail the effect of overworking on their wellness. The nature of the work seemed to make it even more likely that HCBCs would overwork, increasing symptoms of anxiety, depression, and burnout. Agencies would benefit from reevaluating their policies and adjusting productivity and workload expectations to encourage work-life balance among HCBCs. Additionally, agencies would benefit from encouraging HCBCs to develop their own peer consultation networks to reduce isolation and increase HCBCs feelings of being supported. Several HCBCs suggested that HCBC working groups and HCBC support groups would be beneficial.

Finally, it is imperative for agencies and supervisors to create a climate to support HCBC wellness. Agencies and supervisors would benefit from adopting policies and practices that support wellness, such as, providing positive reinforcement and constructive feedback, showing appreciation, increasing compensation, and identifying success, progress, and areas where the HCBC is making a difference. Further, it is recommended that agencies and supervisors evaluate their practices and policies in order to eliminate punitive practices that overemphasize meeting productivity. Agencies need
to evaluate the workload of supervisors in order to create time and space for supervisors to provide quality, clinical supervision. If more support is provided to supervisors, they are more likely to be able to provide support to HCBCs improving HCBC wellness and ultimately client and family outcomes. Increasing HCBC pay would potentially reduce the HCBCs’ tendency to overwork and ignore self-care; however, agencies themselves are limited by the reimbursement rates from the insurance company. Ideally, the Department of Public Welfare in Pennsylvania would increase the reimbursement rates for BHRS services allowing HCBC agencies to pay their HCBCs more.

Counselor educators can encourage HCBCs-in-training to develop self-care practices and professional dispositions that will later sustain them in their home and community based practice. Self-awareness should be encouraged through journaling and reflection in individual and group supervision during practicum and internship. HCBCs-in-training would benefit from exploring how to set boundaries with the work and with clients. The importance of time management and managing documentation demands should be introduced including but not limited to: how to schedule clients to reduce travel time, the benefit of having longer sessions in the home versus a traditional 60 minute session, and the utility of completing documentation at the end of the session. Counselor educators may want to facilitate role plays that approximate the unique scenarios that can occur in the home and community setting in order to encourage HCBCs-in-training to start practicing building rapport, creating a therapeutic space in a chaotic environment, and boundary setting. Guest speakers from HCBC agencies can provide the HCBC-in-training with a behind-the-scenes look at home and community counseling work and how they have successfully navigated challenges in the home setting.
Supervisors, counselor educators, and agency administrators would benefit from evaluating their own ability to maintain a work-life balance, set boundaries, manage the work, and find support. Are these practices being modeled and practiced system wide? Are counselor educators, supervisors, and agency administrators practicing what they preach? It is possible that when HCBCs-in-training and HCBCs see their mentors prioritizing self-care, setting boundaries with the work, and taking care of themselves, that the HCBCs may be more likely to put the teachings into place.
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Appendix A

Semi-structured Guiding Questions for Individual Interviews

In accordance with Charmaz’s recommendations (2014), an interview guide was developed for the individual interviews.

The initial open-ended questions are as follows:
1. Tell me about your work as a HCBC? (How would you describe your job? What do you value most about your job? What is the most difficult aspect of your job?)
2. As a BHRS HCBC, how do you describe counselor wellness?

Intermediate questions:

3. How do you manage your wellness as a BHRS HCBC? How do you go about maintaining your wellness? What do you do?
4. What serves to improve your wellness (probe for individual characteristics/practices, supervisory practices, agency practices)?
5. What do you encounter that challenges your wellness as a BHRS HCBC? (probe for individual, supervisory, and agency practices)
6. How if at all, have your thoughts about counselor wellness changed since you began your work as a BHRS HCBC?
7. How, if at all, have your wellness practices changed since you began your work as a BHRS HCBC?
8. As you look back on your work as a HCBC, what experiences stand out as shaping your wellness?

Ending questions:

9. How have you grown as a HCBC since you began the work? Tell me about the strengths that you discovered or developed through BHRS work that improve your wellness.
10. What do you think are the most important strategies that counselors can implement to maintain HCBC wellness? (ask same question two more times replacing counselors with supervisors and then agencies)
11. After having had experience working within BHRS, what advice regarding counselor wellness would you give someone who has just begun working as a BHRS HCBC? What advice would you offer to a supervisor, new to supervising? What advice would you give an agency as to their wellness practices?
12. Is there something that you might not have thought about before that occurred to you during this interview?
13. Is there something else you think that I should know to understand BHRS HCBC wellness better?
14. Is there anything you would like to ask me?
Semi-structured Guiding Questions for Individual Interviews with Supervisors

The initial open-ended questions are as follows:

1. Tell me about your work as a HCBC supervisor? (How would you describe your job? What do you value most about your job? What is the most difficult aspect of your job? What is the most rewarding aspect)
2. As a BHRS supervisor, how would you define counselor wellness?

Intermediate questions:

3. From your observations, how do HCBCs stay well within the confines of the work? How do HCBCs go about maintaining wellness? What do you see them doing?
4. What serves to improve HCBC wellness (probe for individual characteristics/practices, supervisory practices, agency practices)?
5. What challenges BHRS HCBC wellness? (probe for individual, supervisory, and agency practices)
6. How if at all, have your thoughts about counselor wellness changed since you began your work as a BHRS supervisor?
7. How, if at all, have your supervision practices changed since you first began supervising BHRS HCBCs?
8. As you look back on your work as a BHRS supervisor, what experiences stand out as shaping HCBC wellness? Within supervision? Within agency practices?

Ending questions:

9. How have you grown as a HCBC supervisor since you began the work? Tell me about the strengths that you discovered or developed through BHRS work serve to improve HCBC wellness.
10. What do you think are the most important strategies that counselors can implement to maintain HCBC wellness? (ask same question two more times replacing counselors with supervisors and then agencies)
11. After having had experience working within BHRS, what advice regarding counselor wellness would you give someone who has just begun working as a BHRS HCBC? What advice would offer to a supervisor, new to supervising? What advice would give an agency as to their wellness practices?
12. Is there something that you might not have thought about before that occurred to you during this interview?
13. Is there something else you think that I should know to understand BHRS HCBC wellness better?
14. Is there anything you would like to ask me?
Appendix B

Recruitment Contacts

Email/Phone call to Program Directors Requesting to Recruit Participants for the Study

Subject: HCBCs Experiences of Wellness within BHRS Work

Dear [Program Director’s Name],

My name is Beth Moore and I am a doctoral candidate at Duquesne University. I am contacting you to request permission to recruit MTs and BSCs and MT and BSC supervisors for participation in a research study. I am conducting this study as part of the requirements for my doctoral degree in counselor education and supervision. I am interested in learning how home and community based clinicians stay well despite the challenges encountered in the work. Much of the research to date has focused on the difficulties encountered in the home and community settings and the implications for training and supervision. Research has not yet addressed the wellness practices that sustain home and community based clinicians from the perspectives of the clinicians and supervisors. I would like to conduct individual interviews with BHRS MTs and BSCs and a focus group with BHRS supervisors. In addition, I am seeking your permission to review agency documents related to the training, supervision, and oversight of MTs and BSCs in order to collect data regarding the agency practices designed to support BHRS MTs and BSCs. All information collected will be kept confidential and the results will be reported anonymously. The names of the agencies, clinicians, and supervisors participating will not be associated with the results. From this study, I am hoping to disseminate a model for home and community based counselor wellness based upon the experiences of home and community based counselors and supervisors. This model for wellness may serve to inform clinician, supervision, and agency practices.

I am contacting you because you are listed as the program director for a BHRS agency. For the purpose of recruitment, would I be able to provide information about the study to BHRS clinicians at group supervision or staff meetings, post recruitment flyers at your agency, and/or request that you forward the paragraph below to BHRS clinicians? I have attached a recruitment flyer and the informed consent documents that describe the purpose of the study, study procedures, and the nature of confidentiality. If you are interested in assisting me with recruitment, please contact me via email or cell phone.

This study has been approved by Duquesne University’s Institutional Review Board for the Protection of Human Subjects.

Thanks for your time and consideration,

Beth Moore
Dear Mobile Therapist/Behavior Specialist Consultant,

My name is Beth Moore and I am a doctoral candidate at Duquesne University. I am contacting you regarding your potential participation in a research study that I am conducting as part of the requirements for my doctoral degree in counselor education and supervision. I am seeking to understand how BHRS clinicians stay well despite the challenges encountered in their day to day work. I would also like to understand what strategies are beneficial to home and community based counselor wellness. These may include personal practices and supervisory and organizational practices. From this study, I am hoping to disseminate a model for home and community based counselor wellness based upon the experiences of home and community based counselors. This model for wellness may serve to improve clinician, supervision, and agency practices.

I am interested in talking with MTs and BSCs, currently working for a BHRS agency, who have 1-3 years of experience working within BHRS, and MTs and BSCs with 4 years or more of experience. Participation in this study is absolutely voluntary and has no bearing on your employment within your agency. All information from the study will be kept confidential from agency administrators, supervisors, and other clinicians. I am asking you to participate in an individual interview that will last for approximately 90 minutes and be scheduled at a time and place convenient to you. You won’t receive any compensation for participation, but there won’t be any cost to you either.

If you believe you meet the criteria for participation and are willing to participate in the study, please respond directly to this e-mail or contact me via my cell phone.

Thanks for your consideration,

Beth Moore
Email to BHRS Supervisors

Dear BHRS Supervisors,

My name is Beth Moore and I am a doctoral candidate at Duquesne University. I am contacting you regarding your potential participation in a research study that I am conducting as part of the requirements for my doctoral degree in counselor education and supervision. I am seeking to understand how BHRS clinicians stay well despite the challenges encountered in their day to day work. I would also like to understand what strategies are beneficial to BHRS clinician wellness. These may include individual BHRS clinician practices, in addition to supervisory and organizational practices. From this study, I am hoping to disseminate a model for home and community based counselor wellness based upon the experiences of home and community based counselors and supervisors. This model for wellness may serve to inform clinician, supervision, and agency practices.

I am interested in talking with BHRS supervisors with at least a year of supervision experiences, currently working for a BHRS agency. I would like to recruit 6-8 supervisors to participate in a focus group exploring the role of supervision and agency practices in maintaining BHRS clinician wellness. Participation in this study is absolutely voluntary and has no bearing on your employment within your agency. All information from the study will be kept confidential from agency administrators, supervisors, and other clinicians. Your participation will remain confidential. I am asking you to participate in a focus group that will last for approximately 90 minutes. You won’t receive any compensation for participation, but there won’t be any cost to you either.

If you believe you meet the criteria for participation and are willing to participate in the study, please respond directly to this e-mail or contact me via my cell phone.

Thanks for your consideration,

Beth Moore
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: The Systemic Influences upon the Wellness of Home and Community Based Counselors: A Grounded Theory Study

INVESTIGATOR: Elizabeth Moore, MSEd, NCC, Doctoral Candidate

ADVISOR: Debra Hyatt-Burkhart, Ph.D., LPC, NCC, ACS
Assistant Professor
Duquesne University
School of Education
Department of Counseling, Psychology, and Special Education
412-396-5711

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in Counselor Education and Supervision at Duquesne University.

PURPOSE: You are being asked to participate in a research project that seeks to investigate how master’s-level community based counselors stay well despite the challenges encountered in the work. This investigator seeks to understand what strategies and practices are beneficial to home and community based counselor wellness.

In order to qualify for participation, you must be, either:

a.) employed as a master’s-level BHRS clinician with at least 1-3 years of experience or 4 or greater years of experience

b.) employed as a supervisor of master’s-level BHRS clinicians for at least a period of one year
**PARTICIPANT PROCEDURES:**

To participate in this study, you will be asked to answer questions about BHRS work, the challenges of the work, and personal strategies that you have found to be beneficial to maintaining counselor wellness. You will also be asked about the role of supervision and the agency practices in sustaining BHRS clinician wellness.

The interview will last approximately 45 minutes to 1.5 hours. The interview will be held at a mutually agreed upon location that will ensure the privacy of the participant. The interview will be audio taped and video recorded for later transcription. You will be given the opportunity to review the transcript for accuracy following the interview.

These are the only requests that will be made of you.

**RISKS AND BENEFITS:**

There is no risk to participating in this study. As you are only being asked to discuss your job experiences and how your wellness is impacted, there are no more risks to participating in this study than you would encounter in everyday life. The potential benefit to participating in this study is the contribution that this investigation may make to the wellness practices of home and community based counselors and agency and supervisory practices that support home and community based counselors.

You may or may not experience emotional benefit from participating in this study.

**COMPENSATION:**

There will be no compensation for participation in this study.

Participation in the project will require no monetary cost to you.

**CONFIDENTIALITY:**

Your participation in this study and any personal information that you provide will be kept confidential at all times and to every extent possible.

Your name and the name of the BHRS agency will never appear on any survey or research instruments. No identification will be made in the data analysis. All written and electronic forms and study materials, including consent forms, and audio and videotapes will be kept secure in a locked file in the researcher’s home. All identifying material, including anyone discussed in the interview will be deleted from the tapes at the time of transcription and identifying material such as but not limited to names and the agency will be removed from the transcript. The transcription will be shared with the researcher’s dissertation committee.
Portions of the transcription may be anonymously quoted as illustrations in the dissertation itself. Audiotapes and videotapes will be destroyed immediately after completion of the study. Written materials, such as transcripts and field notes will be retained for no longer than 5 years. All written material will be destroyed in compliance with HIPAA guidelines for document disposal.

**RIGHT TO WITHDRAW:** You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time by contacting the investigator. If you choose to withdraw after engaging in a portion of the study, the researcher will not draw from or make any references to data that has been collected as a result of your individual participation.

**SUMMARY OF RESULTS:** A summary of the results of this research will be supplied to you, at no cost, upon request.

**VOLUNTARY CONSENT:** I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Elizabeth Moore or Debra Hyatt-Burkhart, faculty advisor, at 412-396-5711. Should I have questions regarding protection of human subject issues, I may call Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board, at 412.396.1886.

_______________________________________________  _________________
Participant's Signature      Date

________________________________________________  _________________
Researcher's Signature      Date
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: The Systemic Influences upon the Wellness of Home and Community Based Counselors: A Grounded Theory Study

INVESTIGATOR: Elizabeth Moore, MSEd, NCC, Doctoral Candidate

ADVISOR: Debra Hyatt-Burkhart, Ph.D., LPC, NCC, ACS
Assistant Professor
Duquesne University
School of Education
Department of Counseling, Psychology, and Special Education
412-396-5711

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in Counselor Education and Supervision at Duquesne University.

PURPOSE: You are being asked to participate in a research project that seeks to investigate how master’s-level community based counselors stay well despite the challenges encountered in the work. This investigator seeks to understand what strategies and practices are beneficial to home and community based counselor wellness. Six to eight participants will be recruited to participate in the focus group.

In order to qualify for participation, you must be employed as a supervisor of master’s-level BHRS clinicians for at least a period of one year.
PARTICIPANT PROCEDURES:

To participate in this study, you will be asked to answer questions about BHRS work, the challenges of the work, the agency and supervisory strategies that you have found to be beneficial to maintaining BHRS counselor wellness.

The focus group will last approximately 45 minutes to 1.5 hours. The focus group will be held at a mutually agreed upon location that will ensure the privacy of the participants and will be audio taped and video recorded for later transcription. You will be given the opportunity to review the transcript for accuracy following the interview. You may be asked to participate in a follow-up interview to learn more about your perceptions of BHRS counselor wellness and ways that BHRS clinicians can be supported. If willing, at the time of the follow-up interview, you will be asked to review and sign the informed consent prior to participating in that part of the study.

These are the only requests that will be made of you.

RISKS AND BENEFITS:

There is no risk to participating in this study. As you are only being asked to discuss your job experiences and how your wellness is impacted, there are no more risks to participating in this study than you would encounter in everyday life. The potential benefit to participating in this study is the contribution that this investigation may make to the wellness practices of home and community based counselors and the agency and supervisory practices that support home and community based counselors. You may or may not experience emotional benefit from participating in this study.

COMPENSATION:

There will be no compensation for participation in this study.

Participation in the project will require no monetary cost to you.
CONFIDENTIALITY:
Your participation in this study and any personal information that you provide will be kept confidential at all times and to every extent possible.

The information obtained will be held confidential by the researcher; however, no guarantee can be made that participants in the focus group will not disclose information outside of the group. Every effort will be made to stress confidentiality to the participants throughout the process.

Your name and the name of the BHRS agency will never appear on any survey or research instruments. No identification will be made in the data analysis. All written and electronic forms and study materials, including consent forms, and audio and videotapes will be kept secure in a locked file in the researcher’s home. All identifying material, including anyone discussed in the interview will be deleted from the tapes at the time of transcription and identifying material such as but not limited to names and the agency will be removed from the transcript. The transcription will be shared with the researcher’s dissertation committee. Portions of the transcription may be anonymously quoted as illustrations in the dissertation itself. Your response(s) will only appear in aggregated data summaries. Audiotapes and videotapes will be destroyed immediately after completion of the study. Written materials, such as transcripts and field notes will be retained for no longer than 5 years. All written material will be destroyed in compliance with HIPAA guidelines for document disposal.

RIGHT TO WITHDRAW:
You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time by notifying the investigator. If you choose to withdraw after engaging in a portion of the study, the researcher will not draw from or make any references to data that has been collected as a result of your individual participation.

SUMMARY OF RESULTS:
A summary of the results of this research will be supplied to you, at no cost, upon request.
VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Elizabeth Moore or Debra Hyatt-Burkhart, faculty advisor, at 412-396-5711. Should I have questions regarding protection of human subject issues, I may call Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board, at 412.396.1886.

_______________________________________________  _________________
Participant's Signature      Date

________________________________________________  _________________
Researcher's Signature      Date