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Workplace Supports in the Infant Mental Health Field: A Mixed Methods Investigation

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Workplace Supports in the Infant Mental Health Field: A Mixed Methods Investigation
Tanika Eaves Simpson, Ph.D.
University of Connecticut
2019

This mixed methods investigation explores work-related stress and employee well-being in infant mental health (IMH) practitioners and supervisors. The question of how reflective supervision can be integrated into infant-family serving systems to contain the emotional strains and secondary trauma of direct practice with vulnerable young children and families is gaining traction in the empirical literature (Barron & Paradis, 2010; O’Rourke, 2011; Osofsky, 2009; Shea, 2018; Watson, Gattis, & Neilssen, 2014). However, the relationship between organizational supports and self-care practices in managing work-related stress and promoting employee well-being has yet to be examined in the infant mental health literature.

Two studies were developed to: 1) examine the lived experience of the IMH clinical practitioner and professional/personal self-care practices identified as effective in managing work-related stress, 2) probe the broader IMH workforce about organizational supports and individual self-care practices that may promote management of work-related stress and employee well-being. Inductive, thematic analysis of qualitative data centered around four key themes: individual coping and self-care, reflective supervision as professional self-care, organizational supports facilitating self-care, and barriers to self-care.

The quantitative investigation, surveyed a national sample of 280 infant-family practitioners across varying job titles and sectors. Results of this study yielded findings suggesting significant small to moderate correlations between organizational supports (i.e., structural and relational features) and work-related stress. Results of both investigations raise
important questions about the interdependence of individual and organizational factors that may contribute to employee well-being.
Workplace Supports in the Infant Mental Health Field: A Mixed Methods Investigation

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B.A., Fairfield University, 1996
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Workplace Supports in the Infant Mental Health Field: A Mixed Methods Investigation

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# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>II.</td>
<td>Study I-QUALITATIVE STUDY</td>
<td>3</td>
</tr>
<tr>
<td>III.</td>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>IV.</td>
<td>Methods</td>
<td>12</td>
</tr>
<tr>
<td>V.</td>
<td>Results</td>
<td>18</td>
</tr>
<tr>
<td>VI.</td>
<td>Discussion and Conclusion</td>
<td>29</td>
</tr>
<tr>
<td>VII.</td>
<td>Study II-QUANTITATIVE STUDY</td>
<td>36</td>
</tr>
<tr>
<td>VIII.</td>
<td>Introduction</td>
<td>37</td>
</tr>
<tr>
<td>IX.</td>
<td>Research methods</td>
<td>45</td>
</tr>
<tr>
<td>X.</td>
<td>Results</td>
<td>52</td>
</tr>
<tr>
<td>XI.</td>
<td>Discussion</td>
<td>73</td>
</tr>
<tr>
<td>XII.</td>
<td>Conclusion</td>
<td>88</td>
</tr>
<tr>
<td>XIII.</td>
<td>Integrative Conclusion</td>
<td>90</td>
</tr>
<tr>
<td>XIV.</td>
<td>References</td>
<td>93</td>
</tr>
<tr>
<td>XV.</td>
<td>Appendix A</td>
<td>101</td>
</tr>
<tr>
<td>XVI.</td>
<td>Appendix B</td>
<td>attached</td>
</tr>
<tr>
<td>XVII.</td>
<td>Appendix C</td>
<td>attached</td>
</tr>
</tbody>
</table>
Introduction

Reflective supervision is the cornerstone of professional development and support promoted by leaders in the infant mental health field (IMH). This psychodynamic theoretical model of supervision and staff support in which the supervisor and supervisee enter a collaborative relationship for learning (Shamon-Shanook, 1995), is privileged as the primary means of containing emotionally charged content inherent in IMH practice. The broader ecology of workplace policies and resources, and their influence on workforce stress management have been ignored. This mixed methods investigation uses two studies to probe broader questions about reflective supervision, infant mental health practice, and work-related stress management in the infant mental health workforce.

The first investigation was undertaken to explore clinical practitioner perspectives about the role of reflective supervision in self-care and work-related stress management. The results of this qualitative study suggested that organizational supports other than reflective supervision were equally important in supporting practitioner performance of self-care and stress management. This led to the development of a survey of the broader infant-family workforce to probe practitioners and their supervisors about how their employing organizations, or places of work supported their stress management.

Theoretical frameworks examining the gendered nature of care work (Bubeck, 1995) and an ecological model of the person in environment (Brofenbrenner, 1979) are integrated into each study respectively. A care theory framework is applied in the qualitative study to understand how the competing public and private caregiving demands held by women who are over-represented in the human services sector in general, and in the infant mental health field in particular, impact the performance of self-care and stress management. The quantitative study
takes an ecological approach to investigating the shared relationship between the individual and
the organization in facilitating and promoting self-care practice and employee well-being
(Lizano, 2013; Maltzman, 2011). The results of this mixed methods investigation raise
important questions about the interdependence of individual and organizational factors that may
contribute to employee well-being. The conclusion of this study will explore implications for the
infant mental health field in particular, and human services organizational policy development in
general.
Study 1
Self-care and the Clinical Infant Mental Health Practitioner: A Qualitative Exploration

Abstract
This qualitative investigation seeks to explore the self-care practices clinical infant mental health practitioners report using to manage work-related stress. Twenty-one female clinical infant mental practitioners from various infant-family programs in two states in the U.S. completed an online measure of human service employee burnout (The Maslach Burnout Inventory, 1986), and were interviewed about their daily work experiences. Semi-structured, open-ended qualitative interviews were used to capture the lived experiences of infant mental health professionals. Inductive analysis of coded qualitative interview data yielded results indicating that the majority of the sample engaged in personal and professional (i.e. reflective supervision and collegial support) self-care practices that they found helpful in managing work-related stress. However, saturation of key themes (i.e. individual coping and self-care, reflective supervision is insufficient on its own, organizational supports may have a role in facilitating self-care, barriers like time, money, and competing care demands impede performance of self-care) suggests that self-care at the individual level is not sufficient in the management of work-related stress amongst clinical infant mental practitioners.

Introduction
Care is a central component of the work that practitioners perform when providing direct services to infants, toddlers, and families. The frontline IMH practitioner is charged with providing multiple levels of care to infants, toddlers, and families such as: hands-on bodily care and supervision of infants and toddlers in early care and education settings (both home and
center); intensive medical or developmental intervention for identified problems or illnesses in hospital, clinics, or the home; intense relational interventions with infants and their caregivers; and hands-on assistance with concrete resourcing in the community and/or home (Siegel, Dobbins, Earls, Garner, Pascoe, Wood, & Wegner, 2012; Zeanah, 2009). Because of these significant care demands, reflective supervision and practice are well-established mechanisms in the field designed to enhance and support competent, relationship-based infant mental health practice (O’Rourke, 2011; Parlakian, 2001; Sparrow; 2016; Shea, 2018; Weatherston, Kaplan-Estrin, & Goldberg 2006).

However, we know little about the experience of the clinical infant mental health practitioner’s perspective about reflective supervision and its role as a professional support in infant mental health practice. Does reflective supervision alone compensate for the care demands that these professionals endure to the extent that much of the literature suggests it does? This study investigates just that. Plus, we know that adult women are over-represented in the clinical infant mental health practitioner workforce (Seymour St. John, Thomas, & Norona, 2012), and often juggle equally intensive caregiving demands in the private/personal realm. This further complicates the effects of how much care work these professionals are providing. Because the question of care is so important both professionally and personally, this study explores the self-care practices of clinical infant mental health practitioners and the personal and professional supports they identify as being instrumental to their performance of self-care.

This investigation employs qualitative methods of data collection to capture the lived experience of clinical infant mental health practitioners and to probe more deeply about mechanisms they rely on both personally and professionally, to manage work-related stress. Inductive analysis of coded data gleaned from semi-structured interviews revealed four central
themes: 1) Clinical IMH practitioners relied *most* heavily on individual coping and self-care practices to manage work-related stress, 2) Reflective supervision was widely considered a professional self-care practice, but not sufficient on its own in the management of work-related stress, 3) Specific organizational supports were identified as being equally, or more important in facilitating individual performance of self-care and work-related stress management, and 4) Participants cited barriers to their performance of self-care, especially time, money, and competing professional and personal caregiving demands.

This study gives voice to the perspective of the clinical IMH practitioner who is typically female and at a critical point in her own lifespan development; and charged with providing relationship-based interventions during a fragile point in the family life cycle. Clinical IMH practitioners do value and practice self-care. They also regard reflective supervision as a valuable self-care mechanism. However, the story is more complicated. Study participant responses indicated that: 1) Although self-care is valued as a protective practice in managing work-related stress, engaging in self-care is not always intentional or consistent, 2) Reflective supervision is not a panacea for infant mental health workforce development and support, 3) Organizational structure, climate, and culture have a role to play in promoting and facilitating the practice of self-care, and 4) Dual competing public and private care-giving responsibilities are disproportionately held by women in society which means that it may be more difficult for women to practice self-care due to limited time and money.

The findings of this study offer a narrative that challenges the infant mental health field to consider the performance of care work and its gendered nature, in order to more holistically assess the needs of the workforce; moving from a micro-level approach to workforce development and support, to one that examines macro-level variables including organizational
structures and features that promote effective service delivery and practitioner support and well-being.

**Literature Review**

**Reflective supervision as the primary IMH workforce support.**

For the last two decades, the central solution put forth to address the professional development and support needs of the infant mental health workforce, which includes the management of work-related stress, has been advocacy within the field to integrate reflective supervision into all systems serving young children and families (O’Rourke, 2011; Tomlin & Heller, 2016). Reflective supervision has become a standard benchmark of competent, relationship-based IMH practice and has served as a primary mechanism of professional development and support in the IMH field. (O’Rourke, 2011; Osofsky, 2009; Shea, 2018; Shea, Weatherston, & Goldberg, 2016; Weatherston et, al., 2009).

When implemented properly, reflective supervision allows a parallel process in which the practitioner is held by their supervisor in the same unconditional positive regard that they are expected to hold their client families (Weatherston, 2009). This unconditional positive regard is what allows practitioners and client families to explore new ways of thinking and behaving, creating safety and acceptance for making mistakes or expressing difficult or uncomfortable affect (Schaefer, 2007; Shea, 2018). The essential components of reflective supervision (i.e. collaboration, regularity, and reflection), and its position as a best practice benchmark in infant mental health practice have been empirically established and believed to be essential to workforce development, support, and retention (O’Rourke, 2011; Osofsky, 2009; Parlakian, 2001; Tomlin, Weatherston & Pakov, 2014).
In fact, more recent studies suggest that reflective supervision increases the practitioner’s capacity for reflection and heightened insight leading to greater emotional containment which may be protective against work-related stressors like burnout and secondary traumatic stress (O’Rourke, 2011; Osofsky, 2009; Shea & Goldberg, 2016; Shea, 2018). Additionally, several studies have found that early childhood educators and early interventionists identified receiving reflective supervision as helpful in their management of work-related stress and in enhancing professional development, job satisfaction, and job performance (Frosch, Varwani, Mitchell, Carraccioli & Wiloughby, 2018; Shea, 2018; Watson, Gatti, Cox, Harrison, & Hennes, 2014). However, what is less known is the clinical infant mental health practitioner’s perspectives about reflective supervision and its role as a protective mechanism in managing work-related stress.

**Self-Care.**

Infant mental health practitioners are faced with balancing intense care demands in both the public and private realm. Often, infant mental health practice and service delivery comes with financial, emotional, and psychological costs and rewards inherent in the work of caring. The question of whether and how human service practitioners in general care for themselves (i.e. practice self-care) is gaining more visibility in the empirical literature due to compelling findings suggesting that work-related stress significantly impacts human service employee well-being both professionally and personally (Harrison & Westwood 2009; Killian, 2008; Lizano, 2015; Pearlman, 1995). Until recently, self-care has largely been promoted as an individual effort to combat work-related stress with very little emphasis on the role of organizations in promoting and facilitating employee self-care. Craig & Sprang (2007), Killian (2008), and Sprang, Craig, & Whit-Woolsey, (2010) found that specific self-care and coping strategies in individual
professionals were not good predictors of burnout, secondary traumatic stress, or compassion satisfaction.

In fact, stronger predictive links between professional burnout and secondary traumatic stress were established with work drain, long hours, an inability to separate from work off-hours, and the therapist’s sense of powerlessness within the workplace (Craig & Sprang, 2008; Sprang et al., 2010). These findings support the idea that burnout and secondary traumatic stress within the helping professions may be more a symptom of organizational dysfunction rather than a deficit in competence or coping within the individual professional (Charlesworth, Baines, & Cunningham, 2015; Harrison & Westwood, 2009; Maltzman, 2011; Newell & MacNeil, 2010;).

Organizations and self-care.

The link between burnout and workplace conditions has been empirically investigated with findings that suggest that organizational climate, structure, and culture are essential elements of a human service work environment that promotes burnout reduction and prevention, as well as effective work-related stress management (Acker, 2011; Boyas & Wind, 2014; Charlesworth et al., 2015; Killian, 2008; Kim & Stoner, 2008; Lee et al., 2013, Maltzman, 2011; Wharton, 2009). Additionally, social support inside and outside of work, and employee empowerment or internal locus of control where employees feel a sense of autonomy over their work; have been cited as significant predictors of job satisfaction and burnout (Acker, 2011; Killian, 2008; Kim & Stoner, 2008; Lee et al., 2013).

In a landmark study, Maltzman (2011) examined the process of implementing a self-care model for a large child welfare agency in California targeting: training and orientation of new staff, supervisory roles and relationships, and interpersonal relationships amongst staff. Two core elements of Maltzman’s organizational self-care model were: 1) in-service training designed
to educate new staff about work-related stress and self-care practices, 2) supervisory outreach to staff that normalized secondary traumatic stress and staff needs for emotional support.

Maltzman (2011) is one of the earliest published attempts to describe the process of implementing an organizational self-care model. Its core elements are consistent with findings from more recent literature that suggest supervisory and collegial support, acknowledgement of the realities of secondary trauma and burnout in the organizational culture, promotion of self-care, and a positive, cohesive organizational climate are essential to building resilience in human service employees (Boyas & Wind, 2014; Branch & Kilkenberg, 2015; Howard, 2015; Lee, et al., 2013; Ludick & Figley, 2016). That is, there is a longstanding pattern in the literature showing that there are important organizational features that affect human service employees. Nevertheless, the implications of considering individual differences along with organizational variables as critical elements of work-related stress management and self-care practice have yet to be explored within the infant mental health workforce.

In sum, the literature shows that the infant mental health field relies heavily on reflective supervision to support practitioner management work-related stress. Individual performance of self-care has been widely promoted as a stress coping mechanism in the human services sector with little consideration for how work environments impact employee management of work-related stress. Furthermore, organizations have a role to play in promoting employee care and well-being, but this hasn’t been explored in the infant mental health literature. This study addresses these gaps by considering the interdependence of organizational factors and individual performance of self-care using care theory to better understand the context of the IMH workers’ experience.
Conceptual framework.

The gendered nature of care work and IMH practice.

It is important to define what care actually is in order to gain a better understanding of the unique position of frontline infant mental health service delivery as care work. Bubeck’s (1995) analysis of the definition of care draws from earlier theoretical frameworks (Graham, 1983; Noddings, 1984; 2004; Parker, 1990) to examine four key aspects of care: 1) care as an activity: the attention to the physical and emotional needs of another; 2) the psychology of care: the psychological and emotional rewards and costs associated with caring work, 3) the ethic of care: caring as an attitude characterized by emotional investment rather than as an activity (Noddings, 1984), and 4) the gendered nature of care: care as “women’s work” (Bubeck, 1995, p.60). Bubeck (1995), purports that much of “women’s work is not understood as production or profitable, but rather as care; an activity aimed at meeting the needs of others,” (p. 9). Given the over-representation of women in the infant mental health workforce, and the inherent invisibility of the infant mental health field in contemporary American society, the gendered nature of care will be emphasized and applied to our understanding of the clinical infant mental health practitioner’s performance of self-care to manage work-related stress.

More than just possessing skills essential to competent infant mental health practice, the infant mental health practitioner must be adept at developing and maintaining relationships (Weatherston, Kaplan-Estrin, & Goldberg, 2009). In other theories of care in feminist scholarship, it is this relationship development and maintenance that is fundamental to the performance of care (England, 2005, Hochschild, 2003; Tronto, 2010). Furthermore, a capitalist framework emphasizing production and materialism, relationship-based care work becomes
exploitable. Feminist scholars theorize that this is because care is typically believed to embody feminine characteristics in Western culture. (Bubeck, 1995; Duffy, 2007; England, 2005; Noddings, 1984). Hence, care work, be it tending to the home, or tending to other human beings is largely rendered “women’s work” (Bubeck, 1995, p.60). Cultural assumptions postulate that caring comes more naturally to women than men, that women are nurturers by nature and therefore, care work can be perceived less as work, and more as vocation or a calling where economic compensation, material production, and the benefit of care work to the larger society are minimally considered (Bubeck, 1995; Duffy, 2007; England, 2005).

These above characteristics of care identified in the work on care theory highlight how society fundamentally devalues care. For example, care work professionals often receive relatively low wages and little recognition for performing high intensity emotional labor that incurs personal costs in terms of time, money, and physical/mental well-being (Hochschild, 2003; England 2005; Charlesworth, Baines, & Cunningham, 2015; Lizano, 2015. Those performing care work, and those in need of care work are often members of society’s most vulnerable and marginalized populations (Hochschild, 2003; England, 2005; Duffy, 2007; Wharton, 2009).

Finally, the devaluation of care work in general and the feminization of care labor and come together in care theories come together in the work of Charlesworth et, al. (2013) and Duffy (2007), which argue that female human service professionals (those performing care work in particular), are the most stressed and strained members of the workforce because they are often juggling intense care needs in their relatively low-paying jobs and in their personal lives, with very little support from institutions to strike a healthy balance. Ironically, the burden to perform more care, albeit for oneself as a care worker, has been promoted as the answer these
issues. Practicing self-care is widely promoted in the care professions (Bloomquist, Wood, Trainor, Kim. 2015; Pearlman, 1995; Sansbury, Graves, & Scott, 2015;). However, the performance of self-care is largely individual and typically requires no participation on the part of organizations and institutions. Where does this leave the clinical infant mental health practitioner who is often called to intervene with a vulnerable family during times of crisis?

Carrying the burden of bearing witness to the daily chaos, unpredictability, and peril that vulnerable babies and their caregivers face can create feelings of distress and despair in the clinical infant mental health practitioner that potentially leads to burnout and secondary traumatic stress (O’Rourke, 2011; Osofsky, 2009; Simpson, Robinson, & Brown, 2018). The consequence is a workforce that is overstressed, underpaid, and unstable while being charged with providing intensive psychological and relational support to those most in need: our society’s youngest, most vulnerable, and most invisible population (Lally, 2013). Using the critical frames from care theory, this study sheds light on the unexplored perspective and experience of the clinical infant mental health practitioner in her performance of specialized care work, and the personal and professional mechanisms available to facilitate the practice of her own self-care.

**Methods**

This study investigates and describes the experiences of clinical infant mental health professionals with regards to the self-care practices, both personal and professional, that they rely on to manage work-related stress. What are the experiences of clinical IMH practitioners? Do they consider reflective supervision to be an effective element of their self-care practice? Qualitative methods are best suited to answering questions that seek to understand the meaning or nature of phenomena individuals are experiencing (Strauss & Corbin, 1990). The experience of burnout and the practice of self-care, including receiving reflective supervision, warrant
examination of “intricate details” (Strauss & Corbin, 1990, p. 11) including the feelings, thought processes, and emotions infant mental health clinicians experience in their work, and the supports that they identify as effective at managing work-related stress. Therefore, semi-structured interviews were utilized to capture the lived experiences of infant mental health professionals. Semi-structured, open-ended interviews allow the researcher to develop questions and topics relevant to the research questions being investigated, as well as allow the respondents to articulate their experiences in their own words. This open-ended nature of semi-structured interview questions creates space for interviewees to diverge from the topical content in ways that may offer new ideas, themes, or understanding of the research question or issue at hand (Emerson, 2001).

In addition to interviews, participants also filled out an online survey and completed the Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1986), to gather additional data on the sample about their levels of burnout. The online survey provided demographic questions that also expand our knowledge of the sample. The Maslach Burnout Inventory (MBI) (Maslach et al., 1986) is the most widely used quantitative measure of burnout and focuses on three core dimensions (subscales): emotional exhaustion, depersonalization, and personal accomplishment (Maslach, Schaufeli, & Leiter, 2001; Maslach, 2003). There is a total of 22 items divided into three subscales. Respondents answer items in terms of the frequency with which they experience the feelings for which the items probe on a 7-point Likert scale ranging from 0 (never) to 6 (every day) (Maslach et al., 1986). Published reliability coefficients for subscales are: .90 for emotional exhaustion, .79 for depersonalization, and .71 for personal accomplishment (Maslach et al., 1986). The MBI was administered to probe the sample for levels of work-related stress.
and to get a profile of burnout features in this particular sub-population of the broader IMH workforce.

**Data collection**

A first round of participants was recruited at a site in Colorado through professional connections. This resulted in 8 participants from the nursing and mental health disciplines. To recruit in CT, a web link that led to a survey was posted on a state association for infant mental health website visited by IMH professionals as a resource. An email announcement including this link was also distributed by the website administrator. This email was also distributed to all infant-family program administrators across the state. Participants in Colorado received an email with instructions containing the link to the survey. For participants in both Connecticut and Colorado, the online survey was administered via Qualtrics and included the MBI along with demographic data including gender, number of years in the profession, number of years receiving reflective supervision, and highest educational degree achieved. At the end of the survey when participants consented to scheduling a follow-up interview, each participant created a 4-digit personal code and contacted the interviewer via email with their code in the subject line to schedule the interview.

Inclusion criteria for participation in the study required participants to be licensed, practicing infant mental health clinicians currently receiving reflective supervision in the workplace. Unlicensed infant mental health professionals or those working with infants and toddlers, but not providing direct mental health services, as well as clinical supervisors providing reflective supervision were excluded from participation in the study. This is because the research questions focus on the experience of professionals *delivering specialized* mental health services to infants, toddlers and families and their *particular* perspectives about workplace supports and
personal resources that they identify as useful in managing work-related stress. Therefore, professionals delivering services other than mental health or supervisors providing reflective supervision did not match the characteristics of the intended sample.

Once the survey was completed, the interviewer, in cooperation with the participant, established an appointment time for an in-person interview. Interviews took place at the location of the participant’s choice, mainly at their office or at a quiet table in a local café. On the date of the interview, informed consent was obtained from each participant to record the session prior to beginning the interview. Interviews ranged from 30 to 60 minutes and were recorded using a digital voice recorder. The interview consisted of 14 open-ended questions addressing the domains of: caseload, client engagement, change or growth in the therapeutic relationship, teamwork, clinician experience, and clinician self-care. This article focuses on findings specific to the last domain of questions about clinician self-care. The questions related to this line of inquiry are as follows:

1. What are some professional resources/supports available to you to help you manage work-related stress? How are they helpful/not helpful?
2. If you identified reflective supervision as a professional support/resource, can you tell me some details about the frequency of your meetings, the setting, if it’s individual, group, or both, if there is an agenda for discussion, and anything else you’d like to add?
3. Do you have an intentional self-care plan for yourself? How is this effective? If not, what are other ways you manage work-related stress?

Sample characteristics.

There are approximately 150 practicing infant mental health professionals in Connecticut. Thirty participants met the inclusion criteria for the study. Thirteen completed both the survey
and the individual interview, and 8 were included at the Colorado site, resulting in a total of 21 interview respondents. Participants’ ages ranged from 27-61. Reflecting the demographics of the field, the interview sample was 100% female, 100% post-bachelor’s degree educated, and predominately White with less than 10% being African-American, Asian, or Latina. About 69% of participants were clinical social workers or psychologists, and 31% were either nurses or early intervention specialists. All recruitment processes were approved by the Institutional Review Board in advance.

With regards to burnout features in this sample, over 80% of participants reported feeling emotionally drained at least a few times per month on the Maslach Burnout Inventory. More than half reported feeling used up at the end of the day because of work-related obligations several times per month to several times per week. One-third admitted to feeling too fatigued to face another day at work a few times per month and approximately another third of the sample admitted to feeling strained by working with people all day at least once a month. Almost 35% of all participants reported feeling burnt out from work several times per month. The profile of burnout features in this sample indicates that although all of the participants in this study were receiving reflective supervision, more than half of them were experiencing mild to moderate levels of burnout with emotional exhaustion being the most common feature.

**Data Analysis**

Interviews were transcribed and uploaded to the qualitative research software Dedoose in preparation for analysis. Line by line coding was applied through multiple stages of data analysis. Interviews were read closely and codes were applied to excerpts, phrases, expressions, or words that offered meaningful insights into answering the research question. Digital memos were attached to coded data and we began with broad categories of self-care e.g. ‘personal’ and
‘professional.’ We then developed a large number of parent and child codes illustrating: the types of self-care performed, the actor initiating self-care (individual or organization), values driving the performance of self-care (individual should do, organization should be responsible for), intentionality of self-care, and obstacles to self-care. After reviewing codes for similarity and overlap of content, codes were further collapsed. An inductive analysis rooted in a grounded theory approach was applied to the coding process (Emerson, et al., 1995 cited in Morris, 2007) to further develop codes into themes that emerged from participants’ responses to the semi-structured interview e.g. ‘individual coping’, ‘organizational supports.’ This kind of data analysis is useful in exploratory investigations wherein one may enter the field with certain interests without having developed or tested hypotheses about how participants would answer the interview questions (Glaser & Strauss, 1967, cited in Strauss & Corbin, 1990). Therefore, the inductive coding process reflects what participants revealed as meaningful to them during the interview.

The narratives presented below show how little we know in the IMH field about the lived experience of the clinical IMH practitioner. There is a lack of investigation concerning how clinical IMH workers psychologically and emotionally sustain themselves in order to perform what is often mentally draining, and emotionally exhausting work that requires high performance of intense emotional labor. The in-depth narratives we present below begin to fill this gap in our knowledge. Our data offer implications for future qualitative and quantitative investigation into the experience and perspective of IMH practitioners that takes into account a theoretical framing of the gendered nature of care work and performance of emotional labor, and how the IMH field can advocate for organizational policies that meet the holistic needs of its workforce.
Results

Four key themes emerged from interview coding: *individual coping and self-care practices to manage work-related stress, reflective supervision as a professional self-care practice, identified organizational supports, and barriers to self-care.*

**Individual coping and self-care practices.** All participants in the sample verbally acknowledged that self-care is an important component of work-related stress management. A social worker who was relatively new to the field said: “There are days when I feel emotionally drained and there are days where I feel at the end of my rope. But because of the support, because of the self-care, I’m able to manage.” Another more seasoned social worker noted that integrating mindfulness into her self-care practice has heightened her awareness of moments where she becomes emotionally dysregulated. “Practicing mindfulness as part of my self-care has been huge! When I am aware of what’s happening in my own body and mind, I can help parents explore that within themselves and then be curious about what’s going on for their babies.”

The particular forms self-care takes are evidenced by how two-thirds of the sample reported having an *intentional* self-care plan for themselves that involved a variety of things such as social support networks consisting of friends, colleagues, and family, and consistent physical exercise, not just regular use of reflective supervision. For example, one social worker stated, “Having relationships in your life that are truly supportive outside of work helps. And also having other things in your life. My family belongs to a church, so we have a community that’s completely outside of anything else that we do. I am very intentional about connecting with my community of support on my weekends.” A nurse described how re-connecting to her life away from work is emotionally fortifying “I make it a point to go the gym a few days a week, walk the
dog daily, get to the beach when I can and be in nature, and see friends. I try to balance fun with work.” A social worker who admitted to having difficulty managing work-related stress earlier in her career described her self-care plan: “A big part of my self-care plan is that I do a lot of different things. This is my 35-hour per week job, but I also teach and I have other professional and personal identities. This job does not complete my identity. I see myself as a therapist, a teacher, a girlfriend, and a daughter.”

In terms of how participants enacted self-care, one of the main forms our sample discussed was to cultivate social supports. One social worker noted how valuable it was to work with other women on her team who were also juggling motherhood. “There’s a real sense of humanity on our team, a lot of us are moms and it really helps to be in this work together with that shared perspective.” A seasoned early interventionist reflected on ways colleagues could support one another in practicing self-care. “We can promote the elements of self-care amongst ourselves. Maybe it starts small like by saying to your co-worker, ‘How did your week go?’ It starts small and it starts with us and the relationships we build.” This is unsurprising, as connection with family, friends, and colleagues is promoted in the self-care literature as a restorative practice which allows practitioners, especially those specializing in trauma treatment, to counteract the sense of isolation that is a common reality of the work (Pearlman, 1995).

In line with this, more than three-quarters of participants mentioned that feeling isolated is a common stressor in their work. And all but three practitioners interviewed (about 86%) were delivering home-based services to infants, toddlers, and families. These practitioners reported that the home-based nature of their work required them to spend more time in the field alone than in the office with peers or colleagues, and they felt particularly lonely in their work. Therefore, reconnection with family and friends outside of work, and with colleagues and peers
at weekly staff meetings or conferences was perceived as critical to self-care and work-related stress management. As one social worker mentioned, “Conferences are really helpful I think, just to go out and hear what other people are doing in the work and how they are doing it.” And a nurse stated that, “I think I’d only add that really, truly, I wouldn’t be doing this job if I didn’t have good co-workers.”

Other self-care practices cited include: exercise, meditation, regular engagement with nature, travel, massage, and personal care and grooming practices like haircuts or manicures, and pedicures. For example, a social worker mentioned her integration of exercise and being outdoors as an effective self-care practice: “I like to exercise, so I’m a member of a club and I go and exercise three times a week. I love hiking, I like to be in nature.” In fact, some form of physical activity including aerobic exercise, gardening, or yoga was the second most commonly reported self-care practice in the sample. One clinical psychologist described her reliance on intense physical exercise for work-related stress management as well as her own psychological health in general: “So one of my big self-care things is working out. I love to work out and I love taking classes. What’s kind of nice is that my gym has classes at certain times every week so I can build those into my schedule, and that is a very intentional thing.”

A social worker who was newer to the field and admitted to struggling with anxiety reported that exercise, social connections, and mindfulness were essential elements of her self-care plan. “I know I need to work out every day, meditate, and see friends.” A seasoned early interventionist underscored the importance of physical activity as part of a self-care plan. “One of the big pieces that I think fits well for all of us is committing to some kind of on-going, structured physical activity.” Overall, most participants reported relying on physical activity to
self-regulate or decompress after a stressful day, and as part of a consistent routine of self-care practices to maintain a state of mental and physical well-being.

Finally, there was also consensus among the participants that self-care is a personal responsibility and something practitioners should be doing for themselves. At the same time, they often struggled to do so. For example, one clinical social worker revealed that even though she knew practicing some form of self-care would be beneficial in her management of work-related stress, she struggled with being more intentional about her self-care. “I’m aware I should be doing it. I’m aware I probably should be doing more of it. Self-care is something I struggle with. I don’t know that my self-care is always so adaptive. I think I use a lot of escapism. I guess there are times when I really let myself get exhausted and overworked.” An early interventionist gratefully acknowledged that her employing agency offered many resources to encourage employee self-care and wellness. However, she rarely utilized them “Our agency offers things like free Zumba and yoga classes. Do I take advantage of it as much as I should, absolutely not, but it’s important nonetheless.”

Reflective supervision as a professional support: insufficient on its own. Although approximately 90% of the sample identified reflective supervision as protective against burnout and therefore an integral part of their self-care plan, 10% of the sample stated that reflective supervision was not at all helpful or protective against burnout and they relied more heavily on personal supports and resources to manage work-related stress. While 90% of clinicians do identify reflective supervision as a self-care practice, they did not consider reflective supervision as a primary self-care practice, but rather a component of a self-care plan that emphasized more personal self-care practices. Hence, clinicians in this sample did not view reflective supervision in isolation as an adequate tool to manage work-related stress.
In fact, one infant mental health clinician described her struggle to engage in a reflective supervisory relationship that she did not find helpful due to a lack of safety and trust in the relationship with her supervisor. “I wouldn't say it’s helpful (reflective supervision). Yeah. I mean, I think there's a longing, sometimes, to have that. Especially if I come in with the expectation that if I tell this story or I tell my feelings or even talk about family stresses that get in the way of work, that I'm going to end up being really disappointed and sometimes angry. Yeah, the openness to that deeper exploration just isn’t part of the culture here.”

In another example, an early interventionist shared her disappointment with a reflective supervision group that she joined in hopes of having safe space to explore her feelings about and reactions to her work, only to find that she received advice and direction which made her feel less competent as a practitioner. “Sometimes I feel like other people in the group are trying to give me strategies on what to change, like did you do this…or make this referral? So, I leave sometimes more frustrated and upset than when I came because I feel like I have to defend myself and my work. I feel like it’s being suggested that I don’t know what I’m doing. Even if that isn’t the intention, that is how I internalize it and I really wish the facilitator would direct it back to reflection.” Another excerpt features a nursing infant mental health specialist who emphasized the importance of trust in the supervisor-supervisee relationship. “You need somebody who’s calm, who trusts you to handle the situation. Because I felt I could handle it. You need your supervisor to have that trust in you and sometimes I felt it wasn’t there.”

The previous interview excerpts speak to the elements necessary for a truly reflective supervisory relationship. Safety for deeper exploration of feelings triggered by the work, being collaborative rather than directive, and a basic sense of trust in the relationship are all key ingredients of good reflective supervision (O’Rourke, 2011; Parlakian, 2001; Schaeffer, 2007;
Tomlin, et, al., 2013). If these elements are missing, then it is unclear if the supervision is truly reflective, and therefore its utility as a protective mechanism for managing work-related stress is unclear.

In the following interview excerpts, clinicians discuss mechanisms other than reflective supervision that they find useful in managing work-related stress. An infant mental specialist admitted that she does not consider reflective supervision to be a primary means of self-care. “I would say I rely more on my own personal resources and supports to practice self-care and manage stress than on reflective supervision.” A social worker noted that time away from work restores her so that she can engage in the reflective supervisory relationship more effectively. “It’s really important to be able to take time off when I need a break and not have anyone think less of me. Then I can come back to my supervisor, who I am very connected with and show up ready to do my work.” Finally, one part-time social worker who is also a mother of two school-age children shared how highly she valued her autonomy in setting her schedule: “I think flexibility in scheduling is just as, or more important than the supervision. As a working mom, I need to be able to balance the needs of the families I work with, with the needs of my own family.” Hence, clinicians who did report regular use of reflective supervision as a self-care practice also cited broader organizational factors that they considered to be essential to not only their management of work-related stress, but also their capacity to continue working in the IMH field.

**Identified organizational supports.** Almost all respondents in the sample identified organizational factors other than reflective supervision that they considered integral to managing work-related stress. Flexible work weeks, the option to work part-time, peer support, mindfulness practices embedded in organizational culture, and room for growth or versatility of
professional roles were all cited as important factors in sustaining professional longevity in the infant mental health field. One experienced clinical social worker affirms that reflective supervision is a valuable workplace resource, however she cited her organization’s culture of flexibility as being a primary factor that helps her cope with work-related. “Whether they recognize it as a resource or not, I’m allowed to work a four-day work week which is a resource for me. That gives me a better work-life balance. With only a two-day weekend, there wasn’t enough time to return to my life and my roots before I had to get back to work. So, the three-day weekend makes all the difference because I can remember who I am.”

Another clinical social worker described how having the option to work part-time allowed her to maintain a healthier life-work balance while managing the intensive needs of high acuity families on her caseload, “I have had the great fortune of only working part-time, and I think that especially with the level of – like of the difficulties of the families that we work with, that I have found that very, very helpful, especially because I'm also in the same of life where my children are still in elementary school, and they need me a lot, and they have a million activities, and I want to be able to support those things, to be able to feel like I'm really available to them, and to work.” A social worker who was experienced in the field but new to her current employing agency shared her surprise at the culture of self-care embedded in her organization which emphasized mindfulness and strong peer support networks. “I feel like I’ve learned some new self-care techniques from this job. Some of it is meditation and mindfulness. I’m one of five people who was sent to an intensive training in mindfulness. I have taken pieces of that that are helpful, and are now a part of my self-care. There’s also just a culture of safety here. We all realize how tough this work is and it’s definitely a safe, supportive network that we have. We have some really smart, educated people on the team that you can go to.”
With regards to role versatility and growth, several clinicians noted that having the room to grow and advance as professionals was important to them. For example, a senior early interventionist described how her role is shifting within her organization. “I’ve grown more autonomous in my role over the last few years and I’ve been afforded the opportunity to receive training as a reflective supervisor. That has been extremely rewarding.” In another interview, a nurse underscored the challenge of limited room for advancement in her organization. “For all of the education and training required to do this work, it can be frustrating when opportunities for promotion are limited. It makes you wonder if it’s worth it.”

These findings are aligned with literature on human service employee well-being that argues for organizations having a significant impact on employee physical and psychological well-being, job performance, and job satisfaction (Charlesworth, Baines, & Cunningham, 2015; Harrison & Westwood, 2009; Howard, 2015; Kilian, 2008; Lizano, 2013; Maltzman, 2011; Newell & MacNeil, 2010; Ray, Wong, White, & Heaslip, 2013).

**Barriers to self-care.** While all participants talked about self-care, many of them also discussed barriers to engaging in that care. The most commonly identified barrier to practicing self-care was lack of time and finances. Almost all participants cited the challenge of allocating time for performing self-care and 25% noted financial challenges as an additional barrier. For example, a seasoned social worker and mother of three said “If I had more resources, I’d be doing things like taking yoga classes and going to an acupuncturist regularly, but I work in the non-profit world so it’s hard.” Another clinician found it difficult to balance work, family, and her own needs. “I really need to work on the self-care piece, but with having so much to do and limited time, I easily forget myself.” An early interventionist and mother of twins, laments
“There’s just not enough hours in the day and as my kids get older, there are more expenses to consider.”

In this study sample, some clinicians lamented that for their years of advanced education and training, their compensation was barely enough to make household ends meet. A clinical social worker who was also trained as an infant mental health specialist discussed the realities of working for non-profit organizations. “Well both my husband and I work for non-profits, so it’s not like we really have resources for the extras like nice vacations or indulgences, we do ok, but it’s a struggle sometimes.” Another infant mental health specialist with a nursing background shared her worries about her financial future. “You know so much money gets invested in getting an advanced education. You’re balancing mortgage, student loans, etc. I don’t even want to think about retirement!” Therefore, common self-care practices like gym memberships, travel, personal grooming (i.e. massage, manicure, pedicure) were not perceived as economically viable self-care options amongst participants citing limited financial resources. One seasoned clinical social worker states, “I would love to have a regular manicure or use some vacation days to have a nice getaway. Frankly this job just doesn’t pay enough given I am a new mom with a growing family and I can’t afford to do the kind of self-care I’d like to do.” Another clinical social worker newer to the field and returning to work from maternity leave, discussed the economic challenges of performing specialized care work that requires high levels of education and training but does not compensate commensurately, saying, “As much as I love the work, the level of education, training, and emotional labor required simply do not fit the levels of compensation and this is a real barrier to having longevity in the field.”

Another barrier to engaging in self-care was the fact that the majority of clinicians in the sample were juggling multiple responsibilities in their personal lives as well as managing the
challenges inherent in intensive clinical IMH work. For example, an early interventionist raising twins with exceptional needs said: “It's hard. It's hard because I have twins, so my daughter is the typical twin, whatever typical means. And, um, two teenagers. Two teenagers. And it's just – with my son, the level of my son's needs and having to work and my husband's schedule and now my daughter goes to two high schools. This means I can’t be as flexible with families who miss and reschedule visits. It’s just really hard balancing it all.” Another clinician reflected on how having a child of her own has made her more sensitive to the distress of her client families. “It’s different now that I have my own baby. I’m so much more aware of safety and how so many parents struggle to keep their babies safe in a dangerous world. It makes me question my ability to keep my own child safe.” One social worker said, “I have to be clear about what’s going on (emotionally) inside of me so that I can be available to the people I am in relationship with at work and the people I have personal relationships with in my life outside of work.”

Because women dominate the IMH field, it is unsurprising that our respondents talked about additional caregiving duties, as we know care work is highly gendered (Bubeck, 1995; Duffy, 2007; Hochschild, 2003; Wharton, 2009). More specifically, all but four clinicians were mothers, and about one quarter were also managing the care needs of elderly parents or relatives. One nurse recalled how difficult work became when she was caring for her ailing mother. “When you are already emotionally raw and grieving, the intensity of working with vulnerable families becomes even more triggering.” Another nurse noted that her caregiving roles at work and at home were spilling over. “I’m the caregiver in my family as well which means I am taking the lead in managing my elderly father’s care. It gets to be quite a lot at times.” A social worker recalled her role as case manager both at work and in her family. “When my mother needed
hospice care, of course it was left to me to make the arrangements. It felt like I was doing social work all the time.”

Our sample reflects the larger reality that women bear the brunt of family caregiving duties, even as they have entered the workforce (Duffy, 2007; 2013; England 2005; Hochschild, 2010). They repeatedly cited balancing the demands of their work and personal lives as a source of work-related stress, especially because the emotionally labor-intensive nature of their work makes it more difficult to forget about work when the work day ends. One social worker who was new to the field shared that she struggled to enjoy pleasures as simple as an ice-cream cone due to the deprivation of the families she encountered in her work. “I start to feel guilty when I am enjoying an ice cream cone with my son because I find myself questioning, why do I deserve this indulgence when my families have so little?” A nurse shared her struggles with becoming a new mother while working with vulnerable new mothers. “Honestly, I have trouble sleeping because I have an infant at home, but I also sometimes dream about my families because I am so worried about them. The result is that I am exhausted.” Another social worker and mother of a three-month old describes her routine for transitioning from work to home. “I really try to spend a few minutes in the car in my driveway breathing deeply and getting centered before I go into the house so I can be fully available for my daughter. It’s hard though. I do end up mentally taking some of the families home with me.”

It is this struggle with balance that often interfered with clinicians’ ability to be more intentional about practicing self-care and seeking professional and personal supports when they needed it, a phenomenon that we began the findings section with. To illustrate the connection between additional caregiving duties and the performance of self-care, a social worker who is
also a mother of two young children describes how her regular mindfulness-inspired self-care practice has changed due to the demands of mothering an infant and a toddler:

“I used to have a visualization of it but I don't really need to anymore, is I used to kind of just picture hanging my work self up on a tree, like outside of my door, and going into my house. Now that I have two kids, I don't have time really. I hit the ground running when I get in the door.”

Another clinician said: “I was so consumed with taking care of the families, getting my kids to all of their activities, and trying to keep the house in order, that it took my co-worker to point out that maybe I needed to take some time off.” Yet another practitioner pointed out: “You know as women, we are often conditioned to believe that doing something for ourselves is selfish, when in fact, taking care of ourselves should be a necessity not a luxury. It’s like that cliché about the plane crashing and putting on your own oxygen mask first.”

**Discussion**

In the findings above, we demonstrated the following four key themes we found in the data: 1) participants valued self-care practices, but were not always intentional about engaging in a variety of forms of self-care. 2) participants identified reflective supervision as part of their self-care practice regimen, but not enough on its own. 3) participants identified organizational supports that facilitated their performance of self-care, and 4) participants identified barriers to performing self-care practices, such as competing family responsibilities and financial constraints. Using a critical lens available from care theory, we can see how indeed primarily women are affected by the strains of IMH work, that their work is devalued in terms of pay, and there is an agreement that more care, albeit turned inwards towards themselves which includes
participating in reflective supervision, has been the predominant ask to cope with the fall-out from all the care they do in the work force.

Although every participant valued self-care and recognized the importance of its role in managing work-related stress, significant barriers concerning time, money, and multiple caregiving demands impeded performance of self-care. Indeed, clinical infant mental health practitioners in this study repeatedly reported barriers to their performance of self-care that were connected not only to their wage earnings, but also to limited time due to overwhelming public and private care responsibilities. Participants overwhelmingly relied on their own individual coping skills and performance of self-care outside and away from work more so than any organizational support mechanisms. The most highly valued self-care practice was social connection in and outside of work (i.e. colleagues, peers, supervisors, friends and family). This finding is consistent with the empirical literature on mental health employee well-being that have found significant, positive associations between staff cohesion and high levels of social connections with greater resiliency in employees indicated by lower levels of burnout and higher levels of compassion satisfaction at work (Craig & Sprang, 2007; Killian, 2008; Lizano, 2013, Ludick & Figley, 2016; Maltzman, 2011; & Pearlman, 1995).

Regarding barriers to performance of self-care, clinical infant mental health professionals cited lack of time, finances, and guilt as barriers to their practice of self-care. Infant mental health workers must bear witness to the joys and tragedies vulnerable young children and families face and there are often occasions where there is no specific tool, treatment modality, or strategy that will solve the client family’s problems (Osofsky, 2009). Often, the most effective method of intervention the infant mental health worker can implement is showing up for families consistently and investing themselves wholly in the relationship (Weatherston, 2009). This deep
level of interpersonal involvement can blur work and personal boundaries creating even greater strain for women who are already overextended both at work and at home. This is particularly true for women who are helping professionals and tend to internalize cultural norms and beliefs that assume women are natural caregivers and therefore gain intrinsic, not compensatory fulfillment from performing care work (Duffy, 2007; England, 2005; Graham, 1983; Noddings, 1984, 2004;).

Gendered cultural assumptions that women choose helping professions for their love of the work rather than due to inherent opportunity inequalities in material, production-driven sectors that may prohibit the recruitment and advancement of women (Charlesworth, et, al., 2015; Dill, Price-Glynn, & Rakovski, 2016; Duffy, 2007; England, 2005), may also contribute to the perception that to care for the self is being selfish. This perception may be attributable to the guilt expressed by some study participants about allocating time for self-care when they were already stretched thin due to private caregiving obligations, and keenly aware of their client families having so little in the way of material comforts.

The impact of financial limitations on self-care performance begs the question of why such highly educated and trained professionals struggle to find resources to engage in relatively simple pleasures as part of a self-care plan. According to a 2018 U.S. News and World Report, the average cost of a master’s degree in social work from an accredited institution ranges from about $20,000-$60,000 for a full-time two-year program. Unlike many doctoral programs in the U.S., most professional graduate programs do not have assistantships to fund graduate student tuition. Consequently, a new MSW may have paid over $50,000 for her degree only to land a job with an average starting annual salary of $48,000, especially if she is working with children and families. Starting salaries for male-dominated, blue collar jobs that require significantly
less education and training like electricians for instance, are about the same or even higher than the average starting salary for entry-level master’s prepared positions in mental health (https://www.npr.org/2015/02/02/383335110/economists-say-millennials-should-consider-careers-in-trades). For those specializing in early childhood and home visiting work, the salaries can be even lower. In fact, social work and child psychology were amongst the 10 lowest paying college majors in 2018 (https://www.usnews.com/education/best-colleges/slideshows/10-college-majors-with-the-lowest-starting-salaries?slide=11). These salary trends in the child and family-oriented human services sector raises the question of whether or not the infant mental health field is valued as a profession in U.S. society.

The value of reflective supervision and its role as an organizational mechanism driving IMH workforce development and support is solidly situated in the IMH field. However, participants in this study who expressed dissatisfaction with their reflective supervisory relationships cited: lack of trust, absence of emotional safety, and a directive, rather than reflective stance held by the supervisor. Although the number of participants in the sample who reported dissatisfaction with their supervision was relatively small at about 10%, they identified qualities in their supervisory relationship that are antithetical to the essential elements of reflective supervision which include, trust, emotional safety, and a reflective, collaborative, not directive relationship (Tomlin, et, al., 2014). Yet these participants were receiving reflective supervision provided by their organization that should in theory embody the aforementioned qualities. This poses a challenge for effectively integrating reflective supervision into IMH practice and programming and suggests that the role of reflective supervision as a workforce development and support mechanism warrants a more nuanced examination. For example, questions about how to address barriers to the performance of self-care and its integration into
IMH practice, and how to tailor reflective supervision to address the unique life course and work experiences of practitioners deserve deeper, more systematic investigation.

The complaints clinicians expressed regarding the delivery of reflective supervision, the stance of the supervisor, and questions of how reflective supervision is distinct from administrative and clinical supervision are in line with critiques and debates about what reflective supervision actually is in the IMH field (Eggber, Shamon-Shanook, & Clark, 2010; Shea, Goldberg, & Weatherston, 2016; Tomlin et al., 2014; Watson et al., 2014). In response to this debate, for at least the last decade, efforts have been underway to operationalize reflective supervision in terms of the process, its measurement, and the skills needed to deliver reflective supervision effectively (Goldberg & Paradis, 2016; Shea, Goldberg, & Weatherston, 2016; Watson, Harrison, Hennes, & Harris, 2016). Defining reflective supervision in measurable and observable terms, and setting clear guidelines about the training, knowledge base, and skill set a reflective supervisor must have will likely reduce some of the confusion and disappointment reported by supervisees when their expectations of the reflective supervisory relationship go unmet.

Policy implications.

This study is the first that uses qualitative methods to capture what’s happening on the frontline in the day-to-day experience of clinical infant mental health practice. The themes that emerged in the practitioner narratives warrant our attention. The findings yielded in this study may be iterative to the formulation of research questions designed to investigate the experience and perspectives of the broader IMH workforce regarding workplace supports that facilitate work-related stress management and enhance professional quality of life (Stamm, 2005; 2010).
The results of this study indicate that a framework for understanding the relationship between self-care practices and management of work-related stress amongst infant mental health practitioners must consider the following: 1) burnout and secondary traumatic stress are realities intrinsic to performing human service-oriented care work, especially with traumatized populations, 2) interventions designed to prevent burnout and build worker resilience at both the individual and organizational level are essential to employee well-being and organizational performance.

In considering the role of the organization in promoting and facilitating self-care, organizational support was a central theme derived from the interview responses. According to Maltzman (2011), the structure of an organization determines its culture. For example, organizations that allow for regular staff interaction and communication are more likely to cultivate an organizational culture of staff cohesion and supportive practices. Several study participants cited their collegial support networks as being integral to their practice of self-care and that they in fact learned about the value of self-care from their supervisors and peers. Maltzman’s (2011) assertion that a healthy human service organizational culture consists of supportive, trusting supervisory and collegial relationships, a sense of empowerment (i.e. control or autonomy) in the employee, and a culture that acknowledges the value of self-care and promotes its practice from the top-down, is well supported in the empirical literature (Harrison & Westwood, 2009; Ludick & Figley, 2016; Maltzman, 2011; Osofsky, 2009; Osofsky, et al., 2008; Pearlman, 1995).

Clinicians in this sample repeatedly cited multiple structural and cultural aspects of their respective organizations (i.e. scheduling flexibility, staff cohesion, availability of paid time off, promotion of self-care practice in the culture, and room for professional growth and career
advancement) that facilitated their performance of self-care practices. The findings presented in this study offer a deeper understanding of findings from previous studies supporting the notion that both the individual and the organization must share responsibility for employee well-being and one of the essential elements of employee well-being is the practice of self-care (Howard, 2010; Lizano, 2013; Leichert & Maslach, 2001; Maltzman, 2011; Pearlman, 1995; & Ray et, al., 2013).

In a capitalist society that emphasizes material production (Bubeck, 1995), the human services industry is at a disadvantage by the very nature of the work its employees must perform. The notion of productivity where the goal is to service as many customers as possible is counter-intuitive to the type of relational interventions that are the foundation of human services in general, and elemental to competent infant mental health practice in particular. A paradigm shift in systems is necessary where the performance and promotion of self-care is weaved into the organizational structure of programs serving vulnerable populations and the definition of productivity is re-examined and redefined. Finally, taking some of the responsibility for negotiating private and public care demands solely off of the individual worker via organizational policy changes that consider: re-structuring of work weeks and hours, caseloads, professional autonomy (setting schedules and working remotely with the use of technology), and increasing the availability of part-time positions may have a significant impact on the overall well-being, job satisfaction, and job performance of the infant mental health worker (Simpson, et, al., 2018).
Study 2

Workplace Supports in the Infant Mental Health Field: A Quantitative Exploration

Abstract

This investigation examines associations between organizational supports and work-related stress and satisfaction in a specialized human services workforce population using a social ecological framework (Brofenbrenner, 1979) that considers the interdependent relationship between micro and macro level factors in promoting employee care and well-being within organizations (Lizano, 2013; Maltzman, 2011). A cross-sectional online survey was distributed to a national sample of 280 infant-family frontline practitioners and program supervisors across various child and family service sectors (i.e., early care and education, child welfare, healthcare, home visiting, and mental health). The survey consisted of the Professional Quality of Life Scales (Stamm, 2005; 2010), and a Workplace Supports Survey (Simpson & Robinson, 2018) created for this study. The survey probed participants about levels of personal work-related stress (i.e., burnout, secondary traumatic stress, and compassion satisfaction), and availability of seven types of workplace supports that may assist employee management of work-related stress: tools, organizational policies, information and education, supervisory support, peer support, professional development, and self-care practices.

Correlational analyses revealed significant, small to moderate associations between work-related stress and satisfaction and tools provided in the workplace for job performance, supervisory support, and the availability of information and education about types of work-
related stress (i.e., burnout and vicarious trauma). Cluster analyses yielded findings suggesting that secondary traumatic stress, a particular feature of work-related stress, varied significantly by groupings based on job role. Implications and recommendations for further investigation of the interdependent relationship between organizational and individual mechanisms of managing work-related stress and promoting employee well-being are discussed.

**Introduction**

This investigation is a study that surveys the infant mental health workforce about their identification of workplace supports and individual self-care practices that may facilitate the management of work-related stress. The human services workforce is generally at increased risk for high levels of burnout, secondary traumatic stress, and compromised employee well-being (i.e., psychological, physical, emotional, and mental) (Lizano, 2013). The direct contact, relational nature of human service work requires the on-going performance of emotional labor (Hochschild, 1983; 2001) in which the worker may experience dissonance between the emotions they are experiencing internally and the affect they must express in the interest of customer or client service. These qualities are integral to care work which is often inherent in human service work and contributes to the phenomenon of care work being performed often at the emotional and psychological expense of the carer (Hochschild, 2001; Duffy, 2007; England, 2005; & Wharton, 2009).

Traditional efforts to address the stress management needs of human service workers have largely ignored the interdependent nature of the relationship between the individual and the environment. Hence, the phenomena of work-related burnout and secondary traumatic stress were initially studied at an individual level taking into account personal characteristics of individuals like trauma history and coping mechanisms (Bloomquist et al., 2015; Killian, 2008;
Social ecology, due to its focus on both the individual and the environment, provides a useful framework for this study in considering the shared responsibility of the individual and the organization for promoting employee care and well-being (Ettner & Grzywacz, 2001; Harrison & Westwood, 2009; Howard, 2015; Lizano, 2013; Maltzman, 2011; Ray et al., 2013) (for conceptual model see Appendix A, Figure 3). A hierarchy of organizational factors focused on structures (i.e., tools, policies, information and education, and professional development) and relational features (i.e. supervisory support and peer support) will be examined in this study as elements of the workplace environment. Individual-level performance of self-care practices will be explored in relation to the organizational environment and in association with work related stress and satisfaction.

The design of this survey study was informed by the findings of a qualitative exploration of self-care practices reported by infant mental health clinicians who are practitioners specializing in child-family focused frontline human service work (Simpson, Mauldin, Megan, & Robinson, 2019). Clinicians reported that multiple organizational factors in their workplace influenced their performance of self-care which impacted their ability to manage work-related stress suggesting a relationship between the individual and the environment. The sample being exclusively identified as female raised questions about the consideration of the needs of female care workers who are often disproportionately burdened with managing care needs in both the public and private realms of society (Charlesworth et al., 2013; Duffy, 2007; Duffy et al., 2013; England, 2005; & Hochschild, 2001). Critical analysis from feminist theoretical perspectives about the particular care needs of the human service workforce, and the contextual factors
driving disparities in wage earnings, job visibility, and devaluation of job roles warrants deeper investigation (Charlesworth et al., 2013; Duffy, 2007; Duffy et al., 2013; England, 2005; Tronto, 2010).

**Empirical findings and gaps in the literature**

Efforts to design workplace supports to address and prevent work-related stress (i.e., burnout and secondary traumatic stress), particularly in mental health and child welfare systems have gained increasing attention with interventions ranging from micro-level and interpersonal (self-care and supervision models) to macro-level attempts to influence shifts in structure and culture that promote organizational self-care and well-being (Harrison & Westwood, 2009; Howard, 2015, Maltzman, 2011). Self-care as the principle solution for work-related stress management and compromised employee well-being places the responsibility for managing work-related stress largely on the individual employee (Blomquist, Wood, Trainor, & Kim, 2015; Maltzman, 2011; Pearlman, 1995; Sansbury, Graves, & Scott, 2015). However, there is a growing body of empirical evidence suggesting that both individual and organizational efforts are essential to burnout prevention and employee management of work-related stress (Harrison & Westwood, 2009; Killian, 2008; Maltzman, 2011; Salloum, Kondrat, Johnco, & Olson, 2015).

Results of Killian’s 2008 study of the predictive relationship between self-care practices of mental health professionals and levels of burnout and compassion satisfaction suggests that specific self-care and coping strategies in individual professionals were not good predictors of burnout, compassion fatigue, or compassion satisfaction. In fact, stronger predictive links between levels of burnout, compassion fatigue, and compassion satisfaction were established with work drain, long hours, an inability to separate from work off-hours, and the therapist’s sense of powerlessness within the workplace. These findings suggest that burnout and
compassion fatigue prevention ought to be a joint individual and organizational responsibility in which program and agency systems implement mechanisms for staff to be informed about burnout and compassion fatigue and have access to a full-range of professional and personal self-care resources (Charlesworth, Baines, & Cunningham, 2015; Harrison & Westwood, 2009; Maltzman, 2011; Maslach, Schaufeli, & Leiter, 2001; Newell & MacNeil, 2010).

Furthermore, although there is empirical consensus that individual differences do influence the experience of work-related stress in human service workers, there is also agreement in the literature that burnout and work-related stress is not simply a function of the individual’s lack of ability to manage work-related stress (Craig & Sprang, 2010; Killian, 2008; Maslach et al., 2001; Pearlman, 1995). Ludick & Figley’s 2016 model for building resilience in human service workers at risk for vicarious traumatization, asserts that protective practices like training, supervision, building collegial and social support networks, and self-care are essential to professional longevity. However, workplace conditions, specifically organizational structure and culture, also have a role in the prevalence of burnout, compassion fatigue, and vicarious traumatization amongst front-line human services workers that needs further exploration. (Acker, 2011; Boyas & Wind, 2014; Branch & Klikenberg, 2015; Charlesworth et al., 2015; Kim & Stoner, 2008; Lee et al., 2013; Maltzman, 2011; O’Rourke, 2011; Osofsky, 2009).

Organizational culture is defined as the modeled and observed organizational norms, beliefs, and expectations that are cultivated in staff (Hemmelgarn, Glisson, & James 2006). A human services sector organizational culture that is micromanaging, distrustful of its employees, and dismissive of the challenges employees face in their work is more likely to produce employees who perceive a negative work climate. (Schneider, Erhart, & Macey, 2013). Negative employee perceptions of work climate have been linked to negative relationships with human
service clientele that mirror the distrust and dismissiveness of the organizational culture (Glisson & Hemmelgarn, 1998). Conversely, an organizational culture that values supervisory and collegial support, acknowledges that secondary traumatic stress and burnout are integral to frontline human services work, promotes self-care, and fosters a cohesive organizational climate are essential to building resilience in human service employees (Boyas & Wind, 2014; Branch & Kilkenberg, 2015; Howard, 2015; Killian, 2008; Lee et al., 2013; Ludick & Figley, 2016; Maltzman, 2011). However, what remains less clear in the literature is whether human services organizations are making paradigm shifts in structure and culture to build employee resilience, and if so, how. In the current study, the relational and policy aspects of organizational climate are investigated in relation to professional satisfaction and felt stress. Climate is an inferred construct that is more directly measured by features of the work environment (i.e., staff cohesion, staff perceptions of work environment) (Glisson & Hemmelgarn, 1998; Glisson & James, 2002).

Existing research tools measuring work-related stress and its impact on employees largely examine individual-level items probing for respondents’ thoughts, feelings, and perceptions about performing their work. The ProQol-(Professional Quality of Life Scales) (Stamm, 2005) and the MBI (Maslach Burnout Inventory) (Maslach, 1981), are the most widely used measures of work-related stress in the empirical literature investigating human services professionals. The ProQol was especially designed to measure compassion satisfaction, or the pleasure one derives from helping others; compassion fatigue, known as secondary traumatic stress resulting from helping others who are suffering; and burnout, a chronic state of stress resulting in emotional exhaustion, depersonalization, and a lack of a sense of accomplishment in professionals helping those who are suffering or who have been traumatized (Craig & Sprang, 2010; Maslach, 1981; Stamm, 2005). However, the ProQol and MBI tools attend very little, if at
all, to employee perspectives about workplace conditions that may either alleviate or exacerbate burnout and secondary traumatic stress.

**Infant mental health: A specialized human services workforce**

Practitioners charged with providing parenting education, relationship assessment, intervention, and advocacy for infants, toddlers, and their families perform some of the most intensive emotional labor in the human services sector. Yet little is known about how infant mental health (IMH) practitioners may be affected by burnout and secondary traumatic stress. Osofsky (2009) suggests that strong emotional reactions and processing emotionally triggering content makes secondary traumatic stress and burnout integral to infant mental health work. The central solution put forth to address this problem has been advocacy within the field to integrate reflective supervision into all systems serving young children and families (O’Rourke, 2011; Shea, 2018).

Reflective supervision is adopted from psychodynamic-oriented clinical supervision in which the supervisor and supervisee enter into a relationship for learning based on trust and emotional safety (Shanook, 1995). At the core of this supervisory relationship is the intention to explore the emotional and relational content of infant mental health work in a regular, reflective, collaborative process (Parlakian, 2000). The essential components of reflective supervision, and its position as a best practice benchmark in infant mental health practice have been empirically established and believed to be essential to workforce development, support, and retention (O’Rourke, 2011; Osofsky, 2009; Tomlin, Weatherston & Pakov, 2014).

Receiving reflective supervision is a cornerstone of the infant mental health endorsement process. Promotion of endorsement in the Infant Mental Health Competencies (i.e., theoretical
foundations, law, regulation, and agency policy; systems expertise; direct service skills, working with others, communicating, thinking; and reflecting) is grounded in core beliefs that a well-trained, competent workforce receiving regular professional development and support, including reflective supervision/consultation, promotes increased staff retention, reduced turnover, and overall better service delivery (Tomlin, Hines, & Sturm, 2016; Watson, Bailey, & Storm 2016; Weatherston et al., 2009). All applicants pursuing infant mental health endorsement at every level (i.e., infant-family associate, infant-family specialist, infant mental health specialist, and infant mental health mentor) must have a set minimum of hours of received reflective supervision or consultation depending on the level at which they are seeking endorsement (www.mi-aimh.org). However, what is less known is the infant mental health practitioner’s perspectives about endorsement and reflective supervision and their role in burnout prevention and secondary traumatic stress management.

Results of an exploratory qualitative investigation of IMH practitioner perceptions (N=21) about reflective supervision suggest that qualities like: trust, emotional safety, confidentiality, and availability are key elements of a “reflective-like” supervisory relationship (Simpson, Mauldin, Megan, & Robinson 2019). These identified key elements are consistent with Tomlin et al.’s (2014) critical components of reflective supervision and the qualities inherent in a reflective supervisor. Findings from Simpson et al., (2019) also indicate that although infant mental health practitioners typically identified reflective supervision as part of their self-care practice to manage work-related stress, they also identified organizational features of their workplace that they considered critical to their performance of self-care and work-related stress management.
The aforementioned qualitative investigation was iterative to the design of this quantitative investigation. This study explores the perspective of the broader IMH workforce (i.e., teachers, healthcare practitioners, child welfare workers, program managers and supervisors, home visitors, parent educators, early childhood consultants, and mental health clinicians) about organizational supports including structural and relational features as well as individual performance of self-care practices that may facilitate work-related stress management and promote employee care and well-being (Bloomquist et al., 2015; Harrison & Westwood, 2009; Howard, 2015; Lizano, 2013; Ludick & Figley, 2016; Maltzman, 2011; Pearlman, 1995; Sansbury et al.; 2015).

This study addresses gaps in the literature about work-related stress management in a specialized human services workforce serving infants, toddlers, and their families, and the link between organizational and individual mechanisms identified by this particular workforce as supportive or protective. This investigation answers the following research questions: 1) What specific organizational structures are associated with lower levels of burnout and secondary traumatic stress, and higher levels of compassion satisfaction? 2) What relationship features of organizations (including reflective supervision) are associated with professional quality of life? 3) Is participation in the endorsement process associated with levels of burnout, secondary traumatic stress, and compassion satisfaction? 4) What is the strength of correlation, if any, between the level of endorsement and levels of burnout, secondary traumatic stress, and compassion satisfaction? 5) What is the strength of association, if any, between the number of self-care practices performed and professional quality of life (i.e., levels of burnout, secondary traumatic stress, and compassion satisfaction)? 6) Are there patterns of burnout, secondary traumatic stress, and compassion satisfaction associated with job role?
Research Methods

Participants

In the initial launch of the survey, questions about age and racial identity were unintentionally dropped from the Qualtrics system. IRB approval for a second survey was obtained to re-survey the first 85 participants who completed the survey with missing data about racial identity and age range. Of the 85 survey respondents, 59 completed the second anonymous survey probing for racial identity and age. The sample comprised 280 infant-family practitioners (85 clinical home visitors, 77 supervisors or program managers parent education home visitors, 43 parent education home visitors, 35 outpatient mental health, 18 healthcare providers, 13 child welfare workers, and 7 early care and education providers, 2 did not specify role (missing)). The sample was predominantly female with (268 females, 7 males, one identified as transgender, and 3 identified as non-binary, one did not specify gender (missing)). The participants were from various agencies, community-based programs, and healthcare settings (public and private) across the United States. Participants were mostly from the northeast region of the country (e.g. Connecticut, Massachusetts, and Rhode Island) and the mid-west (e.g., Indiana, Kentucky, Illinois, and Michigan). The remainder of participants were from Florida, Tennessee, Texas, and Washington state. Of the participants who reported their race or ethnicity (n=148; 52.9% of the total sample), the majority identified as White (85%), with Hispanic/Latina being the next largest ethnic/racial group in the sample at 8%. African or Caribbean-American and bi or multi-racial comprised the smallest ethnic/racial populations in the sample at 6% and .9% respectively. The majority of research participants ranged in age from 20-45(60%) with 40% ranging from ages 46-55 and over. The re-survey of participants initially missing demographic information (i.e., racial identity and age range, n=59) indicated similar proportions in terms of racial composition and age.
Regarding education levels, almost 60% of the sample reported a master’s degree as their highest level of education achieved, 30% reported holding a bachelor’s degree, 5% held either an associate’s degree, a high school diploma, or other training, and finally about 5% held a doctoral degree. Regarding infant mental health endorsement, 30% of the sample reported being endorsed with 9% as infant-family associates 41% as infant-family specialists, 33% endorsed as infant mental health specialists and 16% reporting endorsement as infant mental health mentors. An additional 10% of participants reported that they were currently seeking endorsement. The average reported number of years working in the field was 10 or fewer years. However, the largest proportion of the sample reported working in the field for 15 or more years at 37%.

**Measures.**

The online survey was administered via Qualtrics framed by an introduction informing participants that their responses to survey items would be collected as part of an IRB-approved research study investigating the relationship between workplace supports and levels of burnout, secondary traumatic stress, and compassion satisfaction in the IMH workforce (see Appendix B for the complete survey).

*The Professional Quality of Life Scale.*

The Professional Quality of Life Scale (ProQol) is the most widely used measure of the positive and negative effects of working in the helping professions (Stamm, 2005; 2010). According to Stamm (2010), professional quality of life is the quality of life the helper perceives in relation to their work. The ProQol has three subscales: compassion satisfaction (positive aspects of helping others), burnout (feelings of hopelessness about work), and secondary traumatic stress (distress associated with secondary exposure to people who have experienced trauma) (Stamm, 2010). Compassion satisfaction is defined as the positive aspects of helping
others. Burnout refers to feelings of hopelessness and difficulties with effective job performance. Burnout may be associated with a high workload and/or a non-supportive work environment. Secondary traumatic stress is about work-related secondary exposure to people who have experienced extremely stressful or traumatic events (Stamm, 2010). Secondary traumatic stress is closely related to vicarious trauma with similar characteristics including fear, sleep difficulties, and avoidance of reminders of the person’s traumatic experiences (Stamm, 2010).

The range of scores for each 10-item subscale is 10-50 (with never=1 and very often =5). A sum is created for the items of each subscale and then converted to a t-score with a raw score mean of 50 and a raw score standard deviation of 10 (Stamm, 2010). Internal consistency reliabilities for the subscales are reported to be: .87 for compassion satisfaction, .72 for burnout, and .80 for secondary traumatic stress with well-established construct validity (Stamm, 2005; 2010). In this sample (N=280), alpha reliabilities were: .90, .81, and .82 for the compassion satisfaction, burnout, and secondary traumatic stress, subscales respectively. The Professional Quality of Life Scale items can be viewed in Appendix B, page 4.

*Workplace Supports Survey.*

The Workplace Supports Survey was developed to probe the infant mental health workforce about the supports they perceive to be available at their agency/organization that might help them manage the logistical and work-related stress demands of their jobs, and the self-care practices they use as individuals to manage work-related stress. Items were clustered conceptually to reflect seven aspects or domains of workplace supports: the consistency of supervisory support available in the workplace (8 items), the availability of information and education about burnout and vicarious trauma as an occupational hazard in the helping professions (7 items), the amount
of workplace policies facilitating workplace flexibility and job performance (8 items), the availability of professional development support, in terms of promotion, funding, and release time (8 items), the consistency of available peer support in the workplace (7 items), the amount of tools available in the workplace to address the logistical challenges of job performance (8 items), and the amount of self-care practices reported to manage work-related stress (8 items). Definitions of each domain and sample items follow. The Workplace Supports Survey items can be viewed in Appendix B, page 11.

**Tools/logistics.** Tools and logistics encompass the concrete materials and resources survey respondents reported that their organization provides to facilitate job performance. Responses to items are scored as yes/no (where no=0, and yes=1) and items were added to create a total sum that was then averaged. The range of scores was 0-1 and reported as percentages. A total of 8 possible tools were featured in a drop-down list to an item that read: What does your organization provide so that you can manage the unique challenges of your work? (check all that apply):

1. Laptops
2. IPad
3. Company cell phone
4. Company car
5. Mileage reimbursement
6. Reimbursement for other expenses (i.e. personal cell phone use, small client expenses)
7. My agency addresses travel challenges that are a part of my work
8. My agency provides resources to manage travel challenges that are a part of my work

A high percent of yes responses to items indicated a high percentage of possible concrete tools and resources being provided by the organization to facilitate employee management of the logistical aspects of job performance.

**Organizational policies.** Policies encompass mechanisms and resources that are built into the infrastructure of the organization to promote flexibility, employee wellness, job satisfaction,
and facilitate job performance. The workplace policies domain measured the degree to which policies were available within their organization to promote flexibility, employee wellness, job satisfaction, and facilitate job performance. Eight items comprised this domain (with no=0, yes=1, and don’t know=.5). Items were averaged to create a total score with scores ranging from 0-1.0. A sample item was: “My organization offers flexibility in scheduling the work week.” A high score in the workplace policies domain indicated a high number of organizational policies that promote flexibility, employee wellness, and job satisfaction/performance.

**Information and education.** Information and education is defined as in-services, workshops, or other resources the organization offers to staff around managing work-related stress. The goal of information and education is to normalize the realities of burnout and secondary traumatic stress as occupational hazards integral to the helping professions (Maltzman, 2011). The information and education domain measured the extent to which the organization provides tools and resources to employees with the intent of optimal work-related stress management. There were a total number of 7 items in this domain (with no=0, yes=1, and don’t know=.5). Items were averaged to create a total score for the domain with scores ranging from 0-1.0. A sample item was: “My organization provides information about the symptoms of burnout.” A high score in the information and education domain indicated high availability of in-services, trainings, workshops, tools, and resources embedded in the organization that promote staff awareness and management of work-related stress.

**Supervisory support.** Supervisory support refers to the regularity, accessibility, safety, collaboration, and reflection available in supervisory relationships existing in the workplace. The supervisory support subscale measured the extent to which survey participants reported receiving consistent, collaborative, reflective-like supervision and whether or not their
organization had a policy intended for providing reflective supervision to staff. There were a total number of 8 Likert-scale items in this domain. Items were averaged to create a total domain score (with 1=never and 5=always) with a range of scores between 1.0-5.0. A sample item was “My supervisor protects our supervision meeting time and doesn’t allow for distractions when we meet.” A high score in the supervisory support domain indicated that the quality of supervisory support was aligned with critical elements of supervision that is defined as reflective in nature (Tomlin et al., 2014).

**Peer support.** Peer support is defined as connection and consultation with professionals and co-workers performing similar work (Killian, 2008; Ludick & Figley, 2016; Pearlman, 1995). Peer support involves attending workshops and trainings with colleagues, discussing cases both formally and informally, and providing one another with encouragement and reality testing (Killian, 2008). The peer support domain measures how consistently co-workers who share an understanding of the work and caseload responsibilities, are available in the workplace, and the quality of the relationships between co-workers. Seven Likert-scale items comprised the peer support domain of the survey (where 1=never, 3=sometimes, and 5=always). Items were averaged to create a total score with scores ranging from 1.0-5.0. A sample item was “I like and trust my colleagues and my relationships with them makes my job easier.” A high score on the subscale indicated that participants reported consistent workplace availability of co-workers who share similar job duties and work experiences, and offer trusting and supportive relationships that help contain some of the difficult emotional content that accompanies the work.

**Professional Development.** Professional development is defined as training courses, conferences, meetings, or workshops employees participate in to deepen knowledge, acquire new skills, or to obtain endorsement or certification in a specialty area. The professional
development domain was comprised of possible ways an organization could support the professional development of its employees including funding and release time for employees to participate in professional development activities. A total of 8 items were in the professional development domain of the survey (with no=0, yes=1, and don’t know=.5). Items were averaged to create a total score and scores ranged from 0-1.0. A sample item was: “My organization provides financial support for the endorsement process.” A high score in the professional development domain indicated a high level of organizational support (i.e., promotion and advancement, finances, and time off) for employee professional development.

**Self-care.** Self-care practices are defined as anything individuals do intentionally to take care of their mental, physical, and emotional health (Pearlman, 1995). The self-care practices subdomain measured the amount of possible self-care practices survey respondents reported using to manage work-related stress. Self-care practices can be personal or professional in nature meaning individual employees may perform practices while away from work to manage work-related stress (e.g., exercise, meditation, spiritual, social support); or take advantage of resources available within the organization designed for self-care (e.g., in-services, reflective supervision, peer support). A total of 8 items comprised the self-care domain (no=0, yes=1). Items were added to create a total score that was then averaged; the range of scores was 0-1 and reported as percentages. The items read as follows:

“I engage in the following self-care practices to manage work-related stress:”

1. Exercise
2. Healthy eating habits
3. Sleep hygiene
4. Mindfulness practice
5. Reflective supervision
6. Individual or group therapy
7. Using paid time off
8. Social time (family, friends)
A high score on the self-care subscale indicated that participants reported engaging in a high percentage of self-care practices.

**Data Analysis**

Pearson correlational procedures were used to analyze the strength of associations between various structural and relational features of the organization and the prevalence of work-related stress and satisfaction (i.e., burnout, secondary traumatic stress, and compassion satisfaction). Pearson correlational procedures were also used to analyze the strength of associations between individual performance of self-care practices and work-related stress/satisfaction; and organizational supports and performance of self-care practices.

Clustering methods were employed to discover person-centered patterns in data that are not observable by visual inspection or according to a theoretical framework (Denham, Bassett, Mincic, Kalb, Way, Wyatt, & Segal, 2013). This multivariate technique is used for grouping individuals who exhibit similar profiles across a variety of measures or demographic characteristics. In this study, scoring profiles for the Professional Quality of Life Scale were grouped in clusters and cross-tabulated with job roles with the intent of focusing on patterns of compassion satisfaction and work-related stress that may vary within individuals performing certain types of work. The k-means clustering method was used to assign each study participant to a cluster closest to their ProQol score profile values. Follow up analyses examined cluster membership in relation to participant job role and in relation to workplace survey responses.

**RESULTS**

**Preliminary Results**

Survey respondents reported a wide range of organizational supports that were available in facilitating job performance and management of work-related stress. The preliminary results
presented below describe the levels of compassion satisfaction, burnout, and secondary traumatic stress and their interrelationship and similarly, the frequency of organizational supports and their interrelationship reported in the sample as a whole. This section ends with a presentation of the distribution of supports by worker role to highlight the similarities and differences across the several sectors of the workforce that are represented in this sample.

**Distribution of response to Professional Quality of Life (ProQol) scale.** On average, survey participants reported moderate to high levels of compassion satisfaction while also reporting moderate levels of burnout and high levels of secondary traumatic stress (see Table 1). The mean and modal t-scores of the ProQol indicate that this workforce sample was traumatized by their work, yet very dedicated. The mean scores for compassion satisfaction, burnout, and secondary traumatic stress were all 50 with cut-off scores of 44, 43, and 42 respectively. Modal scores indicate that survey participants most frequently reported levels of compassion satisfaction, burnout, and secondary traumatic stress above the cut-off. Although a score above the cut-off in the burnout and secondary traumatic stress subscales is not diagnostic of any psychological disorders related to work stress, a high score does indicate risk for potentially compromised employee well-being and should be addressed with appropriate supports and intervention (Stamm, 2010).

Table 1.

ProQol Scale Descriptive Statistics Based on T-Scores

<table>
<thead>
<tr>
<th>N=280</th>
<th>Comp Satisfaction</th>
<th>Burnout</th>
<th>Sec Traumatic Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>50.00</td>
<td>50.00</td>
<td>50.00</td>
</tr>
<tr>
<td>SD</td>
<td>10.00</td>
<td>10.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Median</td>
<td>51.09</td>
<td>49.45</td>
<td>48.37</td>
</tr>
<tr>
<td>Mode</td>
<td>58.09</td>
<td>47.62</td>
<td>48.37</td>
</tr>
<tr>
<td>Range</td>
<td>10.00-57.50</td>
<td>10.00-51.02</td>
<td>10.00-70.68</td>
</tr>
</tbody>
</table>
Table 2 displays the strength of associations between the subscales on the ProQol for this study sample. The strongest relationship was found to be between burnout and secondary traumatic stress with a strong positive, significant association suggesting that participants in the sample who reported high levels of secondary traumatic stress were also more likely to report high levels of burnout. Compassion satisfaction and burnout were found to have a strong, negative association indicating that survey participants reporting high levels of compassion satisfaction were more likely to report lower levels of burnout. Finally, a significant, moderate, negative correlation between secondary traumatic stress and compassion satisfaction was found indicating that reported higher levels of compassion satisfaction were related to reported lower levels of secondary traumatic stress.

Table 2.
Correlations between Subscales of the ProQol (N=280)

<table>
<thead>
<tr>
<th></th>
<th>Burnout</th>
<th>STS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Traumatic Stress</td>
<td>.691**</td>
<td></td>
</tr>
<tr>
<td>Compassion Satisfaction</td>
<td>-.604**</td>
<td>-.372**</td>
</tr>
</tbody>
</table>

*p < .05, ** p < .01

Distribution of participant response to Workplace Supports Survey. Table 3 displays measures of central tendency describing the domains of the workplace supports survey. Complete item level descriptive data is available in Appendix C; highlights are offered in text to emphasize meaning or salience.

Tools/logistics. Survey respondents reported a moderate amount of resources available in their organization to manage the logistics of job performance; the mean percentage of possible tools and logistics for this domain was 45% with a mode of 50%, indicating that respondents had
about half of possible tools available. The item participants most frequently reported “yes” was mileage reimbursement at 78%. The sample was evenly split on whether their workplace at least “sometimes” (scale point=0.50) provided resources to manage travel needs or not at all. Less than half of survey respondents answered “yes” to reimbursement for small out of pocket expenses related to client care (i.e. emergency food, clothing, or diapers) being available at their workplace. Useful machines/tools (i.e. laptop, Ipad, company phone or car) were the least frequently reported resources.

**Organizational policies.** Respondents reported that 82% of policies probed for on the survey were available to support their work with families. The mean score for the workplace policies domain was 0.82 and a mode of 1.00 or 100%. The item most frequently scored as “yes” (78%) was paid time off. More than half the sample answered “yes” to the following items: flexibility in scheduling the work week (i.e. evening hours, 4-day work weeks, flex-time), family medical leave, and use of sick time for mental health days. The high average frequency of “yes” responses indicates that most survey participants experience organizational policies that support flexibility with regards to scheduling and attending to personal and family health/mental health needs. Some policies were less frequently endorsed. Counseling through an employee assistance program in the workplace was available to only 30% of respondents and a very small percentage identified on-site child care as a workplace resource at 6%.

**Information and education.** The sample on average reported a low availability of information and education about vicarious trauma, burnout and the role of self-care in promoting employee well-being in their organization. The mean score for the information and education domain was 0.33 and the mode was 0. This indicates that most participants did not receive information or education about work-related stress (i.e. burnout and vicarious trauma) or work-
related stress management (self-care practices). The item most frequently scored as “yes” at 40% was: “My organization provides information about self-care practices.” However, only 27% of the sample reported that their workplace *promoted* self-care practices. Fewer than a third of survey participants reported receiving information and education about signs and symptoms of burnout or reported receiving any information about vicarious trauma from their organization.

**Supervisory support.** More than half of survey participants (about 54%) reported on average that they often or always (average 4.00 or 5.00) received consistent, supportive, *reflective-like* supervision in the workplace. The mean score was 4.13 and the mode was 5.00. About one-quarter reported sometimes receiving reflective qualities of supervision (average of 3.00), and another 21% reported rarely or never receiving reflective-like supervision (scale points 2.00 or 1.00 respectively). Considering item level responses, the supervisory support item most frequently reported as “always” (at 48%) was: “My supervisor keeps the content of our sessions confidential.” Other items most frequently answered “always” were: “I feel safe expressing confusion, frustration, and not knowing in supervision,” “My supervisor is available to me beyond regularly scheduled supervision meetings if I need support,” and “My supervisor protects our supervision meeting time and doesn’t allow for distractions when we meet” at 44%, 42%, and 39% respectively. With regards to whether or not organizations intentionally made reflective supervision available, two-thirds of survey respondents reported that their organization had a written policy for providing reflective supervision.

**Peer support.** On average, survey respondents reported that peer support was often available in their organization. The mean and modal score was 3.90. The item most frequently scored as “often” or “always” (scale points 4.00 or 5.00) was: “My colleagues understand the unique challenges I face in my work” (84%). The next two items most frequently reported as
“often” or “always” were: “I like and trust my colleagues and my relationships with them makes my job easier,” and “I feel safe sharing my feelings about the challenges and rewards of my work with my colleagues” at 80% and 79% respectively. Although 43% of survey respondents responded “always” to “My organization encourages front-line staff to seek peer support within the workplace,” about 80% of respondents replied “yes” or “sometimes” (scale points 1.00 and 0.50) to “I seek peer support outside of the workplace.” This raises questions about availability of peer support within the organization. The item most frequently reported as “never” (scale point 1.00) was: “I feel solely responsible for the fate of my clients” at 26%, indicating that a minority of this sample felt that they alone were holding responsibility for client outcomes.

*Professional development.* Survey respondents reported high availability of professional development opportunities within their organization with funding and release time for professional development being less available. The mean score for the professional development domain was 0.61; the mode was 1.00. The item most frequently scored as “yes” (70%) was: “My organization provides opportunities for professional growth.” Almost 70% of the sample also indicated that in-service trainings were available. Although more than half (54%) of survey respondents answered “yes” to “My organization provides funds for professional development,” a little less than half (48%) indicated that release time for professional development and training was available. However, only 25% of survey participants reported “yes” to: “There are opportunities for promotion and advancement in my workplace.”

Regarding the infant mental health endorsement process, although only 21% of participants reported receiving financial support to participate in the process from their workplace. One third of participants reported that their workplace provided training support including reflective supervision hours in preparation for the endorsement.
**Self-care.** Responses to items probing for performance of self-care indicated that on average, survey participants practiced many self-care practices. The mean score in the self-care domain was 71% of eight possible practices. Survey participants responded “yes” most frequently to practicing self-care by engaging in: social time (friends and family), sleep hygiene, and using paid time off at 98%, 87%, and 79% respectively. While two-thirds of the sample replied “yes” to participating in reflective supervision as a self-care practice, only 24% of the sample reported that they sought therapy as part of their self-care practice making this the least frequently reported self-care practice.

Table 3

Workplace Supports Survey Descriptive Statistics

<table>
<thead>
<tr>
<th>Domain</th>
<th>Tools/Logistics</th>
<th>Org. Pol</th>
<th>Info/Ed</th>
<th>Supv</th>
<th>Peer Sup</th>
<th>PD</th>
<th>Self-care</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=280</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>45%</td>
<td>0.82</td>
<td>0.33</td>
<td>4.13</td>
<td>3.90</td>
<td>0.61</td>
<td>71%</td>
</tr>
<tr>
<td>SD</td>
<td>.217</td>
<td>.321</td>
<td>.377</td>
<td>.934</td>
<td>.573</td>
<td>.323</td>
<td>.191</td>
</tr>
<tr>
<td>Median</td>
<td>50%</td>
<td>0.81</td>
<td>0.00</td>
<td>4.30</td>
<td>4.00</td>
<td>0.63</td>
<td>75%</td>
</tr>
<tr>
<td>Mode</td>
<td>50%</td>
<td>1.00</td>
<td>0.00</td>
<td>5.00</td>
<td>3.90</td>
<td>1.00</td>
<td>88%</td>
</tr>
<tr>
<td>Range</td>
<td>0-100%</td>
<td>0-1.00</td>
<td>0-1.00</td>
<td>0-5.00</td>
<td>0-5.00</td>
<td>0-1.00</td>
<td>0-100%</td>
</tr>
</tbody>
</table>

**Reliability and internal consistency within domain.** Several survey domains were evaluated for internal consistency except for tools and self-care because they were based on dichotomous (yes/no) items.

**Tools.** The total score for the concrete organizational resources in the tools/logistics domain of the Workplace Supports Survey was based on dichotomous items, therefore alpha reliability analyses were not performed. Items were developed based on empirical literature review and practice-based knowledge about what tools are essential to frontline infant mental health practice and service delivery.
**Organizational policies.** Items in the organizational policies domain of the Workplace Supports Survey did not show a strong interrelationship as expected, with an alpha of .63. This suggests that the items in this domain may not be fully capturing the underlying dimensions of organizational policy as a construct. The lower alpha can be interpreted as variability in the availability of organizational policies reported in the sample. Survey participants may report access to some but not all of the policies probed. The sample also varied across the types of available policies reported.

**Information and education.** Items in the information/education domain were strongly related with an alpha of .85 and seemed to capture the elements of information and education tailored to prepare human service workers for recognizing signs of burnout and vicarious trauma, and being informed about resources and self-care practices to manage these common features of work-related stress.

**Supervisory support.** Items in the supervisory support domain were highly interrelated with good internal consistency and an alpha of .90. This suggests that the items for this domain were strongly related to one another and probed for the underlying elements (i.e. trust, safety, consistency, and confidentiality) of a particular form of supervision which is reflective-like in content and quality.

**Peer support.** Items in the peer support domain showed acceptable internal consistency with an alpha of .73 suggesting that the items aligned well enough to measure and probe for aspects of collegial relationships that facilitate peer support in managing work demands. These items seem to adequately capture the dimensions of peer support as an organizationally-based source of social connection.
**Professional development.** Professional development items did not appear to fit as well together in measuring workplace conditions related to how professional growth and advancement might help or hinder work-related stress management and employee well-being at an alpha of .62. Items probing for provision of and support of professional development opportunities were grouped with items probing for types and content of professional development. This grouping may somehow conflate two different, but related constructs: support for professional development vs. types of professional development; and perhaps limit internal consistency.

**Self-care.** Given that items in the self-care domain were on a discrete yes/no scale, alpha reliability analyses were not performed. However, the items probing for self-care were formulated based on review of a broad body of empirical literature investigating the importance of self-care and the most highly practiced and recommended forms of self-care (i.e. sleep hygiene, social connection (both personal and professional), and supervisory support) (Harrison & Westood, 2009; Killian, 2008; Ludick & Figley, 2016; Maltzman, 2011; McCann & Pearlman, 1998; & Pearlman, 1995).

**Interrelationships of domains.** As can be seen in Table 4, the survey domains with the strongest associations were tools/logistics with organizational policies ($r=.453$), professional development ($r=.346$), information and education ($r=.301$); peer and supervisory support ($r=.311$); and information and education with organizational policies ($r=.306$). The associations between organizational policies with tools/logistics and information and education domains suggest that there is a significant, positive relationship between policies developed within organizations and whether or not those policies are inclusive of tools for logistical performance of work, and information/education for employees about very particular forms of work-related stress (i.e. burnout, secondary traumatic stress and vicarious traumatization). Organizational
policies were also weakly, but significantly associated with professional development and peer support ($r=.263$, $r=.212$) in a positive direction.

In addition to being moderately associated with organizational policies and tools, information and education held small but significant associations with professional development, self-care, and peer support ($r=.281$, $r=.254$, and $r=.202$ respectively) indicating that having access to information about work-related stress may be related to performance of self-care and relational features of the organization like collegial relationships inherent in peer support.

In addition to its moderate association with peer support, supervisory support was also associated with professional development ($r=.246$). These correlations suggest that supervisory support is related to collegiality and the extent to which peer support is promoted and/or available in an organization. With regards to professional development, the significant but small positive association with supervisory support suggests that there is a relationship between the quality of the supervisory relationship and the availability of professional development opportunities and resources within the organization. Surprisingly, supervisory support was found to have no association with self-care practices ($r=.074$) indicating that the quality of the supervisory relationship is not at all related to whether or not employees practice self-care.

Professional development was weakly associated with information and education ($r=.281$) as well as moderately associated with logistical tools for work performance. These associations suggest that professional development resources and opportunities may be more available in organizations that provide more logistical tools for work performance and offer information and education about work-related stress. Domains with small, but significant, positive associations with professional development included organizational policies and supervisory support ($r=.263$, $r=.246$) suggesting higher likelihood of availability of professional
development opportunities in organizations with a high level of supervisory supports and where there are more organizational policies promoting employee well-being.

Self-care was observed to be weakly associated with tools and information and education \((r=.266, r=.254)\). These relatively small, but significant, positive relationships suggest that employees who had more tools to meet the logistical demands of their work were also more likely to engage in self-care practices; and more likely to be informed and educated about work-related stress and mechanisms for its management.
Table 4

Correlations of Workplace Supports Survey Domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Tools</th>
<th>Org Policies</th>
<th>Info/Ed</th>
<th>Supv Support</th>
<th>Peer Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Policies</td>
<td>.453**</td>
<td>-----</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information/ Education</td>
<td>.301**</td>
<td>.306**</td>
<td>-----</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisory Support</td>
<td>.125*</td>
<td>.147*</td>
<td>.133*</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>Peer Support</td>
<td>.206**</td>
<td>.212**</td>
<td>.202**</td>
<td>.311**</td>
<td>-----</td>
</tr>
<tr>
<td>Professional Development</td>
<td>.346**</td>
<td>.263**</td>
<td>.281**</td>
<td>.246**</td>
<td>.138*</td>
</tr>
<tr>
<td>Self-care</td>
<td>.266**</td>
<td>.168*</td>
<td>.254**</td>
<td>.074</td>
<td>.183*</td>
</tr>
</tbody>
</table>

* p < .05, ** p < .01
**Distribution of reporting by job role in the sample.** Seven job roles were used to differentiate domain responses (see Table 5 for averages for domains by job role). Similarity of responses across roles was more common than was variation.

With regards to workplace tools/logistics, supervisors and program managers reported the highest percentage of resources being available in their organization with roughly half (mean = 49%) of possible resources available. Early care and education teachers reported the lowest percentage of tools and logistics to help them manage their jobs (mean=30%).

Parent education home visitors reported the fewest organizational policies (mean=0.73); all other job roles (i.e. clinical home visitors, child welfare workers, mental health practitioners, health providers, and program supervisors) reported relatively high numbers of organizational policies, with a mean of at least 0.81. Despite being the least resourced, nearly all early care and education teachers reported having all the organizational policies available to promote workplace flexibility (mean=0.95). This indicates that the sample overall reported a high number of organizational policies that promoted workplace flexibility and employee well-being.

Job role responses to the information and education domain were the most variable. Healthcare providers were the least informed about burnout, vicarious trauma and self-care practices (mean=0.28), and child welfare workers were the most informed (mean=0.54).

Survey participants across job roles reported receiving high levels of reflective-like supervisory support (means ranged from 3.90-4.70), most frequently reported by participants working as healthcare providers. Early care and education teachers and home visitors (both clinical and parent education) also reported high levels of supervisory support (mean=4.40 and 4.20 respectively), while high levels of supervisory support were least frequently reported by child welfare workers and mental health practitioners (mean=3.90 for both job roles).
High levels of peer support were also reported with moderate to high frequency (means ranged from 3.70-4.10 across job roles). Health providers, clinical home visitors and program supervisors reported the highest levels of peer support (mean=4.10 and 4.00, respectively). Child welfare workers least frequently reported high levels of peer support (mean=3.70).

Survey participants reported a moderate to high amount of professional development resources available in their organization across job roles (means ranged from 0.58-0.80). Program supervisors reported the highest amount of professional development resources in their organization (mean=0.80) and child welfare workers and health care providers reported the fewest professional development resources available in their organization (mean=0.58 and 0.61, respectively).

Finally, regarding the performance of self-care practices, participants across job roles reported a moderate amount of self-care practices (mean range=0.64-0.75) with the highest number reported by mental health providers (mean=0.75) and the lowest number reported by health care providers (mean=0.64).

Table 5

Comparison of Means by Job Role

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>EarlyCare/Educ</td>
<td>30%</td>
<td>0.95</td>
<td>0.41</td>
<td>4.40</td>
<td>3.90</td>
<td>0.73</td>
<td>70%</td>
</tr>
<tr>
<td>HV Parent Ed</td>
<td>47%</td>
<td>0.73</td>
<td>0.40</td>
<td>4.20</td>
<td>3.90</td>
<td>0.65</td>
<td>70%</td>
</tr>
<tr>
<td>HV Clinical</td>
<td>46%</td>
<td>0.81</td>
<td>0.35</td>
<td>4.20</td>
<td>4.00</td>
<td>0.70</td>
<td>71%</td>
</tr>
<tr>
<td>Child Welfare</td>
<td>43%</td>
<td>0.96</td>
<td>0.54</td>
<td>3.90</td>
<td>3.70</td>
<td>0.58</td>
<td>65%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>39%</td>
<td>0.81</td>
<td>0.44</td>
<td>3.90</td>
<td>3.80</td>
<td>0.67</td>
<td>75%</td>
</tr>
<tr>
<td>Health Pract.</td>
<td>32%</td>
<td>0.83</td>
<td>0.28</td>
<td>4.70</td>
<td>4.10</td>
<td>0.61</td>
<td>64%</td>
</tr>
<tr>
<td>Superv/Manager</td>
<td>49%</td>
<td>0.84</td>
<td>0.47</td>
<td>4.00</td>
<td>4.00</td>
<td>0.80</td>
<td>73%</td>
</tr>
</tbody>
</table>
Research questions.

This investigation sought to examine the strength of associations between organizational supports and work-related stress management via a descriptive analysis of the infant mental health workforce with emphasis on associations between professional quality of life and organizational structures, relationship features in the organization, and individual performance of self-care.

What specific organizational structures are associated with lower levels of burnout and secondary traumatic stress, and higher levels of compassion satisfaction?

Significant associations were found between all four organizational structure domains and the compassion satisfaction aspect of professional quality of life. Participants who reported more access to professional development supports and resources and receiving more information and education about burnout and vicarious trauma reported higher levels of compassion satisfaction. Organizational policies and tools were also weakly, but significantly associated with compassion satisfaction (see Table 6).

Small to moderate significant, negative associations were observed between organizational structure domains: information and education and professional development, and the burnout aspect of professional quality of life; indicating that participants who had access to information and education and professional development resources reported lower levels of burnout. Only the domain: information and education was found to be weakly, but significantly associated with secondary traumatic stress in the negative direction. However, tools and organizational policies were not associated with burnout or secondary traumatic stress. This suggests that survey participants who reported a larger number of organizational policies and workplace tools were
more likely to report higher levels of compassion satisfaction but were not necessarily more likely to report lower levels of burnout and secondary traumatic stress (see Table 6).

Information and education was the only domain that was associated with all three aspects of professional quality of life. Participants who reported receiving more information and education (about burnout, vicarious trauma, and self-care practices) were significantly more likely to report experiencing lower levels of burnout and secondary traumatic stress and higher levels of compassion satisfaction.

**What relationship features of organizations (including reflective supervision) are associated with professional quality of life?**

Survey participants who more frequently reported high levels of “reflective-like” qualities of supervision were less likely to report high levels of burnout and secondary traumatic stress, and more likely to report high levels of satisfaction with their work. (see Table 6 for correlations). With regards to peer support, higher levels of peer support were significantly, negatively associated with levels of burnout; and significantly, positively associated with levels of compassion satisfaction. In other words, participants who reported having high levels of peer support in their organization were less likely to report high levels of burnout and more likely to report high levels of compassion satisfaction. Levels of secondary traumatic stress were not significantly associated with peer support.

**Is participation in the endorsement process associated with levels of burnout, secondary traumatic stress, and compassion satisfaction?**

About 30% of survey respondents reported that they were endorsed and 10% reported that they were seeking endorsement. No significant associations between endorsement status
and professional quality of life (i.e. burnout, secondary traumatic stress, or compassion satisfaction) were observed.

**What is the strength of correlation, if any, between the level of endorsement and levels of burnout, secondary traumatic stress, and compassion satisfaction?**

Approximately 30% of survey respondents reported being endorsed. Of these, 9% were endorsed as infant-family associates, 41% as infant-family specialists, 33% as infant mental health specialists, and about 16% were endorsed as infant mental health mentors. Small, significant, negative associations between endorsement level and secondary traumatic stress were observed. That is, more professionally prepared participants who were endorsed at higher levels were more likely to report lower levels of secondary traumatic stress \((r = -.261, p < .000)\), compared to those endorsed at the paraprofessional levels. No associations between endorsement level and burnout or compassion satisfaction were observed.

**What is the strength of association, if any, between the number of self-care practices performed and professional quality of life (i.e. levels of burnout, secondary traumatic stress, and compassion satisfaction)?**

Survey respondents who reported participating in a high number of self-care practices were also more likely to report higher levels of compassion satisfaction; a small, but significant positive association was observed between performance of self-care practices and compassion satisfaction (see Table 6). A small correlation with burnout suggests that participants reporting more self-care practices were also more likely to report lower levels of burnout, however, they were not necessarily more likely to report lower levels of secondary traumatic stress.
Table 6
Strength of Associations Between Workplace Supports Survey and ProQol

<table>
<thead>
<tr>
<th></th>
<th>Compassion Satisfaction</th>
<th>Burnout</th>
<th>Secondary Traumatic Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tools</td>
<td>.120*</td>
<td>-.100</td>
<td>-.025</td>
</tr>
<tr>
<td>Organizational Policies</td>
<td>.142*</td>
<td>-.101</td>
<td>-.018</td>
</tr>
<tr>
<td>Information/Education</td>
<td>.230**</td>
<td>-.235**</td>
<td>-.128*</td>
</tr>
<tr>
<td>Professional Development</td>
<td>.266**</td>
<td>-.220**</td>
<td>-.104</td>
</tr>
<tr>
<td>Supervisory Support</td>
<td>.207**</td>
<td>-.303**</td>
<td>-.208**</td>
</tr>
<tr>
<td>Peer Support</td>
<td>.307**</td>
<td>-.265**</td>
<td>-.032</td>
</tr>
<tr>
<td>Self-Care</td>
<td>.227**</td>
<td>-.129*</td>
<td>.111</td>
</tr>
</tbody>
</table>

* p < .05, ** p < .01

Are there patterns of burnout, secondary traumatic stress, and compassion satisfaction associated with job role?

We initiated the cluster analysis specifying five groups but found no convergence. Follow-up analysis requesting four groups yielded four professional quality of life clusters that made sense conceptually: profile 1 “Satisfied, Unstressed (n=108); profile 2 “Unsatisfied, Stressed,” (n=49); profile 3 “Satisfied, Stressed,” (n=30); and profile 4 “Unsatisfied, Unstressed” (n=93) (see Table 7). Chi square analysis was used to determine if the two variables: ProQol cluster group membership and job role, were related or independent of one another. Results indicated that job role and ProQol cluster group membership are related (Pearson Chi Square=37.810, df =18, p<.005).

Table 7
## Midpoint Cluster Estimates for ProQol Profiles

<table>
<thead>
<tr>
<th></th>
<th>Profile 1 ‘Satisfied, Unstressed’</th>
<th>Profile 2 ‘Unsatisfied, Stressed’</th>
<th>Profile 3 ‘Satisfied, Stressed’</th>
<th>Profile 4 ‘Unsatisfied Unstressed’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion Satisfaction</td>
<td>49.00</td>
<td>18.00</td>
<td>50.00</td>
<td>17.00</td>
</tr>
<tr>
<td>Burnout</td>
<td>10.00</td>
<td>38.00</td>
<td>30.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Secondary Traumatic Stress</td>
<td>13.00</td>
<td>36.00</td>
<td>50.00</td>
<td>16.00</td>
</tr>
</tbody>
</table>

**Cluster profile job characteristics.** Figure 1 displays the composition of each profile by job classification. The largest group in the sample comprised Profile 1 “Satisfied, Unstressed.” Participants with ProQol scores reflecting the “Satisfied, Unstressed” profile (n=108 about 39% of the total sample) were more likely to be program directors or supervisors and clinical home visitors (65% of profile 1). Mental health (n=15) and health care (n=8) providers’ responses were also most often categorized in cluster 1 (43% of all mental health providers, 44% of all healthcare providers). Profile 2 “Unsatisfied, Stressed” (n=49; 18% of the total sample) largely consisted of clinical home visitors and child welfare workers (n=25; 52% of cluster 2 membership). In fact, the largest proportion of child welfare workers was represented in cluster 2 (n=9; 69% of all child welfare workers in the sample).

Clinical home visitors and program directors were the largest number of practitioners represented in cluster 3 “Satisfied, Stressed” (n=29, 10% of the total sample, clinical home visitors and program directors, n=17; 58% of cluster 3). Surprisingly, the second largest group in the sample comprised profile 4 “Unsatisfied, Unstressed” (n=93; 33% of the total sample). The job roles most represented in this cluster were clinical home visitors and program supervisors or directors. This suggests that participants in more specialized or senior level job
roles were more likely to either be happy with their work with high satisfaction and low stress, or uninspired by their work with low satisfaction and low stress.

Overall, program directors or supervisors, clinical home visitors, mental health practitioners, and health care providers were all more likely to be represented in cluster 1, “Satisfied, Unstressed” than in any other ProQol profile cluster than child welfare workers, early care and education providers, and parent education home visitors. As illustrated in Figure 2, child welfare workers were over-represented in cluster 2, “Unsatisfied, Stressed,” while program directors and supervisors have the greatest representation in cluster 1, “Satisfied, Unstressed.” This indicates that patterns of work-related stress management and professional quality of life experience vary within job roles. These findings raise important questions about how the particular work-stress management and employee care needs of the infant mental health workforce may need individualization based on job role.
Figure 1.

Description of ProQol Cluster Profile
Discussion and Implications

This study focused on a descriptive analysis of the infant mental health workforce with emphasis on associations between organizational structures, relationship features in the organization, and individual performance of self-care associated with professional quality of life. We sought to investigate the experiences of the workforce through the overarching concept of shared responsibility for employee well-being (Lizano, 2013, Maltzman, 2011). This ecologically-informed framework stipulates that both the organization and the individual contribute mechanisms and practices designed to enhance work-related stress management and mitigate the negative impacts of burnout and secondary traumatic stress inherent in front-line, direct infant mental health practice. The study associated these workplace-related experiences
with self-reported levels of compassion satisfaction, secondary traumatic stress, and burnout in a national, cross-sectional sample of infant mental health, or infant-family practitioners. Results from this investigation suggest that some but not all organizational conditions and relationship features within the organization are associated with lower levels of burnout and secondary traumatic stress in employees. In particular, employees who were well-informed about the occupational hazards of helping work and who felt supported by their supervisors and colleagues may be better equipped to manage their work-related stress. This is supported by multiple studies in the empirical literature investigating trauma therapists and child welfare workers (Killian, 2008; Maltzman, 2011; Sansbury et al., 2015; Sprang et al., 2007). The current study adds to the literature about these professionals by investigating relational and structural qualities of the workplace and their associations with self-reported levels of work-related stress and satisfaction.

Availability of information and education regarding burnout, vicarious trauma, and self-care was the least frequently reported organizational support across all worker role groups. And yet, information and supervisory support were the only domains that were significantly associated with lower levels of secondary traumatic stress. Given the emotionally charged nature of infant mental health practice, questions about what sort of preparation helping professionals receive from their workplaces to navigate the realities of working with families at pivotal stages of the family life cycle, and mechanisms for the emotion regulation of both clients/patients and practitioners, are in critical need of answers.

Regarding professional development, empirical findings support the theory that employees who have specialized training and skill sets tailored to performing their work feel more competent and effective and tend to report lower levels of secondary traumatic stress and
higher levels of compassion satisfaction (Craig, 2008; Killian; 2008; Sprang & Craig, 2010). In this study, practitioners who reported a higher number of professional development resources and supports were more likely to report higher levels of compassion satisfaction and lower levels of burnout, but were not more likely to report lower levels of secondary traumatic stress. However, specialized professional training seemed to be a protective factor against burnout and secondary traumatic stress in Sprang et al., (2007), which found that mental health clinicians who received specialized trauma training reported higher levels of compassion satisfaction, lower levels of secondary traumatic stress, and a greater sense of competence than their peers who had not received trauma training. In addition to training, access to effective evidence-based practices for treatment of trauma survivors and trauma-informed self-care practices (i.e., awareness of one’s own emotional states and reactions, seeking supervision, seeking personal therapeutic intervention, and maintaining work-life balance) for the professional have been found to predict significantly lower levels of burnout and higher levels of compassion satisfaction (Craig & Sprang, 2010; Killian, 2008; Salloum et al., 2013). The Workplace Supports Survey designed for this study did not probe for specific types of training and this would be an important future consideration for measurement development.

Survey participants who reported being endorsed at higher levels in the infant mental health competencies were less likely to report high levels of secondary traumatic stress. This correlation should be interpreted with caution given that practitioners who reported higher levels of endorsement were more likely to be program managers and supervisors who consistently reported lower levels of work-related stress whether they were endorsed or not. Nevertheless, the infant mental health endorsement process is characterized as a professional development activity that encourages high levels of reflection, introspection, and self-awareness. These
processes are typically facilitated within the context of a supervisory relationship, and/or peer/collegial support networks (Shea, 2018; Shea, Weatherston, & Goldberg, 2016; Weatherston, Kaplan & Estrin, 2006;). The question of whether or not becoming endorsed is protective in itself due to the collaborative, reflective nature of the process warrants further investigation. The empirical evidence presented along with the findings from this study support the argument that investing in professional development opportunities may be an integral step towards increasing longevity in the human services sector which has long suffered high rates of turnover and professionals leaving the field (Lizano, 2013; Osofsky, 2009; Shea, 2018, Watson et al., 2014).

Availability of tools to perform the logistical demands of work were found to be significantly, positively associated with compassion satisfaction, but not at all associated with secondary traumatic stress or burnout. For those infant mental health practitioners who must balance their time between home/community-based client contact and presence in the office, travel demands are the top logistical challenge, particularly when places of client contact are far distances from one another or from the office. Having access to tools that would allow for working remotely in order to: complete documentation, participate in office staff meetings, and maintain client contact between face-to-face visits could arguably increase efficiency of job performance and reduce unnecessary travel demands and mileage reimbursement expenses (Fenella & Poulsen, 2012). This study found a low-to-moderate availability of tools, and that having more tools is associated with the compassion satisfaction aspect of professional quality of life. However, in relation to other workplace supports, availability of tools was moderately associated with availability of supportive organizational policies. This suggests that access to tools in order to meet the logistical demands of job performance may best be thought of as part
of the organizational policies domain that determines and mandates what sorts of tools are available and provided within the organization.

Organizational policies are critical components of workplace conditions and influence employee perceptions of the social and emotional climate of the workplace (Hemmelgarn, Glisson, & James; James & James, 2009; 2006; Killian, 2008; Maltzman, 2011). In this investigation, small, but significant associations between organizational policies and employee compassion satisfaction were observed. However, the strongest associations were observed between organizational policies, tools, and information and education (see Table 4). As mentioned previously, policies influence availability and access to tools for job performance. Policies also influence employee access to information and education about work-related stress management and we saw in this sample that information and education was the least frequently reported as being available across job roles.

One important factor to consider with regards to organizational policies and professional quality of life is the employee’s perceived sense of autonomy (Craig & Sprang, 2010; Kilian, 2008; Salloum et al., 2013). Employee external locus of control has been suggested to be an important factor in considering burnout, compassion and job satisfaction. When employees feel a sense of control over their work environment in terms of caseload, scheduling, and access to supervisory and peer support, they are more likely to report lower levels of burnout and higher levels of compassion and job satisfaction (Craig & Sprang, 2010; Killian, 2008; Ludick & Figley, 2016; Maltzman, 2011; Pearlman, 1995; Salloum et al., 2013; Sprang et al., 2007). Organizational policies drive all of the aforementioned characteristics of workplace conditions. Therefore, consideration of shifts in human service organizational policy regarding caseload,
flexibility, and relationship features of the work environment may be in order. This study did not take locus of control into account.

Organizational policies also dictate what sort of resources are made available by the workplace to facilitate employee stress management and work/life balance. Paid time off, sick time, and the availability of additional supports through employee assistance programs are now commonplace for many large organizations. In this sample, the low incidence of counseling through employee assistance programs aligns with the low frequency of individual and/or group psychotherapy being reported as a self-care practice. According to Maltzman (2011), Ludick & Figley (2016) and Pearlman (1995), promoting the physical and mental health of the employee is critical to optimal organizational functioning particularly in the health and human services where the employee uses a great deal of him or herself as a tool in their work. This leads us to ask: is it enough to allow people time off to attend to their mental health? Would more people seek counseling if it were available through employee assistance programs?

In this study, we found that supervisory relationships were viewed very positively by the sample as a whole. The relationships human service supervisors cultivate with their employees shape employee perceptions of how supported and valued they feel by their organization regardless of other work demands like caseloads, and acuity of cases (Maltzman, 2011). Items on the survey probing for supervisory support were adapted from Tomlin et al’s (2014) critical components of reflective supervision. Hence the higher participants scored on the supervisory support subscale, the more “reflective-like” their supervision was. Participants in this survey who more frequently reported “reflective-like” supervision were less likely to report high levels of burnout and secondary traumatic stress, and more likely to report high levels of compassion
satisfaction. Hence, supervisory support is moderately and significantly associated with professional quality of life.

Supervisory relationships also set the tone for staff cohesion and the likelihood of staff seeking peer support and forming collegial support networks within the organization which has also been suggested to be a moderator of staff burnout and secondary traumatic stress (Harrison & Westwood, 2009; Killian, 2008 & Maltzman, 2011). Professional and personal social connections are often cited by trauma specialists and other mental health professionals as key elements of self-care practices intended to manage work-related stress (Harrison & Westwood, 2009; Killian, 2008; 2009; Pearlman, 1995). In this sample, peer support was most strongly associated with supervisory support, and small to moderate associations between peer support and compassion satisfaction and burnout were observed (see Tables 4 & 6). Peer support and supervisory support are also considered to be two major constructs of psychologic climate (i.e., whether or not employees perceive their organizational environment to be good or bad) (Schneider, Ehrhart, & Macey, 2013).

It has been suggested in the empirical literature and in practice-based evidence that reflective supervision increases the practitioner’s capacity for reflection and heightened insight leading to greater emotional containment, which may be protective against work-related stressors like burnout and secondary traumatic stress (Dean, 2013; O’Rourke, 2011; Osofsky, 2009; Shea & Goldberg, 2016; Shea, 2018). Reflective supervision’s establishment as a necessary component of competent infant mental health practice is rooted in a parallel process of relationship-based interventions in which the infant mental health practitioner must provide the sort of relationship to the parent that the practitioner intends for the parent to give to the infant (Pawl & St. John, 1998; Shea, 2018). The practitioner’s ability to provide emotional safety,
consistency, non-judgement, compassion, and curiosity in their relationship with the parent is grounded in the reflective supervisory relationship. In other words, the reflective supervisor must offer to the supervisee the same emotional safety, consistent containment, non-judgement, compassion, and curiosity practitioners must offer to parents. This occurs within a collaborative partnership that fortifies the practitioner to return to the challenging work of cultivating relationships with parents and infants that mitigate therapeutic growth and change which is a primary service delivery goal of infant mental health practice (Schaeffer, 2007; Slade, 2016; Weatherston, 2009). It has been suggested, but not empirically tested that when reflection is practiced at all levels of relationships in the organization; safety, trust, and collaboration permeate supervisory, collegial, and client/family connections setting the stage for optimal infant mental health practice (Sparrow, 2016).

In this survey sample, individual-level factors like performance of self-care practices were associated with higher levels of compassion satisfaction but showed little association with lower levels of secondary traumatic stress or burnout. Despite reporting moderate to high levels of both burnout and secondary traumatic stress, survey participants reported relatively high levels of compassion satisfaction indicating that they found meaning and purpose in their work even though they found it stressful. This was found to be a consistent trend in the sample; the cluster analysis of patterns of satisfaction and stress also suggested that it varied by job role.

Clinical level IMH professionals showed the largest representation in the ProQol profile called “Satisfied, Stressed” indicating that they reported moderate levels of burn-out, were highly traumatized, and yet reported high levels of compassion satisfaction. The group found to be most represented in the ProQol cluster named “Satisfied, Unstressed” indicating low levels of burnout and secondary traumatic stress while reporting high levels of compassion satisfaction
were program managers and supervisors. It may be that program managers and supervisors, in spite of myriad administrative duties, are somewhat removed from the relational dynamics between practitioners and families and therefore don’t experience the same direct effects of secondary traumatic stress. Furthermore, as the results of this study suggest, program managers and supervisors may have more access to organizational supports that facilitate performance of self-care and management of work-related stress.

A surprising finding was that healthcare providers reported receiving the least amount of information and education about work-related stress and self-care practices, and like program directors and supervisors were just as likely to be in ProQol profile called, “Unstressed, Satisfied,” as they were to be in the ProQol profile, “Unstressed, Unsatisfied.” Despite being the most informed group in the sample with regards to work-related stress and self-care, child welfare workers reported few self-care practices and showed the greatest representation in the ProQol profile “Unsatisfied, Stressed” reporting higher levels of burnout and secondary traumatic stress and lower levels of compassion satisfaction. Both healthcare providers and child welfare workers reported the least amount of self-care practices and lower availability of professional development opportunities and resources than any other job role group in the sample.

Education about the realities of burnout, secondary traumatic stress, and vicarious trauma as an occupational hazard of human service work should be essential elements of new employee orientation at every program or agency (Harrison & Westwood; 2009; Ludick & Figley, 2016; Maltzman, 2011). Yet normalizing strong emotional reactions to distressing case material or client trauma is not commonly encouraged in human service organizational culture. In fact, many staff express shame or a sense of incompetence for being distressed over case material
(Maltzman, 2011; Mc Cann & Pearlman, 1998; & Pearlman, 1995). With regards to self-care, even if education and information is available within the organization, the culture of the organization influences whether or not people feel safe openly practicing self-care (Pearlman, 1995). If the culture of the organization interprets self-deprivation as dedication and hard work, its employees may be less likely to engage in self-care practices and perceive that taking care of oneself is selfish and overly indulgent (Maltzman, 2011; Saaktvine, 2000). This study did not investigate attitudes permeating organizational culture with regards to how perceptions about a strong work ethic may be associated with the performance of self-care practices amongst employees.

As previously noted, child welfare workers were found to report the lowest availability of professional development resources of all worker role groups reported in this sample. Child welfare workers are serving some of society’s most vulnerable children, particularly if they are working with infants and toddlers. That they report such low availability of professional development resources in the organization should be cause for alarm. What are the implications of having workers with inadequate access to training and skill-building serving our youngest and most fragile populations?

One example of efforts to provide specialized training to child welfare workers is Connecticut’s Department of Children and Families training partnership with Head Start and the Connecticut Association for Infant Mental Health (Dealy, Robinson, Simpson, & Madeira, 2019). This 8-week training series is rooted in the infant mental health competencies and prepares child welfare investigators, case workers, and supervisors to deliver child-protective services using attachment-based, reflective, trauma-informed approaches. Anecdotal reports from training participants suggest that this intensive training may be transformative in its impact.
on how child welfare workers think about attachment and separation, development, and consider the experience of infants involved in the child welfare system.

However, it should be noted that this training is not uniformly available across Connecticut or across the United States, and there are currently no mechanisms in place to measure whether or not receiving the training is associated with changes in practice (J. Dean, personal communication, May 2018; Jones-Hardin, personal communication, May 2018). In addition to child welfare workers, healthcare providers in this sample also reported low availability of professional development. Given that little more than half of this sample reported having funds for professional development and less than half reported having release time to participate in professional development activities, it’s not surprising that those helping professionals who may benefit most from professional development resources may not be receiving the full benefit.

With regards to the individual performance of self-care, the results of the Workplace Supports Survey suggest that participants relied more heavily on personal resources (i.e. social time, sleep, eating, and exercise habits) than on organizational resources (i.e. supervision, information and education, and professional development) for their self-care. The one organizational resource most frequently reported to be available that might support employee self-care was the provision of paid time off. This suggests that PTO may be a critical element of self-care performance, but perhaps not enough on its own. Holistic self-care practices are empirically supported as consisting of five domains: physical, professional, emotional, psychological, and spiritual (Bell et al., 2003; Bloomquist, Wood, Trainor, & Kim, 2015). However, the question of whether or not one domain is more important than the other, or the
effectiveness of performing one particular type of self-care vs. performing a variety of self-care practices has yet to be explored.

The findings from this study do not tell us whether or not people who report a greater range of self-care practices are more likely to choose organizations that promote employee well-being, offering more resources and support; or whether organizations offering more resources and supports produce employees who are more likely to practice self-care. This would be a compelling question for future investigation. A substantial body of literature suggests the latter and advocates that the organization has a key role in informing and promoting the value of employee self-care, and that individual employees also have a role to play in practicing self-care to manage work-related stress (Bell et al., 2003; Howard, 2007; Harrison & Westwood, 2010; Lizano, 2013; Ludick & Figley, 2016; Maltzman, 2011; Ray et al., 2013; Sansbury et al., 2015).

To date, no studies have found causal links between organizational supports or individual performance of self-care and work-related stress management (Killian, 2008; Lizano, 2013 Craig & Sprang, 2010; Sansbury et al., 2015; Sprang et al., 2007). In fact, Sprang et al., (2007) and Killian (2008) both found that individual performance of self-care on its own was not a good predictor of work-related stress (i.e., burnout and secondary traumatic stress). Most studies cited in this investigation used a cross-sectional design which is useful for exploring and systematically describing phenomena in larger sample sizes. However, longitudinal or randomized study designs might more effectively capture patterns of work-related stress in particular human services sub-groups. Longitudinal designs also have the ability to track employees across organizational settings and over time potentially leading to discoveries of predictive and causal links between organizational and individual variables and work-related stress management and employee well-being.
Given the fluidity of the job market, particularly in the human services sector which is known for its high rates of turnover, the feasibility of longitudinal study design would be complicated. With regards to randomized study designs, their use has been limited to investigating the efficacy of targeted interventions like Mindfulness-Based Stress Reduction and Transcendental Meditation (Jaansen, Heerkens, Kuijer, Van der Heiden, 2018; Shapiro, Astin, Bishop, & Cordova, 2005) in promoting employee well-being within organizations. A limited amount of studies has employed qualitative, ethnographic methods to examine organizational level interventions related to employee well-being and self-care (Bloomquist et al., 2015; Maltzman, 2011; Sansbury et al., 2013). Qualitative methods of investigation are critical to understanding the unique aspects of work-related stress and the differences in particular subgroups of the human services workforce, as not all human services employees have the same work environment or clientele.

Organizational failure to promote employee self-care may be rooted in values related to gender and the protestant work ethic inherent in the sociohistorical context of American culture (Bubeck, 1995; Duffy, 2007; Hochschild, 2003). Given that this study sample overwhelmingly identified as women, we must consider that societal gender expectations and biases dictate that women take care of everyone but themselves and permeate female dominated professions that largely consist of caring work (Bubeck, 1995, Duffy, 2007; England, 2005; & Noddings, 2004). Hence, it’s not surprising that promoting and implementing self-care practices at the organizational level would be a challenge requiring a real shift in organizational culture (Bloomquist et al., 2015; Maltzman, 2011; Sansbury et al., 2015).

According to traditional American values about work, hard work is often defined in terms of quantity and production. Work that is considered labor typically results in a material product
that can be commodified (Bubeck, 1995; Duffy et al., 2007; England, 2005; Hochschild, 1983; 2003). “Good” workers are supposed to show up to work no matter if they are sick, tired, distressed, or otherwise afflicted, and they are supposed to put in whatever hours are needed to get the job done. This material production-driven model of work and the “good” worker is a conundrum for the human service professional in general, and the infant mental health worker in particular when so much of the work and the intended outcome or “product” is rooted in the relationship and the practitioner’s use of her own inner resources.

**Limitations of the study.** This investigation makes a valuable contribution to the empirical literature in the infant mental health field in its attempt to survey the broader infant mental health workforce about work-related stress and the organizational and individual level mechanisms available to manage it. The findings of this study are consistent with previous empirical studies investigating the phenomena of burnout and secondary traumatic stress in the helping professions which purport that both the individual *and* the organization are contributing factors to employee care and well-being (Duffy, Albelda & Hammonds, 2013; Esaki, Benamati, Yanosy, Middleton, Hopson, Hummer, & Bloom, 2013; Killian, 2008; Lizano, 2013; Ludick & Figley, 2016; Maltzman, 2011; Maslach & Leitner, 2010; Pearlman, 1995; Schneider et al., 2012).

However, it should be noted that the characteristics of the sample may not have been representative of the infant-family workforce as a whole. There are many practitioners working with infants, toddlers, and families who would not identify as part of the infant mental health workforce. Although child welfare, healthcare, early intervention, mental health, and home visiting were represented as worker roles in the sample, the majority of participants in this study were indeed clinical-level infant mental health practitioners despite efforts to recruit more
broadly. Hence, it may be that self-selection of participants drove the results of the survey compromising the generalizability of study results to the overall infant-family workforce.

Although the Workplace Supports Survey has the potential to be a valuable measurement tool for assessing workplace conditions including organizational structures and relational features, further item development is necessary. In this study, survey items did not probe more deeply for relationship qualities in supervisory and peer relationships or employee perceptions of the psychologic climate of the organizations in which they worked. This survey also failed to probe for the frequency with which employees utilized organizational supports; or the distinction between the existence of organizational policies to promote employee work-life balance vs. actual implementation of said policies. The survey did not probe for specific types of professional development available within organizations which can influence levels of work-related stress particularly where trauma-informed training is concerned (Craig & Sprang, 2010; Ludick & Figley, 2016; Sprang et al., 2007). The addition of these types of items to the survey could offer a more in-depth investigation and analysis of the association between employee perceptions of work climate and professional quality of life; and the relationship between the existence of organizational policies promoting work-life balance and the actual practices of the organization.

With regards to data analysis, methods employed in this investigation were largely descriptive and do not offer results suggesting predictive or causal links between organizational or individual practices and professional quality of life (i.e. burnout, secondary traumatic stress, and compassion satisfaction). Future directions would include more sophisticated multivariate analyses including multiple regression.
Finally, with regards to individual performance of self-care, items simply probed for whether or not people performed specific practices on a yes/no scale. The amount of time spent performing self-care and the question of whether or not certain self-care practices were more effective than others was not explored in this investigation. Other studies have examined the specific benefits of particular self-care practices including mindfulness, journaling, and making social connections amongst trauma therapists (Bell et al., 2003; Bloomquist et al., 2015; Sansbury et al., 2015). However, these studies have not been comparative in nature and findings do not offer conclusive data about the comparable effectiveness of certain self-care practices over others. Given the low frequency with which some worker roles reported performing self-care (particularly among healthcare and child welfare workers), further exploration of self-care practices using comparative methods may offer insights into what specific types of self-care practitioners find most effective vs. the amount of self-care practiced.

**Conclusion**

**Future Questions**

The effects of burnout and secondary traumatic stress on the helper and the potential impact on human service delivery systems have raised questions about prevention and reduction mechanisms that are protective of the workforce. Traditionally, helping professionals have been left to manage work-related stress on their own. The notion of shared organizational and individual responsibility for employee care and well-being in the human services is gaining traction in the empirical literature (Bloomquist, et al., 2015; Lizano, 2013, Maltzman, 2011; & Sansbury, et al., 2015). Although this study examines workplace conditions identified by a specialized human service workforce to support work-related stress management, questions
remain about how organizational resources are utilized, and if they are not utilized, what the barriers are.

Several questions warrant more in-depth examination and systematic investigation in the interest of enriching the scholarly discourse about human services organizations and structural, cultural factors influencing human services workforce development and support: How do organizations implement policies designed to support employee well-being? How frequently is self-care performed? Are certain self-care practices more effective than others? And, what are common barriers to performing self-care?

The infant mental health field is a specialized human service sector that has not been investigated with regards to organizational and individual factors contributing to the management of work-related stress. Particular sub-groups in this workforce like: child welfare workers, healthcare providers, and clinical practitioners may be among the most susceptible to burnout and secondary traumatic stress due to the intensive, relational nature of the helping relationship; and the timing of an often crisis-focused intervention occurring at a fragile time in the family life cycle. Gaining an understanding of what practices can be protective at both the individual and organizational level, from the perspective of these particular infant mental health practitioners, would be iterative to policy and practice development that promotes high-quality, effective service delivery grounded in the tenets of competency-based infant mental health practice, while supporting and protecting the workforce and the families they serve.
Integrative Conclusion

Implications for Intervention and Policy

The findings of this mixed methods investigation suggest that there is much work to be done in supporting the infant mental health workforce. Although the results of the quantitative piece of this investigation support the merits of “reflective-like” supervision in promoting higher professional quality of life, we see that in both study samples, skilled IMH practitioners who were receiving reflective or “reflective-like” supervision were still reporting moderate to high levels of burnout and secondary traumatic stress. In fact, there was a consensus among participants in the qualitative study that although reflective supervision was an important component of their efforts to manage work-related stress, it was not adequate on its own. These findings challenge the infant mental health field’s heavy reliance on reflective supervision, a micro-level, dyadic interpersonal process, as a primary workforce support mechanism.

Given compelling qualitative findings and significant associations observed between structural and relational features of the work environment and professional quality of life, any discourse around infant mental health workforce development and support must consider the organization as a target for intervention. For instance, what mechanisms exist within an organization to support the implementation of good reflective supervision? Are there trained supervisors, cultural buy-in, a proper balance of time managing caseloads and documentation to allow for regular meetings, flexibility in scheduling?

It is not enough to implement programs and interventions (i.e., supervision models, mindfulness and meditation practices, promoting self-care) that only address behaviors and attitudes at the individual level. The culture and climate of the organization must support and promote self-care across all levels (administrative, supervisory, and frontline), as well as develop
and implement policies designed to promote an organizational self-care model (Maltzman, 2011). Furthermore, the disparities in representation of gender, pay equity, and the disproportionate strain of balancing personal and private care demands reported by women IMH practitioners in these studies indicate that traditional values about what constitutes work and work that is worthwhile, are deeply in need of re-examination.

This mixed-methods investigation applies a feminist care theory and socioecological framework (Bubeck, 1995; Duffy, 2007; England, 2005; Hochschild, 2003; Noddings, 2000; Brofenbrenner, 1979) to examining the lived experience of a sub-group of IMH practitioners, and the interplay between the organization and the individual in addressing the employee care needs of the broader infant mental health workforce. This investigation is the first to consider the perspective of the practitioner with regards to effective methods of work-related stress management and the influence of the work environment. The Workplace Supports Survey (Simpson & Robinson, 2018), is also the first tool designed to measure both individual perceptions and characteristics of the employee and structural and relational features of the organizations where they work. This type of measure would be instrumental in conducting a needs assessment of the infant mental health workforce with an eye towards taking an individualized approach to intervention based on practitioner roles and the culture of the organizations in which they work. The first step, however is to open up this discourse in the field and in the empirical literature. From a policy perspective, it is not enough to advocate for increasing public awareness about promoting the health and well-being of (especially vulnerable) young children and their families without advocating for the holistic professional development and support of the workforce caring for them.
Findings yielded from both studies in this investigation are consistent with other findings from well-established empirical literature that suggests: 1) positive interpersonal relationships (i.e., supervisory and peer) in and out of the workplace, 2) availability of professional development that enhances practitioner sense of competency, 3) information and education about burnout and secondary traumatic stress, and 4) the promotion of holistic self-care (both professional and personal) practices, are integral components of employee health and well-being. Employee health and well-being ultimately impacts the longevity and stability of the workforce. This is a critical consideration for the infant mental health field in particular, where consistency and stability of relationships is essential to best practice.

In conclusion, organizations, supervisors, and practitioners can use the findings from both studies to consider shifts in attitudes, perceptions and practices concerning individual and organizational features related to employee care and well-being. Supervisory and peer support and cohesion and organizational responsibility for training and preparation that reflects the realities of the work require intentional practice and implementation. Pre-professional education about burnout and secondary traumatic stress as occupational hazards of frontline human service work should be included in all curricula preparing human service professionals. And finally, organizational policies and practices that facilitate and promote individual performance of self-care at the professional and personal level should be integrated into human service organizations. Perhaps more than any other human service field, in infant mental health, the professional is the personal (Tosone, 2012). We cannot afford to rest all of the challenges and burdens of competent, relationship-based infant mental health practice on the shoulders of the dedicated, predominantly female practitioners who perform the invaluable work of ensuring our society’s future.
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Appendix A

Figure 3

Conceptual model of the shared responsibility between the organization and the individual for employee care and well-being
Welcome: You are being asked to complete this survey as part of an Institutional Review Board-approved research study investigating workplace supports and their impact on burnout, compassion fatigue, and compassion satisfaction in the infant mental health workforce. When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in negative and positive ways. Consider each of the following questions about you and your current work situation. Select the choice that honestly reflects how frequently you experienced these things in the last 30 DAYS. As a thank you for participating, there will be a drawing for a $50 Amazon gift card for every 50 people who complete the survey. Please click the anonymous survey link at the end of this survey to enter the drawing.

NOTE: Please note that independent contractors, per-diem employees, practitioners in private practice, student interns, and volunteers DO NOT meet eligibility criteria to participate in this survey. If you are retired but currently working in the field, you must be employed by an agency at least part-time. If you have been on leave from your job for more than 30 days, you do not meet eligibility criteria to complete this survey. If you have recently returned from leave or vacation, please wait until you have been back at work for at least 30 DAYS before you complete this survey.

Q1. Please select which best describes the setting where you see children and families

- [ ] Home-based
- [ ] Classroom
- [ ] Outpatient Clinic
- [ ] Community-Based/ Non-Profit Agency
- [ ] Inpatient Psychiatric Facility
- [ ] Children’s Hospital
- [ ] Primary Pediatric Care Practice
- [ ] Private For-Profit Agency
- [ ] State, Municipal, or County Agency (including child welfare or foster care)
- [ ] Other
Q2. Please select the title that best describes your role

- Early Care and Education Teacher
- Early Care and Education Assistant Teacher
- Family Daycare Home Provider
- Home Visitor (parent education, case management, healthy start, early head start)
- Home Visitor (health provider, clinical allied health provider, early intervention, clinical mental health provider)
- Child Protection or Child Welfare Investigator
- Child Protection or Child Welfare Case Manager
- Early Childhood Mental Health Consultant
- Clinical Mental Health Provider (Outpatient)
- Clinical Allied Health Professional (OT, PT, SLP) Outpatient or Hospital
- Healthcare Provider
- Program Director (specify early care and education, child welfare, mental health, etc.)
- Supervisor (specify administrative, clinical, reflective)

Q3. Number of years working with infants, toddlers, and families

- 0-3 years
- 3-5 years
- 5-10 years
- 10-15 years
- 15+ years

Q4. Highest degree earned

- High School Diploma
- Associate's
- Bachelor's
- Master's
- Doctoral (Ph.D. or Psy.D.)
- Other
Q5. Endorsement Status

☐ Not endorsed
☐ Seeking endorsement
☐ Endorsed
☐ This item does not apply to my work situation

Q6. Level of Endorsement

☐ Level I-Infant-Family Associate
☐ Level II-Infant-Family Specialist
☐ Level III-Infant Mental Health Specialist
☐ Level IV-Infant Mental Health Mentor (specify Clinical, Policy, Researcher/Faculty)

☐ This item does not apply to my work situation

Q7. Number of Years Endorsed

☐ 0-2 years
☐ 2-5 years
☐ 5-10 years
☐ 10 + years
☐ This item does not apply to my work

Q8. Please select the item that best describes how you identify yourself

☐ White (Non-Hispanic, European, Mediterranean)
☐ Black (African, Afro-Caribbean, African-American, Non-Hispanic)
☐ Latino/a or Hispanic
☐ Asian or Pacific Islander
☐ Native American
☐ Middle Eastern
☐ Bi or multi-racial
Q9. Are you bi or multi-lingual?

- yes (if yes specify language (s))
- no

Q10. Please select the item that best describes how you identify yourself

- Male
- Female
- Transgender
- Non-binary

Q11. Please indicate your age range

- 20-35
- 36-45
- 46-55
- 55+

Q12. Please select the item that indicates the region of the country you work in

- New England (CT, MA, RI, NH, VT, ME)
- Mid-Atlantic (NY, NJ, PA, DE, MD, Washington, DC, VA, West VA)
- Southeastern (AL, FL, GA, KY, MS, NC, OK, SC, TN, AR, LA)
- Southwestern (AZ, CA, CO, NM, NV, TX, UT)
- Mid-western (IA, IL, IN, KS, MI, MO, MN, NE, ND, OH, SD, WI)
- Pacific Northwest (AK, HI, ID, MT, OR, WA, WY)

Q13. Professional Quality of Life Scales (ProQOL): I am happy.

- never
- rarely
- sometimes
- often
- very often
Q14. ProQOL: I am preoccupied with more than one person I (help).

- never
- rarely
- sometimes
- often
- very often

Q15. ProQOL: I get satisfaction from being able to help people.

- never
- rarely
- sometimes
- often
- very often

Q16. ProQOL: I feel connected to others.

- never
- rarely
- sometimes
- often
- very often

Q17. ProQOL: I jump or am startled by unexpected sounds.

- never
- rarely
- sometimes
- often
- very often
Q18. ProQOL: I feel invigorated after working with those I help.

☐ never
☐ rarely
☐ sometimes
☐ often
☐ very often

Q19. ProQOL: I find it difficult to separate my personal life from my life as a helper.

☐ never
☐ rarely
☐ sometimes
☐ often
☐ very often

Q20. ProQOL: I am not as productive at work because I am losing sleep over traumatic experiences of a person I help

☐ never
☐ rarely
☐ sometimes
☐ often
☐ very often

Q21. ProQOL: I think that I might have been affected by the traumatic stress of those I help.

☐ never
☐ rarely
☐ sometimes
☐ often
☐ very often
Q22. ProQOL: I feel trapped by my job as a helper.

☐ never
☐ rarely
☐ sometimes
☐ often
☐ very often

Q23. ProQOL: Because of my helping I have felt "on edge" about various things.

☐ never
☐ rarely
☐ sometimes
☐ often
☐ very often

Q24. ProQOL: I like my work as a helper.

☐ never
☐ rarely
☐ sometimes
☐ often
☐ very often

Q25. ProQOL: I feel depressed because of the traumatic experiences of the people I help.

☐ never
☐ rarely
☐ sometimes
☐ often
☐ very often

Q26. ProQOL: I feel as though I am experiencing the trauma of someone I have helped.

☐ never
☐ rarely
☐ sometimes
☐ often
☑ very often
Q27. ProQOL: I have beliefs that sustain me.

☐ never
☐ rarely
☐ sometimes
☐ often
☐ very often

Q28. ProQOL: I am pleased with how I am able to keep up with helping techniques and protocols.

☐ never
☐ rarely
☐ sometimes
☐ often
☐ very often

Q29. ProQOL: I am the person I always wanted to be.

☐ never
☐ rarely
☐ sometimes
☐ often
☐ very often

Q30. ProQOL: My work makes me feel satisfied.

☐ never
☐ rarely
☐ sometimes
☐ often
☐ very often

Q31. ProQOL: I feel worn out because of my work as a helper.

☐ never
☐ rarely
☐ sometimes
☐ often
☐ very often
Q32. ProQOL: I have happy thoughts and feelings about those I help and how I could help them.

- never
- rarely
- sometimes
- often
- very often

Q33. ProQOL: I feel overwhelmed because my case (work) load seems endless.

- never
- rarely
- sometimes
- often
- very often

Q34. ProQOL: I believe I can make a difference through my work.

- never
- rarely
- sometimes
- often
- very often

Q35. ProQOL: I avoid certain activities or situations because they remind me of frightening experiences of the people I help.

- never
- rarely
- sometimes
- often
- very often
Q36. ProQOL: I am proud of what I can do to help.

- never
- rarely
- sometimes
- often
- very often

Q37. ProQOL: As a result of my helping, I have intrusive, frightening thoughts.

- never
- rarely
- sometimes
- often
- very often

Q38. ProQOL: I feel "bogged down" by the system.

- never
- rarely
- sometimes
- often
- very often

Q39. ProQOL: I have thoughts that I am a "success" as a helper.

- never
- rarely
- sometimes
- often
- very often
Q40. ProQOL: I can't recall important parts of my work with trauma victims.

- never
- rarely
- sometimes
- often
- very often

Q41. ProQOL: I am a very caring person.

- never
- rarely
- sometimes
- often
- very often
Q42. ProQOL: I am happy that I chose to do this work.

- never
- rarely
- sometimes
- often
- very often

Q43. SUPERVISORY SUPPORT: My supervisor protects our supervision meeting time and doesn't allow distractions when we meet

- never
- rarely
- sometimes
- often
- always
- unknown

Q44. SUPERVISORY SUPPORT: My supervisor is available to me beyond regularly scheduled supervision meetings if I need support

- never
- rarely
- sometimes
- often
- always
- unknown
Q45. SUPERVISORY SUPPORT: I feel safe expressing confusion, frustration, and not knowing in supervision

- never
- rarely
- sometimes
- often
- always
- unknown

Q46. SUPERVISORY SUPPORT: My supervisor is attentive to how my experience of the work impacts my relationships with client families

- never
- rarely
- sometimes
- often
- always
- unknown

Q47. SUPERVISORY SUPPORT: My supervisor is sensitive to how my own life course events may impact my feelings about my work

- never
- rarely
- sometimes
- often
- always
- unknown
Q48. SUPERVISORY SUPPORT: My supervisor keeps the content of our sessions confidential

- never
- rarely
- sometimes
- often
- always
- unknown

Q49. SUPERVISORY SUPPORT: I am fearful that what I share in supervision will be used against me in job performance evaluations or promotion decisions

- never
- rarely
- sometimes
- often
- always
- unknown

Q50. SUPERVISORY SUPPORT: My agency has a policy for providing reflective supervision

- yes
- no

Q51. PEER SUPPORT: I work with colleagues who have similar work experiences to my own

- never
- rarely
- sometimes
- often
- always
- unknown
Q52. PEER SUPPORT: I like and trust my colleagues and my relationships with them makes my job easier

☐ never
☐ rarely
☐ sometimes
☐ often
☐ always
☐ unknown

Q53. PEER SUPPORT: My colleagues understand the unique challenges I face in my work

☐ never
☐ rarely
☐ sometimes
☐ often
☐ always
☐ unknown

Q54. PEER SUPPORT: I feel safe sharing my feelings about the challenges and rewards of my work with my colleagues

☐ never
☐ rarely
☐ sometimes
☐ often
☐ always
☐ unknown
Q55. PEER SUPPORT: I feel solely responsible for the fate of my clients

○ never
○ rarely
○ sometimes
○ often
○ always
○ unknown

Q56. PEER SUPPORT: At least one colleague partners with me in holding the difficult emotional content of my cases

○ never
○ rarely
○ sometimes
○ often
○ always
○ unknown

Q57. ORGANIZATIONAL CLIMATE: My organization provides information about symptoms of burnout

○ yes
○ no
○ sometimes
○ unknown

Q58. ORGANIZATIONAL CLIMATE: My organization provides information about vicarious trauma (signs and symptoms)

○ yes
○ no
○ sometimes
○ unknown
Q59. ORGANIZATIONAL CLIMATE: My organization provides information about self-care practices

- yes
- sometimes
- no
- unknown

Q60. ORGANIZATIONAL CLIMATE: My organization consistently promotes self-care practices in frontline staff and in supervisory staff

- yes
- sometimes
- no
- unknown

Q61. ORGANIZATIONAL CLIMATE: My organization encourages frontline staff to seek peer support within the workplace

- yes
- sometimes
- no
- unknown

Q62. ORGANIZATIONAL CLIMATE: I seek peer support outside of the workplace

- yes
- sometimes
- no
- unknown

Q63. ORGANIZATIONAL CLIMATE: My organization provides opportunities for professional growth

- yes
- sometimes
- no
- unknown
Q64. ORGANIZATIONAL CLIMATE: My organization provides financial support for the endorsement process

- yes
- sometimes
- no
- unknown

Q65. ORGANIZATIONAL CLIMATE: My organization provides training support for the endorsement process (including reflective supervision hours)

- yes
- sometimes
- no
- unknown

Q66. ORGANIZATIONAL CLIMATE: There are opportunities for promotion and advancement in my workplace

- yes
- sometimes
- no
- unknown

Q67. ORGANIZATIONAL POLICIES: My organization allows the use of sick time for mental health days off

- yes
- sometimes
- no
- unknown
Q68. ORGANIZATIONAL POLICIES: My organization offers flexibility in scheduling the work week (evening hours, 4-day work weeks, flex time)

☐ yes
☐ sometimes
☐ no
☐ unknown

Q69. ORGANIZATIONAL POLICIES: My organization offers part-time or job share positions

☐ yes
☐ sometimes
☐ no
☐ unknown

Q70. ORGANIZATIONAL POLICIES: I feel I am paid in the salary range commensurate with my education, training, and experience

☐ yes
☐ sometimes
☐ no
☐ unknown

Q71. ORGANIZATIONAL POLICIES: My organization addresses travel challenges that are a part of my work (for home-visiting or community-based positions where out of office work is essential)

☐ yes
☐ sometimes
☐ no
☐ unknown
☐ this does not apply to my work
Q72. ORGANIZATIONAL POLICIES: My organization provides resources to manage the travel challenges that are part of my work

- yes
- sometimes
- no
- unknown
- this does not apply to my work

Q73. ORGANIZATIONAL POLICIES: What does your organization provide so that you can manage the unique challenges of your work? (check all that apply)

- Laptops
- iPads
- Company cell phone
- Company car
- Mileage Reimbursement (full or partial?)
- Reimbursement for other expenses (cell phone use, small client expenses)
- Options to work remotely outside of office (using laptop, cell phone, IPad, etc)
- Professional Development (what kinds of trainings?)
- Funds for professional development and training
- Release time for professional development and training
- In-services (relevant trainings and workshops provided in the workplace)
- Orientation (includes education re: burnout, vicarious trauma, and self-care)
- Counseling (employee assistance program)
- Paid time off
- Family medical leave
- Mental Health Days in addition to sick days
- On-site childcare
- Other
Q74. ORGANIZATIONAL POLICIES: Overall, do you feel your organization's policies help you to do your work?

☐ yes
☐ no
☐ don't know

Q75. What is one thing you would like your organization to provide to help you manage work-related stress?

☐ Click to write Choice 1

Q76. SELF-CARE: I engage in the following self-care practices to manage work-related stress: Exercise

☐ Yes
☐ No

Q77. SELF-CARE: Healthy eating habits

☐ Yes
☐ No

Q78. SELF-CARE: Sleep hygiene

☐ Yes
☐ No

Q79. SELF-CARE: Mindfulness Practices

☐ Yes
☐ No
Q80. SELF-CARE: Reflective Supervision

☐ Yes
☐ No

Q81. SELF-CARE: Individual or Group Therapy

☐ Yes
☐ No

Q82. SELF-CARE: Using Paid Time Off

☐ Yes
☐ No

Q83. SELF-CARE: Social Time (friends, family)

☐ Yes
☐ No
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### Appendix C
Item-level descriptive statistics

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>Standard Dev</th>
<th>Median</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tools/Logistics Domain</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My organization addresses travel challenges that are a part of my work.</td>
<td>60%</td>
<td>.441</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>My organization provides resources to manage travel challenges that are part of my work.</td>
<td>55%</td>
<td>.417</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>My organization provides REIMBURSEMENT FOR OTHER EXPENSES (i.e. personal cell phone usage, small client expenses) so that I can manage my work.</td>
<td>44%</td>
<td>.497</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>My organization provides MILEAGE REIMBURSEMENT so that I can manage my work.</td>
<td>78%</td>
<td>.414</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>My organization provides a COMPANY CAR so that I can manage my work.</td>
<td>11%</td>
<td>.319</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>My organization provides a COMPANY CELL PHONE so that I can manage my work.</td>
<td>43%</td>
<td>.495</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>My organization provides IPADS so that I can manage my work.</td>
<td>18%</td>
<td>.384</td>
<td>.000</td>
<td>.000</td>
</tr>
</tbody>
</table>
My organization provides LAPTOPS so that I can manage my work.

**Organizational Policies Domain**

My organization allows the use of sick time for mental health days off.

My organization offers flexibility in scheduling the work week (evening hours, 4-day work weeks, flex time).

My organization offers part-time or job share positions.

My organization offers options to work remotely outside of the office (i.e. use of laptop, cell phone, iPad, etc.).

My organization provides paid time off.

My organization provides mental health days in addition to sick days.

My organization provides family medical leave.

My organization provides counseling through an Employee Assistance Program.

My organization provides on-site childcare.

I feel I am paid in the salary range commensurate with my
education, training, and experience.

Overall, do you feel your organization’s policies help you to do your work?

<table>
<thead>
<tr>
<th>Domain</th>
<th>Score1</th>
<th>Score2</th>
<th>Score3</th>
<th>Score4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Info-Ed Domain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My organization provides information about symptoms of burnout.</td>
<td>.485</td>
<td>.409</td>
<td>.500</td>
<td>.000</td>
</tr>
<tr>
<td>My organization provides information about vicarious trauma (signs and symptoms).</td>
<td>.488</td>
<td>.410</td>
<td>.500</td>
<td>.000</td>
</tr>
<tr>
<td>My organization provides information about self-care practices.</td>
<td>.492</td>
<td>.459</td>
<td>.500</td>
<td>.000</td>
</tr>
<tr>
<td>My organization consistently promotes self-care practices in frontline and supervisory staff.</td>
<td>.409</td>
<td>.425</td>
<td>.500</td>
<td>.000</td>
</tr>
<tr>
<td>My organization’s orientation includes education about burnout, vicarious trauma, and self-care.</td>
<td>.310</td>
<td>.465</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>Supervisory Support Domain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My supervisor protects our meeting time and doesn’t allow distractions when we meet.</td>
<td>3.91</td>
<td>1.29</td>
<td>4.00</td>
<td>4.00</td>
</tr>
<tr>
<td>My supervisor is available to me beyond regularly scheduled supervision meetings if I need support.</td>
<td>4.15</td>
<td>1.08</td>
<td>4.00</td>
<td>5.00</td>
</tr>
<tr>
<td>I feel safe expressing confusion, frustration, and not knowing in supervision.</td>
<td>4.05</td>
<td>1.18</td>
<td>4.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Statement</td>
<td>Rating</td>
<td>SD</td>
<td>Median</td>
<td>Max</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>--------</td>
<td>-----</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>My supervisor is attentive to how my experience of the work impacts my relationship with client families.</td>
<td>4.00</td>
<td>1.19</td>
<td>4.00.</td>
<td>5.00</td>
</tr>
<tr>
<td>My supervisor is sensitive to how my own life course events may impact my feelings about my work.</td>
<td>3.98</td>
<td>1.21</td>
<td>4.00</td>
<td>5.00</td>
</tr>
<tr>
<td>My supervisor keeps the content of our sessions confidential.</td>
<td>4.71</td>
<td>1.05</td>
<td>5.00</td>
<td>5.00</td>
</tr>
<tr>
<td>I am fearful that what I share in supervision will be used against me in job performance evaluations or promotion decisions.</td>
<td>2.27</td>
<td>1.44</td>
<td>2.00</td>
<td>1.00</td>
</tr>
<tr>
<td>My agency has a policy for providing reflective supervision.</td>
<td>1.33</td>
<td>.472</td>
<td>1.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>

**Peer Support Domain**

| I work with colleagues who have similar work experiences to my own.       | 4.08   | .920| 4.00   | 4.00 |
| I like and trust my colleagues and my relationships with them makes my job easier | 4.19   | .826| 4.00   | 4.00 |
| My colleagues understand the unique challenges I face in my work.        | 4.30   | .838| 4.00   | 5.00 |
| I feel safe sharing my feelings about the challenges and rewards of my work with my colleagues. | 4.15   | .885| 4.00   | 5.00 |
| I feel solely responsible for the fate of my clients                      | 2.24   | 1.01| 2.00   | 2.00 |
At least one colleague partners with me in holding the difficult emotional content of my cases.  

My organization encourages frontline staff to seek support within the workplace.  

I seek peer support outside of the workplace.  

**Prof Dev. Domain**  
My organization provides opportunities for professional growth.  

Professional development is available.  

Funds are available for professional development and training.  

Release time is available for professional development and training.  

In-services are available.  

My organization provides financial support for the endorsement process.  

My organization provides training support for the endorsement process (including reflective supervision hours).  

There are opportunities for promotion and advancement in my workplace.
**Self-care Domain**

<table>
<thead>
<tr>
<th>Practice</th>
<th>Engagement</th>
<th>p-value</th>
<th>Confidence Level</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>I engage in EXERCISE as a self-care practice to manage work-related stress</td>
<td>73%</td>
<td>.445</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>I engage in HEALTHY EATING HABITS as a self-care practice to manage work-related stress.</td>
<td>76%</td>
<td>.428</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>I engage in SLEEP HYGIENE as a self-care practice to manage work-related stress.</td>
<td>87%</td>
<td>.332</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>I engage in MINDFULNESS PRACTICES as a self-care practice to manage work-related stress.</td>
<td>63%</td>
<td>.484</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>I engage in REFLECTIVE SUPERVISION as a self-care practice to manage work-related stress.</td>
<td>66%</td>
<td>.473</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>I engage in INDIVIDUAL or GROUP THERAPY as a self-care practice to manage work-related stress.</td>
<td>24%</td>
<td>.433</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>I engage in USING PAID TIME OFF as a self-care practice to manage work-related stress.</td>
<td>79%</td>
<td>.407</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>I engage in SOCIAL TIME WITH FRIENDS AND FAMILY as a self-care practice to manage work-related stress.</td>
<td>98%</td>
<td>.119</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>