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An Exploration of Home-based Therapists' Supervisory Experiences: A Phenomenological Inquiry

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An Exploration of Home-based Therapists' Supervisory Experiences:

A Phenomenological Inquiry

By

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Table of Contents

List of Tables

Abstract

In-home family therapy has become one of the most common options of treatment for providing services to families who do not typically utilize a private clinic (Lawson, 2005; Reiter, 2000; Yorgason, McWey, & Felts, 2005). Researchers have given some attention to the topic of home-based therapy and to general supervision, but little attention has focused on the actual supervision experiences of home-based therapy providers.

This phenomenological study explored the supervision experiences of seven past and current in-home therapists: marriage and family therapists (MFTs) and social workers (MSWs). Semi-structured interviews were conducted with the participants, and data was analyzed to develop structured descriptions and meanings via highlighted "significant statements" that described the participants' experiences (Kvale, 2007).

The participants' descriptive accounts were categorized as 1) in-home therapy descriptions, 2) factors affecting in-home therapy supervision, and 3) effective and ineffective supervisory practices. Implications of the research findings suggested that clinicians' needs and expectations related to safety, burn out, and supervisory knowledge were often unmet. Supervisory practices that appeared significantly effective were 1) developing trusting supervisor-supervisee relationships, 2) reviewing models and clinical application collaboratively, and 3) actively prioritizing clinician safety and burn out prevention.

CHAPTER I: INTRODUCTION

Rationale for Topic Selection

      The training provided for the sub-specialty of in-home family therapy is very limited in many community-based agencies and academic programs (Mattek, Jorgenson, and Fox, 2010)**.** Some agencies rely heavily on the training of academic programs and the therapeutic skill and sensitivity of the therapists they hire; but in-home therapists often feel the need for more training and guidance (Adams & Maynard, 2000; Lawson, 2005; Worth & Blow, 2010). While therapists may feel some confidence regarding their therapeutic skill, their ability to apply office-based training and preparation in the home setting can be a challenge (Roberts, 2006). When this and other challenges are not mastered in a timely manner, therapists may quickly burnout and leave in-home therapy jobs, which result in high rates of turn over for entry level positions (Culbreth, Woodford, Levitt, and May, 2005). While there is little documentation to support the idea that changing therapists in the midst of treatment can have an adverse effect on outcomes (Caplan, 2014; Clark, Cole, & Robertson, 2014), one may intuitively expect that interrupting the therapeutic relationship and rebuilding trust with another therapist in treatment can deflate clients' trust and treatment motivation. Furthermore, it is rare to see seasoned therapists working as in-home therapists for community agencies (Maachi, Johnson, & Durtschi, 2014). For example, seasoned therapists, especially upon obtaining licensure, either move into supervisory positions within their company or pursue other opportunities not involving the challenges of in-home therapy work.

After eight years of `working in home-based therapy as a clinician and supervisor, and noticing clinicians' behavior patterns, I developed a concern for determining whether home-based clinicians are getting the support that they need from supervisors. My experience with in-home therapy work spans across three community agencies--all with differing specialties, training processes, and preferred therapeutic models. While some mental health agencies provide internal training, my personal experience (and those of my in-home therapy colleagues) is that many beginning therapists seldom feel prepared for the encounters faced in home-based therapy work.

In this paper, I will provide a brief introduction to the history and nature of home-based therapy as well as the supervision of in-home services in order to lay groundwork for exploring the supervisory experiences of in-home therapists. In the next section, I will provide a brief historical perspective of in-home therapy, an overview of in-home therapy and supervision, followed by a brief focus of this study. Before moving ahead, I would like to define some key terms.

Definitions of Key Terms

Case staffing

Case presentation led by a clinician in a supervision session in which s/he provides information about a client's background, presenting problem, legal/ethical issues, crisis/safety issues, culture, assessment and diagnosis, treatment plan, and progress of treatment. Also called "a staffing".

Home-based services

Home-based services are defined by Lawson (2005, pg. 437) as counseling and case management services provided to families who have a child identified as being at imminent risk for removal from the home.

In-home family therapy

In-home family therapy is a type of home-based services usually provided by community programs designated to support with problems that threaten dissolution of the family unit, such as juvenile delinquency, child removal due to abuse or neglect cases, intense parent-child conflict, or unmanaged psychiatric or emotional disorders (Zarski & Zygmond, 1989).

Supervision

Oversight and management of therapists to facilitate professional growth of therapeutic skills through training, teaching, and modeling as needed while the therapist serves clients (Zarski & Zygmond, 1989).

Therapist

Refers to persons practicing therapy in the mental health profession.

MFT: Marriage and Family Therapist

A person trained to practice marriage and family therapy wherein the "practice of marriage and family therapy" is defined as the use of scientific and applied marriage and

family theories, methods, and procedures for the purpose of describing, evaluating, and modifying marital, family, and individual behavior, within the context of marital and family systems, including the context of marital formation and dissolution, and is based on marriage and family systems theory, marriage and family development, human development, normal and abnormal behavior, psychopathology, human sexuality, psychotherapeutic and marriage and family therapy theories and techniques.

CSW: Clinical Social Worker

A person trained to practice clinical social work wherein the "practice of clinical social work" is defined as the use of scientific and applied knowledge, theories, and methods for the purpose of describing, preventing, evaluating, and treating individual, couple, marital, family, or group behavior, based on the person-in-situation perspective of psychosocial development, normal and abnormal behavior, psychopathology, unconscious motivation, interpersonal relationships, environmental stress, differential assessment, differential planning, and data gathering.

Historical Perspective

When considering the history of home visits and marriage and family therapy, home-based therapy is relatively new to the field of marriage and family therapy. Jordan, Alvarado, Braley, and Williams (2001) provide an overview of the creation and progress of home-based services. The authors describe in-home therapy as the last option for families in crisis to get services that are family focused and strength-based. Further, many services of the past were not designed to strengthen and maintain the family unit.

In-home work started in the 1800s, intervening on child abuse situations, nearly always leading to child removal. In the 1970s, "*Homebuilders*" was piloted to try in-home therapy work for the distinct purpose of keeping the family unit together, and additional in-home programs with similar purposes eventually came about. Reiter (2000) noted some ways that in-home work was utilized before the 1970s, as one-time intake assessment sessions or to help certain multi-problem families, but as this practice didn't get much recognition until the law was passed in the 1970s, today's format of in-home services has followed the ground work laid by "Homebuilders" programs. Christensen (1995) also described the "passage of Public Law 96-272" (p.306) for several states in the 1970s in order to address the need to maintain the safety of children while in their homes with biological family/parents. This alternative to foster care and other forms of family disruption were instituted to keep more families together instead of ripping them apart. The 80's decade brought the Behavioral Science Institute for training on and a grander spread of home-based services to address child abuse intervention, mental wellness, and juvenile justice problems (Jordan, Alvarado, Braley, and Williams, 2001). Such programs have continued to open, spread, and develop evidence-based practices to demonstrate success rates.

Overview of In-home Therapy and Supervision

Evidence-based practice. The National Registry of Evidence-based Programs and Practices (NREPP) provides a registry of programs that give support for mental health and substance abuse. NREPP recognizes 64 evidence-based family intervention programs that include parenting, individual therapy, family therapy, skills training, and other services in the home environment. While programs differ in some ways, there are

general similarities, such as the focus on family dynamics, around-the-clock availability, and working with the system in the community. Evidence-based models that are typically associated with home-based therapy appeared to be homebuilders, brief strategic, functional family therapy, multi-systemic therapies, and a multidimensional treatment foster care model (Fraser & Haapala, 1987; Henggeler & Less, 2003; Sexton & Alexander, 2000; Worth and Blow, 2010).

Evidence-based intensive in-home programs may have certain similarities such as provision of intensive case supervision, providing low caseloads for the therapist, remaining on-call for crisis situations that may occur in the family 24/7, as well as providing extensive training and supervision for maintenance of fidelity to the model. This intensive level of support and built-in attention to supervision may prove useful to client care, supervisee development, and outcomes for both. It is common for these models to be used with at-risk populations and community based services to provide relatively brief and intense services tailored to the family's needs. "Despite subtle differences between the models, each addresses similar components including the environment and context, the family roles and expectations, the therapist roles and expectations, the therapeutic relationship, and the goals of clinical work" (Maachi & O'Conner, 2010, p. 9). There are multiple approaches and methods that are applied to in-home therapy.

Supervision methods. Community agencies and school training programs may differ in their approach, focus, and level of responsibility for training in specific areas for the clinician. Indirect supervision is very common across the mental health field. External practicums in master's and doctoral programs, off site supervision situations, and

licensure supervision are comparable circumstances in which the supervisor is not directly observing the therapist but has to provide some guidance through indirect supervision. Mattek, Jorgenson, and Fox (2010) observed student counselors doing in-home therapy and conducted surveys to address self-efficacy and training needs. High levels of satisfaction and improved confidence levels in their counseling skills were reported, indicating that home-based training programs and internships may be the perfect training grounds for therapists in school to prepare for such careers.

Multiple modalities are recommended for training, including face-to-face trainings, video, online, and CD trainings with the benefit of contributing to the CEUs needed for licensure renewal (Walter & Petr, 2006). Supervision and training options can include individual supervision in office/private, team/peer supervision in office, in-home observation of therapist with client, phone supervision (especially for crisis situations), and colleague consultation (Camper and Taitt, 2011). In-home observation, also known as participant supervision, has received little attention but demonstrated advantages to self-report. Nonetheless, many supervisors avoid the practical difficulty of live observation since it takes more time, planning and attention to other issues (Falke, Lawson, Pandit, & Patrick, 2015).

In-home supervision represents an opportunity to influence the therapist's decisions as they influence the family, not necessarily to act on the family directly. Peer consultation and feedback from clients should be highly valued and integrated into the supervision process; in fact, the entire team could be included in a live supervision session. Zarski, et al (1991) suggest that in-home supervision is best suited or placed in the client's home during the therapy time frame, but there may be ways to adjust the

supervisor's level of interaction if visiting the client's home sooner or later in the development of the therapist-client relationship. It may prove important to appropriately plan with the supervisee how this supervision strategy in the home may impact the therapist and family; these conversations will need to address plans and preparations for before, during, and after the in-home supervisory session. The debriefing after the live supervision should include the supervisor's thoughts on the family's progress, the therapist's development, and direct feedback on implementation of interventions and suggestions.

Supervision may appear to take on the combined format of group and individual supervision much more often than either group or individual supervision alone, while other options include unled peer supervision or no supervision. Additionally, the majority of respondents received supervision at least once per week. This study also included supervisors, most of whom were social workers who had some training in supervision. Overall, supervisees were satisfied more often with supervision overall, frequency, duration, content, quality, supervisor competence, and supervisee improved development (Zarski, 1991, p. 91). Self-report was used much more often than direct observation of sessions via tape or live visits/co-therapy.

Lawson (2005) described several significant studies that were completed on the supervision of in-home therapy. Findings suggest live supervision should be used in conjunction with self-report and skill-focused trainings. Intensity of supervision should match the intensity of services provided, perhaps several hours per week. Videotaping sessions may help when live supervision is not possible, as well as, using group supervision in addition to individual in order to magnify the benefits of learning from

peers. Most counselors who were surveyed reported feeling less supported and getting less supervision than they would like. Good supervision will enhance the supervisee-client relationships and supervisee confidence as a clinician. To have the intended effect, supervision needs to address how to provide services in this context, including managing sessions, using the home environment, and attention to systemic issues and safety. Live or taped sessions are a necessity, and newer therapists should observe more experienced therapists. Other areas of significance include case conceptualization and helping the clinician to understand his or her biases and worldview about clients. In order to see the importance of various methods, supervisors need to receive training that focuses on the specialized needs of in-home therapists.

Supervision training. AAMFT provides standards for approving MFT supervisors, as well as guidelines for assessing the supervisory candidate (AAMFT approved supervisor guide 2014). The guidelines include regular monitoring for at least 18 months with written and verbal evaluations. There are supervision-training courses available. The AAMFT has competencies for supervisors to follow, including a system of receiving supervision for one's supervisory activities. The qualifications attempt to insure that MFTs receive quality supervision; however, one may argue that MFTs who conduct in-home work may need an added level of supervision that attends to some of the specific challenges unique to in-home work (Adams & Maynard, 2000; Christensen, 1995). Nonetheless, there may be some differences in the way that MFTs and other psychotherapy professionals are supervised since there are some differences in the training and certain requirements for other mental health disciplines (American Counseling Association, 2005; National Association of Social Workers, 2001).

Supervision models that focus specifically on home-based services and public sector programs have been offered, some suggesting use of group supervision to train the supervisors (Abassary & Goodrich, 2014; Getz & Agnew, 1999; Hoge, Migdole, Farkas, Ponce, & Hunnicutt, 2011). Such models can help bridge some of the gaps that may exist between psychotherapists with different base trainings.

Milne, Sheikh, Pattison & Wilkinson (2011) looked at clinical supervision training to determine whether there is evidence of specialized supervisory training that improves the supervision experience. They attempted to summarize from eleven articles the commonly cited ways of training supervisors that seem to work across the multiple controlled studies. Their meta-analysis is not specific to the field of MFT but more general to the psychotherapy field at large. Ultimately, the most support was found for "feedback, educational role-play, and modeling (live/video demonstration)" (p.62) as supervisory techniques that appear to have an effect on supervisee and positive client impact. Additionally, those same techniques received the most support across the studies as the way to train the supervisors who, in turn, used those techniques with supervisees. These findings were consistent with the long ago suggested elements of supervisor preparation: "theoretical content, simulated experience and in vivo practice with supervisees" (p.63). There is still a need to explore and define a systematic, replicable way to evaluate the effectiveness of training given to supervisors, whether through impact on client treatment or impact on supervisee development. The findings applied primarily to workshop settings as trainings for supervisors and focused on supervisors providing one-on-one supervision. It is also worth note that according to Watkins (2011)

meta-analysis, there are mixed reviews on how much supervision actually impacts client outcomes.

Supervision topics. It may prove helpful for in-home therapists to be trained in systems theory as well as structural therapy (Zarski & Zygmond, 1989), but training also needs to be complemented with supervision that involves additional teaching and practicing systemically. The supervisor should expect to model for the therapist how certain principles and skills may be implemented with clients. Direct observation, session tapings, and self-report can all provide information for the supervisor to guide the therapist in improving "relationship skills, conceptual skills, observational skills, and therapeutic skills" (p. 123).

Lawson and Foster (2005) looked at the ego development, or skill level, of in-home therapists. Supervision needs were affected by the counselor's development and recommendations were given to evaluate in-home work, provide training to both supervisors and therapists on clinical and safety issues, and to maintain open flexibility while providing services (Christensen, 1995). Addressing therapists based on their level of ability and professional and personal development is foundational to successful supervision and growth (Zarski, Sand-Pringle, Greenbank, & Cibik, 1991). The beginner therapist has different abilities and skills from a master therapist and thereby requires different supervisory interventions. For example, a beginner therapist may benefit more from supervision that provides case conceptualization, "structure, support […and practice with] formulating hypotheses" (Zarski, Sand-Pringle, Greenbank, & Cibik, 1991, pg. 134) about the family members' behaviors.

In the next level of development, the therapist's supervisor may focus on therapeutic tasks and advanced interventions, and progressively the supervision will involve less structure and more focus on the therapist's engagement of the family's strengths to empower the family to initiate their own changes. Finally, a master clinician's supervision experience would likely seem more advanced with foci like the supervisee's "use of ritual, metaphor, or paradoxical interventions with the family" (p.135).

The goals of supervision were most often reported to be ethics, agency policy, teamwork, self of the therapist, and clinical skills (Culbreth, Woodford, Levitt, and May, 2005). The supervisees reported that supervisors were most likely to use support and encouragement, providing information, and giving advice during supervision sessions, with confrontation, influence, self-disclosure, and homework happening much more occasionally. Supervisors from this sample generally appeared to be providing the type of supervision desired by supervisees but many supervisees wanted less frequent, biweekly check ins. It is suggested for agency supervisors to leave agency policy and related concerns to another forum in order to allow supervision to focus more specifically on clinical needs, and self of the therapist. It is also suggested to provide a structured format to the supervision to attend the aforementioned. Supervisees appeared to want more attention paid to ethics, boundaries, and supervisee development. It may be helpful to incorporate another format into the regular self-report supervision as an occasional supplement, but supervisors may need additional training on how to make the most of these opportunities, especially since the majority of the supervisors were reported as master's level educated and supervisory training is not typically addressed in master's

degree programs. A guide or code of ethical conduct specific to in-home work for supervisors and clinicians may prove useful (Culbreth, Woodford, Levitt, and May, 2005).

      Ethics and legal ramifications. Ethics serve to govern the practice of mental health and to establish and maintain a level of trust with the general public regarding the professional behavior of mental health professionals. Governing principles are intended to prevent harm to the client, clinician, supervisor and the profession itself (AAMFT Code of Ethics). In some cases, the supervisee may mishandle the therapy process or termination, may have inappropriate relationships with clients, uncontrolled biases, or may neglect to provide therapy altogether. Supervisors must remember their ultimate legal responsibility for the supervisees' behavior with clients. Thus, supervisors must acquaint themselves with each case and receive regular updates regarding each of the contacts. The style of the supervisor may dictate whether to use videotapes of sessions, progress notes, live observation or other methods while providing guidance (Glenn & Serovich, 1994). While many supervisors' style is to rely on self-report from the supervisee regarding what needs to be addressed in supervision, the supervisor is directly liable for supervisee's conduct. Hence, it is imperative that supervisors insure appropriate monitoring and documentation. "Written supervision record was central to courts' decision" in supervisory malpractice suits. In light of those cases and rulings, suggestions on documentation was given: be sure to document "decision processes regarding critical incidents, failing to document informed consent, and failing to obtain and review past supervision records when warranted" (Falvey and Cohen, 2003, p.68).

Falvey & Cohen, (2003) noted the slow development across several decades of the practice of documenting supervision of mental health services. The AAMFT has specified particular requirements of training and experience to qualify supervisors as prepared to meet necessary standards for adequate supervision of marriage and family therapists. The standards include certain documentation requirements and occasional evaluations of the supervisee. Glenn & Serovich (1994) addressed the need to document supervision appropriately in order to protect the supervisor, supervisee, and clients as well as to promote excellent quality of care, evaluate the supervisee with supporting evidence of growth and areas of development.

Documentation of directives and guidance will help the supervisor to keep a trail of supervisee follow through and other administrative details of the cases; additionally, supervisees may benefit from having a reference and reminder of the directions that were given. A formal document may be helpful to consistently record changes, progress, needs and suggestions that are discussed in supervision (Glenn & Serovich, 1994). A supervision contract may include an outline of the expectancies for the provided training, areas of development, evaluations, and accounts of the meetings (including cancelled and missed supervisions), as well as expectations for dealing with supervisor-supervisee conflicts. Contracts need to include guiding principles and goals that will help dictate how the time is spent, step-by-step instructions for addressing crisis issues, a description of the evaluation process, assignments and duties of both parties, a description of the approach to supervision, and additional information. It may also be helpful to maintain documentation of the training and recommendations given in each session in order to follow up on the implementation (Falvey & Cohen, 2003). Creating and implementing

such structure and boundaries may prove useful to guide the therapist and supervisor in addressing common topic areas related to in-home therapy work.

Focus of the Study

Methods of supervision are available in the literature. Therapists' needs and preferences have been explored, and factors affecting the efficacy of home-based therapy have been explored through evidence-based practice. Still, there is very limited attention in the literature to determine what supervisors of in-home therapists are actually doing or how supervisee's perceive them. In the following literature review, I will describe how the challenges and benefits of home-based therapy impact the therapist and client in order to consider how the supervisor addresses these issues.

CHAPTER II: LITERATURE REVIEW

Over many years, home-based services have evolved to meet the changing and growing needs of families. As communities are heavily dependent on the strength of the family units, agencies attempt to address the needs of community members by strengthening families and helping families to stay together with healthy relationships and home life.

There is increased pressure from government and other funding organizations to provide evidence-based treatment by which the agency can demonstrate and document how the provider introduced positive change to the family or individuals. In-home therapy may be the answer to that growing concern. As the requirement for low cost, effective, evidenced based practice continues to increase, there are common practices and components that seem to occur across agencies. The cost of home-based services has repeatedly been shown to be cheaper than foster care, residential treatments and other out of home placements. Additionally, in-home services seemed related to less use of medical services and shorter lengths of medical and therapy use (Crane, Hillin, & Jakubowski, 2005). One controlled study compared in-patient and home-based treatment groups to find no significant differences in the therapy results at discharge and at follow up (Mattejat, Hirt, Wilken, Schmidt, & Remschmidt, 2001). However, Wilmshurst (2002) observed a difference in the long-term impact of residential versus home-based therapy. The in-home therapy provided longer lasting positive changes than the residential program in which children were removed from family for 5 out of 7 days per week.

Community agencies that provide in-home family therapy share the commonality of addressing at-risk families and youth. These clients often do not use typical outpatient

services, so introducing ecological or family systems therapy models and approaches is a

positive shock to the family system (Walter & Petr, 2006). There is some overlap of

supervision topics that are addressed for providers in the home environment and in office

based training settings, for example, crisis intervention. However, there are several

concerns that are unique to or magnified by home-based services. Additionally, while it is

possible that multi-problem families seek services in an office or clinic, the trends in the

literature suggest that certain systemic problems are more common in low income and

minority populations (Culbreth, Woodford, Levitt, and May, 2005). While some clients

dealing with issues of sexual abuse, single parenting, drug/alcohol abuse, severe mental

illness, and adolescent development may seek help in a clinic setting, the literature

further suggests that some populations avoid clinic settings and do not seek therapeutic

assistance. However, when issues of child neglect and abuse lead to court ordered

services, several additional problems may arise as the clinician assesses the needs of the

client family. It is furthermore expected that burn out and "therapist demoralization" can

occur in the office or home-based treatment; however, the turn over that occurs with

home-based providers is documented at a greater and speedier rate (Adams and Maynard,

2000, pg. 45). The burden to oversee provision of good, cost-effective treatment lies with

the supervisors of in-home therapy providers. Indeed, the supervisor must balance the

needs and demands of funders, agencies, clinicians and clients (Rubin, 1997).

Overview of Supervision Topics

As home-based therapy programs have continued to grow over the last century,

various models of client treatment and clinical supervision have been offered. Indeed,

many have offered suggestions for supervision of in-home therapists (Adams & Maynard,

2000; Camper & Taitt, 2011; Christensen, 1995; Culbreth, Woodford, Levitt & May, 2004; Worth & Blow, 2010). However, as clinicians receive training and education, the general knowledge acquired is normally geared toward office based services which differ greatly from the home-based environment (Adams and Maynard, 2000; Walter & Petr, 2006). It is pertinent that the supervisor of home-based clinicians attends to common challenges and topics unique to this subfield, including unpredictability of the home environment, managing ethical quandaries, maintaining appropriate boundaries, attending to ethics and safety while developing a positive therapeutic relationship, as well as juggling the involvement of multiple systems (Christensen, 1995; Worth & Blow, 2010). Sometimes what works well for the client may be stressful for the clinician to deliver, and sometimes the clinician's objectives or approach may offend or intimidate the client family. These and other issues create a balance beam on which client and therapist needs can sometimes seem to outweigh each other (Rubin, 2007). In the following section, I will address challenges that supervision should attend to, including building a positive therapeutic relationship, engagement, ethics and confidentiality, safety, environment, boundaries, and burn out.

In-Home Therapy Challenges to Address in Supervision

       Therapeutic relationship. Supervision has to offer practical ways to help beginning clinicians build strong therapeutic relationships with clients. Additionally, it is important to recognize that clients and clinicians may not have the same ideas of what makes a positive therapy relationship. McWey, Humphreys, & Pazdera (2011) found that therapists and clients differ in perceptions of what makes good home-based therapy. Therapists were concerned about training, whereas clients were concerned about non-

judgment and therapists' personal, lived experiences. Those clients may think that a

therapist would be less judgmental if they could share personal problems and successes

raising children or share family problems that the therapist handled effectively. The

clients' assumptions seemed to be that personal advice and empathy for client situations

would not be perceived as cold, impersonal text book knowledge. Additionally, the client

sample suggested that directness and some coaching may be desirable to improve

parental skills and communication; however, clients were also weary of therapists

thinking they "know" and "understand" the client experience (McWey, et al, 2011, p.

145). Achieving desired outcomes can make a significant difference for a family and self-

assurance for the therapist; however, the clients and therapists in this study warned about

taking failures personally. Therapist factors noted as significant included personality,

using a gradual pace, non-critical stance, and straightforwardness (McWey, 2008).

Simultaneously, building a positive relationship with clients often leads to personal

invitations to family dinnertime or can lead to inappropriate advances and client dress,

giving and receiving gifts, clients showing affection, and clients inviting therapists to

personal family events (Camper & Taitt, 2011). Clients want to feel close to their

therapist, and declining some family invitations may offend clients and hinder the joining

process, but building a positive therapeutic relationship is directly related to strong

engagement of a client. In light of these findings, supervision must face the challenge of

helping clinicians learn clients' expectations and adjust the clinical approach to each

client's cultural and personality differences. Strong therapeutic relationships are directly

related to engaging client families.

Engagement. Reiter (2000) focused specifically on how to join while providing in-home therapy. Several areas that were noted include certain benefits such as the clinician's ability to customize services to the family, obtain advantageous information about the family, and gain more access to families who can't come to the clinic (especially multiple times per week). Reiter noted that putting the family at ease helps them to feel less vulnerable and sends a message of respect for the client by going to them. While frequent therapy in the home interrupts the clients' daily routine, joining with the client family can set them at ease by "following some of their behavior patterns" (p.30). He makes the case that joining can be more significant than theory or other therapist factors, to accomplish effective treatment.

Milton Erickson was noted by Reiter (2000) as a perfect example of how well it works to use "peoples' patterns of behavior and responses" (p. 31) to enhance treatment. Reiter emphasized paying close attention to the little things that clients say and do in order to maximize use of their patterns. For example, one could allow the family to choose where in the home to meet and follow family customs such as shoe removal at the door to show respect. However, instead of asking for a tour, compliment the décor of the home as the family invites one to different areas of the house. In addition to compliments, he says to ask questions about family pictures, traditions, and interests like the TV show that is playing or video games being played. By having therapeutic conversation while observing their natural routines for homework, dinner, etc., the clinician can engage everyone and even consider accepting a drink of water and dinner, if they insist. He also recommends explaining one's role and agency as separate entities from the courts, DCF or other mandates. According to Jordan, Alvarado, Braley, and Williams (2001), the

therapist is advised to meet each family member individually and as a whole in order to properly join before developing plans and goals, clarifying boundaries and expectations, maintaining consistent supervision and training in systemic therapies, paying special attention to positives and strengths before stressing negative patterns or mistakes. Later, it is important for the therapist to pay more attention to the family's process of interacting instead of the content of their conversations. It is important for the therapist to maintain multiple perspectives in the home environment and to examine his or her attitudes and beliefs about the family's culture and identified problems.

Lack of engagement typically leads to high rates of client drop out. Variables associated with client attrition can include family members who are not committed to therapy who could discourage the others in the family system from committing to therapy or to hard-pressed changes. Violence in the home may intimidate victims from speaking up about real issues due to danger. In addition, perpetrators of violence would likely be afraid of losing their family unit and structure. Client families sometimes have certain stigma and preconceived notions of therapy that detract from their willingness to participate. Lack of involvement of fathers is another structural issue to the sessions and family system dynamics that may significantly impact the effectiveness and willingness of the family to receive treatment (Camper & Taitt, 2011).

In the aforementioned situations, the therapist will face many more challenges to engage the families. Therapists may simply fail to join or connect with a client family. Indeed, home-based therapists must develop an ability to manage court ordered, chaotic, multi problem families who are in crisis, as the client family shows vulnerability when problems are revealed. Timing and pacing are significant here because clients often shut

down if rushed to a vulnerable place with no perceived benefit. Therapists may also have problems connecting to a client family when they are perceived as part of the "system" that threatens removal of the children. Families wrestling with the state over custody of their children have high levels of associated stress, and the therapist has to manage the relationship between the family and the government agency. Again, supervision must help the therapist face these challenges head on in order to build a therapeutic relationship and engage the client family, while attending to ethical issues that will arise.

Ethics and confidentiality. Various ethical dilemmas, many unique to in-home work, may arise, and supervision will likely be different for these clinicians as they address them. Roberts (2006) examined therapists that worked with children under the age of eighteen, using in-home or multi-systemic therapy. Comparison between office based and in-home therapists' ethical dilemmas were the primary focus. In-home therapists noted significantly higher perceived instances of confidentiality and role confusion ethical dilemmas than their office based colleagues. In-home therapists stated that they received significantly less individual supervision than office-based therapists receive, used clinical consultation less frequently, and were more likely to withhold information from their direct supervisors (Roberts, 2006). Beginning therapists may be more likely to struggle with the privacy that adolescent clients demand and therapeutic need for parents to know what the youth addresses in therapy sessions (Thomas, McCollum & Snyder, 1999). This specific situation is different from working with adults, except in cases of domestic violence, which present a safety concern for clients and therapists. However, beginners have also reported confidentiality issues with the collateral/referral source.

In-home therapists often deal with ethics and boundary issues that are not common in office work. Confidentiality and ethics are significant concerns in the home environment when guests come over or are visiting from out of town (Culbreth, Woodford, Levitt & May, 2005; Thomas, McCollum & Snyder, 1999). There can often be confidentiality concerns with occurrences of unexpected drop-in visits by friends and neighbors, awkward questions by non-clients, or lack of privacy to talk about sensitive topics. Sometimes the therapist may feel bound to keep secrets about harboring, informal adoption, or seeing weapons or drug paraphernalia (Camper & Taitt, 2011). Each of these situations can be muddy in their own way, and supervision is the best environment to clear up ambiguities. Yet in addition to the challenges of joining with multi-problem families and working through uncertainties, safety issues tend to add an additional stress to in-home work and needs to be addressed with an empathetic supervisor.

Safety. Lyter & Abbott (2007) focused in on safety, based on the idea that we live in a violent society, and cautioned supervisors to take seriously the fears of beginning in-home therapists instead of unintentionally inducing shame or denying risks. They suggest that clinicians in the field under report incidents of compromised safety as well as threats from clients. Isolation is a concern for the therapist who works quite independently, perhaps getting supervision weekly (Culbreth, Woodford, Levitt & May, 2005). It was suggested that agencies often do not address issues of safety in formal policy, but supervisors have the responsibility of addressing safety issues during training and to "assign cases within the area of supervisees' expertise" (Lyter & Abbott, 2007, p.23). Agencies are strongly encouraged to display a safety plan and include it in the policy manual, provide training on the safety plan throughout each person's time of

employment, including de-escalation training, self-defense training, and risk assessment. The therapist also has a responsibility for adequate preparation, professionalism, and knowledge of how to handle crises and boundary setting. Some beginners reported dealing with hostility and client's misunderstanding of the therapist's role (Thomas, McCollum & Snyder, 1999). Nelson and Morris (2003) also noted safety issues that may come up for the therapist, especially in situations where a therapist may be afraid of the client's neighborhood or cultural stereotypes. In addition, the therapist needs special preparation for conflict in the home as clients become more comfortable because the formality of the office often hides these dynamics or at least they are presented in a manner that may be more easily managed (Camper & Taitt, 2011). Therapists may experience situations related to encountering scary dogs, parking in dark unfamiliar places, getting blocked in the driveway, and unfamiliar unsafe neighborhoods. When clients see pets as family members, beginning therapists may hesitate to request isolation of the pet during session. Additionally, serving clients in poor socio-economic communities sometimes includes poor lighting of apartment buildings and parking lots. Although more experienced therapists have reported less concern about safety issues (Worth & Blow, 2010), supervisors must initiate safety conversations and prepare therapists for possible situations while also acknowledging to them that not every safety hazard can be predicted. Therefore, general safety plans are necessary. Outside of safety concerns that occur for home-based therapists, there are advantages to working in the home environment.

      Environment. Thomas, McCollum & Snyder (1999) discussed some benefits of the home environment. The researchers explored the transition of applying clinic-learned

skills to the in-home therapy program. The therapists provided solution-focused therapy

once per week for about 90 minutes with some phone calls between sessions. The

transition was facilitated with supervision, reading literature on in-home therapy, using

collateral support, and planning strategies. The MFT interns described having more

information about the clients as a result of working in the home and having more

informal "social quality that felt more familiar than professional" when they interacted

with the client families in the intimacy of their homes. They obtained a lot of information

from the referral source and case manager who also continued to work with the family

(Thomas, McCollum & Snyder, 1999). In addition to the benefits, they discussed

challenges with boundaries, distractions, and less structured sessions. These trainees

hesitated to follow through with plans established in supervision to set a structure for

location and allowable interruptions. They struggled with respecting the parental

authority over the children while trying to set the structure. In the home environment,

terminating sessions did not feel as clear-cut and it was challenging to prioritize the

problems when multiple major issues were apparent that they did not typically see in the

office setting. These beginning therapists further reported lack of confidence to address

issues related to systemic poverty and learning to adjust their approach with low

functioning families with little resources (Thomas, McCollum & Snyder, 1999).

McWey, Humphreys, & Pazdera (2011) noted several ways in which the benefits

of in-home can also be challenges. For example, accessibility of services to underserved

populations who are less likely to desire services and associate stigma to therapy. In

addition, the home environment may be more convenient for the family in regard to

scheduling and transportation, but also overwhelming to have a stranger in one's personal

space in addition to other community service providers that may be court ordered.

When Worth and Blow (2010) analyzed qualities, attitudes and therapeutic

practices common to therapists in home-based therapy, they found what appeared to be

contrasts between requirements of service provision with therapist attitudes about the

delivery. The less experienced therapists seem to have more difficulty joining, but

findings also suggested that engaging clients in the home setting appeared to enhance the

joining process and encourage empathy on behalf of the clinician (Worth & Blow, 2010).

Christensen (1995) used a small group of therapists with clinic and home-based

experiences to interview and determine their points of view. They highlighted ways that

the home environment can enhance and challenge the therapy process as the therapist is

able to learn more about the family than what they might typically say in a clinic, but also

that all of these details may not be necessary for the sake of creating an effective

treatment plan. The family therapy trained clinician was able to report more advantages

to home over the clinic. Many of the therapists seemed to have very negative opinions

about being effective with providing home-based services, preferring to provide services

in a clinic (Christensen, 1995). The potentially negative feedback received from the

surveyed clinicians suggested that the in-home environment comes with too many

distractions for the family. Even the family's hygiene may be an unexpected source of

discomfort for the therapist who is accustomed to a clean, freshly deodorized, organized,

and pet-free office space to conduct sessions in. Due to the common distractions and

unexpected changes that occur in session structure and direction, additional time

management skills may be needed, or even taught in supervision, as well as help with

planning travel. This is especially likely with large caseloads. The office, the park or library could be backup locations to help with managing home distractions. Ultimately, in the home-based therapy sector, these environmental influences affect the majority of the client population. Therefore, supervisors of in-home therapists will be more prepared if they have encountered these sorts of struggles before and if they can empathize with the clinician's struggle, equipping them with practical strategies.

Boundaries. McWey (2008) explored client perceptions of in-home services received, and obtained favorable feedback from clients with implications for therapist availability and service delivery. The client voice was McWey's main focus, and all twenty of the client families expressed having profited from participation in services in one of three ways: "support, skill building and therapist factors" (p52). Most of the participants felt supported due to the therapist being intensely available in and between sessions. Learned skills such as parenting without physical punishment were reported; however, the intensity creates a slippery slope for working harder than the client, which also can translate into enabling versus empowering the client.

The client voice regarding improving the in-home therapy process focused on having services last longer and having more frequent visits during crisis, and wanting to contact the therapist after discharge. These findings suggest that therapists need to assess the clients' support networks and prepare for discharge from the onset of the therapy to prepare them weekly for termination and provide intensity commensurate with the needs of the client family. Indeed, discharges must be properly planned so that clients do not feel abandoned and to ensure generalization of positive changes to future problems (McWey, Humphreys, & Pazdera, 2011). Therapists may have to work hard to not be too

invested in the client's outcome; otherwise, the therapist will definitely work harder than the client to make changes happen for them.

Culbreth, Woodford, Levitt, and May (2005) addressed the supervision needs of in-home therapists and suggest that it is typical for home-based counseling to be intensively provided with multiple sessions and constant therapist availability for crises. Taking one's time was a noted learned skill, in addition to holding sessions twice per week and for several months to provide adequate support. Still, crisis calls, needy multi-problem families, and wavering boundary lines may overwhelm the therapist. Thus managing appropriate boundaries is yet another area for supervisors to initiate much needed conversations.

Jager, Bak, Barber, Bozek, Bocknek, & Weir (2009) described the experiences of MFT interns as they struggled to know how to act as MFTs in the real-world context of child welfare. They addressed such issues as empowering families to operate within the context of their life challenges while trying to respect the families' socioeconomic limitations. The trainees reported working with other community stakeholders to create a more tightly wrapped provision of services to meet varying needs of the family. Yet, many times, there are challenges with getting enough community partners involved for successful wrap around care. These trainees became more aware of their 'privilege' and struggled with a sense of responsibility associated with the profession of MFT in regard to social injustice. Determining their role and appropriate boundaries within each of those areas led to significant struggles with person of the therapist issues (Jager, Bak, Barber, Bozek, Bocknek, & Weir, 2009) and issues of burn out.

Burn out. Camper & Taitt (2011) suggested that therapists providing in-home services should expect to work with multi-problem families coping with juvenile delinquency, multiple forms of abuse or neglect, and psychiatric or emotional disorders-- encountering a wide variety of issues. Many new therapists working in agency settings find themselves unprepared to cope with the complexity of this type of work, especially the balance of pleasing the client, the agency, funders and community systems and stakeholders. The aim of Camper and Taitt's workshop was to help maturing therapists manage the realities of working with these populations. The conference presenters shared challenges with meeting productivity demands, effectively applying theoretical models, and balancing personal lives with 24/7 on-call employment. Burn out for the therapist may partially be due to 24-hour availability in addition to lack of specified training, and perhaps even some doubts regarding the effectiveness of treatment. There was lengthy discussion about the struggles to meet productivity demands and provide accurate and timely documentation. Feelings of burn out were reported as being related to driving to multiple destinations within a day, often to find client no shows and last minute cancellations. This experience compounded with managing the schedule of multiple clients seemed to contribute to stress and feelings of burn out. The definitions of "proper support" may not be altogether clear, so it may be helpful to define such guidelines from both the supervisor and supervisee perspective in order to prevent burn out and ensure the best provision of clinical care (Worth and Blow, 2010, p.471).

Maachi, Johnson, & Durtschi (2014) confirmed some intuitive correlations between workload, experience, supervision and quality of life. They determined that high caseloads, especially for newer therapists, were related to more stress and lower job

satisfaction. However, higher job satisfaction was related to getting more support through supervision and taking care of self. They highlighted the stress of complicated cases, driving between clients, separation from colleagues and managing the chaos associated with home-based treatment. Ultimately, the authors posited that maintaining lower caseloads would allow more time for managing paperwork and making support systems available. They also suggested that more experienced therapists may appear to enjoy their jobs more because those for whom home-based therapy was not a good fit sought other opportunities in the field. This correlated with other reports of high turnover rates in this subfield (Maachi, Johnson, & Durtschi, 2014). Nonetheless, it was still unclear what approaches to supervision and even self-care specifics were most helpful to home-based therapists. It also remained unclear what factors led to participants' perception of increased work load—number of hours providing therapy, documentation, travel, etc.

Following the treatment plan seemed to work well for the home-based clinician when the multiple problems seemed overwhelming to manage. The clinicians took time to learn about the structure of the family dynamics in order to determine how to best partner with them. Issues of safety were addressed by having collaterals or co-therapists to conduct the session with them and by refusing to meet with perpetrators of abuse, especially as it is contraindicated. The clinicians also gradually allowed 90 minutes instead of 50 minutes for sessions. Self-talk was used to deal with anxiety. Driving time before and after sessions was used to get into an appropriate frame of mind, whether that meant thinking about the session or not thinking about the session. Interns had to learn to deal with the fact that they had a limited scope of practice and could not fix all of their clients' problems and that it would be a better use of time to focus on issues that the

clients were invested in changing. Failure to learn these lessons would contribute to feeling overwhelmed, working too hard, and lack of fulfillment (Thomas, McCollum & Snyder, 1999).

Chapter II Summary

Current literature addresses the nature, success, supervision methods and modalities of home-based services. However, very little documentation currently exists that describes what supervisors do and how supervisees perceive supervision of in-home therapy work. Models of supervision may be designed to meet therapists' needs for support, knowledge, and balance (Getz & Agnew, 1999; Hoge, Migdole, Farkas, Ponce, & Hunnicutt, 2011). Culbreth, et al. (2005) suggested that although various supervision models are reportedly utilized, it might be necessary to investigate further what approaches supervisors are actually using, and furthermore, what approaches do clinicians prefer or find most useful. Still, there has been limited attention in the literature exploring how supervisees' perceive the supervision of in-home therapy services. Hence, the focus of this paper is to explore the supervision experiences of home-based providers. What follows is a description of the methods I will employ for this exploration.

CHAPTER III: METHODOLOGY

In this chapter, I provide a rationale for the use of qualitative research and specifically the phenomenological approach. I present an overview, explain the semi-structured interview questions, provide justification for the sampled participants, and outline the data collection procedures. Additionally, I describe the steps taken to maintain quality control and control researcher bias.

Overview of Qualitative Approach

Creswell (2007) suggests that qualitative research is best suited for examination of meaning that people may ascribe to the world: If there is an issue to be explored to determine if there is a problem, or to determine if explanations and accounts of successful and effective supervision are common. As a clinician, I believed that my colleagues' expressed needs and requests were not heard or understood. At times, it was challenging to articulate personal or professional needs in supervisions where productivity or agency protocol was prioritized. Therefore, qualitative research can give rise to "silenced voices" (p.40) of home-based therapists, on the front line, working with clients. The information that we need to obtain about supervision of home-based services is far from one-dimensional. Furthermore, the complexity of the needs of supervisors, clinicians, and clients will be best captured in a design that allows for "talking directly with people […] and allowing them to tell the stories unencumbered by what we expect to find or what we have read in the literature" (p.40).

By using the qualitative approach, we can find greater understanding of some of the results discovered in the literature, such as discovering reasons why certain modalities work well in supervision or how and why certain topics are explored more deeply than

others. Creswell (2007) states that, "We conduct qualitative research because we want to understand the contexts or settings in which participants in a study address a problem or issue" (p. 40).

There are multiple approaches to qualitative research that allow the researcher to capture the participants' experiences—narrative approaches are useful for creating descriptions and creating stories about an individual within a contextual focus; grounded theory approaches are useful for developing a theoretical framework about a group's lived experience; and ethnographies are useful for studying groups directly in their environment as they engage in their lived experiences. However, in order to emphasize the participants' descriptions of their experiences, a phenomenological approach is most appropriate. Phenomenology lends more toward uncovering or deriving the meaning of several individuals' "lived experiences of a concept or phenomenon" (p.40). In the next section, I will describe how phenomenology allowed me to capture what all of the participants share across their experiences as home-based therapy providers.

Phenomenology Overview

Qualitative research helps us to discover "deeper thoughts and behaviors that governed [participants'] responses" (Creswell, 2007, pg. 40). Under the qualitative umbrella, there are multiple approaches to phenomenology as have been implemented by Moustakas, Kvale, von Eckartsberg and the Duquesne group. Moustakas (1994) notes that his heuristic design differs as the participant explores the issue using multiple experiences and ways of communicating those experiences, like narratives, journals, or other depictions. This heuristic approach appears to utilize a combination of phenomenological and narrative research techniques. . The transcendental

phenomenological approach requires the investigator to bracket personal experiences and knowledge about an issue in order to obtain a pure unguided description of the participants' experiences. Subsequently, the investigator must demonstrate significant self-regulation to prevent guiding the participants.

Therefore, I chose to employ the transcendental phenomenological approach to understand the common experience of supervisees who conduct in-home therapy (Moustakas, 1994) by using "comprehensive descriptions that provide the basis of a reflective structural analysis" (Moustakas, 1994, pg. 16). The goal was the development of descriptions of their experiences in a way that remains free of the researcher's judgments. As noted by Creswell (2007), "We conduct qualitative research when we want to empower individuals to share their stories, hear their voices, and minimize the power relationships that often exist between a researcher and the participants in a study" (p.40).

Kvale Interviewing Method and Analysis

Within the phenomenological approach, a life world interview is an open way to learn from an interviewee (Kvale, 2007). The semi-structured life-world interview looks for depictions of the interviewee's life or world as he or she makes meaning of the specific phenomenon. The interview addresses certain themes and questions but is not so scripted that changes are not permitted to tailor the conversation to the interviewee's story.

To set the stage appropriately, the interviewer must help the interviewee to feel comfortable, similar to the parallel process of conducting a therapy session. It can be difficult sharing personal experiences with a stranger. Active listening is one way to

communicate intense interest and insure accurate understanding of the interviewee. Briefing the interviewee before jumping into specific questions can put him or her at ease. In addition, the interviewer has an opportunity to describe the subject matter and purpose of the interview as well as reasons for taping the conversation (Kvale, 2007). It may help to predict for the interviewee that any range of feelings may occur by the end of the interview, including anxiety. Debriefing necessarily occurs after the interview by asking if the interviewee has anything more to say and by asking him or her about his or her experience of the interview. It may also demonstrate a level of appreciation for the story if the interviewer summarizes some of the main points taken from the interview. In order to capture the significance of non-verbal communication that may occur during the interview, the interviewee may take notes of gestures and bodily movements. In addition, the interviewer can take a few minutes after the interview is over to reflect on the analog communication and record the interviewer's impressions since this information will not be otherwise captured in the transcription of the interview (Kvale, 2007).

Interviewing. A script can be a useful guide in the interview process to structure the conversation to cover certain topics or specific questions (Kvale, 2007). Each interview question must be weighed to show consideration for how well the question will elicit the knowledge sought and how the question will affect the relational interaction between the interviewer and interviewee. Since the interview data will be analyzed by coding the answers, meanings will be processed during the interview to aid in later categorization. The dynamics of the relationship with the interview participants will prove significant by affecting how freely the information is shared in conversation. When interviewees feel uncomfortable or unsure about certain details, it can lead to withholding

data or an inability to tap into the essence of the experience in order to share with the interviewer. Questions must be short and easy to understand but inviting and able to invoke free flowing conversation.

When preparing the interview, it is important to convert research questions away from formal jargon and toward everyday vernacular. Certain details like asking the participant to describe: 'What happened and how did it happen?', 'How did you feel then?', 'What did you experience?'" (Kvale, 2007, pg. 59) may help to obtain unrestrained and minimally prompted responses and descriptions from the interviewees. 'Why' questions are not as desirable because they are more likely to lead the interviewee to overly analyze their experience instead of sharing freely and allowing the researcher to analyze the data. When asked, *why* questions are best placed at the end of an interview. The main goal of the researcher's questions is to gather enough descriptions to formulate an encompassing understanding about the interviewees experience individually and as it is comparable to other participants.

Opening the interview with a concrete situation, such as remembering one's first or best supervisory experience, can be followed up by additional questions that request more detail or examples (Kvale, 2007). The interviewer must pay close attention to body language and intonations in order to ask for elaboration on words that are weighed with complex emotions or thoughts. Unpacking such statements will help guide the conversation and prompt the researcher to request more detail on how the subject behaves when experiencing different emotions or bodily reactions they may describe as part of their experience. Additional understanding about the subject's thought process can be obtained indirectly by asking him or her to describe their perception of other's

experiences or reactions to in-home supervision, and more directly by asking if he or she has experienced specific formats of supervision such as individual, group, live or indirect. Silence is welcome in the course of the conversation and long, tangential answers can be politely summarized and redirected to another topic. Active listening and rephrasing the interviewees' responses is a welcoming way to show one's interest and to stimulate more descriptions (Kvale, 2007).

Interview questions. Moustakas (1994) prepares the researcher to engage in "the Epoche process" (pg. 60) to set aside biases, personal experiences and understandings of the phenomenon. Similar to controlling for one's bias when approaching a client with a stance of curiosity, the interviewer must consciously hold her predisposition in one hand while privileging the participant's voice with the other hand.

To avoid imposing too much of my personal bias in questioning, I loosely structured the conversation around several questions. I asked, "What has been your experience of home-based therapy supervision?" Additional follow up questions were tailored to match the participants' reported experiences and were generated based on participants responses, such as "What happened and how did it happen? How did you feel then?" To insure that I gained an extensive coverage of participants' experiences, I posed the following final question: "What other significant aspects of your experience can you share with me? I also asked permission to contact participants with follow-up questions and invited each to contact me should they think of other experiences that we did not discuss.

Semi-structured interview questions. Based on the intention of this study and in order to obtain rich descriptions from participants regarding their supervision

experiences, the interview was semi-structured. I asked the following general questions

with small variations based on the participants' responses. For example, if a participant

answered question number one by stating that supervision was not that great, the follow

up questions might be, "What happened that leads you to say the supervision was not

great?" or "How did the supervision fall short of being a great experience for you?"

1. What has been your experience in home-based therapy supervision?

2. What happened?

3. How did it happen?

4. How did you feel then?

5. What other significant aspects of your supervision experience can you share with
   me?

The semi-structure of the interview allowed the interview questions to be tailored to each

individuals experience and allowed for clarification questions to ensure meanings were

clear.

Participants and Sampling

I obtained the sample by contacting past or current home-based therapists, who

received supervision while providing home-based services, via convenient sampling. I

called known local in-home therapists, describing the nature of the study and requesting

permission to conduct an interview at an agreed upon location. After interviewing the

known in-home therapists, I asked if they would like to refer others who met the criteria.

Participants' eligibility was determined by several criteria. A participant was included

based on their willingness to participate in an audiotaped interview. Ten therapists with

an interest in describing their supervision experiences was the target goal. While no

specific requirements were placed on the training history or disciplines of the participants (i.e. MFTs, Social workers, MHCs were all welcome), the participants were asked to share demographic information about their degree training. They were also asked to describe how many years they have spent practicing in-home therapy. No in-home therapists were contacted if he or she received supervision from me directly.

Data Collection and Procedure

In phenomenological exploration, interviewing is the method through which data is collected. The interview is interactive with open-ended questions that may be developed in advance and designed to draw out a detailed complete description of the interviewee's experience. Often the phenomenological interview may begin with an informal conversation and gently guide the participant to think intently about his or her lived experience before describing the experience fully (Moustakas, 1994).

After obtaining institutional review board IRB approval, I called twelve potential participants with the goal of reaching and scheduling ten participants. When speaking on the phone, I provided a brief synopsis of the study, and I offered to email an informed consent agreement (See appendix B). In some situations, I had to leave a message and wait for a return call. When individuals agreed to participate, I verified eligibility according to the stated criteria before scheduling the interview appointment and location. At the appointment, after consent was secured from participants and any questions were answered, I conducted and audio recorded interviews at the agreed upon location and time. At the beginning of recording, the participants were asked to choose a pseudonym. The interviews lasted no longer than 60 minutes including a short debriefing. I took field notes to make note of body language and reactions of participants to questions. Following

the interviews, I thanked the participants for their time and provided guidelines for follow up in case they decided that they want information about the conclusions of the study. After each interview, I stored notes and the audio recorder in a locked cabinet in my home office. I transcribed interviews in my home office using headphones to protect confidentiality. Data from interviews were transcribed and saved onto a password protected flash drive and all data was locked in a cabinet in my home office. I de-identified any names mentioned during the interview with use of pseudonyms.

Data Analysis

I conducted the data analysis to develop structured descriptions and meanings and "significant statements" that highlighted the participants' experiences of in-home therapy and supervision. Next, clusters of meaning were developed to describe participants' experiences and the contexts of supervision (Moustakas, 1994). I asked clarifying questions to assess the accuracy of my understanding and interpretations of meaning during the interview, following Kvale's (2007) steps to increase the validity of the data analysis that was completed later.

Kvale (2007) outlined six general steps to analyzing data. First, minimal interpretation occurs as a free flowing interview elicits spontaneous descriptions about the interviewee's experience, including emotions and actions. This is followed by acknowledging new ideas or understandings developed by the interviewee as a result of the conversations. For example, a home-based therapist may realize that individual supervision is a better fit for her. The interview could prompt the realization that competitive tension with other therapists gets in the way of supervision. The third segment of the general analysis process relies on interviewer's skill to summarize and

articulate back to the interviewee to clarify intended meanings—"a 'self-correcting' interview" (pg. 102). The interviewer can continue the next step of analyzing the entire recorded conversation (alone or with the interviewee) to determine the meanings of the interview conversations. When analyzing the transcribed conversation, I employed coding and categorization techniques to focus on meaning versus other possible concentrations:

> "With categorization involving either/or decisions, it is preferable with precise pre-interview definitions of the categories and careful probing during the interview to ascertain how the statements may be categorized. When the codes or categories are not to be developed until interviewing and analysis, it is important during the interviews to obtain rich descriptions of the specific phenomena to be coded or categorized" (pg. 105).

Specifically regarding coding and categorizing, I attached keywords to portions of transcribed text to more easily recognize the topic of a statement. Additionally, I categorized as I systematically structured the transcriptions into groupings, providing summarizing tables and figures.

Role of the Researcher

As a researcher I have eight years of experience in home-based work, two of which I spent in a supervisory position. I received training for supervision by taking an approved supervisor course, receiving supervisory mentoring, and completing agency based training for supervising an evidence-based model. The researcher's biases may include preferences toward live, direct supervision and attention to family systems topics more than issues of safety. My experience as a therapist influenced me in such a way that

I felt overwhelmed and inadequate many times but sought specific help during supervision. Some supervisory experiences were less than satisfactory, and in those cases, the supervisor did not seem to offer suggestions that I did not think of for myself. Satisfactory supervision experiences were challenging of my assumptions, expectations and therapeutic knowledge. The researcher's role and responsibility is to bracket these experiences and listen for the themes and significant topics highlighted by the participants. I bracketed my biases by adhering to the semi-structured interview questions, journaling my thoughts and feelings through the interview process and consulting with the co-investigator (dissertation chair). While the primary researcher has experience as supervisee and supervisor of in-home therapy services, the phenomenology approach will allow participants to share their individual experiences with minimal influence from the researcher.

CHAPTER IV: RESEARCH FINDINGS

The purpose of this study was to explore the supervision experiences of in-home therapy providers. As described above, semi-structured life-world interviews were conducted to obtain depictions of the interviewees' experiences as they made meaning of in-home therapy supervision. The interview elicited certain themes and questions but was not so scripted that the investigator could not make changes to tailor the conversations to the interviewees' stories. Before outlining the themes, here is a brief description of the participants

Participant Demographics

I contacted twelve in-home therapists and scheduled ten interviews. Out of the ten interviews, seven participants kept their appointments. The participants described themselves as master's level clinicians who currently or in the recent past worked in the field of in-home therapy. The participants' ages ranged from twenty-six to thirty-eight, and each of the participants represented a black culture—either African American or Black Caribbean. Two participants expressed starting non-clinical in-home work before obtaining a master's degree; however, I asked them only to reference their master's level experience of in-home therapy. As illustrated in Table 1, of the seven participants, three obtained master's degrees in social work; four obtained master's degrees in marriage and family therapy. Two expressed enrollment in MFT clinical doctoral programs, one in a non-clinical doctorate. The number of years that each therapist spent in the home-based therapy field ranged from one to six years.

Table 1: Participant Demographics

Name	Master's degree/training	Type of agency	Years of in-home experience
Charlene	MFT	general mental and behavioral health	1
Darla	MFT	general mental and behavioral health	2
Holly	MSW	general mental and behavioral health; substance abuse outpatient	2
Kelly	MSW	foster care; EBP; cognitive-behavioral therapy	3
Jennifer	MFT	general mental and behavioral health	4
Toni	MFT	general mental and behavioral health; EBP; functional family therapy	5
M.P.	MSW	general mental and behavioral health; EBP; substance abuse; domestic violence	6

Following the interview, I began the analysis utilizing Kvale's (2007) method. Kvale's meaning condensation analysis involves several steps:

"First, the complete interview is read through to get a sense of the whole. Then, the natural 'meaning units' of the text, such as they are expressed by the subjects, are determined by the researcher. Third, the theme that dominates a natural meaning unit is restated by the researcher as simply as possible, thematizing the statements from the subject's viewpoint as understood by the researcher." (Kvale, pg. 107)

The interviewees highlighted several issues as being significant to the home-based therapy supervision experience. Significant statements were grouped into themes by checking for similarities and contrasts across participants. I categorized the themes as

applying to 1) in-home descriptions, 2) factors of supervision, and 3) effective and ineffective supervision practices. Finally, I described meaningful realizations including the certain impact that the interview itself had upon some participants' view of supervision and their in-home experience.

Participants' Descriptions of In-home Therapy

There were some statements about home-based therapy that seemed to provide context for the participants' perceived supervision experiences. The participants described several aspects about their experience as an in-home therapist that did not appear to be directly related to what their supervisor's did in supervision. These aspects included a discussion about having limited career options after master's degree programs, working for agencies with certain specialties, issues of agency determined productivity and salary (not determined by the supervisor), travel requirements, inherent safety concerns, environmental factors, working in isolation and receiving minimal preparation in master's degree programs. What follows is a summary of the participants' statements about these aspects of in-home therapy.

Limited or no other options. Home-based therapy was described by more than one participant as "the natural thing to go into" after graduating from master's level therapy programs because of limited job opportunities for non-licensed therapists. Darla suggested that you have to "pay your dues and be an in-home counselor whether you wanted to or not", and Jennifer agreed adding that "people are always hiring for in-home".

Specialties. Participants described agencies with varieties of structure and specialties. Some agencies focused the home-based services on evidence-based practice

such as functional family therapy, or consisted of outpatient substance abuse programs, reunification programs, group home transition services, therapeutic foster homes with long-term placements and other specialties. Multiple participants seemed to agree that finding an agency with good training and good supervision on any of the specialty topics was "the luck of the draw", as Darla reported. Kelly also said that many times the "agencies would have good training or supervision but hardly ever both, and sometimes both were subpar". Participants did not seem to have a problem with agency specialties, but more so lack of training and good supervision for the job.

Productivity and salary. Sometimes, Darla said, "the [company] expectation was ridiculous" as far as the amount of work expected in a salaried position, or only paying the therapist if they turn in documentation, and manage not to have cancellations**.** Other participants, like Jennifer, complained about the pay, "If I didn't see a client, I didn't get paid so I couldn't pay the bills that way". Darla also expressed that non-profits in general do not pay as well as they should for the amount of work expected of the clinician. Moreover, multiple participants associate accepting the lower pay with paying dues to the field. They expressed receiving advice during master's degree programs that they should expect to pay dues by working in the home-based therapy field to get hours for licensure.

Isolation. Kelly described the in-home therapist as a "lonely island" as she noted that there was very limited contact with supervisors or colleagues as she went through her week of work (Culbreth, Woodford, Levitt & May, 2005). Holly agreed that most clinicians get one hour of supervision for seeing their clients for 30 to 40 hours per week. Multiple participants noted that they only went to the office once per week for a meeting, supervision and documentation, trying to fit everything into one day at the office. On the

other hand, Jennifer asserts, "Really, your car is your office." Often clinicians were

completing paperwork in the car while waiting for a client's arrival, waiting between

sessions and making the most of no show appointments (Thomas, McCollum & Snyder,

1999).

Safety. Safety was the single most mentioned concern during the interview

process. Jennifer was the exception, stating that she did not have to work on many very

difficult cases, but did note:

"There were a lot of uncomfortable situations in doing home therapy, just in

some of the areas that you would have to go to and the time of day. Having to go

to some of these sessions, I prefer during daylight hours, but there are some

clients that are only available at a certain time so in order to make sure they're

seen during that week, you have to schedule outside of the norm" (Jennifer).

Nonetheless, she acknowledged that it is helpful to utilize the surroundings of the home.

Nearly every participant had concerns about safety as part of the job since they

typically served low-income families in impoverished, high crime areas. Toni

passionately expressed concerns about drugs and weapons:

"A lot of in-home therapists are maybe newer to the field… so safety is huge, like

knowing not to bring your purse in…Even violence or drugs, I have been in

situations where a father … showed me that he had a knife in his pocket. That was

very scary."

Environment. Kelly expressed that, "home-based therapy, could be great, but

also could be not great at the same time. So it's different if the client was coming to the

office." Jennifer gave a similar opinion:

All those factors, you're able to see it firsthand. Definitely a lot of good

information I was able to get from going to the environment."

Nevertheless, the benefits of in-home do not come without challenges (Christensen,

1995; McWey, Humphreys, & Pazdera, 2011). As M.P. expressed pros and cons, she

stated:

"In-home is a different kind of work because you're throwing yourself into

somebody else's environment that you might not fully agree with how they live or

how they function, but it also opens you're eyes to … truly learn people in their

environment".

She also expressed her opinion that in-home therapy is more successful because clients

are more honest and transparent in their comfort zone.

Distractions are prevalent in most homes when therapy is taking place. Darla

acknowledges that, "You got a lot of interruptions, when you're inside someone's home".

Darla suggested that training in how to "turn off distractions" would be beneficial in

dealing with the natural in-home occurrences such as the TV playing, visiting neighbors,

and phone calls (Snyder & McCollum, 1999). Multiple participants agreed that

distractions are so prevalent in the home, the supervisor will need to provide training,

especially to new therapists, on how to be comfortable saying, let's turn off the TV, the

phone, etc. Many new therapists struggle with finding appropriate boundaries around

being directive and being polite. As Darla stated it,

"If you're a new therapist, and you are just completely green, and all you want to

do is help people, and change the world you have to be comfortable saying,' let's

turn off the TV, we can play Xbox the last five minutes of the session'….

Because people are so uncomfortable talking about what's going on in their lives,

the distraction helps… and I think there needs to be a class, or some training on

how to deal with the distractions. Cause I'll be honest with you. The Young and

the Restless is a distraction for me…because I want to know what's going on with

Victor, Nick, Jackie and them. Distraction is not just for the clients only, but the

therapist as well. If you have a movie on that just came out on DVD, and you

been meaning to see that movie… because the therapists are just humans as well.

So it can be a distraction for everybody in the house. Even the dog can be a

distraction."

Travel. Another aspect of in-home therapy is frequent travel (Christensen, 1995).
Jennifer noted that a common frustration is:

"the driving back and forth, all these people cutting me off in traffic, you've got

to get yourself together before you go in there because I can't come in there with

all of that, this kid has no idea what I just went through on the road".

Jennifer also agreed with the 'lonely island' feeling because "your car is your office…
and you come in like once a week just to turn in your paperwork". Charlene also noted
significant problems with travel since her clients were each 30-45 minutes of driving
each way.

School preparation. Only one participant commented substantially regarding
wishing she were more prepared for in-home before graduating the master's degree
program (Roberts, 2006). Toni expressed an opinion that,

"School addresses therapies, but I don't feel they prepared us for in-home

therapy. I think they more prepared us if we worked in an office."

She said it would be helpful to learn issues specific to working in in-home settings, i.e. safety, paperwork, interventions, etc. Ultimately, her perceived lack of preparation led to feeling lack of confidence, not knowing what she did not know, and going into the field blind.

Table 2 provides a simplified outline of the significant statements and formulated themes that were just discussed.

Table 2: Participants' Descriptions of In-home Therapy

Selected examples of coded statements and related formulated meanings

Formulated meanings/themes	Exemplars
Limited or no other options	*pay your dues*
	the natural thing to go into
	be an in-home counselor whether you want to or not
In-home therapy specialties	*evidence-based practice such as functional family therapy*
	outpatient substance abuse programs
	reunification programs
	group home transition services
	therapeutic foster homes with long term placements
Low salary for high work load	*expectations were ridiculous*
	if I didn't see the client I didn't get paid
	non-profits don't pay as well as they should [for the amount of work]
Isolation	*lonely island*
	one hour of supervision for 30 to 40 hours of seeing clients
	your car is your office
Safety concerns	*uncomfortable situations*
	some of the areas that you have to go to
	the time of day or night
Impact of the home environment	*you're throwing yourself into somebody else's environment*
	because it's harder to lie in your comfortable environment
	in-home has a higher… success rate
	you're able to see it firsthand
	distractions are prevalent in most homes
Stressful travel requirements	*driving back and forth*
	people cutting me off in traffic
	45 minute drive each way
Lack of school preparation for in-home	*school didn't prepare us*
	prepared us for office work
	that would be good to address at school first

Participants' Descriptions of Home-based Therapy Supervision

There were some statements about the supervision experience as home-based therapy providers that seemed to provide a context for understanding the participants' perceptions about effective and meaningful supervision practices. The participants described several aspects about their supervision experience that they seemed to neither attribute to supervisors as a fault nor strength, but rather as part of the territory. These aspects included a discussion about the limited scope of supervision, group supervision, the impact of working for smaller programs with smaller caseloads, agency workshops and trainings (not provided by the supervisor), and supervisee expectations of supervision. These aspects of supervision did not appear to be directly attributed to the supervisor's decisions, but to the nature of the work, supervisees' individual behaviors and expectations as well as the agencies' structure and requirements.

Limited scope. The limited scope of supervision appeared to be attributed to the nature of the work and the supervisee's idiosyncratic behaviors and expectations. Holly thought it was important to note that

> "Supervision has helped a lot but supervision can only help as far as you allow it. That's an hour a week and you're spending 30, 40 hours in the field" with clients".

Another participant, Darla, noted that there is only so much for which supervision could have prepared her. She noted also that many situations simply require thinking on one's feet and figuring it out, processing in supervision later. Even Charlene noted that she struggled sometimes with whether supervision could actually help her and whether she needed her supervisor's intervention.

"So what do I do now, do I sit back and let you therapize me because you're my

supervisor, or do I just try to deal with it because I do need the supervision?

In summary, one hour of supervision attempts to cover so many hours of clinical service,

and the unpredictable nature of in-home therapy can hardly be prepared for in such a

limited time. Additionally, even if the supervisor is attempting to be helpful, the

supervisee may not be receptive or may not feel that the info or approach is helpful.

Power differential. Charlene is the only participant that spoke very directly about

the impact of power and hierarchy on her supervision experience. She said,

"It's multilayered, [because] there's a power differential, so I can't tell you that

you're full of crap. And I know you're full of crap, [but] you sign my paycheck. If

you are my supervisor, 1) I wouldn't need you to hold up my license, or 2) hold

up my pay check. That is the power differential. I know people in group

supervision who decided to rock the boat, and it has complicated their lives. I'm

not going to do that".

Charlene's example demonstrates reasons why supervisees may not be verbal about their

desire for something different. She struggled with a sense that she whether she

appreciated what she was getting or not, agreed or not, wanted to have supervision or not,

challenging one's supervisor is not worth the problems that will arise. These struggles are

consistent with the literature (Lemire, 2009). In the next theme, I discuss supervisees'

expectations.

Supervisee expectations. The impact of supervisees' expectations and perceived

needs did not appear to be attributed to the supervisor's decisions or actions,

effectiveness or ineffectiveness. Multiple participants' descriptions acknowledge that

supervisees can tend to have high expectations of supervision and can easily get

disappointed when the expectations are not met. Moreover, several also acknowledge that

often, and for various reasons, those expectations or needs were not clearly

communicated to the supervisor, perhaps due to lack of formal contracts (Glenn &

Serovich, 1994; Falvey & Cohen, 2003). For example, Kelly had an expectation for focus

on "clinical application, professional growth and development" but felt the supervisor's

focus was "paperwork check in"; however, she did not report requesting a change in the

supervisor's approach. M.P. described her high expectations,

> "Supervision is supposed to challenge me. It is supposed to give me confidence. It
>
> is supposed to help me to grow in my profession. As well as, it helps you to…
>
> open your eyes to your own flaws or areas of growth. [Supervision] should be
>
> digging in you to really recognize those and to know if it's blocking you or if it's
>
> even enhancing you."

While M.P. was very satisfied with most of her supervision experience, she also states, "I

never requested anything", but instead there was a dependence on the supervisor to

innately know what was needed and to guide the conversation. In many ways this makes

sense, because therapists new to the field likely have less confidence in their skills, don't

know what they need or how to articulate their needs. In addition, generally speaking,

people may tend not to challenge experienced supervisors, especially when their job is at

stake, as Charlene mentioned in the power differential theme.

One participant, Kelly, noted from her experience that supervisor turnover does

not have to have a negative effect on supervisees when the company has appropriate

structure and training. She noted that her perception of her first job was that company-

wide, the supervisors seemed to follow the evidence-based practice and company structure for supervision practices. This made her experience nearly seamless when her initial supervisor resigned. However, Kelly acknowledged that there might be a tendency to compare all other supervisors and work places to one good experience that was a good fit and then serves as a measuring stick for all others to measure up to. However, this could lead to narrowly defined parameters for what effective supervision looks like.

In addition, Kelly noted that the supervisee's level of education and experience might affect the therapists' receptivity to supervision and the supervisor. Also, having negative or inadequate supervision experiences at various points in the career can turn the therapist off from seeking healthy, helpful consultation—for fear of being disappointed or having her ideas negated. On the other hand, supervisees may differ in perceptions about whether they need supervision at all, if they have more experience or have obtained licensure, they may be more critical of the supervisor. However, for Kelly in particular, rejection of the supervisor was directly related to Kelly's increased experience, getting licensed and pursuing higher learning in a doctoral program leading to increased confidence. Alternatively, other participants, like Holly, strongly asserted an expectation that no therapist arrives to a level of expertise that warrants no longer needing or seeking supervision. M.P. also stated, "When you get seasoned you think you know everything, you think you've seen everything and you haven't".

One supervisee noted that she, and likely others, stayed in bad supervision relationships in order to get hours for licensure and then move on with their lives. Her expectation was that finding a better supervisor was not a guarantee, and often meant

having to pay out of pocket versus using supervision at one's job. However, getting her hours signed off on was a sure thing if she stayed put. It was more secure in that way.

Toni expressed,

"I really wish they had more MFTs in the supervisor position that actually supervised versus having to go outside of your agency to get that. I think they should have a person of each concentration at each job. It just makes it easier where you have somebody that understands that lens. So you're dealing with somebody that has a psychology background they might not look at things the same way they might just say okay that person is bad, instead of MFTs that might say, that person is not bad maybe they're just very challenged and strong-willed".

There was one supervisee who seemed to have lower expectations than others regarding what was desired from a supervisor. For example, Jennifer was only concerned about being drilled on models and application so that she could be prepared for the licensure exam. She did not seem to think it was abnormal that she figured out most of the other challenges on her own or by consulting with colleagues in the field on her own time. Jennifer reported high satisfaction with supervision.

Charlene expressed having relatively simple expectations as well despite the fact that she knew her supervisor before she was hired. Charlene was "expecting to talk about my cases and talk about what was expected" for job requirements. Moreover, she felt that she received more than she expected. Additionally, she expressed that due to their prior relationship, her supervisor

"Was probably more caring to me because she knew me…not that she wasn't caring to everyone else, but it probably weighed on her more, because she knew

me. Um, I imagine she probably, might have handled the situation differently if

she didn't know me, she probably wouldn't have gone that far, gone to bat for

me…if she didn't know me. Kind of a multiple dual relationship put a strain on

her". However, she also acknowledges that it affected how Charlene handled

decisions about staying on the job despite wanting to leave, "I stayed longer than I

should have. But we also discussed that, it looks bad on your supervisor if another

person leaves. I know that it would have looked better for her if I stayed and

worked it out."

Although Charlene did not describe these as altered expectations, based on a dual

relationship, she and her supervisor seemed to have adjusted expectations of one another.

This is consistent with literature on dual supervisory relationships (Tromski-Klingshirn,

2007).

In this sample, supervisee expectations appear to range from simple to

complicated. One was satisfied with reviewing models to prepare for the licensure exam.

On the other hand, other participants expected to be challenged toward introspection and

to have seamless transitions between supervisors. Additional expectations were to see

supervisors demonstrate higher learning or doctoral level expertise and relate directly to

MFT training. This range of expectations and perhaps ignorance about what is adequate

supervision can be addressed by teaching students in training programs what should

occur in effective supervision (O'connor, 2001).

Programmatic structure. In addition to the limited scope of supervision and the

range of supervision expectations, the structure of agency programs affected the

supervision experience. This aspect of structure appeared attributed to the agency

decisions that supervisors and supervisees had to comply with, such as size of caseload, group supervisions and workshops and trainings provided by the agency.

Caseload size. Smaller programs and caseloads were said to help the supervision process. Participants suggested that brief in-home therapy programs are better managed than longer-term programs without clear discharge goals. Kelly was more specific to say that large caseloads and large workloads per client result in an inability to cover all pertinent needs in supervision. Too much gets in the way of the therapeutic/clinical aspect of the job. Jennifer also agreed that she had to stand up for herself and tell her supervisor that "the number that I had on my case load got a little out of control".

The structure of supervision sessions, times and location was significant for supervisors to be able to create opportunities to see what the therapist is doing with clients. Smaller programs and especially smaller caseloads get a more positive reaction from supervisees because the structure allows for more time spent with individual clients and more individualized attention to the supervisee. Kelly says that supervisors may have to be more intentional about

> "Finding more opportunities to see what the therapist is doing or checking in with the client to see what's going on. Since in home-based, you really leave the therapist on an island, it's up to the supervisor to be sure that they're equipped. Not just equipped with paper work and pen, but equipped with skills, applications…and understanding progress".

Group supervision. The group process was helpful (Lawson, 2005) and optional in Kelly's situation. But Toni also expressed,

"I think group settings were better with supervision because you're going to learn

from the other people in the room also maybe they had a question that you had

and they asked before you. I like that they didn't have a problem in agency talking

about cases, and they went around so everybody had an opportunity to speak.

Nobody seemed like they got the lower hand of the attention for that time being.

The supervision was for maybe an hour if that. She did a good job".

Jennifer shared the viewpoint:

"I think it's just good being able to talk about your client and everybody give their

perspective of how to address that client with their modalities that they use. Also

sometimes you would just have a subject and she'd just talk about a certain

subject".

Jennifer also acknowledged that she prefers group supervision when she is stuck in a

case, "other people that are kind of there to maybe think things through with you".

However, Charlene did not enjoy such team and group participation. Her

experience was,

"People will need to give feedback to you to add to their team participation points

because they were being graded…it was their job. I felt pressure when other

people would staff their cases, because I had to [give feedback]. And when other

people have spent thirty minutes on a case, I'm done".

Charlene described herself as quiet in groups and does not believe that setting works well

for everyone. Therefore, group supervision was not a priority for her. She continued to

say,

"It became ridiculous because our meetings would go longer than they needed to,

and if we had clients afterwards, don't hold me back, I am already concerned

about productivity…but [I have] to validate someone who wants me to talk."

Her supervisor's suggestions to her around this issue were to "throw some things in,

volunteer before wordier group members, and at least look like you're interested".

Regardless, Charlene never saw personal benefit from group supervision.

Workshops and trainings. Most participants agreed that trainings can be very

valuable, and in evidence-based practice, such trainings are expected. Moreover, positive

experiences seemed to result from programs that had that type of structure, where

supervision was cohesive with the trainings. Workshops and trainings were noted as very

helpful and a strength of certain home-based therapy programs. However, Kelly stated

that workshops and trainings should always be tied into supervision and trainings needed

to be followed up with application of materials. At another agency, intensive training was

provided and tied into supervision because the whole program was based on one model.

In addition, resources and continuing education were highly valued by participants. To

summarize, structure in the agency was helpful when the whole program including

supervision tied together and flowed based on a model.

Table 3 provides a simplified outline of the significant statements and formulated

themes that were just discussed.

Table 3: Participants' Descriptions of In-home Therapy Supervision

Selected examples of coded statements and related formulated meanings

Formulated meanings/themes	Exemplars
Limited scope	*supervision can only help as far as you allow it* *nothing can prepare you for the experience of going into the home* *be an in-home counselor whether you want to or not*
Power differential	*there's a power differential* *I know you're full of crap, [but] you sign my paycheck* *[don't] hold up my license* *[don't] hold up my pay check* *people… decided to rock the boat, and it has complicated their lives*
Supervisee expectations	*supervision is supposed to challenge me* *it is supposed to give me confidence* *it is supposed to help me to grow in my profession* *wish they had more MFTs in the supervisor position* *expecting to talk about my cases and talk about what was expected of me* *going towards licensure* *agency number one … had my expectations to be very high of the next agency*
Programmatic Structure	*the number that I had on my case load got a little out of control* *in agency talking about cases* *supervision was for maybe an hour* *group settings were better with supervision* *I felt pressure when other people would staff their cases* *our meetings would go longer than they needed to* *workshops and training did not transfer over into supervision* *what we receive the training on, we actually [reviewed in] supervision*

Participants' Descriptions of Effective and Ineffective Supervision Practices

There were a few aspects of supervision that nearly all supervisees experienced, including discussion about productivity, paperwork, models and case staffing. Additional aspects were described as effective or not effective for the supervision process. Themes indicating areas that they described as either effective or ineffective practices included supervision structure, handling safety and crisis situations, personality conflicts and compatibility, receiving simultaneous supervision from agency and non-agency supervisors, collaboration, relevant in-home therapy knowledge and accountability. Additional topics, that clinicians noted as significant to be addressed in supervision included boundaries, professional growth and development, documentation, productivity, engagement, person of the therapist issues, burn out and self-care as well as ethics. Finally, several participants described what was most meaningful about their supervision experience.

Supervision structure. The structure of supervision sets a context for the rest of the supervision experience. The time and location is best arranged to be mutually convenient and containing minimal distractions. Kelly noted the importance of showing support with a reliable structure to supervision. She expressed that if clinical supervision is structured to "focus on client progress, professional development, and clinical collaboration, between the [supervisor and supervisee], the therapist doesn't feel like they are on an island". Additionally, M.P. remembers her first supervisor in the field was lacking structure so extensively that, "she would miss or forget" supervisions or "have one of the counselors that are already there to give me supervision". This severe lack of structure led to distinct feelings of very limited support and feeling isolated.

Toni also expressed issues with her supervisor's lack of structure with supervision in her home:

"I don't have a personal problem with cats. But I feel like if your cats running all over the place, you got to tend to your cat and then come back to me. Your phone might ring then you have to come back to me. That's not a good place to have supervision".

On the other hand, Jennifer did not highlight issues with location or time as problematic. Instead, she had a positive, structured experience based on the atmosphere and organization of the time and space. Jennifer described structured supervision as one that "was guided in a definite way". And she continued saying,

"It was a really relaxed atmosphere, but she definitely had things that she wanted to discuss. It was certain things that she wanted to make sure that we covered, and that it was in line with the various models, so that you're making sure that you're utilizing them properly, so when it comes time to take your [licensure] exam"… you'll pass.

It appears that time and location must work for both parties in order for the atmosphere to be conducive to exchanging information.

Safety. Although nearly all participants highlighted safety concerns, several exemplars stand out. Toni passionately expressed:

"I believe a lot of in-home therapists are maybe newer to the field, maybe they are not licensed, and they can't get a different type of job per se, so safety is huge, like knowing not to bring your purse in."

She also contrasted the office with home-based work:

"We are going into people's houses. We're not sitting behind a desk or talking to somebody in our office. It changes the dynamics altogether. Even how to park your car… like don't park your car in the driveway where somebody can come behind you. Park your car on the street. Make sure that you put your purse in your trunk before you even get to the area because people do break into people's houses. I even got threatened in my car one time. As my client was walking to his house, he said he was going to throw a brick at my car. Yes. He threatened to throw a brick because he didn't want to deal with me. And I was new to him. I had just started, and I was only doing assessments, and he already didn't want to be addressed."

Toni also expressed figuring things out alone because they were not addressed in supervision:

"In supervision definitely [safety] wasn't addressed. These are things that maybe we as therapists would talk about or you figured it out. Not to wear a skirt to somebody's home, wear pants. Wear closed toed shoes, don't wear flip-flops. I know some people are in-home therapists and they have flip-flops on or heels on. That's not safe. You don't know what you're walking into."

Although Toni didn't get direct supervision, she seemed to figure things out with time or through talking with colleagues. This seemed to be a common practice among several participants.

Another participant, Holly felt her supervisor did not prioritize safety even when Holly brought up her concerns in crises. Holly described unsafe situations like severe domestic violence history in a home, high crime neighborhoods and a psychotic client

threatening to kill two roommates when they arrived. However, Holly's supervisor advised her to meet in the back room of an unsafe home with a kid so he would feel more comfortable. Her supervisor seemed to disagree with Holly's strategies for staying safe, including parking her car in the direction that she needed to leave or calling police support from her car instead of waiting in the home with the client. Holly reported that her supervisor attempted to offer simple solutions to or ignore difficult safety issues by suggesting things such as, "Oh you'll have short term disability [if anything bad happens to you]."

Holly also expressed that in other supervision experiences she has received more support if she felt unsafe:

"They'd be like girl get out of there. Like I don't care, if they're going to kill somebody, your job is not to be a police officer. You call 911 and you get out. Your safety is priority. And the contrast for that is, again, somebody that sits in the office all day long who have direct supervision with another therapist or another clinician, and who are also working in the field would understand. 'Okay hey, when your gut tells you it's time to go, you pack up. I don't care if you tell them that your car's on fire you've got to go, find a reason and get out. But this particular [supervisor] was very concerned with billable units because our particular region was very low on billable units. 'Well this is a five hour crisis, this is great for billing, this is going to be awesome and if you get out alive, it's an even greater story to tell!' So I believe, that not that she was incompetent or that I shouldn't have been upset. I believe that there were external issues that really [affected her judgment]…"

While one cannot guarantee what Holly's supervisor was thinking, the stress of managing multiple aspects of supervision has been cited as impactful to supervisor's decision-making (Dill, 2007).

In Darla's case, she had a mixture of bad situations that neither she nor her supervisor was prepared for but they did a good job of processing and supporting her afterward. Initially, Darla expressed concern for others she has seen in the field. Darla noted that:

> "Most of the people in our field are women; many of them are quiet women. This is their first time going into the hood, and all they know of the hood is Dangerous Minds or Boyz In The Hood [movies]. They really don't know [what to do], and I am not saying that to, to put them down, or to be degrading. It's just all they know… and it's not a bad thing, but it might be a scary situation. The neighborhood might be scary, the home might be scary. Plus, the last in-home supervisor that I had did not seem to care about safety in my opinion. She had no problem with wanting her therapist to work till nine-ten-eleven o'clock at night…"

However when describing the supervisor before her,

> "Safety was the most important thing to her, and I can honestly say that I have never had the experience before, in any other agency. Yes they all want you to be safe, but if your client won't meet until 7:00 PM, and you don't leave out there until ten, eleven o'clock at night, the supervisor doesn't care … "If the neighborhood was not known to be safe, then you made that appointment as early as possible."

Darla even had an assessment to complete at a maximum-security prison. She said,

> "I remember praying before I went in, praying while I was there, and praying
> when I got out… because I didn't know and my supervisor did not realize I was
> going to maximum security prison because she assumed it was a regular local
> jail."

In another situation, a client lost their pet, and Darla received supportive supervision that
prioritized her safety:

> "They had eight foot boa constrictors that got out of their cages and they could
> not find them. And the house was so nasty that they couldn't find it. My
> supervisor said, 'Oh hell know, you're not going back'… But nothing can prepare
> you for eight foot boa constrictors, or pit bulls … I had people throw things at
> me…There is nothing to prepare you for what you see in in-home counseling.
> …But the processing afterward was adequate. Beyond adequate. I got to sit down
> In front of some people and say this is what happened …What do we do here?" …
> There have been times when I had to tell supervisors where I was going to be,
> throughout the week. But as time has gone on, if my husband was out of town on
> business, and if I'm talking my dad…I'll say, 'Daddy this is my supervisors
> number…I'm going to this bad neighborhood. If you don't hear from me within
> an hour and a half, you need to call me. If you don't get me, you need to call her.
> And tell her this is where she is, I'm concerned.' I've learned to do that over the
> years as a safety precaution for me.

Unlike Holly, Darla never had a disagreement with a supervisor regarding her efforts or
ideas about staying safe.

"I have walked around with mace in my purse, and I have never had to use it. But I'll be honest with you; I have considered getting a gun. But I was just like if I have to get a gun to drive around and do my job, then I have to stop doing what I am doing."

Although the supportive supervision experiences were not as common, the participants expressed great appreciation for the moments that they felt cared about. Issues of safety were a significant focus in the literature related to home-based therapy (Culbreth, Woodford, Levitt & May, 2005; Lyter & Abbott, 2007; Nelson and Morris, 2003; Thomas, McCollum & Snyder, 1999; Worth & Blow, 2010).

Personality and leadership style. Supervisors' personality strengths, clashes and conflicts were often brought up as significant to the supervision experience. Personality was noted as a strength more often if it was easy-going and open to feedback. Of the participants, M.P. described the warmest and most positive relationship with her supervisor of five years, stating, "Supervision is like your own therapy". She noted that her supervisor was "supportive, a problem solver, goal oriented and solution focused"; she also described not feeling judged, criticized or belittled. M.P. noted that she always felt encouraged and challenged, which made it easy for her to appreciate and highly respect her supervisor's transformational leadership style.

Sometimes, the supervisor seemed too rigidly set in a model that did not fit the supervisee. While a model can provide helpful structure for supervision, it appeared to get in the way if held too rigidly. It was also reported that a supervisor could make the effort to be clinical but still not be helpful due to personality clashes and differences of opinions regarding clinical application of modalities, and due to lack of communicating

reasons for addressing certain things, or not meeting the therapist at their place of need. Some participants complained about micromanaging an experienced therapist and providing too little guidance to a new therapist. For example, Darla felt demeaned by the "micromanager", who gave no "permission to breathe" unless she asked for in specific ways.

For example, Kelly noted, "Being exposed to other models through the family therapy doctoral program" widened her interest in practicing different approaches, but her supervisor was "was not in agreement with any of those models". He focused rigidly on "behavior modification and some psychoanalytic". She continued, "It's okay to have your model, but to understand that the model has different components, not just behavioral modification."

In other personality clashes, Holly described the possibility that her personality and way of thinking as well as her approach to life and to supervision has led to problems or conflicts with supervisors.

"People think that I can be an over achiever and kind of just doing my own thing, and it might be misinterpreted. I have a really strong personality and I come across a little bulldoggish, so I think that might have been it. And their personality was very different. I've had some very passive 'Okay, alright, no problem' supervisors where my personality comes in kind of like "raaahh" you know, and saying, 'Tell me! Teach me! Help me grow! And that could come across a little intimidating or rude or disgruntled or whatever negative connotation they can put towards it. [One supervisor] expressed that they felt like I was head strong, and I came back with 'well what's wrong with that? Okay so do you want someone

that's not passionate about their work? And they expressed to me that it can come across in a way that is I guess demeaning to somebody who is in a position of authority above you where you are kind of opinionated and very verbal. But that's the way I grew up, I grew up where if you have a question, you ask it. There is no such thing as a dumb question, and you ask until you gain clarity, until you understand, until you're sure that you're able to go out [and do your job]. And if you tell me '[Holly] the sky is green', I need you to come out now and explain to me how you see green and not blue so I can go tell my clients this is green and really believe in what I'm doing. I'm not going to go, 'Oh well my supervisor said it was green so you guys have to flow with it being green.' I really need to understand, and I have a very deep-rooted thing of having to understand. I need to know what it is I'm doing. So I'll come back, and I'll ask a million times, and it may come across as condescending or whatever, or questioning their judgment or being rebellious or insubordinate. But [supervisor's directives] honestly need to come from a place where I understand what it is you're asking me to go out into this field and do."

Race and cultural differences. Darla was the only participant that brought up the issue of race, insults and cultural differences causing an issue. She had issues with insults although the supervisor may not have intentionally done so.

"At times, whether she meant to or not, she was a bit insulting, I thought that it may have been a cultural thing... She was a bit insulting…from time to time … Giving a backhanded compliment."

A backhanded compliment is what Darla describes as saying something positive but it can be construed as a passive-aggressive insult.

> "She looked at me and told me that I speak very well. Which I found to be very insulting, because, I am thinking to myself, 'As opposed to what? As opposed to whom? I'm from the United States, I'm supposed to. Did you expect less, in some way? Are you surprised that I speak well?'"

However, Darla regrets that she did not address it with her supervisor right away.

> "I think, I should have said listen, [You think I speak well, as opposed to whom? Or [to say], all the stereotypes you see [about black people] are not true."

However, that was not Darla's worse insult experience,

> "I was called colored before by another supervisor. I didn't say anything then. I just went to her afterwards because [I had to] bring it, [my temper], back down. [Then I told her], 'we prefer African American, not colored'. I don't know where she got that from. I am thinking she went way back generations ago to get 'colored' [and skipped over] Negros, black, African Americans."

Darla notes that this is a rare issue to come up in supervision conversations and she also notes that,

> "I've had some great black supervisors, and I've had some great white supervisors but then again, I had bad of both… and unfortunately the bad of both stand out more than the good."

So much so, that Darla perceives that she has trust issues related to such encounters. But Darla also notes that although she is a very outspoken person with strong opinions,

"I was raised not to rock the boat when it came to supervisors. You had to keep your job, you've got bills. And especially when I became a parent; it's more pressure. You got bills, kids, responsibilities; you cannot afford to lose your job. And I think that is why, I have always, well when I was working for others, I kept things to myself. I picked my battles, very, very carefully…very carefully. And there's time when the 'bad' supervisor stood up to the plate and did what needed to be done, and when I brought up an issue…they rose to the occasion".

Agency versus non-agency supervisors. Several participants noted differences between supervisors since most of them saw two supervisors—one job appointed and one chosen independently for licensure supervision. Holly expressed, "Maybe one will feel more freedom to address issues differently". She continued to say,

 "I think there's also a level of work-related stress, like we have stress related to our paperwork and our documentation and our supervisors have stress related to being able to adequately track our documentation and get it and make sure that they're on target because we're operating under their license or whatever the particular guise of that supervision role may be".

In Holly's case, her licensure supervisor was a much better fit for her.

Toni expressed differences between supervisors in both settings, but also expressed disappointment in both instances. She stated,

"Supervision, when it came to in-home with the agencies I work for, most of them did not have expertise in marriage and family therapy. A lot of times, they just did supervision, and it was just real life issues. They didn't go into theories or understanding the ins and outs to prepare you for the test because at the end of the

day that's what supervision is for, to prepare for the test and make sure you have somebody to lean on in certain situations. … Supervision outside of any agency I worked, for seeing a licensed supervisor in marriage and family therapy, was also a little awkward to me. I don't know if it was a power trip thing, but I didn't feel like they were specific to my needs. They kind of wanted to talk about their stuff and how they wanted to teach me versus asking me what I need to pass the test. … I believe with the agency, it was adequate for what it was. When it came to supervision outside of the agency, I would say it was inadequate because the person had their own agenda. And they didn't really ask me, 'Okay what are you doing right now at work? And how is that working?' And try to mirror that with what I would need to pass the test. … I believe now in hindsight, I would have probably wanted to be in a group vs. being one-on-one. And if ever I needed on-on-one, I would get that individual attention as needed. … I never felt comfortable to say, 'Hey can we talk about what I need for this and that with regards to you know the test?' or to say, 'Also I'm having this issue. How would you address it as a marriage or family therapist?' I didn't have that. …She was a little scattery to me. And it seemed like she had a lot going on so even though it was one-on-one there was just a lot going on in her house a lot of things she would have to do maybe she would have to cancel or… it just wasn't the best situation".

Toni seemed to describe a lot of issues regarding lack of structure and lack of needed content. Agency supervisors in her case were more structured and organized around her needs. Toni also expressed,

"It's great when you can get a supervisor in-house cause then you don't have to pay. That's huge you know? And that is something that they already contracted to do with their job duties, so it's never where they're going to brush you off. You're always going to have an open door, at least in my experience I did. What else is good with it was other people; they had different things that they brought to the table. So maybe be one was dealing with a person who was never diagnosed with autism and they were one hundred percent autistic. Maybe it was something of substance abuse or another thing. Everything got addressed. And I don't want to say [it happened] just because that person already had it in their job duties but I felt like that person made sure she was able to meet the needs of the staff that was in the group setting. It wasn't just about policy and procedure which they always have to address."

While Toni had a good experience with agency supervisors, Jennifer had a much different depiction to share. Jennifer expressed disappointment that in her experience,

"Agency supervisors don't necessarily know what they're doing and the amount of work it takes to do in-home visits. I think the demand that they may have on you in going to see these clients and you know the time that it takes to get there, things that you will possibly encounter in session that may spill over , time-wise, things like that [they don't understand]. But I will say, so far, what I've experienced is that a lot of them were in a position, a supervisory role, and they didn't necessarily know what it took to do that ground work, as a therapist…. They were not satisfied with the progress that was being made, so I had a lot of conversations [explaining] certain things that [the supervisor] may not see or

notice or understand, and it's because it's being looked at through a totally different lens. I found that a little difficult. Found myself not just being in a therapy session with the client, but [also] having to apply [similar] skills with the supervisor. Not necessarily like I'm counseling them, but I think with the training that I have had, it helped me to deal with them a little bit differently. A lot of reframing to help them to understand the progress that was being made."

This was such a significant issue for Jennifer that she purposefully avoided attempting to have agency supervisors meet her supervision needs and reserved her questions and needs for her licensure supervisor.

While Holly, Toni and Jennifer had varying levels of disappointment, two with agency supervision and one with licensure supervision, Charlene described satisfactory experiences from both of her supervisors. She did acknowledge though that the one with more years of experience was definitely obvious. Charlene noticed a "different personality between supervisors".

"Different people brought out different things, like what one supervisor wanted to know, it was very self- focused. So she wanted to know, how I was doing with things, if any of my stuff was showing up in the room. She wanted to know if I was leaving [work] at the office… Then naturally my supervisor on site was responsible for those clients, so her questions have to be different. They were more around is there an incident report? Did you call it in? Because she has multiple clients and responsibilities, her bottom-line is, it is a business. Funding is definitely involved, and then the ethical component, and liability, and there things that you have to cross off, that we would talk about or focus on, unlike licensure.

…I got different things from different people. Had I not had one or the other,

honestly I would have suffered more. Just my licensure supervisor was a little

more relaxed, but I'm sure if she was running the organization she would not be.

So it was actually a good combination to have both supervisors at the same time."

The mixed reviews about both supervisors are consistent with literature on dual

supervisory relationships (Tromski-Klingshirn, 2007).

Collaboration. Collaborating with supervisees regarding what they feel they need

from supervision would help the supervisor to be attentive to the needs of the therapist

based on both of their assessments. Holly complained that collaboration with her

supervisor was difficult:

"[My agency supervisor] was a person that would tell you that she would like

look something up and get back to you. And when you come back and pose her

the same question, just for extra clarification or direction, she wouldn't really

have looked into it or had forgotten or would want to do it right then in the middle

of supervision. And even so, like she would go through and access things like

Google Scholars. She wouldn't really go and seek out supervision to better

supervise me. Like if you're going to use a medium that I already have access to,

I'm not really being able to glean anything from you. So it made it difficult to

really take her seriously, having to ask her anything really clinical."

Holly's licensure supervisor met her desire to collaborate.

Jennifer described one practical conversation that she had with her supervisor where they

began to share ideas. Jennifer described what collaboration looked like with her

supervisor:

"Have you tried such and such with this because it seems like that might possibly resonate with them in order to either get them to a place where they're either talking more or coming up with more solutions on their own, or however the situation may go."

Accountability. Holly expressed that all clinicians need someone to

"Continually seek supervision from and that it should be somebody they've been with and can try and stay with long term, so that [the supervisor is] able to see both your growth and areas that you need to grow in."

This is how she described the importance of holding clinicians accountable for continued growth. She also admired that her licensure supervisor:

"videoed everything [which] really held him more accountable… the idea of thinking in the back of my head that everything that I'm doing is being recorded, like live, really helped me and continues to help me in my practice to deliver the best services to individuals as possible. […] "Sometimes he would go back through those videos and review supervisions […]. He would video all of his [therapy] sessions. And then we were able to then watch what he did in sessions and critique and go back and forth on what we thought was beneficial and not beneficial. As well as we've seen videos of him in supervision watching the videos with his supervisor, where we're getting both ends of it. It was helpful being able to really understand the questions that someone who's been doing therapy for longer than I think either one of us has been alive has done it as well as how someone who works under that person is doing it and kind of taking it back and thinking 'okay, how would we like to do it?' What would be different

about what I would do if I was actually being recorded? I think it really holds people, or at least it holds me accountable, thinking about when I'm writing a note, am I writing a note based on my interpretation of what happened or of what actually happened. And I think that the video thing is really cool."

Relevant knowledge. Multiple supervisees described a need for their supervisor to maintain closeness to in-home work to remain relevant with suggestions and to empathize with and better understand in-home therapists' needs by interacting with clients in their environments. Toni expressed:

"Supervision to somebody that does private practice, I think, is different. If I was in private practice and you're in private practice, maybe we can work together. But if you're in private practice and I'm in in-home, I don't believe it really meshes well…. It doesn't have to be an active caseload, but I do believe they have to definitely have experience in in-home to have an understanding. Some people are lucky enough that they don't to do in-home but a lot of people do have to start from in-home. If you got lucky and you went straight to private practice that's great but you probably shouldn't be supervising me because you won't understand where I'm coming from and the things I have to deal with."

In one instance, Kelly said, "Though he's been in the [therapy] field a long time, I'm like this guy doesn't know what's going on". She expressed feeling that he needed to have "more interactions with the clients". She also gave a suggestion during the interview, "some agencies have a model where the supervisor is the one that does the initial segment or closing segment. I just believe that somewhere along the line, the supervisor should do an assessment to be sure that their therapist is on the right path."

Supervisors need to stay up to date with trainings and latest research. Holly described:

"[My] first agency supervisor was not very knowledgeable about things that were going on and new trends going on. […] Topics I would bring were things she was unfamiliar with because she had been out of the field for quite some time and the training that was provided to her was not reflective of what was actually going on in the population. […] Different drugs like spice or flakka, and she had not really heard of them nor had any interventions to use towards them. […] "Psychosis and other issues we weren't prepared to deal with."

On the other hand, with the licensure supervisor:

"He was an active practitioner, and he worked in the field and did a lot of trauma-based work. So he was able to help me put on trauma-colored glasses to deal with a lot of the issues that the youth I was working with were dealing with. As well as how to apply different modalities and interventions to help them out, not being really directive on the substance abuse component."

Holly expressed that it made a big difference for him to be an active practitioner vs. the other supervisor not having an active caseload. She continued saying:

"It made him able to understand and relate to different things that someone who has not been in the field may not pick up on, and may not think to ask or challenge me on. For example, I have very poor affect regulation. I would talk about somebody [a client] and my face would change and he asked me, 'Do you check your feelings and your emotions when dealing with this client?' He asked me about counter-transference. He would really get actively involved in my

ability to provide services as a practitioner, and kind of check me and challenge

my belief systems in things and make sure that I was able to give clients

unconditional positive regard regardless of whether or not I was experiencing any

kind of therapeutic fatigue or burn out."

Of all the participants, Jennifer was the only one whose experience was positive despite her supervisor not having an active caseload. Jennifer described a significant appreciation for her supervisor's "wealth of knowledge" and her vast library of resources from which she could recommend readings and relevant educational materials. Jennifer noted that her licensure supervisor never asked about a lot of specifics to in-home. However, she felt the supervisor more than made up for it with her vast knowledge and uncanny ability to reference models as application to virtually every problem or issue.

Boundaries. Establishing appropriate boundaries appeared to be a learned skill in which therapists had to learn to establish cancellation and no show policies, to prevent over involvement with the family by differentiating between friendship and therapeutic relationships, as well as limiting any case management services. Charlene expressed some struggles with these areas and attributes supervision to helping learn to manage these issues with clients. "I just have a soft spot for clients," she admitted. Additionally, she considers that her burn out could have been significantly delayed or prevented if she had learned to establish appropriate boundaries with clients sooner (Snyder & McCollum, 1999).

Documentation. Across the board, participants had the same understanding that paperwork is significant since it provides necessary proof of clinical service delivery. Commonly mentioned documentation topics were timeliness, measurable treatment plans,

and recording weekly progress in case notes. However, Kelly also noted that "sometimes supervision could be too focused on paperwork and the conversations about paperwork did not make me better with paperwork". She suggested that other strategies are needed for internalizing good documentation habits. Having strong structure around the paperwork, as often goes along with evidence-based practice, was viewed positively by participants because it was hard to fall behind if you followed the model appropriately. In addition, structure may have involved the agency decision to have two separate designated supervisions—one was optional and focused on group process and paperwork and the other was individually focused on clinical application. According to Kelly, having structure helps the supervision process— as one can focus less on paperwork by providing and maintaining structure.

Another mentioned issue was that high turnover might result in late paperwork transfer to other therapists. Separating clinical supervision from paperwork monitoring can help therapists to feel that the paperwork issues are not overshadowing the importance of the clinical work with clients. However, Kelly even indicated that due to frustrating clinical conversations with a rigid supervisor, she would intentionally focus on paperwork issues in order to avoid having time to discuss conflicting views on therapy modalities.

M.P. noted that:

"If you don't have the documentation, it didn't happen", so her supervisor had a transparent approach to using the team to hold each other accountable for turning in documents on time. [The supervisor] developed certain tools, spreadsheets or

trackers from like our first year, or she'll put it on the board so that we knew

documentation-wise where we were and what needed to get done."

This may be an example of structure that prevents dominating supervision time with

conversations about late documentation.

Professional growth and development. Professional growth and development

can mean different things to different people. For example, Charlene seemed to feel that

her agency supervisor really impacted her growth by talking about "models and different

ways to be effective". Additionally, it seemed important that they discussed "if [in-home]

was the right place for me" or whether Charlene needed to seek growth opportunities

elsewhere for her career.

On the other hand, some supervisees seemed to focus specifically on clinical

application when mentioning professional growth. For example, Kelly expressed that

supervision needs to focus on clear goals and outcomes for clients in order to provide

direction to the supervision conversations. Kelly noted that addressing client progress in a

way that is collaborative between therapist and client, as well as between therapist and

supervisor, was helpful for growth. Supervisors need to make sure therapists are

"equipped with skills and applications" for assessing the home, safety, clinical needs.

Alternatively, Holly noted that the supervisor cannot take full responsibility for

professional growth and development, and she attributes her growth partially to her

supervisor, saying,

> "Supervision only works if you're fully involved, so I don't think it's supervision-
>
> based issue, I think it's a clinician-based issue. There are times we feel like we
>
> don't have anything else to grow in or anywhere else to develop and evolve in.

And for me, I've hit that point with some of the kids on my case load that have been there forever, where it's kind of like, okay well you know like I'm kind of the expert on this kid because I can tell you when this kid is going to escalate, how to deescalate them. And that's kind of the area where I think there's always something to grow in and supervision really helps with that. 'Well okay well, if this kid presents this way next week, how are you going to behave? Like how are you going to react to that?' So I don't think there's ever a time where I won't need supervision to help grow in something that I couldn't identify to be better in. I don't think you ever get a handle on it where you're just like able to play super human therapist and just knock it out the park every time".

Productivity. M.P. stated a strong opinion that:

"Productiveness comes naturally [when] you feel 'respected or [treated like] I'm a person'. You want to perform; you want to get that support. … [My supervisor] doesn't say 'oh I don't care about numbers', she cares about numbers because there are times where she has to cover numbers because that's her job. But from going in, and this is from like maybe my third month even being there, I was able to see her type of leadership style. It's because she values people as individuals and values the strength that people bring. I work more efficiently, I make sure I work because I want to make not just her proud, we want the team to do what we've got to do."

While other participants said less about the effectiveness of supervision practices around productivity, multiple supervisees noted the stress related to consistently maintaining productivity.

Engagement. A few participants mentioned needing supervision to improve their engagement skills. For example, Charlene noted that her supervisor did well with helping her to join with clients and establish appropriate boundaries while doing so. Managing cancellations was an issue and Charlene attributes her engagement issues with the clients feeling unable to identify with her. M.P. also acknowledged more challenges

"Engaging them in their home. Because you could walk in, thinking 'I'm going to take these tools with me, and I'm going to do this and I'm going to do that'. Quite frankly, when it's in-home therapy, it's more about making sure the family's comfortable with you even coming to their door. Different techniques".

Additional challenges expressed by Toni were that:

"A lot of times, in in-home I'm finding, they have been around the bend before with therapy, so you're just another person. You have to have a different rapport when you go in. You can't just go in and say 'Okay we need to get this addressed.' Solution focus is the best modality I found that worked for me. Seeing what the supports are and things like that makes it very much easier. In certain other therapies you may need to have that client for a longer time. But solution focus, with agencies usually giving three to six months, maybe nine if that. It depends on the agency you work for. So when I was doing foster care you might have the kids longer because they're in foster care. Maybe they're getting adopted. But if I was dealing with a juvenile, once the judge finally made his decision alright we're going to take these charges off or you're going go to jail. So that was three months. In other places that I worked, I did some contracting for an agency and it was for however long I can have them. Because they had

Medicaid so every agency is different. Another thing when you're building

rapport. You want them to open the door the second time you come. The first time

they'll do it because they know most of the time they're mandated to do it. But

the second time you want to be able to be welcomed to come back and that plays

a big part in rapport. And I think what solution focused [therapy] does with being

the cheerleader, being positive and reframing a lot of things, you open the door

for you to actually have communication, a good back and forth with that family or

client".

Person of the therapist. Issues related to the person of the therapist were noted

as significant to be discussed but also to receive specific tools and suggestions on

managing biases and personal or professional needs. According to this sample,

supervisors need to show concern for what is going on with the therapist and how they

are managing. Additionally, supervisees want to feel supported with the decisions that

they make to go the extra mile for clients. These expressions were consistent with

literature (Aponte & Kissil, 2014). One example, Darla, felt complimented when her

supervisor called her a bulldog after she advocated for her client in community settings.

"I never did anything disrespectful or unethical, everything that I did was professional,

and so [the supervisor] never had any problem with me". She acknowledges that having

the support that her supervisor would back her up affected her being able to stand up for

her clients when she felt their rights were being violated in community meetings. The

supervisee attributed her actions and the support of her supervisors to the life situation of

being parents. She perceives that the supervisors and she could identify with the client

parents' needs as a parent, and based on personal convictions about discrimination and

mistreatment of minority populations, felt compelled to step in and advocate without apology.

Charlene also stated that she used supervision to help her:

"To see children differently, [specifically], how to kind of reconcile diagnosing and medicating children. I don't really like medication, but I came across cases where children needed to be medicated. So we kind of talked about putting aside how may have I felt about it, and looking at it objectively".

Holly focused on a different aspect of person of the therapist issues.

"So I think as clinicians, we'll present with whatever our strength is in supervision and not necessarily go for those things that we really struggle with. So sometimes people present one way, and that's for anybody anywhere, they present one way in supervision and a completely different way somewhere else and it could be from a lot of factors, whether their supervisor intimidated them, or they want to impress them. There are a lot of underlying issues that might also cause countertransference in supervision."

Holly described what keeps her from presenting a "false self" in supervision:

"I don't really care what they think…. At the end of the day, my job is to come in there and spend an hour sucking them dry of information. Going in there and learning the most that I can in that hour to become a better person. It's not just about my job or clocking in or clocking out. That one hour for me is for me to go through and pick your brain so it's literally dry and on the point of death where I can go through and take all this information out and go out into the community and use what you've given me plus what I already have to go through and really

help people…. And I cancel, if I feel like I am not in the mood to talk to you

today, or I feel like this is not going to work, I'm not going to be able to open and

present there, I'll just reschedule for another day. There are days where I'm like,

'I don't want to talk to this lady today'.

It seemed important to Holly that in supervision, the point is really for her to get

whatever she can from the supervisor. It does not really matter what the supervisor thinks

about her at the end of the supervision session. This approach keeps her honest and

forthcoming.

Burn out and self-care. Kelly and several others attribute high turnover to large

caseloads, large workloads per client, lack of support, excessive travel, low pay and

seeking a change for more growth and development. M.P. agrees that stress levels are

high for the therapist and supervisor, but she also says,

"My reason for being and staying [in the field the last] five years is because of my

supervisor, because I felt comfortable. I felt, again, supported".

M.P. also discussed self-care, saying,

"In our field, when you have given everybody you, and you've given everything, I

think sometimes you get to a plateau where you must, must, must at some point

think about yourself, because you'll then lose yourself. You have to think about

yourself, take yourself away to regroup and to come back".

M.P.'s supervisor would also help her avoid burn out by asking,

"Are you working hard or are you working smart? Maybe you need a day off, or

maybe you need a vacation. Or the question, when are you going to take a

vacation?"

For M.P., "Supervision itself is self-care". It reminds her to "tell myself that this family is not my family and they will be there when I come back [from vacation] next week".

M.P. was asked by the investigator to clarify how she responded to her supervisor encouraging her to continue in-home work despite M.P.'s statements that she wanted to quit this type of work—whether she sensed that her supervisor was looking out for M.P.'s best interest. M.P. responded,

"She doesn't talk me into staying. It's not a pep talk to be like 'You can do it!'. No, it's never that. It's 'Where are you? What are you doing? Is this still what you want to do? This is what you said you like to do.' More of just building that introspective to have me self-reflect to see what can I do differently, or what am I doing that's making me feel like this. 'Do you need to take that time which you need to regroup yourself?' And having me making that decision, so that when I hit the door, I have options. She reminds us that we're humans and its okay to feel like I'm overwhelmed. It's okay to feel like that, and just having somebody to just tell you that you're not doing anything wrong feeling like this and you're not selfish because you feel like this, makes a difference. Makes me actually want to take the day, come back to do the work with this person who supports me as much as she does."

Holly approached avoiding burn out from a very different method.

"I personally, am not an outdoors person. Just recently I took one of my kids fishing because she was like, I really enjoy fishing, this is what helps me and so it's more so stepping outside my comfort zone. If I ask this client to challenge themselves one day okay, the next time you have a though to harm yourself and

go through thought stopping and these things that are really outside of their

norms, far be it for me to tell you I'm not going to go fishing with you. If that's

what you feel is really helping you out, if that's what your relaxation technique is

for the week and you've figured out that you can fish on a budget because all you

need is some breadcrumbs and your hook, you know what I mean. So, I think that

that's really been the thing that's stopped me from having burn out and taking out

that time when a kid just doesn't really understand something … Things that I

would never catch just watching these ratchet TV shows, these kids are watching

and they're relating to the trauma and the hurt these people are expressing where

we're looking and okay well, this is a waste of an hour of good TV, these kids are

saying well I can relate to seeing someone being bad to my mom, or me liking

somebody of the same gender, and these things that you wouldn't think about that

wouldn't come up in 'How was your week?' So I think those are things that help

me avoid burning out."

Jennifer seemed to burn out despite her attempts at self-care. "Whether I liked it

or not, you have to do it", which ultimately led to her burning out.

"Which is why, now, I'm definitely on a part time level because you kind of get to

a point to where, you know, we learned this from the beginning, 'you do no

harm', you know. So after you get to a point to where [you question] 'what am I

really giving my client?', you know, I don't really want to give them something

that's sub-par. I don't want to hurt them in any way, shape, or form. If I'm in

there and if I don't have enough to give them, then I'm not going to do it. I'll have

to take a break, I'll have to step back and just reevaluate, 'Okay, am I able to still

do this?"

However, even with a lot of self-talk, vacations and taking a break, she was not able to

recover and remain in the field. Jennifer noted that, "While it's a little bitter sweet" to

remember her days of serving in the home, she says, "I'm not trying to do in-home" even

though she sees several benefits to doing in-home therapy,

Charlene noted that her supervisor did a lot to encourage her to stay in home-

based therapy, as they would "discuss different struggles"; she felt "support to go either

way". Nonetheless, she did feel an allegiance to her supervisor, related to their personal

relationship and her supervisor standing up for Charlene when management questioned

her low productivity. Charlene perceived that her supervisor identified with her idea that

the productivity was "well not impossible, but realistically therapist self-care would

suffer". So burn out was the ultimate result, despite the ample "empathy and caring"

received from agency and non-agency supervisors. Charlene also attributed:

"travel [which was] forty-five [minutes] one way, and twenty-five clients living

that distance at one hour [session] for each of them, then paperwork, and

whatever else. What should be a forty hour job turns into sixty and forever."

Charlene only offered the possibility that "we could have talked more about my cases

than we did" in the beginning of the job and maybe she would have developed better

habits early on. Ultimately she notes that no one else is to blame, "burning out was, more

so, on me and my lack of self-care".

Ethics. The participants also seemed to report different, although not necessarily

contrasting, ideas about addressing ethics. Toni expressed that some issues are tricky

about whether to report or maintain confidentiality. For example, "A young boy that was a juvenile; he had stacks of weed that I saw." Therefore, she asked her supervisor how to handle seeing drug paraphernalia in clients' homes.

Charlene acknowledged that her agency supervisor was faced with a "multilayered dilemma". The job expectations were to "meet your hours but don't do anything unethical" despite ridiculous productivity requirements. Therefore, their ethics conversations were about preventing fraud. Charlene expressed discussing more ethical situations with her licensure supervisor.

> "I was just checking to make sure that my decision was right. Like a client invited me to her wedding after working with, DCF, you know, her husband had to be removed, and so we worked on them getting back together in therapy. then the client was like, I'm really heartbroken…I told her I would not go, and then I talked to my supervisor and see what s/he said to make sure, I was not being…with boundaries, whatever… just to make sure that I was on the right side of being therapeutic and being human.

Her overall lesson was to "trust the decisions that I am making".

Alternatively, Holly focused more on clinician responsibility to be ethical and honest.

> "I can get supervised to death and not care what they're saying and do whatever I want when I'm in the field and come back and present differently in supervision, but the idea's that supervision's there to help me. At the end of the day, my supervisor gets paid whatever they're paid whether they see me or not, whether I'm honest of not. The idea is how can I then go through into the field and impact

and change lives. And also grow from it". … "It's frustrating. I have some
colleagues that'll go in supervision and they go and spit out all these great
modalities and you look, you may see them or shadow them or go with them for a
tandem session and you're just like 'Where's that person from supervision?'

To summarize the many themes and exemplars in this category, Tables 4.1 to 4.3
provide a simplified outline of the significant statements and formulated themes.

Table 4.1: Effective and ineffective supervision practices, I

Selected examples of coded statements and related formulated meanings

Formulated meanings/themes	Exemplars
Supervision structure	*she, [the supervisor], would miss or forget* *have one of the counselors that are already there to give me supervision* *a good place to have supervision* *really relaxed atmosphere* *she definitely had things that she wanted to discuss*
Personality and leadership style	*supportive, a problem solver, goal oriented and solution focused* *transformational leadership style* *Micromanager* *permission to breathe* *come across a little bulldoggish* *come across a little intimidating or rude or disgruntled*
Race and Cultural Differences	*it may have been a cultural thing* *she was a bit insulting* *giving a backhanded compliment* *are you surprised that I speak well?* *I was called colored* *I've had some great black supervisors, and I've had some great white supervisors but I had bad of both*
Agency versus Non-agency supervisors	*one will feel more freedom to address issues differently* *level of work-related stress* *get a supervisor in-house cause then you don't have to pay* *agency supervisors don't necessarily know what they're doing and the amount of work it takes to do in-home visits* *avoided agency supervisors and reserved her questions and needs for licensure supervisor* *different personality between supervisors* *different people brought out different things* *had I not had one or the other, honestly I would have suffered more*
Collaboration	*difficult to really take her seriously* *have you tried such and such* *you should be asked what do you need* *she had her own agenda*

Table 4.2: Effective and ineffective supervision practices, II

Selected examples of coded statements and related formulated meanings

Formulated meanings/themes	Exemplars
Safety	*knowing not to bring your purse in*
	he showed me that he had a knife in his pocket
	very scary
	don't park your car in the driveway where somebody can come behind you
	put your purse in your trunk before you even get to the area
	work till nine-ten-eleven o'clock at night
	eight foot boa constrictors that got out of their cages and they could not find them
	I had people throw things at me
	very high crime rates
	your safety is priority
	sitting next to the closest door, next to the closest exit, next to my car, with my keys on me
	call 911 from my car
	I can't carry mace on me, I can't carry a knife
	in supervision definitely [safety] wasn't addressed
	wear pants, wear closed toe shoes
	he said he was going to throw a brick at my car
Accountability	*continually seek supervision*
	being recorded
	critique and go back and forth
Relevant knowledge	*relevant suggestions*
	have experience in in-home
	if you went straight to private practice that's great, but you probably shouldn't be supervising me
	things she was unfamiliar with because she had been out of the field for quite some time
	able to understand and relate to different things
Boundaries	*turn off the TV*
	managing cancellations
	being therapeutic and being human
Documentation	*too focused on paperwork*
	conversations about paperwork did not make me better with paperwork
	put it on the board so that we knew documentation-wise where we were and what needed to get done

Table 4.3: Effective and ineffective supervision practices, III

Selected examples of coded statements and related formulated meanings

Formulated meanings/themes	Exemplars
Professional growth and development	*different ways to be effective* *equipped with skills and applications* *grow in something that I couldn't identify*
Productivity	*comes naturally [when] you feel respected* *work more efficiently* *want the team to do what we've got to do*
Engagement	*making sure the family is comfortable* *they have been around the bend before with therapy* *be welcomed to come back*
Person of the therapist	*putting aside how I may have felt about it* *looking at it objectively* *we'll present with whatever our strength is in supervision*
Burn out and self-care	*must at some point think about yourself* *you'll then lose yourself* *take yourself away to regroup and to come back* *are you working hard or are you working smart?* *take a vacation* *supervision itself is self-care* *is this still what you want to do* *we're humans and its okay to feel like I'm overwhelmed* *productivity was well not impossible, but realistically therapist self-care would suffer*
Ethics	*stacks of weed that I saw* *make sure that my decision was right* *I'm honest*

Meaningful Realizations

  Everything is helpful. Holly expressed the important of taking the good and bad supervision experiences and making the most of them:

  "I don't think anything was ever not helpful or less helpful than something else. I might have been less receptive, at a point, to hear what was being said to me, but I believe all the experiences that I've had to date have allowed me to grow in some shape, form, or fashion. Which means that if something helped me out, even if it was something that rubbed me the wrong way and challenged me to grow and to do better so there's not anything that was not beneficial or less beneficial than something else. I think it's all equally beneficial. … "our field changes and evolves and we have this new DSM-5 and new things and new disorders that have come up, that we're kind of like forever learning and growing and empirical evidence changes and all this other stuff happens, I really believe that it's important to be able to grow with what's going on … So, I think that's what I mean by growing and learning. Supervision I think is really a key aspect in that because often time when supervisors are having that extra time in the office and not with clients, they are reading up on things and going through journal articles that I may never see, or even know exist, so, yeah."

As Holly noted, an evolving field requires the supervisor and clinician to evolve and grow as well.

  Impact of the interview. Some participants expressed at the end of the interview that the process had significant affects and elicited certain feelings, all positive. One participant, Kelly, expressed that "the interview was relaxing and releasing", enabling her

to get a lot off [her] chest. The interview process also involved some reframes as the investigator sought clarification on stated descriptions. For example, reframing may have affected Kelly's thinking about whether a supervisor's actions made sense and clarified what she really needed from supervision.

Kelly started describing mixed feelings. "I liked [the job], but I also hated supervision". When probed for reasons why, she explained, "[the supervisor] wanted to have what I consider 'real supervision', talk about cases and clinical application … [but] I only wanted to have supervision about the difficult cases".

The primary investigator clarified, "You don't want to have to go in-depth with the 'easy ones'… you kind of got them figured out; you're already on the right track; they're making progress… You don't want to have to go in depth with those." Kelly affirmed.

So the investigator continued, "How do you make sense of it, that the supervisor needed to get a sense of your clinical skills, and how you handled cases, and then she was able to give you more space, more freedom to practice freely?"

Kelly replied, "Yeah, yeah maybe that's what it was". Nevertheless, Kelly maintained her confidence, "I am licensed, I don't need supervision", and she continued to explain that the supervisor would focus a lot on how Kelly assessed and diagnosed clients.

Therefore, the investigator continued to ask, "So the supervision may have been to make sure the supervisor agreed with your diagnosis?"

She replied, "Yes. Which, now that I look back, was important, was valuable." Nonetheless, she maintained, "I think when you're licensed, you should be asked what do

you need. What are your needs and what is it that you like to focus on?" Kelly seemed to

indicate that while the supervisor's agenda may have been understandable and necessary,

collaboration is still a highly valued piece of the relationship between supervisor and

supervisee.

> Darla spoke more about how there is more to contribute to the field regarding in-
>
> home therapy.
>
> "You brought up some things that I had forgotten. Which is a good thing. It was
>
> good to be able to laugh about stuff that happened to me in my career. I think
>
> that…We can all write reams of books on our experiences dealing with people in-
>
> home. I got the snake chapter!"

M.P.'s attention was drawn to the idea that good supervisors deserve more

recognition since they are so rare and hard to come by:

> "It was good, it let me think. You know, I don't really think about the questions
>
> you're asking all the time, so it truly helped me. I really do love my supervisor, I
>
> guess. Yes, I think I'll buy her lunch today. No, but really, the interview was
>
> really good. I enjoyed that it really did make me think. It made me think because
>
> I'm at my five year mark, you know? It made me reflect."

Jennifer seemed to enjoy the opportunity to re-evaluate the experiences in her

career and examine where she is headed for next steps. Appreciating the challenges she

faced and the growth she gained while doing in-home was an important outcome of this

interview:

> "I think it kind of brought a few things more to the forefront. It takes me back to
>
> those places, like 'I don't really have to deal with a lot of that stuff' [from in-

home]. Because where I am now, we do majority Christian counseling so it aligns more with my faith, my beliefs. Most of the clients that come in are under that premise so we're able to apply certain things in a very different way, which is kind of what I was looking for with some of the clients that I worked with before when I was doing in-home. So I think this [interview] process is kind of just bringing back, …there were times where even though I may have been burned out, but I really enjoyed what I was doing. There were sometimes where I think in-home was very beneficial in dealing with the clients because now there's some time where I may be in a session with somebody and I'm like 'oh, I wonder where they're living. So all those factors, you're able to see it firsthand…. This kind of process of going back over some of those [memories], it's been helpful in bringing some of those memories back and those were some okay days, you know, you were on the ground level, you were learning you were working, first couple years working in the field, so you pick up a lot of experience that way. So, I would definitely suggest for a therapist starting out to do in-home."

CHAPTER V: DISCUSSION AND IMPLICATIONS

The purpose of this study was to explore the supervision experiences of in-home therapy providers. In chapter one, I discussed the importance of addressing the needs of in-home therapists in order to improve client care, therapist growth and support, as well as to improve the process of supervision. I gave a brief summary of my involvement in the field of in-home therapy in order to establish a context for my interest, concerns and commitment to improving this area of the psychotherapy field. I provided a brief historical perspective of how in-home treatment fits into the field of marriage and family therapy, followed by an overview of current in-home therapy practice and current supervision methods, training and topics.

In chapter two, I provided an overview of the literature, acknowledging that in-home therapy appears to be more cost effective than other psychotherapeutic interventions. I also highlighted common aspects of community agencies and how those factors affect the supervision process and topics that need to be addressed. I discussed challenges that are unique to, or magnified by, in-home therapy that supervisor's should address.

In chapter three, I provided a rationale for using qualitative research methods, providing specific information about the phenomenological approach and Kvale's (2007) specific interviewing method and analysis. I detailed the steps that I used to interview participants, gather the data used to investigate their experiences and to analyze their descriptive statements. I, again, concisely provided details about my interactions with the field of in-home therapy in order to discuss the importance of bracketing my experiences and biases in order to minimally influence the participants and the data analysis.

In chapter four, I presented the descriptions of the participants and findings of the analysis. The findings included three main categories that were descriptions of home-based therapy, home-based therapy supervision, and effective and ineffective supervision practices. The three categories each contained multiple themes. In addition, I described meaningful realizations that the participants mentioned that did not fit well into the categories and themes, including participants' efforts to make meaningful connections and participants' experiences of the interview process.

Finally, in this chapter, I will discuss the significance of the results. I will reflect on the categories and themes presented in chapter four in order to make connections to the viewpoints and concepts previously presented in the literature. I will discuss implications of the research findings and consider the limitations of this study. To conclude, I will recommend future research ideas related to the field of marriage and family therapy and home-based therapy services.

Implications for Marriage and Family Therapy

Home-based therapy. Although participants were asked specifically about supervision experiences, they could not discuss supervision without detailing general aspects of the subfield of home-based therapy. The responses painted a picture of the nature of in-home work and ways it differs from therapy in other environments. The participants described several aspects about their experience as in-home therapists that did not appear directly related to their perception of what supervisors did in supervision. These themes appear to describe the context in which the participants experience supervision and make sense of their jobs overall. These aspects included a discussion about having limited career options after master's degree programs, specialties in home-

based therapy, low salary for high workload, stressful travel requirements, inherent safety concerns, home environmental factors, working in isolation and receiving minimal preparation in master's degree programs for home-based work.

Of the themes that were noted in participants' descriptions of in-home therapy, some of them were already mentioned in the literature on in-home therapy supervision (Culbreth, Woodford, Levitt, and May, 2005). This may be an indication that in-home therapy services generates very similar issues for the clinician and client populations regardless of location and other factors. Specifically, in-home agency work commonly has specialties related to parenting, foster care, family reunifications, etc. In addition, community agencies tend to give clinicians a heavy workload, although evidence-based practices tend to maintain smaller caseloads with more intensity and paperwork associated with each client. With the participants of this study, the evidence-based programs received praise for their structure, organization and support given to therapists.

Another theme, stressful travel requirements, emerged as inherent in the job of in-home therapy due to meeting the clients in their environments (Maachi, Johnson, & Durtschi, 2014), and the main concerns from the current study's sample seemed to be about length of travel time and dealing with bad traffic. Agencies often subsidize travel with reimbursement for mileage and car wear and tear. In the event that an agency does not reimburse, these work expenses qualify as tax write-offs to receive credit or reimbursement. However, the participants of this study did not seem occupied with the financial strain as much as the emotional toll of long drives in traffic having residual effects on clinical service delivery. The literature has offered suggestions to process

cases, plan for session, or even not think about cases; the therapist must determine what works best for her (Maachi, Johnson, & Durtschi, 2014).

Within the themes of travel, safety and burn out, the participants of this study appear to resent the double bind of working very late hours in crime-infested neighborhoods while trying to maintain self-care and personal safety. However, the agency requirement for productivity and the effort to be convenient for clients overrides the therapist's need for a safer schedule. Furthermore, the paradoxical nature of the situation undermines supervision conversations when supervisors must verbally demonstrate support by prioritizing self-care and safety. Is there a real solution to the issue of working late hours in unsafe neighborhoods that allows client, clinician and agency needs to be met? The responsibility to meet client needs and in-home therapist needs is a struggle and in some ways maybe even impossible to balance, and when that happens, the client welfare must be the supervisor's priority (Rubin, 1997). However, each of these challenges must be addressed head on in supervision for home-based providers. When clinicians do not feel safe due to environment or violent clients, they most likely cannot fully focus on providing good clinical service. Furthermore, if the intensity that the client family needs requires multiple intense sessions per week, supervision must attend to safety planning in addition to ethics, boundaries and feelings of burnout that office-based practitioners do not experience in the same way. With effective supervision, however, there are many factors of success and benefits to in-home therapy to explore. Supervision can creatively address clients' environments and presenting problems that present safety concerns; for example, co-therapy or other safety

planning options can mitigate clinicians' safety concerns by (Falke, Lawson, Pandit, & Patrick, 2015).

Environmental issues of in-home therapy are about not only safety but also ample distractions that come with TV, phone calls, visitors and all manner of interruptions. Interrupting neighbors and family members can compromise confidentiality. In addition, since even casually dressed social workers and therapists look distinctively different from neighborhood locals, neighbors can infer the reason for consistent weekly visits. With other challenges, when family members do not want to participate, it is easier for them to stay in their room or avoid the home altogether at the scheduled time for the session. Client parents who are struggling with parenting skills and couples who do not want to directly face their relationship problems often cannot get family members to participate in session. While there are definite benefits to observing family dynamics in the natural environment, other issues come up such as where to meet in the home, whether to meet with children alone when they seem stifled by parental presence, how close to sit to the door even if the family prefers another location, whether to meet at alternate locations. The experienced supervisor can predict some of these situations and decisions that therapist new to the field will have to face. Of course, supervisors cannot prepare anyone for literally every encounter, but clinicians can feel more confident about the work they are going to do if they are armed with strategies on how to handle issues that are likely to come occur.

Isolation was described by the participants as being an island, but there is a certain flexibility and freedom that comes with in-home work. When clinicians are able to schedule a particular week to see all clients in the first four days of the week, they

might manage to take an unofficial vacation as a long weekend. With the flexibility of

making one's own schedule, doctor appointments and other errands can be scheduled into

the day without taking days or official hours off work to complete the personal tasks. The

isolation that clinicians experience in home-based therapy provision comes from seeing

coworkers once per week, but it can be mitigated with co-therapy and more frequent

check-ins (Falke, Lawson, Pandit, & Patrick, 2015). However, supervisors would also

need to adjust the management style based on the development of the clinician,

understanding that one size will not fit all. Clinicians will need to be assessed based on

their knowledge, competence, confidence and commitment to multiple aspects of the job

description.

Other themes that participants of this study mentioned included 1) limited or no

other employment options and 2) low salary for high workload. The participants'

perceptions that there were limited or no other options for how to use their degree may be

an indication that some educational programs have very limited resources dedicated to

assisting with job placement and career planning. Also, it is possible that the south

Florida area in which these participants received training, currently reside and work may

be more limited than other areas of the state or country in regards to opportunities for

non-licensed, master's level therapists. While each of the participants can agree that they

received invaluable experience as a home-based therapist, to do so under the guise that

there are no other options is not favorable. Participants may have been unaware of

options such as supervised private practice, life coaching, consulting, or using additional

certifications to work unlicensed as mediators. If some participants were aware of those

possibilities, the opportunities may not have appeared attainable or stable for income. In

addition to simple career coaching, making additional certifications or referring to certification programs may aid master's level therapists with obtaining additional training that will increase their marketability and career options. Training programs may need to improve career planning services as well as providing resources for job opportunities post-graduation. Additionally, salary for in-home therapists changes based on years of experience, between agencies and by region. Otherwise, unlicensed therapists may accept lower paying employment in exchange free or reimbursed supervision toward licensure as well as inclusive trainings and workshops that many agencies provide.

Improving preparation in master's programs for clinicians who choose to provide home-based therapy would address the final theme in the home-based therapy category. The participants of this sample noted that they felt minimally prepared for in-home therapy work. However, preparation in master's degree programs varies regarding the specifics of electives and internships available. Since not all therapists will enter the in-home subfield, offering optional electives and internships is a sensible route to school preparation for the master's level clinician.

Home-based therapy supervision. As the findings also indicated, the home-based therapy supervision category themes included the limited scope of supervision, the power differential, programmatic structure to include group supervision, the impact of working for smaller programs with smaller caseloads, agency workshops and trainings (not provided by the supervisor), and supervisee expectations of supervision. These aspects of supervision did not appear to be directly attributed to the supervisor's decisions, but to the nature of the work, supervisees' individual behaviors and expectations as well as the agencies' structure and requirements.

Two themes, limited scope of supervision and supervisee expectations seemed related as both aspects of supervision attend to the supervisee's responsibility. The participant's mention of the limited scope of supervision was a call to attend to personal responsibility for growth, development and ethics. There also appeared to be a lack in this sample of clinicians making their needs and requests known to supervisors. While some clinicians felt stifled by the supervisors' personal agendas and others felt that their supervisors intuitively knew what they needed, supervision can be much more usefully structured and organized if clinicians at least attempt to help establish with their supervisor what some of the expectations and needs are in supervision. As expectations vary between supervisees and across the course of one supervisee's development, it is imperative for supervisees to speak up about their needs, even at the expense of potential conflict with a supervisor. As one participant noted, she was able to improve disagreeable conversations with supervisors by speaking with therapeutic skill. Consulting with colleagues can assist with preparing for potentially intimidating conversations. Still, supervisees would do well to recognize that there are limits to what a supervisor can provide, especially considering that agency supervisors are working within constraints of agency policy. These considerations may improve the already limited scope of supervision.

The theme that focused on programmatic and supervision structure included issues that affect both in-home and office based therapists. However, as participants in the study noted, it is very important for a supervisor with strong home-based experience to have the relevant knowledge desired by supervisees and for the supervision to be a good fit. The mention of group supervision came with positives and negatives. Most

positive sentiments appreciated the feedback from multiple perspectives and hearing about others' cases, learning from peers and their approaches and holding one another accountable for good clinical work. On the other hand, as different personalities will interface, some clinicians will not thrive in the group supervision settings. In agency settings, group supervision is often not optional. Furthermore, challenging a quiet therapist to speak up and contribute to a case staffing can be just as helpful developmentally as challenging talkative staff to refrain from dominating. One participant did state that the supervisor gave her suggestions on how to contribute more— speaking before dominant personalities and maintaining some eye contact in order to look, and perhaps become, more interested in the group conversations. However, there understandably would need to be a balance that accounts for different personalities and different strengths in team members, as in any group.

A common theme in supervisory relationships, the inherent power differential involves the types of challenges mentioned by the participants, in which, some supervisees will not feel comfortable to be honest with their supervisors when they are not getting what they need. Unfortunately, it was my understanding that supervisees continued in unsatisfactory supervisory relationships in order to meet certain goals such as licensure or to keep from getting reprimanded or fired. In addition, race and cultural differences can also cause issues or bring strength to both office based and in-home supervision relationships. As one participant experienced feeling insulted around race but also feeling the need to be careful how she addressed the issue with her supervisor. Power differential clearly affected the participant's freedom to express herself freely. However, there was no indication by any participants in this sample that race and culture has to

match in order to facilitate a positive supervisor-supervisee relationship. This is consistent with literature on cross-cultural supervisory relationships and literature on supervisory power (Lemire, 2009; Marshall & Weiling, 2003).

Two themes, smaller programs or caseloads and agency sponsored workshops and trainings, seemed related around issues of evidence-based practice. The participants noted that smaller caseloads were also beneficial for the supervision process because more time could be applied to the clinical needs of fewer clients instead of having to spread the supervision time across so many people. Additionally, the agencies with smaller caseloads tended to use evidence based practice, such as multi-systemic therapy (MST) and functional family therapy (FFT), also providing significant structure for the clinical process, documentation, workshop trainings and the supervision process. While no participants stated any complaints about the restraints and rigidity of evidence based practice, clinicians may need to initiate conversations with supervisors about whether the specific EBP is a good fit. While the supervisor at an agency will likely struggle with balancing staff turnover and meeting staff's needs to work in a program that fits, finding staff that fit with the evidence-based model will result in better service provision and outcomes. Agency workshops were highly valued among the participants, but I sense that clinicians do not often get to choose the workshop topics. If the supervisor has the decision making power or influence to do so, workshops will be better received if supervisees are asked for which topics they would like additional training.

Effective and ineffective supervision practices. Additional aspects were described as effective or not effective for the supervision process. The themes of note in this category include supervision structure, handling safety and crisis situations,

personality conflicts and compatibility, receiving simultaneous supervision from agency and non-agency supervisors, collaboration, relevant in-home therapy knowledge and accountability. Additional themes that the clinicians in this sample noted as significant to be addressed in supervision include boundaries, professional growth and development, documentation, productivity, engagement, person of the therapist issues, race and cultural differences, burn out and self-care as well as ethics. The participants experienced supervisors handling issues in the above themes in effective and ineffective ways.

Several of these topics are not necessarily unique to the in-home therapy experience, such as supervision structure, personality and leadership style, race and cultural differences, accountability, collaboration, boundaries, documentation, professional growth and development, and person of the therapist issues. These areas are often addressed for in-home and office-based therapists.

The structure of supervision based on this sample's responses referred to time, location, atmosphere, and planned topics. Distractions seemed to be the main concern as well as times when a supervisor did not show up for scheduled sessions. Personality conflicts and incompatibility occurred for nearly every participant with at least one of their supervisors. Such conflicts are not necessarily a negative thing because having different viewpoints is often a great source of growth for both parties if the disagreements are handled maturely and professionally. However, as participants described supervisors who were very rigid and focused on one agenda, it appears that the participants did not see a desirable opportunity for growth. Conflict is inevitable at some point in one's career, and the supervisee's one-down position places her in a position of submission and acquiescence. Alternatively, some participants described avoiding certain conversations

with certain supervisors in order to prevent conflictual conversations about clinical work. However, the impact of this strategy upon the supervisory relationship is immeasurable. Such a scenario most often undermines a clinician's job satisfaction and appears to be a large contributor to turn over in this small sample. Isomorphic to the therapy process, therapists must master the skill of engaging clients despite differences in personality and worldviews; similarly, supervisors must appreciate the art of engaging clinicians regardless of differences in personality, worldview, etc. Although supervision may be guided by certain policies, goals and requirements, partnering with the clinician to accomplish those tasks can help mitigate issues of personality compatibility. Similar to co-creating a treatment plan with clients that addresses concerns from the referral source and different systems involved, the supervisor can model for the clinician by co-creating goals and objectives for supervision even if the topics are influenced by agency policy, state laws, and the supervisor's individualized approach. This level of collaboration can resolve issues expressed by the participants of this study, who sometimes felt supervisors were too rigidly planted in a certain model or agenda.

There are also areas mentioned by the participants of this study that have unique challenges that are magnified by the nature of in-home work, such as safety, burn out, agency and non-agency supervisors, supervisory knowledge relevant to in-home work, some boundary issues, engagement, and unique ethical quandaries.

Safety concerns and burn out were the two most heavily discussed items that participants brought up during the study. While the literature on self-care seems to have gained significant attention (Eastwood & Ecklund, 2008; Maachi, Johnson, & Durtschi, 2014; Negash & Sahin, 2011; Rosenberg & Pace, 2006), overwhelmed in-home clinicians

may not devote much time to reviewing developments or information. However, as supervisors actively work to support their clinicians with decreasing feelings of burn out, perusing the literature may contribute to new ideas and increase the supervisors' awareness of the importance of addressing this issue intentionally and more often. Clinicians in this study clearly desire to have supervisors that encourage earlier cut off times for session. For the clinician, this translates into feeling supported, valued as a person and cared for by the supervisor. Often, supervisors do not address burn out until the therapist communicates that the feelings have been in effect for some time. To some extent, burn out or compassion fatigue may be inevitable since the basic nature of in-home work is so demanding. However, delaying and lessening the degree of burn out is an achievable goal worth pursuing. To this end, multiple factors can be considered in supervision including limiting the caseload and productivity requirements, increasing the employee morale with appreciations and team building, increasing vacation times per year and watching for signs of vicarious trauma, poor boundaries or over investment. Supervisors may need to provide practical tips. For example, some practical ideas that may help include, working systemically to include community stakeholders who may already be involved with the family and using such stakeholders to assist with positive changes and providing resources and opportunities. Additionally, in the first sessions, the therapist should address client family expectations of services, clarifying for the client what are the differences between therapy and case management so that they have realistic expectations of what to expect. Therapists should also use first sessions to learn the family understanding of the problem, organize a schedule and establish the cancellation policy. Poor boundaries often lead to burn out. Balance must be strategic so that a

therapist does not work seven days a week, leading to burn out. It is a good rule of thumb to schedule clients' sessions based on client addresses so that clients who live near one another are scheduled around the same time—this minimizes driving back and forth around town. Additionally, marking dates on a calendar will help to maintain paperwork deadlines and to set goals based on the program length (Camper and Taitt, 2011), using the team to hold one another accountable for paperwork as well. Practical strategies coupled with appropriate training and modeling will demonstrate to supervisees that the supervisor has the relevant knowledge to help navigate the complexities of home-based work.

Describing differences in the experiences received from agency supervisors and non -agency supervisors is an aspect of the supervision process that participants seemed to regard as a significant difference. There seemed to be an additional freedom for licensure supervisors that were not burdened by the balancing act of agency policy and funding stipulations. The additional freedom more often resulted in taking more latitude to address issues more personal to the needs of the therapist. On the other hand, agency supervisors are understandably preoccupied with the business of maintaining a well-oiled and profitable establishment (Tromski-Klingshirn, 2007). Multiple participants also reported the experience that agency supervisors did not seem to "know what they are doing". This may be partially attributable to lack of supervision training in master's degree programs. Additionally, if an experienced in-home therapist is promoted within agency to a supervisory position, supervisory training may not be required or provided. While the new supervisor may have a couple years of in-home experience, the supervisee

may sense the limitations in the supervisor's knowledge base, supervisory techniques, and management skills.

While the supervisor of home-based services pulls from her clinical experiences to provide guidance and practical suggestions to supervisees, the participants seemed perceptive about whether the supervisor's knowledge was relevant to in-home work. This may become more apparent when addressing boundary issues, engagement in the home, and unique ethical decisions. The participants seemed to need the supervisor to guide them on how to handle dinnertime, gift offers, invitations to attend sports games and recitals as well as birthday parties or weddings. When in-home therapists spend several days a week and several hours per session in the client's home, some client families struggle to see the clinician in their appropriate role. On the other hand, client families may simply feel insulted if their cultural common courtesy is repeatedly rejected. When families successfully discharge, many may offer gifts to the clinician to show appreciation. While supervision cannot prevent ethical dilemmas, and therapists will have to learn to think on their feet, preliminary conversations about many of these issues can prepare the therapist for how to handle relatively unique scenarios.

Finally, several participants described what was most meaningful about their supervision and the interview experience. One major take away was that all supervision experiences are helpful. Even if the supervisee does not enjoy the process or agree with her supervisor, there are valuable lessons to learn from supervision. The supervisee may make a note of what not to do if she ever supervises someone else, or minimally she may learn what a good fit is for her in supervision, so she can clearly communicate that to future supervisors. Additionally, participants expressed appreciating that the interview

process helped them to rethink some things and put their career path in perspective. One participant remarked that it is important to show sincere appreciation to supervisors who provide a good service because great supervisory relationships are rare and invaluable.

Limitations of the Study

With any study, there are limitations. Although steps were taken, such as following semi-structured interview questions, journaling thoughts and feelings and consulting with my dissertation chair to bracket my biases, my experiences as in-home therapist and in-home therapy supervisor cannot not influence the interview and analysis process. However, with the efforts employed, the data yielded unanticipated findings. Notwithstanding, I acknowledge the limitation of convenience sampling which may account for all of the participants fitting within classifications similar to that of the researcher, i.e. black, female, late twenties to late thirties in age. While individuals outside of these characteristics were invited to participate, they did not schedule or keep their interview appointments. Nonetheless, these specific classifications may have affected the findings as minority women inevitably have a different perspective of low income, high-risk job requirements than women of other colors or men. Additionally, I have a connection with the each of the participants from previous years as either coworkers or classmates in MFT master's or doctoral programs. While confidentiality was assured and maintained, participants may have wondered if I extrapolated and determined the identity of their supervisors. In addition, I acknowledge the impact of follow-up questions possibly bringing more attention to certain aspects of participants' stories; I situated follow up questions in the participants' responses, asking them to expound on topics that they mentioned. Additionally, the specific training of the

supervisors that were experienced by this sample is unknown but may have had a significant impact on the supervision provided.

Recommendations for Future Research

There are many opportunities and options to explore regarding further research on the supervision of home-based therapists. Further exploration about the supervisory relationship in the context of home-based therapy is necessary. Supervisors and supervisees who report having a positive working relationship may be interviewed to see what works in "good fit" supervision relationships in the home-based therapy context. Supervisors can be interviewed or surveyed independently to explore more current responses regarding how supervisors address issues related to in-home therapy work, manage the complexities of agency and funding requirements, and meet the conflicting needs of clinicians and clients. Additionally, any supervisory training supervisors have received can be explored, as well as continuing education steps that they utilize in order to maintain current knowledge about the field. Supervisors may also have their own thoughts about trying to balance clinicians' safety and self-care with the fiscal needs and agency policies.

Several participants expressed feeling limited and trapped into doing in-home work to start their career after graduating from clinical master's degree programs. To address the question of post- master's opportunities, surveys could be disbursed to graduating students of master's degree programs across the region to determine their career plans and employment prospects. In addition, examining therapy-training programs can show what different programs offer in terms of career guidance and preparation.

If agencies are willing to participate, comparisons can be made about the requirements such as productivity and the benefits such as average starting salary, vacation and other provisions for employee appreciation. Any supervisors who have writing experience should consider partnering with a supervisee to write up a case study when progress has been exceptional. Such a case study can focus on client improvement as well as the developments that occurred in the supervision process. Similarly, a supervisor could choose to have clinicians who are new to the field to keep a journal of their experiences including supervision experiences.

Handbooks for successful work in home-based therapy may be a helpful contribution to the field, complete with strategies and techniques for building therapeutic alliance in the home, common specialties of in-home therapy, managing safety concerns, productivity, documentation and burn out, as well as providing ideas for making the most of home-based therapy supervision.

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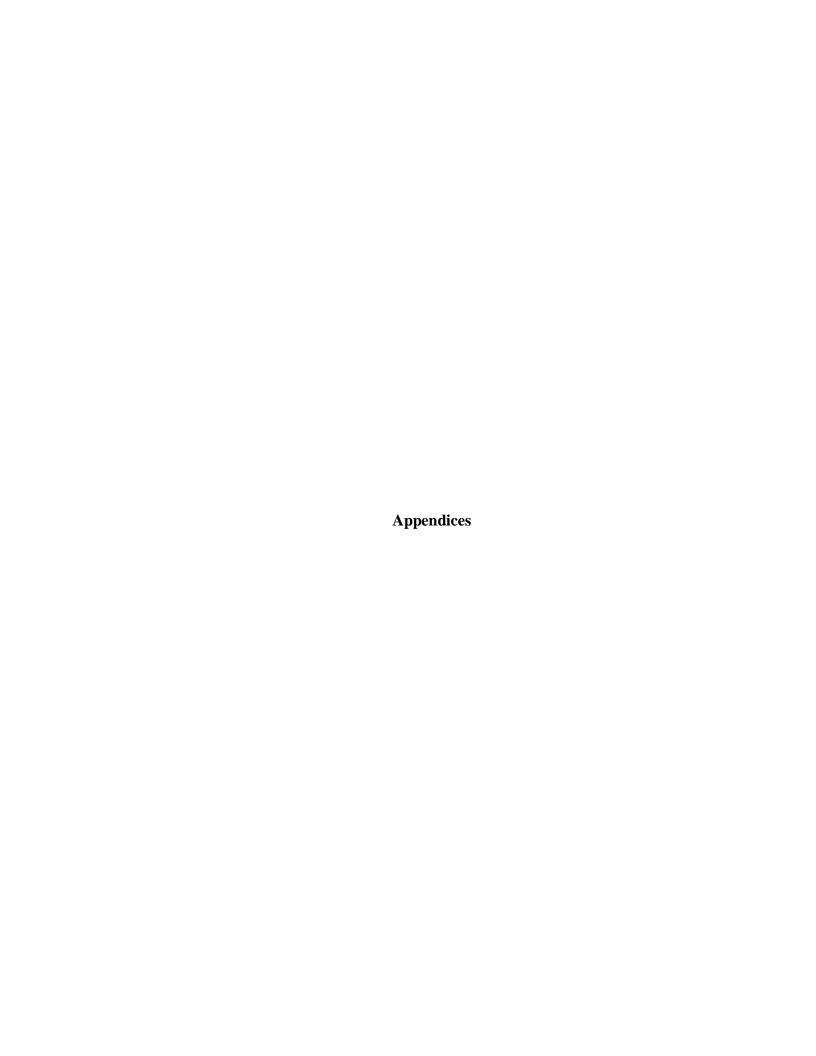Negash, S. & Sahin, S. (2011). Compassion Fatigue in Marriage and Family Therapy:

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Appendices

Appendix A

Script for Invitation to Participate

Phone: Hello, this is Cherrie Camper, and I am a doctoral student at Nova Southeastern University. I am inviting you to participate in a research study to fulfill dissertation requirements for the doctoral degree. I am exploring the supervision experiences of in-home therapy providers. If you agree to participate, I will interview you for approximately one hour and voice record the interview while asking about your experience of home based therapy supervision. The audio recording will be available to be heard by personnel from the IRB, my dissertation chair and myself. If you provide me your email, I will send you the consent form for review and then contact you again in 24 hours for scheduling. Here is my phone number if you have any questions: 706-325-0852.

Face to face conversation: Hello, I am Cherrie Camper, and I am a doctoral student at Nova Southeastern University. I am inviting you to participate in a research study to fulfill dissertation requirements for the doctoral degree. I am exploring the supervision experiences of in-home therapy providers. If you agree to participate, I will interview you for approximately one hour and voice record the interview while asking about your experience of home based therapy supervision. The audio recording will be available to be heard by personnel from the IRB, my dissertation chair and myself. If you provide me your email, I will send you the consent form for review and then contact you again in 24 hours for scheduling. Here is my phone number if you have any questions: 706-325-0852. May I also have your phone number?

Email: Hello, I am Cherrie Camper, and I am a doctoral student at Nova Southeastern University. I am inviting you to participate in a research study to fulfill dissertation requirements for the doctoral degree. I am exploring the supervision experiences of in-home therapy providers. If you agree to participate, I will interview you for approximately one hour and voice record the interview while asking about your experience of home based therapy supervision. The audio recording will be available to be heard by personnel from the IRB, my dissertation chair and myself. Please see the attached consent form for your review, and I will contact you again in 24 hours to see if you would like to schedule an interview. Please reply to this email with your phone number as well, so I may contact you. Here is my phone number if you have any questions: 706-325-0852.

Appendix B

Consent Form for Participation in the Research Study Entitled
An Exploration of Home-based Therapists' Supervisory Experiences

Funding Source: None.
IRB protocol #:

Principal investigator	Co-investigator
Cherrie Camper, M.S.	Debra Nixon, Ph.D.
3301 College Avenue	3301 College Avenue
Ft Lauderdale, FL 33314	Ft Lauderdale, FL 33314
(706) 325-0852	(954) 262-3008
mccrory@nova.edu	nixond@nova.edu

For questions/concerns about your research rights, contact:
Human Research Oversight Board (Institutional Review Board or IRB)
Nova Southeastern University
(954) 262-5369/Toll Free: 866-499-0790
IRB@nsu.nova.edu

What is the study about?
You are invited to participate in a research study. The goal of this study is to explore your experience of home-based therapy supervision in a one-on-one, face-to-face interview. The purpose of the interview is to get a description of your experience during supervision of your in-home therapy work.

Why are you asking me?
The reason for asking you to participate is because you are currently or have in the past been a home-based therapy provider who had received or is receiving supervision. There will be approximately 10 participants in this research study.

What will I be doing if I agree to be in the study?
You will attend a one–on-one, face-to-face interview to engage in an exploratory conversation about your home-based supervision experiences. The interview is expected to last approximately one hour to include a debriefing that will immediately follow to clarify any queries you may have. The interview will be conducted by Cherrie Camper at the private and closed location and at the time that is convenient for both you and Mrs. Camper. If at any time during the interview you experience any discomfort, you are free to excuse yourself from the interview and will not be obliged to disclose anything related to this discomfort, if this occurs, you are free to leave the interview at any time.

Initials: _____   Date: _____   Page 1 of 5

Is there any audio or video recording?
This research project will include voice recording of the interview. A voice-recording tool, "Philips Voice Tracer", will be placed on a table in front of the interviewee to capture all the spoken words. This audio recording will be available to be heard by Cherrie Camper, personnel from the IRB, and Cherrie Camper's dissertation chair. The recordings will be transcribed by Cherrie Camper using headphones in her home office onto her password protected flash drive. All recordings will be kept securely in a locked filing cabinet in Cherrie Camper's home office. Instead of using your name, you will be asked to choose a pseudonym. Where ever a name may be mentioned that might potentially identify a real person, the researcher will employ the use of the pseudonym. The recordings will be kept for 36 months, and destroyed after that time through shredding physical data and deleting electronic data. Because your voice will be potentially identifiable by anyone who hears the recording, your confidentiality for things you say on the recording cannot be guaranteed although the researcher will limit access to the recordings as described herein.

What are the dangers to me?
Although all studies have risks, risks to you are minimal, meaning they are not thought to be greater than other risks you experience every day. The procedures or activities in this study may have unknown or unforeseeable risks. If you have any concerns about the risks or benefits of participating in this study, you can contact Mrs. Cherrie Camper, her chair, Dr. Debra Nixon or the university's human research oversight board (the Institutional Review Board or IRB) at the numbers indicated above.

The following measures will be taken to minimize any potential risk:
Psychological Discomfort – There is minimal risk that psychological or emotional distress will occur. While this study is not intended to cause you any distress, you may feel some anxiety in recalling or describing your experiences. If at any time, you feel that you are experiencing too much distress, you may refrain from sharing your experiences, take a break, or you may discontinue participation. If you still feel distress after the attempts of the interviewer to restore your calm, please feel free to request a referral; however, there is no commitment to provide free care or payment for any unfavorable outcomes resulting from participation in this research.

Should further help be required for you in dealing with possible distress, Ms. Camper will provide referrals for individual therapy, but you will assume the full costs associated with the services sought. You are reminded that Ms. Camper will not be able to provide these clinical services due to conflict of interest, but appropriate referrals will be made to clinicians with the necessary competencies to assist participants with the issues that may arise. The procedures or activities in this study may have unknown or unforeseeable risks.

Invasion of Privacy – All information obtained in the research will be mandatorily acknowledged as private and personal by Ms. Camper, with the exceptions of information concerning elderly abuse/neglect or child abuse/neglect (as such abuse-related information requires legally mandated reporting to pertinent authorities).

Initials: _____ Date: _____   **Page 2 of 5**

Confidentiality – Ms. Camper is conscientious about the responsibility of safeguarding your emotional, psychological and physical well-being. In recognition of the above stated, she has established secure procedures to protect your identity which may prevent potential harm.

To ensure confidentiality, Ms. Camper:
• Will not use actual names that may be linked to your identity; pseudonyms will be used throughout the study and in the final text, with the exception of this consent form. Ms. Camper advises you to maintain confidentiality and privacy to minimize the potential for harm and discomfort.
• Will transcribe interviews in a private, secure setting with the use of headphones to ensure privacy and confidentiality.
• Will secure all electronic recording devices, written notes, and transcriptions containing data obtained in the research in a locked cabinet and secured office to which only Ms. Camper will have access.
• Will secure all electronic data in a password-protected computer accessible only by Ms. Camper.
• Discussion of confidential information will be done in a private closed setting to maintain confidentiality. The location chosen will ensure that non-participants are not present and/or they cannot hear any information discussed during the interview(s).
• Ms. Camper will seek your consent prior to sharing any information.
• All research information will be kept for a minimum of three years after the completion of the study.
• With the exception of this informed consent form, all direct links to identifiers will be removed and kept for three years following the completion of the research. However, since your voice may be potentially known by anyone who hears the interviews, confidentiality for things said during the interview may be challenging. Foreseeing this challenge, Ms. Camper will strictly limit access to the interviews to selected persons, including the dissertation chair, the IRB and herself.

If you have any questions about the research, your research rights, or have a research-related injury, please contact Ms. Camper and Debra Nixon, Ph.D. You may also contact the IRB at the numbers indicated above with questions as to your research rights.

Will I get paid for being in the study? Will it cost me anything?
There are no costs to you or payments made for participating in this study. There are no direct benefits for you taking part in this study. However, there may be a few indirect benefits for taking part in this research as participants may recognize what has worked well for them during supervision and may gain insight to improve current supervision experiences, developing more meaningful and effective supervision relationships. Additionally, participants may benefit from self-acknowledgement and gaining a clearer sense of purpose regarding in-home work provision and use of supervision. Finally, participants may feel empowered and give rise to a voice that may otherwise go unheard—to discuss the supervisee's perception of supervision.

How will you keep my information private?
All information obtained in this study is strictly confidential unless disclosure is required by law. I am a mandatory reporter of child abuse, elderly abuse, and serious suicidal or homicidal ideations. In addition, the IRB, regulatory agencies, and the chair of my dissertation may review research records.

All the information obtained from the study, i.e., the voice recordings and the transcripts will be kept in a locked filing cabinet at Cherrie Camper's, home office. Following completion of the study, the investigator is required to keep the information for a period of 36 months before deleting and/or shredding them.

I will be responsible for the safety and security of the audio recorder and it will be kept in a locked filing cabinet along with other confidential documentation. At no time will you be required to identify yourself by name on the recordings, only pseudonyms will be used. If this occurs by mistake then I will use pseudonyms during transcription for identifying information without losing any other valuable data collected. At no time will the voice recording tool, "Philips Voice Tracer", be left unsecure.

The transcripts will remain on a password protected flash drive for added security
All information obtained in the study is strictly confidential unless disclosure is required by law.

What if I do not want to participate or I want to leave the study?
You have the right to leave this study at any time or refuse to participate. If you do decide to leave or you decide not to participate, you will not experience any penalty or loss of services you have a right to receive. If you choose to withdraw, any information collected about you **before** the date you withdraw participation will be kept in the research records for 36 months but you may request that it not be used.

Other Considerations:
If the researchers learn anything which might change your mind about being involved, you will be told of this information.

Voluntary Consent by Participant:
By signing below, you indicate that
- this study has been explained to you
- you have read this document or it has been read to you
- your questions about this research study have been answered
- you have been told that you may ask the researchers any study related questions in the future or contact them in the event of a research-related injury
- you have been told that you may ask Institutional Review Board (IRB) personnel questions about your study rights
- you are entitled to a copy of this form after you have read and signed it
- you voluntarily agree to participate in the study entitled, An Exploration of Home-based Therapists' Supervisory Experiences

Initials: _____   Date: _____   **Page 4 of 5**

Participant's Signature: _____ Date: _____

Participant's Name: _____ Date: _____

Signature of Person Obtaining Consent:
_____

Date: _____

Appendix C

Script for Follow up to Invitation to Participate

Phone: Hello again, this is Cherrie Camper, and I am following up with you regarding the invitation to participate in a research study and interview about your experience of home based therapy supervision. If you have any questions about the consent form, I can answer them now, and if you like, we can schedule an interview time. …Thank you for your time.

Face to face conversation: Hello again, I'm Cherrie Camper, and I am following up with you regarding the invitation to participate in a research study and interview about your experience of home based therapy supervision. If you have any questions about the consent form, I can answer them now, and if you like, we can schedule an interview time. …Thank you for your time.

Email: Hello again, I'm Cherrie Camper, and I am following up with you regarding the invitation to participate in a research study and interview about your experience of home based therapy supervision. If you have any questions about the consent form, I can answer them now, and if you like, we can schedule an interview time. …Thank you for your time.

Appendix D

Script for Interview and Debriefing

Interview: My name is Cherrie Camper and I am a doctoral student at Nova Southeastern University. Thank you for being here today as we explore your supervision experiences as an in-home therapy provider. The interview will be approximately one hour, but if at any time during the interview you experience any discomfort or need to take a break, you are free to excuse yourself and you may skip questions you would prefer not to answer. If at any point you are uncomfortable with my note-taking or questioning, please let me know as soon as possible so I can change what I'm doing.

"Do you have any questions about me, my research, or our interview before we begin?"

> Opening Question: What has been your experience in home-based therapy supervision?
> Follow up: What happened?
>   How did it happen?
>   How did you feel then?
>   What other significant aspects of your supervision experience can you share with me?

Debriefing: Thank you for your participation. Is there anything else about your experience that you would like to share at this time? If you don't mind, can you share what was your experience of the interview process? I may contact you if I need clarification. If you are interested in the results, let me know and I will share the conclusions. Finally, at this time, I would like to obtain contact information for any individuals whom you think would meet criteria for this research study about individuals' experiences of home based therapy supervision. If you know of any potential participants, I can receive their information now. …Thank you for your time.

Appendix E

Script to Request New Participants

Phone: Hello again, this is Cherrie Camper, and I am following up with you to obtain contact information for the individuals whom you thought would meet criteria for this research study about individuals' experiences of home based therapy supervision. If you have any potential participants, I can receive their information now. …Thank you for your time.

Face to face conversation: Hello again, this is Cherrie Camper, and I am following up with you to obtain contact information for the individuals whom you thought would meet criteria for this research study about individuals' experiences of home based therapy supervision. If you have any potential participants, I can receive their information now. …Thank you for your time.

Email: Hello again, this is Cherrie Camper, and I am following up with you to obtain contact information for the individuals whom you thought would meet criteria for this research study about individuals' experiences of home based therapy supervision. If you have any potential participants, email or call me with their information. …Thank you for your time.

Biographical Sketch

Cherrie Camper started early in a life of service to her church and community, holding church leadership positions from the age of sixteen and conducting community projects from the age of fourteen. In 2005, Cherrie completed a Bachelor of Science degree in Psychology, while on a Pre-Med track at Mercer University in Macon, GA. Before moving to Florida, Cherrie traveled to Hong Kong for a few months to teach English to groups of teens.

In Florida, Cherrie completed a Master of Science degree in Marriage and Family Therapy from Nova Southeastern University in 2007 and in 2015 satisfied all requirements for the PhD. She works hard to balance life as a wife, mother, church and community leader and professional. As a Licensed Marriage and Family Therapist, Cherrie has enjoyed her experiences as a home-based clinician and supervisor of a home-based family therapy program dedicated to domestic violence and substance abuse problems. She is currently awaiting publication in several professional journals and has expressed research interests in the supervision of other therapists and improving therapeutic services and access to minority populations.