Perceptions of the Home-Based Counseling Experience: Preparation and Ethics

by

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ABSTRACT

Home-based counselors experience demands, obstacles, and opportunities not present for office-based counselors. The literature reveals that many counselors do not feel adequately prepared to conduct therapy outside of the traditional office setting. The purpose of this study is to help fill this void in the literature by exploring the experiences of home-based counselors and the kind of training and supervision they received from their academic institutions and agencies of employment to conduct home-based counseling. An additional focus was to investigate how prepared they believe they are to provide this type of counseling, particularly in an area of ethics. Interviews and document reviews were utilized to examine perspectives of counselors providing home-based services to their clients.

None of the participants felt like their educational institutions contained any preparation for home-based counseling. Two of the participants were satisfied with their agency preparation, three were not satisfied with the training their agencies provided, and one received no agency preparation for home-based counseling. Common ethical issues were discussed in light of how they are unique to the home environment and participants talked about how they handle ethical dilemmas and what resources they find helpful to do so. Participants expressed what would be helpful to make them more effective home-based counselors, leading to recommendations for educational institutions, home-based counseling agencies, home-based counselors, and the field of counseling.

CHAPTER 1

INTRODUCTION

Background of the Study

Counselors receive training that covers an impressive span of topics, populations, and techniques, that prepare them for professional life after graduate school. Most of this training follows the assumption that the counselor is providing services in an office or inpatient setting (Christensen, 1995; Cortes, 2004; Lawson & Foster, 2005; Macchi & O'Conner, 2010). Once counselors arrive at home-based agencies, they are sometimes given details about how to adapt to the home setting, but the agencies may not cover some of the topics provided in graduate school like ethical and multicultural issues in counseling, which could leave gaps in knowledge and understanding of the nuances and differences in setting.

This study explored how prepared counselors feel about providing counseling in the client's home, rather than a traditional office setting. A special focus was given to their perceptions of the adequacy of their preparation and supervision and ethical issues experienced in the home setting.

Home-based counseling has been referred to by many names: home-based services, in-home services, family-based services (Adams & Maynard, 2000), family-centered services, intense family services, home-based family therapy (Jordan, Alvarado, Braley & Williams, 2001), and family preservation services (Banach, 1999; Woodford, 1999). As these names imply, this type of counseling usually occurs in the home, focuses on families, and tends to be intensive. Despite the name, home based counseling can take

place in other community settings such as schools or daycare centers, parks, grocery stores, or any other location of the family's choosing. The distinction between home based-counseling and traditional office-based counseling is that home-based counseling occurs in the client's natural environment or in a place of the client's choosing with the intention of utilizing the natural environment as part of the assessment and treatment process. Examples of home-based counseling are helping a seven-year-old with social skills in a park, providing interventions to a family whose two-year-old has excessive tantrums in the grocery store, or focusing on a sixteen-year-old's problems with his teachers in the school. The environment and how the child or family responds to the environment provides therapeutic input towards solutions geared specifically towards the child or family.

While home-based services are provided to clientele of all ages such as homebound elderly patients (Blass, Rye, Robbins, Miner, Handel, Carroll, et al, 2006; Cabin, 2010; Kang-Yi & Gellis, 2010), adults with medical issues (Stephenson & Wiles, 2000), children and adults receiving psychiatric treatment (Gerace, Tiller, Anderson, Miller, Ward & Munoz, 1990), and veterans of the armed forces (Hicken & Plowhead, 2010), most home-based programs are child and family focused. Since most counseling research is aimed at child and family populations and because there were no participants in the study serving adult clients outside of the parenting context, the terminology used in the proposed study will be aimed at counseling with families and child and adolescent populations.

The guiding assumptions for providing counseling in the family's home are although parents are experts on their children, they can be helped with additional support

and information on child development, family strengths, and ways to address a present problem and negative family dynamics (Cook & Sparks, 2008; Klass, 1997; Wasik & Bryant, 2001). With parental empowerment and assistance getting basic needs met, families and children can thrive and hopefully stay together as a family unit. This option is preferable to out-of-home placement and families being separated (Lukenda, 1997; Schwartz & AuClaire, 1995; Wasik & Bryant, 2001).

Home-based treatment focuses on the family system, how the family functions within this system and how the family reacts to the child who is the identified client (Klass, 1997; Macchi & O'Connor, 2010). Home-based services follow the policy of the least restrictive environment by providing services in the family's natural environment and working towards the goal of keeping children in the home and out of more restrictive settings like residential treatment centers, foster care, psychiatric hospitals, group homes, or correctional facilities (Schwartz & AuClaire, 1995; Woodford, 1999).

Home-based Counseling vs. Office-based Counseling

Key to understanding what home-based counseling looks like is knowing the differences between office-based counseling and home-based counseling. Being in the home environment gives the counselor insight into the family that would not be gained if the family came to an office. In the home-based scenario the counselor can watch how the family interacts in its natural environment (Hicken & Plowhead, 2010; Zur, 2007). This provides counselors the opportunity to watch the family utilize therapeutic interventions and to give immediate feedback as well as take note of factors in the home that maintain the presenting problem (Christensen, 1995; Schwartz & AuClaire, 1995; Woods, 1988). Additionally, skill generalization, or ability to use or transfer a skill into

the environment in which it is needed, is enhanced when the skills are taught in the home rather than the more unnatural office environment (Fuller, 2004; Schwartz & AuClaire, 1995).

Living conditions such as neighborhood environment and home conditions can give information about the family that could help with assessment and treatment planning (Christensen, 1995; Fuller, 2004; Gerace, Tiller, Anderson, Miller, Ward & Munoz, 1990; Hicken & Plowhead; 2010; Stinchfield, 2002). Some salient questions are: Is the neighborhood safe? Are people loitering outside? Is the home safe? Clean? Dark? How is it decorated? Who is in the home? Due to the uncontrollable nature of the home environment, counselors have to deal with more distractions than they would face in an office, like people coming in and out, TV and radio noise, pets and children running around, and cigarette smoke (Macchi & O'Conner, 2010). Clients may also feel free to do things they normally would not do in an office setting like lie on the sofa, take phone calls during the session, slap a child for misbehaving, or prepare a snack (Strom-Gottfried, 2009).

One benefit home-based counseling has over office-based counseling is being able to involve people who may not come to an office (Boyd-Franklin & Bry, 2000; Hicken & Plowhead, 2010; Stinchfield, 2002; Woodford, 1999; Woods, 1988). This could include people who cannot afford transportation, are reluctant to go into an office to see a counselor because of perceived stigma attached to counseling, have had previous negative experiences with mental health agencies, families with infants and young children, and immigrant or ethnic minority families (Cottrell, 1994; Zur, 2007). Going into the client's home may make the family feel more valued (Hicken & Plowhead,

2010), which is important for a clientele who is frequently involved in involuntary systems mandating counseling services. The referral sources, which are often Child Protective Services (CPS), Juvenile Justice, and Early Intervention and Education programs, lead home-based counselors to a particularly vulnerable population which may not have received help without involvement with these agencies. With the family's consent, involving these systems and other resources such as neighbors, schools, and civic organizations is more easily done in home-based counseling which could assist in treatment and obtaining much-needed resources (Hicken & Plowhead, 2010; Macchi & O'Connor, 2010; Reiter, 2000; Woods, 1988).

The balance of power is also different outside of the counseling office. Being on the client's turf changes the balance of who is "in charge" and some therapists struggle with setting boundaries in someone else's home (Christensen, 1995; Snyder & McCollum, 1999). The family may have a greater comfort level (Balgopal, Patcher & Henderson, 1988; Reiter, 2000) and feel more empowered (Hicken & Plowhead, 2010) being in their own home, which lends itself to a more egalitarian therapeutic relationship. Alternatively, the counselor may have less comfort and more anxiety, stress, and burnout due to unpredictability related to being in a dangerous neighborhood, an unsanitary house or working with clients with a history of violence (Adams & Maynard, 2000; Cottrell, 1994; Macchi & O'Conner, 2010; Stinchfield, 2002; Strom-Gottfried, 2009; Zur, 2007).

Counseling outside of an office requires more organization, since counselors may work out of their cars and must have great office management skills, knowledge of counseling, and time management skills to account for extras such as travel time between appointments (Hicken & Plowhead, 2010; Stinchfield, 2002). In addition, many agencies

providing home-based counseling work closely with other professionals, either in a team therapy model or in collaboration with involved agencies such as juvenile probation or Child Protective Services. This provides not only an opportunity for the professionals to model positive interactions and conflict management (Adams & Maynard, 2000), but also it requires counselors to be more familiar with these agencies and multisystemic models of counseling (Lukenda, 1997).

Theoretical Lens

One of the most commonly used theoretical foundations in home-based counseling is Bronfenbrenner's (1979, 1989, 2005) Ecological Theory of Human Development (Lindblad-Goldberg, Dore, & Stern, 1998; Schwartz & AuClaire, 1995; Wasik & Bryant, 2001; Woodford, 1999). The focus of this theory is on the interaction between the person, who is forever active and growing, and the environment, which is in a state of constant change (Bronfenbrenner, 1979). Bronfenbrenner (1979) points out the importance of perception, saying, "What matters for behavior and development is the environment as it is perceived rather than as it may exist in objective reality." (p. 4). This view is in accordance with the phenomenological nature of the proposed study as it strives to reveal the perceptions of home-based counselors.

Bronfenbrenner (1989, 2005) describes five concentric structures making up the ecological environment that interact to systemically affect a person's development: Microsystems, mesosystems, exosystems, macrosystems, and chronosystems. The structure most immediate and directly influential to a person is the microsystem, which consist of "activities, roles, and interpersonal relations" (Bronfenbrenner, 1979; p. 22) experienced by the person. Examples of microsystems are a person's home, immediate

family members, and peers. Microsystems of a counselor participating in this study might be the place of employment, clinical supervisor, university, client family, and the client's home in which counseling occurs. Next, the mesosystem consists of an interrelation between microsystems, for example the relationship between the counselor's university instruction and training gained at the counselor's place of employment. The exosystem involves the broader community in which there is no direct interaction, although it has a more indirect influence on the developing person, for instance the safety of the client's neighborhood, other helping social systems such as Child Protective Services, and mass media. Attitudes, values, laws, and customs of the subculture or culture make up the macrosystem, which is the underlying influence to all of the other systems. Examples of macrosystems relevant to this study are the ACA Code of Ethics (2005), the culture of the client family, and laws governing services for children. Finally, the chronosystem addresses the impact of time, life and historical events. These events are divided into external events such as graduation or obtaining full counseling licensure and internal events like sickness or professional burnout.

According to Bronfenbrenner (1979), the interaction of these systems provides the explanation for individual differences in knowledge, beliefs, values, and actions. The therapeutic value lies in the ability to find the strengths already present in the structures and identify resources and areas of possible improvement and intervention. This theory is both relevant to the families being served by home-based agencies and to examining the development of home-based counselors as they interact with their personal and professional environments and continually grow within the systems in which they function.

Statement of the Problem

Although some research on home-based counseling delves into differences between office-based and home-based counseling, few studies explore the experiences of counselors working outside of the office. No studies were found that go into depth about ethical issues, decision-making processes, and helpful resources. The majority of the existing studies were conducted before the new Code of Ethics (ACA, 2005) was written and before ethics courses became more prevalent in counselor education programs (Neukrug & Milliken, 2011). Further, ethics continuing education is mandated for licensure renewal, thus suggesting this study has the potential to reveal new and different perspectives.

Cortes (2004) points out that traditional counselor training focuses on interaction with the counselor and family without a focus on the family's natural environment, thus causing the home-based counselor to not receive valuable training for home-based assessment and treatment. Counselors also receive little supervision on home-based issues, or if they do, their academic supervision may contradict that of their agency supervision (Lawson, 2005; Lawson & Foster, 2005; Stinchfield, 2002). In discussing the "difficulty and intensity" (p. 456) of home-based services, Macchi and O'Conner (2010) concluded that counselors are unprepared in this modality and in some instances can undermine treatment effectiveness and contribute to a client family's negative perceptions of therapy. Studies need to be conducted to illuminate the experiences and perceptions of how prepared counselors feel to provide services in home and community settings and how prepared they feel to handle ethical issues in the home and community.

Research Questions

Knowing that home-based counselors have different experiences than office-based counselors, this study sought to answer the following questions:

- How do the participants perceive home-based counseling is experienced compared to office-based counseling?
- How prepared do home-based counselors feel to provide counseling in the client's home and community and in what ways do they feel their preparation program and place of employment did or did not prepare them for this form of counseling?
- What do the participants perceive about ethical dilemmas that occur in home-based counseling and how prepared do counselors feel to competently handle these situations?

Purpose and Significance of the Study

The purpose of this study is to fill a void in the literature by exploring the experiences of home-based counselors and giving them a voice relating to what they experience in the community. Unlike previous studies, the current study goes into depth on training, supervision, useful resources for home-visiting counselors and perceptions of preparedness to counsel in the home and handle ethical dilemmas specific to this counseling environment. Unlike existing studies, this study also explored what home-based counselors perceive would be useful in making them more effective in their role.

The results of this study are important to counselor preparation programs that strive to keep their curriculum up-to-date with current counseling trends and ensure the counselors graduating from their programs are prepared to handle a variety of therapeutic

situations outside of the office. Agencies employing home-based counselors may also be interested in this study's results because this research could provide agencies with information on where there are gaps in knowledge and help them address these gaps as needed. Addressing the training, supervision, and support needs of home-based counselors could also help agencies retain their counselors and help avoid professional burnout, job stress, and staff turnover (Tracy, Bean, Gwatkin, & Hill, 1992; Wasik & Roberts, 1994). Counselors providing services in-home could benefit from this study because this particular area of counseling is often isolated, thus allowing them to talk with others who have similar experiences. Further, it could be beneficial in providing information on where additional training and supervision are needed as well as what helpful resources are available to handle ethical dilemmas. Finally, recipients of home-based counseling could benefit from this study if it results in increased knowledge and preparation of their counselors to therapeutically utilize the home environment.

Limitations of the Study

Qualitative research is useful to gain in-depth perspectives from a smaller group of participants, unlike quantitative research, which tends to have a greater number of participants with more generalizability. The purpose of this study is not to generalize, but to learn about and from the experiences of home-based counselors. While every attempt was made to include a diverse group of participants, the population of home-based counselors willing to take the time to participants in the study was small and primarily Caucasian, so true diversity was difficult to obtain.

Inclusion and Exclusion Criteria of Participants

This study examined how prepared Licensed Professional Counselors feel about providing counseling in the home or other natural client settings. Licensed Professional Counselor – Interns were not used, as interns are expected to feel generally less prepared to counsel than those who have completed licensure requirements. Other licensed therapists such as psychologists and Marriage and Family Therapists were not included since they follow different ethical codes and have different training and supervision than counselors. Counselors were only included if at least half of their sessions are outside of the traditional office or hospital setting and only if they are currently conducting home-based therapy.

Definition of Terms

Boundaries of competence – competence based on "education, training, supervised experience, state and national professional credentials, and appropriate professional experience." (ACA, 2005, p. 9).

Case consultation – Reviewing one's cases with a supervisor or group of colleagues to conceptualize the case and obtain feedback and suggestions.

Confidentiality – "The ethical duty to fulfill a contract or promise to clients that the information revealed during therapy will be protected from unauthorized disclosure." (Arthur & Swanson, 1993, p. 7).

Counselor burnout – "characterized by a state of emotional exhaustion, cynicism, reduced personal accomplishment; emotional, physical, and cognitive fatigue" (ACA, 2009, p. 377).

Counselor impairment – "Impairment occurs when there is a significant negative impact on a counselor's professional functioning which compromises client care or poses the potential for harm to the client." (Lawson & Venart, 2003).

Co-visit – A visit in which two or more counselors or therapists conduct therapy at the same time in order to coordinate interventions or provide therapeutic services as a team. The co-visit team can be comprised of counselors or other health professionals like occupational therapists, nurses, dieticians, or speech therapists.

Demoralization – A feeling of being overwhelmed, discouraged, and frustrated with one's situation or ability to function effectively (Adams and Maynard, 2000).

Ethical Decision-Making – The process of applying ethical and legal knowledge and using decision making skills to solve complex ethical dilemmas with the intent of maximizing benefits while minimizing harm (Lambie, Ieva, Mullen & Hayes, 2011).

Ethical dilemma – "A circumstance that is perplexing because a decision is required between equally unacceptable or unfavorable choices…involving a conflict of moral standards or imperatives." (Leong, 2008, p. 186).

Ethics – "What is good and bad or the study of human conduct and values." (Van Hoose & Kottler, 1985, p. 2).

Home-based counseling – Counseling provided by a licensed counselor in the client's natural environment. This is usually in the home, but can also be settings in which the client needs therapeutic intervention such as parks, grocery stores, or daycares.

Informed consent – Provides sufficient information to a client or potential client about the counseling relationship and process upon initiation of counseling relationship and throughout so that he or she can make an informed decision before undertaking the

counseling relationship (ACA, 2009).

Multi-stressed families – Families experiencing numerous and chronic types of stress such as lack of resources, environmental stress, debt, school and work problems, and illnesses (van Lawick & Bom, 2008).

Natural environment – the places, routines, activities, and people making up the client's typical day-to-day experience.

Ride-alongs – the practice of riding with another home-based counselor from home to home to observe them or work as a team to conduct therapy.

Training – "the instruction and practice of skills related to the counseling profession. Training contributes to the ongoing proficiency of students and professional counselors." (ACA, 2005, p. 20)

Vulnerable population – a population with special needs, disabilities or delays; a population at risk of abuse, neglect, or removal from the home or family of origin.

CHAPTER 2

A REVIEW OF THE RELEVANT LITERATURE

History of Home-Based Counseling

For centuries, the family has been the primary intervener and influence in terms of health, education, and social upbringing (Levenstein, 1981). Outside intervention was sought with the family physician or church to address these issues when the family did not have the resources to solve its issues. Organized home visits to the sick by religious groups occurred as early as 200 A.D. (Wasik & Bryant, 2001). For more than 200 years, Friendly Visitors, charitable members of the community, would go into people's homes to help them with various material and social needs (Bremner, 1971; Worth & Blow, 2010). In the early 1900's, the profession of social work extended from these practices, whereby most of the visits were in the family's home (Woodford, 1999). This early form of home-visiting focused not only on the family's direct needs, but also on utilizing the family's natural support systems to improve overall family functioning.

In the 1950's, Family Centered Services were provided for "multi problem families" (Reiter, 2000, p. 28), currently referred to as "multi-stressed families" (Madsen, 2007; van Lawick & Bom, 2008). As the family unit and view of the importance of parents' role in their children's' lives increased, a shift occurred in which families were no longer encouraged to automatically put children with disabilities into facilities (Wasik & Bryant, 2001). In the 1960s and 1970s, other social trends geared towards children and families' needs came about, namely the child advocacy movement and establishment of interest groups for children (Schwartz & AuClaire, 1995). These movements paved the

way for the Juvenile Justice and Delinquency Act of 1974, which established home-based services surrounding the juvenile's family unit to prevent more restrictive out-of-home placement (Worth & Blow, 2010). In a similar vein, The Adoption Assistance and Child Welfare Act of 1980 was implemented to reduce out-of-home placements and work on family reunification, child safety in the home, and parenting skills to help the family stay together (Wells & Biegel, 1991). Essentially, this meant that more services were provided in the family home. Another legislative act that led to the flourishing of services provided in the home was the Family Preservation Act of 1992, an act whose purpose was to preserve the family unit and to improve services to children in the foster and adoption systems (Stinchfield, 2002).

More recent legislation addresses pregnant women, mothers, babies, and young children in early intervention efforts. The American Recovery and Reinvestment Act (U.S. Congress, 2009) provides funds for Early Head Start and Head Start programs that include home visits to the child's home and additional program slots for young children to attend these early intervention programs which address social needs and early school readiness. The Patient Protection and Affordable Care Act (U.S. Congress, 2010) includes more than a billion dollars for home-based services through the Maternal, Infant, and Early Childhood Home Visiting program, a program aiming to improve child outcomes and proof of utilization of evidence-based therapies (Boller, Strong, & Daro, 2010).

These legislative acts affect the children served by home-based services today, specifically children involved in the juvenile justice and child protective systems,

children with serious mental health and behavioral issues, and children with developmental delays.

Ethical Issues in Home-Based Counseling

Counseling in the client's home and community leads to unique ethical dilemmas whereby common ethical dilemmas are experienced in unique ways (Bryant, Lyons & Wasik, 1990; Strom-Gottfried, 2009; Wasik & Bryant, 2001). How these situations are dealt with may also differ due to contextual factors (Blass, Rye, Robbins, Miner, Handel, Carroll, et. al, 2006) such as family preferences, referral sources and their levels of involvement, and safety needs of the family and counselor. To complicate matters, many of these contexts as well as the larger social context in general change over time, therefore making ethical behavior an ongoing professional journey (Calley, 2009). Strom-Gottfried (2009) posits that ethical decision-making is more difficult in home-based settings because the counselor is exposed to more information than just an office interview, has greater autonomy, and experiences less control over the therapy environment.

Calley (2009) notes that most of the professional literature on ethics is based on general counseling practice and does not target specific settings. Since it would be impossible for counselor educators to cover every possible counseling scenario for counselors-in-training, core areas of knowledge are taught as well as information related to counseling practice. The counseling profession follows the American Counseling Association Code of Ethics, standards that guide ethical knowledge and actions (ACA, 2005). Although the ACA Code of Ethics does not specifically address counseling in the client's home, it does outline general standards counselors should follow to provide

ethical and competent services. The following is a review of some of the basic ethical standards that are germane to home-based counseling.

Professional Competency

Fuller (2004) states, "Home-based family therapy is not merely center-based therapy displaced into patients' homes, but rather requires the therapist to integrate different rules of conduct and, at times, different forms of intervention." (p. 179). Knowing how to conduct therapy in the home requires a different skill set and knowledge level, and thus some counselors might consider home-based counseling a specialization. Despite this, the establishment of home-based standards and guidelines for treatment are in their infancy stage and are therefore not unified into any organization for home-based counselors (Hicken & Plowhead, 2010; Macchi & O'Connor, 2010).

An important issue regarding professional competency includes knowing how to modify office-based techniques and strategies to incorporate the home environment and knowing how to handle information provided by the environment in therapeutic ways, seeking and keeping up-to-date with professional training, and staying informed about the vulnerable populations generally worked with in the home (Macchi & O'Connor, 2010). Keeping within the boundaries of professional training and not trying to address areas outside of counselor training such as physical health or developmental problems is an area discussed by Bryant, Lyons and Wasik (1990) and Levenstein (1981). These authors concluded that because home-based counselors may be the only helping professionals in contact with the family, they often feel compelled to help the family with all problems, whether the problems are related to the counseling goal or not. Counselors must avoid

trying to be all things to all people and recognize when referrals to other professionals or agencies are warranted.

Similarly, the ACA Code of Ethics (2005, p. 9) discusses training and competency for new areas of practice,

> "Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm." (C.2.b. p. 9)

Counselor Impairment and Burnout

As mentioned previously, home-based practitioners often work with vulnerable populations at risk for abuse, neglect, incarceration, family violence, and removal from the home. Under these circumstances, a failed counseling intervention has high stakes for the child, family, and counselor. Other issues related to working in clients' homes that contribute to high stress and burnout are safety issues, less control over counseling sessions and environments, and travel issues such as driving long distances and in traffic (Adams & Maynard, 2000; Christensen, 1995). Wasik and Bryant (2001) add impediments such as low pay, insufficient training and preparation for the job, heavy caseloads, ungrateful clients, and political factors. Knowing the signs of burnout and taking self-care measures are imperative for home-based counselors, especially since they often work in isolation of other counselors and may not have other professionals nearby to notice the impairment.

Impairment is discussed in the ACA Code of Ethics as follows:

> "Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work…" (C.2.g. p. 9)

Informed Consent

During the informed consent process, the counselor informs the client about the therapeutic process and relationship. This information helps the family make informed decisions about counseling (Freed & Drake, 1999) and assists the counselor in setting and maintaining boundaries (Banach, 1999; Klass, 1997; Knapp & Slattery, 2004); crossing boundaries is one of the most cited ethical issues in home-based counseling literature (Christensen, 1995; Lukenda, 1997; Snyder & McCollum, 1999; Worth & Blow, 2010). It is prudent for the home-based counselor to address how home-based counseling differs from office-based counseling and what the counselor's and family's roles are during the informed consent process (Klass, 1997). Since many clients are in mandated treatment, discussion should involve the counselor's obligation to the referring agency and how this affects privacy and confidentiality.

The ACA Code of Ethics addresses informed consent and the inclusion of counselor training and experience, the nature of the counseling relationship, and the way information will be conveyed to other treatment team members in the following:

> "Clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor. Counselors have an obligation to review in writing and verbally with clients the rights and responsibilities of both the counselor and the client. Informed consent is an ongoing part of the counseling process, and counselors appropriately document discussions of informed consent throughout the counseling relationship." (A.2.a, p. 4).

> "Counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor's qualifications, credentials, and relevant experience; continuation of services upon the incapacitation or death of a counselor; and other pertinent information. Counselors take steps to ensure that clients understand the implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements. Clients have the right to confidentiality and to be provided with an explanation of its limitations (including how supervisors and/or treatment team professionals are involved); to obtain clear information about their records; to participate in the ongoing counseling plans; and to refuse any services or modality change and to be advised of the consequences of such refusal." (A.2.b, p. 4)

Confidentiality and Privacy

Counseling outside of a secure, private office setting lends itself to unique confidentiality and privacy issues. Just by letting a counselor into its home, a family accepts an extra loss of privacy since the counselor can see personal items in the home and further, neighbors may be able to identify the counselor as being part of a particular agency (Lauka, 2012; Roberts, 2006; Wasik & Bryant, 2001). Hicken and Plowhead (2010) and Zur (2007) caution about the illusion of privacy in the home, especially since the risk of being overheard by caretakers or family members not involved in therapy or visiting friends and neighbors is great. It is difficult for the counselor as a visitor to ask extra people to leave the home, so this issue should be discussed in the informed consent process at the outset of therapy and throughout as needed (ACA, 2005, B.1.d, p. 7).

Other frequently encountered issues are sharing information with the treatment team and witnessing reportable incidents like abuse, neglect, illegal activity, or violations of the terms of probation (Bryant, Lyons & Wasik, 1990; Freed & Drake, 1999; Roberts, 2006; Schwartz & AuClaire, 1995). Despite the above issues, the ACA Code of Ethics speaks of confidentiality as a right when it includes:

> "Clients have the right to confidentiality and to be provided with an explanation of its limitations (including how supervisors and/or treatment team professionals are involved); to obtain clear information about their records; to participate in the ongoing counseling plans; and to refuse any services or modality change and to be advised of the consequences of such refusal." (ACA, 2005, A.2.b., p. 4).

Carrying client records in briefcases and cars is also a common practice for home-based counselors since they may go from visit to visit without returning to the office to file progress notes (Bryant, Lyons & Wasik, 1990; Roberts, 2006). This is a procedure that could result in a serious breach of confidentiality if the counselor accidently leaves her briefcase or work phone with client information behind or if the car gets broken into. The ACA Code of Ethics encourages extreme caution with client records in the following statement, "Counselors ensure that records are kept in a secure location and that only authorized persons have access to records." (B.6.a., p. 8).

Coerciveness and Intrusiveness

Since home-based counselors often counsel children who are at risk of removal from their homes, they may have many clients involved in the juvenile justice system and child protective system, therefore they may have a greater caseload of involuntary clients. Although clients or families initiate most therapeutic relationships and there are generally no repercussions for terminating therapy, this is not always the situation in home-based counseling. In addition, some of the systems have a mandatory reporting component to keep the case worker or probation officer involved with progress and compliance of terms of probation or family safety plans, which at times can compromise client autonomy, confidentiality, and the therapeutic relationship. The ACA Code of Ethics (2005) partially addresses this problem by stating, "Clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate

information about the counseling process and the counselor…" (A.2.a., p. 4). The counselor should let the client know what will happen if he or she chooses not to participate or to discontinue the counseling relationship. Further, "When counseling minors or persons unable to give voluntary consent, counselors seek the assent of clients to services, and include them in decision making as appropriate." (A.2.d., p. 4).

Levenstein (1981) discusses the related issue of service intensity. Home-based programs tend to be quite intensive in nature and they may subtly pressure families to receive services on the program's terms. Values and goals from the involved agencies may be forced upon the family and the family may not feel like they are in the position to refuse. Further, they may be worried that not going along with the recommendations may reflect poorly on their parental judgment or show a lack of caring for the child (Schwartz & AuClaire, 1995). Additionally, the counselor must focus on client autonomy when providing advice and interventions as there is often a balance between what the client thinks is right and what "the system" thinks is right (Bryant, Lyons & Wasik, 1990; Schwartz & AuClaire, 1995). Counselors may sometimes feel compelled to solve the client's problem for the client instead of empowering the client to solve his or her own problems. Slattery (2005) refers to this as a blurring of paternalism versus beneficence. The ACA Code of Ethics states, "Counselors recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf." (A.2.d., p. 4).

Boundaries

The intensity of home-based counseling in collaboration with the personal nature of being in the client's home can make counseling feel more social and guest oriented (Bryant, Lyons & Wasik, 1990; Klass, 1997; Lauka, 2012; Macchi & O'Connor; Snyder & McCollum, 1999) and thus lead to more difficulty maintaining professional boundaries. The informality of entering people's homes tends to make families more likely to ask the counselor personal questions or ask the counselor to help out with household tasks (Cook & Sparks, 2008; Hicken & Plowhead, 2010) like folding laundry while they talk or asking the counselor to watch dinner on the stove while the mother changes the baby's diaper. Families may also feel the need to take on host duties such as tidying the house before counseling sessions and trying to meet possible needs of the counselor (Slattery, 2005) such as asking how their day is going or if they would like something to drink. Bryant, Lyons and Wasik (1990) focus on the additional issue of directly observing the family's poverty and need and wanting to help meet those needs by doing things such as bringing groceries or clothes from their own children.

Besides warning against sexual relationships involving current or former clients and their family members, the ACA Code (A.5.a. & A.5.b., p. 5) guides nonprofessional interactions and relationships by stating, "Counselor–client nonprofessional relationships with clients, former clients, their romantic partners, or their family members should be avoided, except when the interaction is potentially beneficial to the client." (A.5 c., p. 5). These potentially beneficial interactions encompass some situations that could be encountered in home or community-based counseling such as formal ceremonies and hospital visits to a family member. These guidelines give counselors a few examples of

acceptable counselor-client interactions but leave many of the unique encounters experienced in the home unaddressed.

Multicultural Competence

As noted above, a family's home can be a source of information about their culture of origin, level of acculturation, interests, and what they deem important. Additionally, in one way or another, counselors' cultural makeup is likely to differ from that of their clients, whether it is ethnicity, socioeconomic status, age, or other characteristics. It is always important for counselors to be culturally aware and responsive, but this is especially relevant in the home setting where certain customs should be followed (e.g. for instance removing one's shoes before entering the home). Another common custom is the offering of food, drink and small gifts when coming into a client's home (Fuller, 2004). Multicultural sensitivity is mentioned in terms of a clear and understandable informed consent (A.2.c., p. 4) and culturally sensitive assessment (E.8., p. 13), as well as the avoidance of imposing one's own beliefs and values upon the client (A.4.b., p. 4), and the receipt of gifts (A.10.e.).

Termination of Services

The two major issues related to termination of services found in the literature relate to program structure and repercussions of terminating counseling. Like most counseling programs, home-based providers have limited resources and must monitor use of those resources. Counselors may have to discontinue services due to a pre-set number of offered sessions ending or the client no longer qualifying for services (Blass, Rye, Robbins, Miner, Hande, Carroll et al, 2006; Wasik & Bryant, 2001). A situation often occurs when neither the counselor nor the client feels ready to end the helping

relationship. On the other hand, it can be difficult to end the relationship when the family would like to do so because it may feel bound to disinvite the counselor from their home. Counselors may also question what to do with a client who does not seem to be benefitting from services or who is noncompliant with treatment. If the counselor terminates the relationship and ends counseling, an important question arises: will the child be removed from the home, become incarcerated or hospitalized? Essentially, the stakes of termination may be higher due to the nature of the clientele and referring agencies.

When discussing termination issues, the ACA Code of Ethics warns against client abandonment and neglect (A.11.a, p. 6) and encourages referral to other resources when the counselor deems he or she cannot help the client (A.11.b., p. 6). Additionally, the counselor is ethically able to discontinue counseling when he or she has been threatened or feels unsafe with a client (A.11.c., p. 6), which may be more likely to happen in the client's home environment away from coworkers and other means of support (Christensen, 1995). Regardless of the circumstances of termination, it is very important for the counselor to prepare for termination by discussing it ahead of time and when possible, reviewing accomplishments and providing referrals if needed (Wasik & Bryant, 2001).

Research on Perceptions of Home-Based Counselors

While numerous studies exist that research the benefits of home-based counseling with specific populations or present theories and ideas, only 15 studies were found that explore the perceptions of the counselors involved in this type of therapy.

General Perceptions of Home-Based Counselors

Tracy, Bean, Gwatkin and Hill (1992) conducted a study on family preservation workers to explore their levels of job satisfaction and stress related to the demands of their position. Thirty-five people participated in the cross-sectional survey study, 70% of the participants had master's degrees in either social work or psychology and 30% had bachelor's degrees in a related human services field. The researchers administered survey questions assessing participants' attitudes towards the job, job stress, job satisfaction, and burnout using the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981). Three out of five of the circumstances rated as most difficult for the family preservation workers were specific to home-based counseling: seeing difficult living conditions of their clients, going into high-crime areas, and travelling to see their clients in bad weather conditions. The remaining two were working with abused children and the impact of recommending the child's removal from the home. Participants rated as moderately to highly emotionally exhausted despite reporting satisfaction with their lives and jobs. Possible reasons for this emotional exhaustion besides the circumstances listed above relate to job-specific issues like brevity and intensity of services, crisis nature of referrals and services, working with multi-stressed families, and being on-call and available to their families 24 hours a day. It is interesting to note that this was a pilot study and no further related studies were found by this author. Although generalizability is limited due to the small sample size, the study does provide a glimpse into the experiences of family preservation workers.

Christensen (1995) used focus groups to study the perceptions of 10 home-based counselors working with clients who were mandated to receive home-based counseling.

Most of them found the home environment distracting and countertherapeutic and found the need to set limits and boundaries with the families served, although not all of them were comfortable setting these boundaries on the family's turf. They felt the office serves as a natural boundary that does not exist in the home. The counselors agreed that office work took less time to be effective than home-based work due to the distractions and lack of boundaries. Most of the counselors were concerned for their own safety as well as the safety of family members not only during sessions but after they left the home. All counselors participating in the study agreed that they would like more training in home visiting.

Snyder and McCollum (1999) studied Marriage and Family Interns who were trained for clinic-based counseling to see what differences they perceived in the home environment. Six interns, from two different programs, provided services to families receiving the Head Start early education program and participated in the study. Many of these interns noted a difference in the formality of the clinic as opposed to the more social setting perceived in the home-based counseling. The things they stated as being most important were accepting the family's situation and determining what could be done about it, redefining confidentiality and boundaries, joining with the family and pacing sessions, and handling therapeutic challenges in the home.

A qualitative study conducted by Banach (1999) involved the experiences of six bachelors level social workers, two of whom were in a student internship status, and the program director for a home nursing agency providing services for children at risk of psychiatric placement. The focus of the study was what these workers liked most about the job and what they found most challenging. The most common benefits of home-based

work were flexible hours, autonomy, and intensity of service provided to families, and seeing positive changes after interventions. Issues experienced as most difficult were maintaining boundaries in such an intimate setting and terminating services with their families.

Perceived Preparedness and Competency

The impact of training on home-based providers' attitudes was studied by Pecora (1985) using a pre-test, post-test design and two days of training sessions addressing strategies to use in the home, stress management, crisis work and prevention, family engagement, assessment and goal setting, and continuity of services. As in research published by Banach (1999) and Tracy, Bean, Gwatkin and Hill (1992), bachelors and master's level providers were included in the study. Fifty-six participants answered survey items utilizing a Likert scale to assess attitudes. Pecora found significant shifts in worker attitudes in 23 of the 27 areas assessed, illustrating that training did indeed have a noticeable effect on the home-based workers' attitudes relating to their jobs and suggesting an increased feeling of competence gained from the training.

Wasik & Roberts (1994) researched supervision experiences, as well as home visitor characteristics and training. This study utilized a 54-item survey to gain information from 1,904 participants who described their agency settings, themselves, and their growth experiences. Agency categories revealed in the study were educational, social service, health, and Head Start (which has components of the other three categories). The study revealed that most of the agencies hired home-visitors with at least a bachelor's degree (85%) and about 11-14% required a master's degree. Some employed paraprofessionals who were generally paired with degreed professionals to conduct

therapy as a team. Seventy-nine percent of the Head Start respondents reported having in-service training and written materials about home-visiting. Seventy-one percent of the social service respondents indicated they had this training while education agencies reported the lowest amount of training, with public education agencies reporting 47% and private education agencies reporting 43%. Ninety-two percent of agencies reported the presence of individual supervision, 72% have some form of group supervision, and 73% have some kind of on-site supervision. The reported frequency of supervision ranged from once a week to quarterly. The most frequently cited important characteristics that home-visitors should have are helper characteristics like warmth and empathy, knowledge of community and resources, and "strong interpersonal and communication skills" (p. 340). Wasik and Roberts recommended for more training and supervision to avoid home-visitor burnout, stress, and under-preparedness.

Lukenda (1997) surveyed 30 and interviewed 27 doctoral psychology students as well as two supervisors working at the Rutgers Counseling Program's home-therapy clinic. She studied six specific counseling categories: basic counseling competencies, home-based counseling, family therapy, school and court consultation, cross-cultural counseling, and co-therapy. Lukenda found that 83% of her participants felt they had less than adequate training to provide counseling in clients' homes. The supervisors stated that the most prominent issue in supervision is situations encountered in the home that would not happen in traditional office settings. Considering the amount of clients' involvement with other agencies, counselors in the study expressed a desire to learn more about community agencies and multisystemic therapy issues so that they could better advocate for their clients and ethically interact with these agencies. Boundary issues were

a frequent concern, with counselors noting boundaries are different in the home than in an office setting. In the cross-cultural counseling category, 60% of the participants had taken a multicultural counseling course and 43% rated their multicultural training as inadequate. Lukenda suggested the development of a training manual that would potentially be used by the Rutgers program.

A study that delved into the experiences of home-based therapists was conducted by Adams and Maynard (2000) using a focus group approach to interview home-based therapists. Twelve Marriage and Family Therapists participated in two separate focus groups. As in Christensen's study, they had fears about family members' safety after they left the session, but unlike Christensen's study, they did not fear for their own safety. The participants of this study expressed that they were familiar with family therapy, but not as familiar with case management and community resources. They were familiar with crisis protocols for the office, but not sure about how these protocols would translate into the community environment. On one hand, they were happy overall with their Marriage and Family Therapy training, but on the other hand, many felt a sense of burnout and demoralization.

A dissertation conducted by Stinchfield (2002) explored the competencies needed by home-based therapists. The author conducted individual interviews and one focus group, from which she obtained the feedback that the competencies basic to home-based therapy are different from the ones needed for office-based counseling. Specific competencies mentioned were handling the balance of power in the home environment, ethical issues stemming from the home, safety issues, cultural competence, ability to join with the family in their environment, burnout, and training and supervision needs. Only

one out of 10 counselors in the study had heard of home-based counseling in their training program. Stinchfield advocates for consistency in regulations, terminology and training for home based counseling so that the field can be more cohesive and counselors more prepared.

Lawson and Foster (2005) examined ego development, conceptual complexity, and supervision satisfaction of home-based workers. Their respondents had varying levels of ego development, which relates to how one interacts with others and influences the environment. The participants with graduate training had higher conceptual levels, which is how they conceptualize treatment. This is logical since the respondents with bachelor's degrees, associate's degrees and high school diplomas have not had any counselor training. The majority of counselors (90%) received case consultation supervision, 27.5% reported live supervision and 6.7% used videotapes of their sessions in supervision. Eight percent were happy with their level of supervision and 17.5% felt they received too much supervision. Almost one fourth of the counselors received one hour or less of supervision per month and about one fifth received one hour or less of group supervision per month. A little more than half (56%) reported weekly supervision. Even with this amount of counselors receiving weekly supervision, seventy-four percent were dissatisfied with their current level of supervision and felt unsupported by the lack of supervision. These findings are similar to Wasik and Roberts' (1994) study, which also showed an unmet need for increased supervision.

Worth and Blow (2010) conducted a quantitative study of counselors, social workers, and marriage and family therapists exploring the attitudes and experiences of home visiting. They administered a 58-item survey that had 57 Likert-type items and one

open answer item about ethical dilemmas the participants had faced. Most of the participants said the home environment helped build rapport with the family. Sixty-eight percent thought clients appreciate the collaboration involved in home therapy and 55% thought being in the home gave them a therapeutic advantage. About 84% said they did not have any coursework or supervision addressing home-based therapy and half of the respondents wanted this coursework and supervision. Social workers felt the most prepared to do therapy in the home. Most of the participants reported ethical concerns like confidentiality, boundaries, and legal issues like families violating terms of Child Protective Services or probation. It is interesting to note that while half of the respondents wanted more training and supervision, half of them were satisfied with their current level of training and supervision, which is a higher level of satisfaction than reported by Lawson and Foster (2005) and Wasik and Roberts (1994).

While developing an internship training program for home-based service delivery, Mattek, Jorgenson and Fox (2010) conducted a study to determine the effects of their year-long training and supervision on the interns' levels of self-efficacy and satisfaction with the training. Ten internship students received intensive training on working with diverse families who live in poverty, early child development and related clinical skills, evidenced-based treatment procedures, and data collection. Interns observed experienced counselors in person and via training videotapes before they practiced new skills independently; they received weekly supervision to process their experiences. The authors modified the Counselor Activity Self-Efficacy Scales (CASES) (Lent, Hill & Hoffman, 2003) to be more appropriate for home-based therapy and found significant increases in self-efficacy scores at the end of the training and internship. Using a seven-

point Likert scale (with one being poor and seven being excellent), students rated the training as good or excellent (M = 6.40, SD = .96) as well as the quality of their clinical experience (M = 6.60, SD = .51). This study supports the suggestions by Christensen (1995), Cortes (2004) and Lawson and Foster (2005) to provide specific training that addresses unique issues found while counseling in clients' homes.

Research on Ethics Knowledge and Preparation

From the studies mentioned in the previous section, all mentioned the ethical challenges in home-visiting. Some specifically addressed ethical issues faced by home visitors like boundaries (Banach, 1999; Christensen, 1995; Lukenda, 1997; Snyder & McCollum, 1999; Worth & Blow, 2010), confidentiality (Snyder & McCollum, 1999; Worth & Blow, 2010), cultural competency (Lukenda, 1997; Stinchfield, 2002), and mandated clients or mandatory reporting due to referral source (Christensen, 1995; Banach, 1999).

While theoretical articles and books about ethics and legal issues in the counseling profession are abundant, few studies were found detailing counselors' comfort with ethical dilemmas and legal issues. Due to the paucity of research on ethical issues faced by home-based counselors, research articles featuring the general therapy population are included in the review.

Perceptions of Ethical Issues in General Mental Health Providers

Pope, Tabachnick, and Keith-Speigel (1987) conducted one of the first ethical surveys to study the ethical beliefs and behaviors of psychologists. From their study, 456 psychologists rated 83 ethical behaviors in terms of to what extent they engaged in the behavior and how ethical or unethical they believed the behavior to be. They also rated

how effective available resources were in guiding ethical behavior. The researchers found that behavior and beliefs seemed to be congruent overall. Psychologists rated colleagues, internships, and codes of ethics to be the most helpful resources when facing an ethical dilemma. This study seems to indicate that there is often not a consensus when ethical behavior is involved and there are many instances where therapists are unsure about the ethical nature of a dilemma.

Gibson and Pope duplicated Pope, Tabachnick, and Keith-Speigel's (1987) study in 1993 using a sample of National Certified Counselors and adding a few ethical situations to the survey. It is interesting to note that at that time, 27% of the respondents said they had no ethics instruction in their graduate coursework, a situation that is not likely to occur today. Only 29% had a formal ethics course and 68% had ethics instruction integrated into numerous graduate courses but no formal course. Like the previous study, colleagues and ethical codes were rated as being most helpful, but unlike the previous study, ethics committees, journals and state licensing boards were rated as helpful. Using the same scale, Neukrug and Milliken (2011) examined a group of American Counseling Association members to see what behaviors they deemed ethical or unethical. The number of counselors exposed to ethics education was much higher as compared to Gibson and Pope's 1993 study, with almost 98% of the respondents having a formal course in ethics. An interesting result of the study was that 25-50% of the respondents could not agree on whether 40% of the items were ethical or not. Many of these items were not included in Pope and Gibson's (1993) study and included more modern issues such as use of technology and end-of-life issues.

In 1989, a large scale study was conducted by Borys and Pope that surveyed psychologists, psychiatrists and social workers regarding their attitudes about ethical issues and their practices. In their study, 2,133 therapists responded with the researchers reporting that the psychologists, psychiatrists, and social workers had similar attitudes about most ethical issues. Males were found to have more lenient attitudes towards social and financial involvements and were more likely to have non-sexual dual relationships with female clients than male clients. Like the previous studies, this study did not examine helpful resources for ethical issues.

Zibert, Engels, Kern and Durodoye (1998) conducted a study of 357 members of the Texas Counseling Association to determine if there are differences in ethical knowledge based on practice setting, age, gender, years of formal education, formal coursework in ethics, credentials, or theory of counseling. They gave 25 ethical vignettes from an ethics casebook published by ACA to see what the counselors would do in those situations. The casebook contained preferred answers to the dilemmas, which was matched to the participants' answers. The authors found that ethical knowledge was not significantly related to age, years of formal education, formal coursework in ethics, theory of counseling, or credentials. Women scored higher in ethical knowledge than men. There was a difference in ethical knowledge based on setting: private practitioners scored slightly higher than school counselors and counselors from combined "other" settings (military, private school, rehabilitation, business, and probation/corrections) scored higher than community agency counselors. There were only 14 counselors in the "other" setting, while there were 215 in the public school setting, so an even comparison

may not have been possible. There was no mention as to whether any of the participants had read the nationally published casebook prior to the study.

Lambie, Hagedorn, and Ieva (2010) conducted research on ethical decision-making, social-cognitive development, and ethical and legal knowledge with counselor education students. A pre-test, post-test design was utilized to study the effect of an ethics course on the above-mentioned constructs. The researchers found that while ethical and legal knowledge did increase significantly, their social-cognitive development scores and ethical decision making scores showed no significant increase. They concluded that knowledge can increase quickly while ability to appropriately apply this knowledge takes a greater amount of time and experience.

Hermann, Legget, and Remley (2008) focused on the paucity of research into legal concerns of counselors and attempted to contribute to this area with their survey of 444 counselors in school and community settings. The purpose of their survey was to determine which issues counselors commonly faced and their perceived ability to respond to these issues. They also assessed whether there were differences in responses in school counselors versus community counselors and how ethics preparation affected their current practices. The most commonly encountered legal issues were determining whether a client was suicidal, the reporting of suspected child abuse and neglect, and determining if a client posed a danger to others. Most counselors felt well prepared to determine whether to report child abuse or neglect (87%) and 77% felt prepared to assess suicidality. The area in which counselors felt least prepared was how to respond to a subpoena. Community-based counselors reported feeling better prepared than school-based counselors in all items on the survey except for mandatory reporting. Seventy-five

percent of the counselors reported that they have had a class specific to ethics and legal issues and 63% had ethics or legal continuing education in the past three years. Not surprisingly, those who had coursework or continuing education in ethical and legal issues felt more competent in dealing with these issues.

Perceptions of Ethical Issues in Home-Based Counselors

Three studies were found that were based specifically on ethical issues in home-based treatment. The first study by Blass, Rye, Robbins, Miner, Handel, Carroll et al (2006) used a non-empirical "consensus process" (p. 843) to determine the most common ethical issues faced by psychiatric nurses serving homebound elderly patients. Five ethical issues unique to home-based services were identified. The first involved the agency seeking out the clients and the clients' right to refuse treatment. Most of the patients served by the agency had cognitive impairments and were not always considered competent to make medical decisions or maintain their own safety, so nurses struggled with when to encourage services after initial refusal and when to accept refusal. A related issue was patient autonomy versus asserting beneficence when nurses were not sure of the patient's ability to make competent decisions. Protecting confidentiality was seen as a challenge since the nursing team was easily identifiable and often approached by concerned neighbors and family members. Nurses also had concerns about termination issues such as dismissing patients who did not seem to be benefitting from the program and running out of resources to serve the patient, which was also tied to the fifth concern of cost versus benefit of care. Results of this study should be viewed in light of the fact that it was not an empirical study with a formal research process.

A dissertation by Roberts (2006) compared the experiences of therapists providing home-based services with those providing more traditional office-based services using a survey. Of the 97 therapists responding, 59.8% worked with clients primarily in the home, 38.1% were primarily office based and two respondents were equally in the home and office. Home-based therapists had more difficulty with issues relating to confidentiality and role-confusion than their office-based counterparts. Home-based therapists also reported less individual supervision and use of consultation to get help with issues that came up during therapy, and they were more likely to withhold information from their supervisors. While almost 91% of the participants held master's degrees, only 38% report being state licensed. Roberts does not give details about the educational background of his sample, other than about 21% were social workers and about 26% were counselors. It is unclear what type of therapist the other 53% was or why 62% of the therapists did not obtain state licenses. Roberts found that those with state licenses had the same ethical concerns as those who did not. Additionally, therapists who had taken an ethics course (about 81%) did not report different concerns than those who had not taken a formal ethics course.

More recently, Lauka (2012) studied perceptions of ethical situations in home-based counseling using a quantitative survey method. He surveyed counselors, social workers, and psychologists to examine if personal counselor variables affected their views of ethical situations encountered in the home. Lauka found no differences in perception of ethical situations based on gender, discipline, education, employment status, years of experience counseling in the home or as a licensed counselor, and license held. Like Roberts (2006), Lauka compared responses between home-based counselors (n

= 71) and office-based counselors (n = 37), but unlike Roberts, Lauka did not find any differences in perceptions of ethical issues between counselors of the two settings. In his suggestions for further research, Lauka called for research that delves into specific training and supervision of home-based counselors and how this relates to the experience of ethical situations.

The studies in this section illustrate the evolving nature of ethical dilemmas, training, and counselors' abilities to respond appropriately. While some of these studies inform readers about aspects of home-based counseling and the perspectives of counselors providing this service, none of them provide detail about comfort with ethical situations as they are experienced in the home, detail on types of training and supervision, and resources accessed by home-based counselors. The current study aims to fill the gap in the literature by examining what kind of training counselors have received to do home based-counseling and how prepared they feel to provide this counseling, especially in the areas mentioned above.

SECTION III

METHODOLOGY

Introduction

The research methodology for this study is reported in this chapter. This information is organized into the following sections: (1) research questions, (2) research design, (3) participant selection, (4) data sources, (5) data management, (6) data analysis, (7) ethical considerations, and (8) criteria for goodness.

Research Questions

As discussed in the literature review, home-based counseling is experienced quite differently from office-based counseling. The intention of the current study was to answer the question, "What are the experiences of home-based counselors?", and more specifically, "How prepared do home-based counselors feel to provide counseling in the clients' homes or communities and specifically in the area of ethics?". The research questions are as follows:

- How do the participants perceive home-based counseling is experienced compared to office-based counseling?
- How prepared do home-based counselors feel to provide counseling in the client's home and community and in what ways do they feel their preparation program and place of employment did or did not prepare them for this form of counseling?
- What do the participants perceive about ethical dilemmas that occur in home-based counseling and how prepared do counselors feel to competently handle these situations?

Research Design

This study sought to explore patterns and themes in the perceptions of home-based counselors, therefore qualitative research was chosen. Denzin and Lincoln (2000) state that qualitative research studies people in their natural settings and the meanings they give to their experiences, in other words, it "makes the world visible" (p. 4). Sustained contact with participants in their natural environment serves to reveal authentic experiences as well as patterns and themes in the groups' experiences. Qualitative research also aims to expand on existing literature and explore a problem, and in some cases it serves as a call to action (Creswell, 2007).

The benefit of using a qualitative design is that one can obtain rich descriptions of a phenomenon that has not been widely studied. Whereas quantitative researchers assume uniformity and predictability in the world, qualitative researchers acknowledge that meaning is different for different people and groups, which is what Lincoln and Guba (1985) refer to as "multiple constructed realities" (p. 37). These constructed realities are developed from our experiences, values and beliefs in life and are unique to each person. Qualitative design allows openly exploring a phenomenon without imposing preconceived assumptions on the thing being studied, an ideal situation when trying to understand lived experiences and the meaning given to these experiences by each individual participant. Participants can elaborate wherever they see fit and are not held to the specific questions that would be asked in a quantitative design, thus allowing pertinent information relating to the counselors' experiences, beliefs, attitudes, and perceptions to be gathered (Gay, Mills, & Airasian, 2006). The flexibility of the design allows for additional probing to participants' answers, for instance asking "why" or

"how" questions. The flexibility also allows the researcher to follow the experiences and meanings given by counselors without attempting to control the context or environment, as is done in quantitative research (Gay, Mills, & Airasian, 2006). In addition, this design allows the researcher to obtain examples from counselors' experiences, which is helpful to gain insight into how they have dealt with ethical dilemmas and their comfort level with counseling in non-traditional settings.

Under the umbrella of qualitative design, this study used phenomenological framework to explore the experiences of home-based counselors. Phenomenology is a constructivist approach, meaning that people generate meaning from the experiences they have had in addition to their thoughts and ideas about those experiences (Wertz, 2005). Similarly, Schwandt (1997) adds, "In general, constructivists reject scientific realism – the view that our theories chart, map, or refer to real features of the world – and scientific objectivity – when it is defined as accurate representation of the way the world really is." (p. 20). Hays and Wood (2011) maintain that, "Phenomenologists seek to understand the individual and collective internal experience for a phenomenon of interest" (p. 291) understanding that multiple realities exist between counselors experiencing a phenomenon; in this case home-based counseling. Hays and Wood add that phenomenology is congruent with counseling and counseling practices, which also probe for detailed descriptions of client experiences.

The design of the phenomenological study used was a case study, which Stake (2000) defines as an "investigation of a phenomenon, population, or general condition" (p. 473) or a bounded integrated system with working parts. Flyvberg (2011) expands on Stake's definition of a case study, saying the researcher must decide what the unit of

study is and where that unit's boundaries are. The phenomenon in this study, then, is home-based counseling, and the population was counselors who provide most of their services in the clients' homes or communities.

Flyvberg (2011, p. 301) provides four defining characteristics of case studies that help frame the proposed study: 1.) They are defined by what is chosen to be studied, with some kind of unit with specific boundaries, for instance a specific person or population; 2.) They are expected to have great depth and intensity; 3.) The case being studied evolves over time; 4.) They are contextual to the environments being studied.

Participant Selection

The participants in this study consisted of Licensed Professional Counselors (LPC) who provide most of their sessions in the client's home or community environment as opposed to office or hospital settings. LPC-Interns were not used since they are expected to feel generally less prepared to conduct counseling than fully licensed counselors. Mental health providers with licenses other than LPC (e.g. Licensed Marriage and Family Therapists, psychologists, social workers) were not used since they have different educational backgrounds and ethical codes than LPCs.

The goal in qualitative sampling is to select participants who will be "good key informants" (Gay, Mills, & Airasian, 2006, p. 113) or "information-rich cases" (Patton, 2002) that can contribute to the understanding of home-based counseling. Sampling in qualitative studies, therefore, tends to be more purposeful and less random. A degree of generalizability is forgone to find specific participants who will be able to provide the in-depth experiential information needed. Since qualitative research focuses more on depth

and examining representative cases (Stake, 2000), having a specific number of cases is not as important as in quantitative research.

For this study, purposeful sampling, namely criterion and snowball sampling was used since participants were needed who have conducted counseling in the home (the criterion), and this specialization of counseling is relatively rare outside of large metropolitan areas. I started with some known home-based counselors, then I utilized these participants to identify additional potential participants in other cities until the desired number of participants was reached, which for this study was six participants. With regard to maximum variation sampling, which attempts to gain diversity in participants (ACA, 2009), I attempted to choose participants with different demographic variables like ethnicity, years of experience as a counselor, and agency of employment. I was successful in gaining participants who are male and female, Caucasian and Hispanic, and range from licensed this year to licensed for 10 years.

The participants were solicited via email asking them to participate in the study. They were informed of measures of confidentiality and were given information from the Texas Tech University Institutional Review Board for the Protection of Human Subjects as a resource and were assured that participation is voluntary and can be discontinued at any time. An informed consent was be signed, outlining the purpose of the study, benefits and risks of participation, and asking for consent to be audio taped during interviews.

Data Sources

Preissle (2006) posits that qualitative data collection utilizes all of the human senses to collect information about people and the world around us. Keeping track of such comprehensive and rich information during the process of collecting data helps the

researcher with analysis and allows the reader to enter the world being studied. The type of strategies and methods chosen depend on the research question (Berg, 2004; Denzin & Lincoln, 2003).

In this study, perceptions of how prepared home-visiting counselors feel about conducting counseling sessions in the client's natural environment were being studied, so methods able to access these perceptions were chosen. Interviews were utilized to gain information about the participants' experiences. A study of documents from the participants' training programs, association membership (American Counseling Association) and places of employment enhanced the information gained from the participants. Finally, a researcher's journal was used throughout the process to contribute to triangulation of data, which will be discussed more in the "criteria for goodness" section.

Interviews

Phenomenological studies typically rely on the use of interviews as the primary source of data collection (Rossman & Rallis, 2003). Glesne (2006) exhorts that interviews give researchers "the opportunity to learn about what you cannot see and to explore alternative explanations of what you do see." (p. 81). They provide context, details, and descriptions about the phenomenon under examination (Sorrell & Redmond, 1995), especially when the phenomenon occurs internally, as do beliefs, opinions, and values. Interview questions are produced by previous experiences of the phenomenon being studied, observations, and the research question being asked (Glesne, 2006). The interview questions in this study were constructed from the researcher's seven years of experience providing home-based services and current home-visiting research.

Additionally, some of the questions were pilot tested on one participant for a qualitative class project. The test participant and professor of the class gave feedback on the questions, which underwent some revision. As the focus of the study became clearer, additional questions were added and reviewed by a professor who teaches qualitative research.

There are three types of interviews: unstructured or informal conversational interviews, semi-structured interviews, and structured or standardized open-ended interviews (Gall, Gall & Borg, 2007; Glesne, 2006). As the name implies, unstructured interviews do not follow a detailed interview guide, but do lead the participant to the desired information in a more conversational manner. Structured or standardized interviews are the least in-depth and contain predetermined questions worded the same for each participant. They tend to provide for less flexibility and spontaneity than the other types. The interview schedule in this study consisted of semi-structured interviews, which start with specific open questions that allow the participants to elaborate as needed even if the topic goes in a different direction. Order and wording of questions can vary in semi-structured interviews.

A more general interview with grand tour questions (Spradley, 1979) occurred at the beginning of the process to gather information and begin establishing rapport. According to Spradley, grand tour questions encourage participants to give a verbal description of the culture (e.g. people, places, events, activities) under examination. This initial "grand tour" allowed exploration of the counselor's background, perceptions of preparedness, and daily typical experiences counseling in the home. A more specific interview was used later in the process that explored information relating to ethical

experiences, dilemmas, and resources. This interview provided the chance to follow up on the previous interview and gain in-depth information about the counselors' perceptions. A final interview was conducted to allow for follow up questions and clarification of previously gained information. Participants had the chance to add any information they had thought of since the beginning of the study, review the transcripts of previous interviews, elaborate on any comments, revise any statements, and give feedback on the researcher's interpretations from the interviews and document reviews. With the participants' permission, the interviews were audio-recorded and transcribed for data analysis and participant review.

Documents

Documents were the second type of data used in this study. Rossman and Rallis (2003) define documents as "written records of a person's life or an organization's functioning" (p. 98). Lincoln and Guba (1985) further distinguish between documents and records by emphasizing that records are produced to record some kind of event or accounting, like birth certificates or meeting minutes. Documents, on the other hand, are not prepared in response to a request. The documents sought for this study consisted of materials from the participants' training programs, places of employment, and professional associations. This included training materials, policies and procedures from their agencies, research articles, the ACA Code of Ethics (2005), any other ethical code the participants are required to heed, and Council for Accreditation of Counseling & Related Educational Programs (CACREP) standards (2009), which provide learning standards to accredited counselor preparation programs. None of the participants were able to produce documents from their educational institutions. During the analysis of

documents, this researcher was specifically looking for any references to ethics that relate to counseling in the client's natural environment and what is included in training materials and how that compares to the training the participants expressed that they had and desired. Documents published by the American Counseling Association, while framing this study, were also examined for their relevance to home-based counseling and the issues inherent to this type of counseling.

Researcher's Journal

A researcher's journal was used throughout the study to help conceptualize the research process and document thoughts, feelings, and concerns of the researcher that might arise. The journal was kept through all steps of setting up the study, data collection, and data analysis. More information on the journaling process and its role in limiting bias is included in the Criteria for Goodness section.

Data Management

The research process occurred over four and a half months. The first round of interviews and transcription of these interviews occurred in the first month. The second round of interviews also took a month to obtain and transcribe. The final round of interviews took a month. Jamie and Ray were the only two participants whose interviews were not spread out over three months because they joined the study later than the rest, so their interviews spanned two months. The document review occurred from the second interview to the end of the study. While data analysis occurred throughout the process, two weeks were set aside for intensive analysis. The rest of the time was spent preparing and writing the results and conclusions.

Electronic data were kept in analytic files on the computer to assist with data management and analysis. The qualitative research analysis program Dedoose was used to store, code, and analyze data. Interview tapes and transcripts are identified by the pseudonym chosen by each participant and have been kept in a locked closet to insure confidentiality. Audio files were destroyed after transcription and the transcripts will be destroyed upon completion of the study.

Data Analysis

If there is something most leaders in the qualitative research field agree on, it is that data analysis should occur during data collection and not solely after all data has been collected (ex: Glesne, 2006; Rossman & Rallis, 2003; Stake, 2000). According to Glesne (2006), concurrent data analysis helps shape the study. Emerging themes from this early analysis can alert the researcher to questions not previously considered that can be asked in the remaining interviews. Early and ongoing analysis also keeps data from becoming too unwieldy and overwhelming to the researcher (Rossman & Rallis).

Rossman and Rallis (2003), reflecting that "data analysis is the process of bringing order, structure, and meaning to the mass of collected data" (p. 278), suggest some steps to guide the process of analysis. Following their guidelines, I first organized the data using Dedoose, which is secure web-based research analysis software. One method of organization is suggested by Glesne (2006) and involves creating analytic files to separate data by data type, person, emerging themes, or quotations. This helped me find information more easily, began coding schemes that carried on throughout analysis, and helped with condensation of data (Rossman & Rallis, 2003). During and after organizing data, I took steps to become familiar with the data. This entailed transcribing

the interviews and reading them, as well as the documents collected, many times to gain an overall feel for the information (Agar, 1980). Wertz (2005) advises searching for collective perspectives across participants, moving from part to part and part to whole. Hays and Wood (2011) add that differences in experiences should also be noted in order to better understand what has been collected, which was done in the data analysis process.

While becoming familiar with the data, Rossman and Rallis (2003) advise generating categories and themes, with categories describing explicit information and themes describing more implicit processes. Some of these categories and themes were inductive, meaning they emerge through analysis and are not preconceived (Ellingson, 2011; Glesne, 2006; Patton, 2002), while others were deductive and stemming from the related literature and parameters of the study (Rossman & Rallis, 2003). In the process of generating categories and themes, I searched for significant statements that illustrate how home visiting is experienced, a process Moustakas (1994) calls horizontalization. While practicing horizontalization, each aspect of experience is given equal value, then examined at a distance to help minimize bias gained from prior experiences that might influence our assumptions of what is most important (Moustakas, 1994; Rehorick & Bentz, 2008). This was particularly important since I have personal experiences in the phenomenon under examination that could have affected my perceptions of what is valuable to the study.

Once initial categories and themes were generated, I started coding the data, adding categories and themes as needed. Some ideas had multiple codes if they transcended more than one category or theme. The process of coding occurred multiple

times throughout the study since themes and categories will inherently change from the start of coding as additional ideas are encountered. Broad codes were used at the beginning, followed by more specific sub codes.

After coding my data, I interpreted the analysis done on the data. This is where synthesis occurs, meaning is attributed, essence is brought forth, and possible explanations are posited (Creswell, 2007; Rossman & Rallis, 2003). Interpretation is where the participants' stories come together and the phenomenon is described in terms of people, places, events, and experiences (Rossman & Rallis, 2003). Part of interpretation includes searching for alternative understandings. This included talking to people in the home-based counseling field about my interpretations and asking for other possible explanations for the findings. The literature was also revisited to include external points of view.

Finally, categories and themes from the coding and analysis were collapsed into major themes and used to write a description of context and what the participants experienced (Creswell, 2007). Creswell suggests the researcher interpret what happened (textural description) and how it was experienced (structural description), at which point the researcher can "develop an essence" of the experience (p. 157), which is described to readers in chapters four and five. According to Glesne (2006), three roles should be kept in mind when presenting the participants' stories – that of an artist presenting the art, or participants' experiences, in interesting and creative ways; the translator relating home-visiting culture to the readers; and the transformer spurring identification and self-reflection in the readers.

Ethical Considerations

The ACA Code of Ethics (2005) mandates that counselors obtain and maintain the informed consent of all participants, and that this consent lets the participants know the perceived benefits and risks to the study as well as their right to participate voluntarily or withdraw at any time. Informed consent is also important in the matter of dual relationships, or my case, involving counselors from my community in the current study. The Code of Ethics of the American Anthropological Association (2009) emphasizes that informed consent should be used to foster openness and discuss the limits of the relationship. This was done to protect the integrity of the study and the relationships that have been built in my counseling community. Glesne (2006) also provides details about how to handle information that pertains to the study that is received as a coworker or friend and not as a researcher, thus suggesting that the participant choose whether or not that information should be included in the study.

Maintaining anonymity and confidentiality of the participants is of utmost importance for any study, but is especially salient when participants are chosen from a small group where they could be identified by process of elimination. In light of this, the researcher ensured that participants came from multiple sites from various agencies and universities so discovering the participants' identities or those of their environments becomes very difficult, if not impossible.

My choice not to use observation as a data collection method was an additional ethical consideration made in this study. As stated in the introduction, home-based services are generally provided to vulnerable populations and almost always include minors, so observation of a counseling session in the clients' homes was eliminated as an

option. Due to the confidential and private nature of counseling sessions and protection of the clientele served in home-based counseling, the costs of involving this population through observations in their homes seem to outweigh the benefits.

Finally, accountability and accuracy are extremely important in qualitative research. This is summed up neatly by Guba and Lincoln (1981) who state: "An unethical case writer could so select among available data that virtually anything he wished could be illustrated." (p. 378). To maintain the highest amount of accuracy possible, member checks and an audit trail were utilized. A researcher journal was also used to reflect on the process in order to minimize bias.

Criteria for Goodness

As Denzin and Lincoln (2000) state, "objective reality can never be captured" (p. 8). The goal of qualitative research, instead, is to gain a thorough understanding of a phenomenon while maintaining the highest possible level of quality. In quantitative research, reliability and validity help determine the quality and rigor of the study (Patton, 2002). Qualitative research, on the other hand, focuses on trustworthiness.

Lincoln and Guba (1985) discuss trustworthiness at length, giving four conditions for a trustworthy study: credibility, transferability, dependability, and confirmability. Credibility, as the name implies, addresses how credible findings and interpretations appear. Strategies that were used to establish credibility are prolonged engagement, triangulation, peer debriefing, and member checks. Prolonged engagement means the researcher spends enough time with participants to establish trust and rapport, learn the culture, derive meaning from the context, and overcome biases as much as possible. Participants were interviewed three times over the span of two to three months.

Triangulation requires that multiple informants, sources of data, or theories be used to ensure that a fuller and varied picture of the phenomenon is gathered. Interviews, documents, and records were used representing multiple informants from different home-based agencies to help with credibility. Peer debriefing involves using someone not involved in the study as a devil's advocate – someone who can explore the process with the researcher and help foster awareness. A counseling psychology professor knowledgeable in qualitative research and the field of home-based counseling was utilized as a peer debriefer to provide input. The participants were consulted in member checks to make sure their comments were perceived accurately and to provide a summary of their information, which is helpful during data analysis. Transcripts of their interviews were given to each participant to obtain their feedback and allow for revisions or additions. Participants were asked to comment on the themes gained from all participants as another form of member checking.

The second condition for trustworthiness, transferability, refers to the degree to which the results found in the study can be applicable to similar populations in other contexts. Transferability was enhanced in this study by utilizing thick description of the study's participants, processes, and assumptions guiding the study that provide a detailed database of information that can be used by others to determine whether the findings could transfer to their own contexts. Following Shenton's (2004) suggestions, I have included information to the reader on the participants and their organizations including number of participants and organizations and restrictions on participation. I have also included detailed information on data collection methods, number and length of interviews, and time period of data collection. In essence, it is the researcher's

responsibility to provide enough information through thick description so the readers can decide if the information transfers, or is applicable to their situation.

In order to address dependability or showing that the findings are consistent, I have provided detail about research design and implementation, the process of data collection, and a reflection of the research process. This, according to Shenton (2004), allows the reader to understand the process, and if desired to replicate it in future studies. Further strategies that address dependability are triangulation of data and sources and the use of analytic files and an audit trail. The audit trail is used during and after the data interpretation process to serve as justification for how conclusions came about and is included in Appendix I. Documents and interview transcripts have been continuously matched up to statements and interpretations made in the results section to increase dependability.

Audit trails are also used to establish confirmability, or the degree to which the results come from the participants and not the influence of the researcher's bias. A reflexive journal kept throughout the research process has been key in documenting methodologies, feelings, thoughts, processes, and logistics that can be consulted to search for bias. Specifically, the audit trail clearly describes the field notes, summaries or experiences and data reduction processes, how categories and themes came about, and rationale for decisions made throughout the study (Lincoln & Guba, 1985). The documents, journal notes, and transcripts of the interviews were numbered by line and referenced in the final presentation of data so assumptions and conclusions are supported by raw data. Finally, triangulation has contributed to the establishment of confirmability. Three of Denzin's (1978) basic types of triangulation have been utilized in the proposed

study: Data triangulation, methodological triangulation, and analyst triangulation. Data triangulation involves collecting data over time and various contexts and using multiple participants. Methodological triangulation involves using multiple methods of data collection like interviews, documents, and records. Analyst triangulation utilizes multiple analysts to explore multiple ways to view the data. In this study, this has been done by using a peer debriefer and encouraging participants to review their transcripts and my interpretation of the resulting patterns and themes.

Chapter IV

Results

The results chapter includes information about the participants and the data gathered from their interviews detailing their experiences counseling in clients' homes and communities. After a description of the study's six participants and a context of the researcher, the themes and subthemes gained from the data analysis will follow. Material in chapters four and five is followed by notional brackets at the end of sentences and paragraphs that correspond to the Audit Trail in Appendix H. This lets readers know where the information originated, including participant name or name of training document, interview number, page number, and line numbers.

Description of Participants

To maintain the anonymity of participants, pseudonyms are used in place of their names and their agencies' names and descriptive data is kept to non-identifying information. Agency names were created and any similarities to existing agency names are purely incidental. All six participants were gathered from the Southwest United States and as indicated earlier, were chosen to be a representative sampling of the general home-based counselor population. All participants completed three interviews and submitted training documents provided by their agencies or licensing boards for analysis.

Suzy. Suzy is a White female in her late 20's who has been licensed for approximately one year. Through her master's internships, Suzy has worked with an inpatient substance abuse population, college students, children and their parents, and

adults in general office-based counseling. She began working at Children Inc., a home-based agency with a variety of health and mental health professionals serving children and their families, about two years ago as a paraprofessional. Once she became fully licensed, she moved into a counselor position [1]. Suzy submitted a large training binder and a link to training video webinars that are required for all new employees at Children Inc. Suzy graduated with her master's degree from a large university that focused on general counselor preparation with a particular focus on ethics and theories [2]. Suzy's theories of practice are Behavioral Theory and Cognitive Behavioral Therapy [3].

Ryan. Ryan is a White male in his late 30's who did home-based counseling for teenagers involved in the legal system and now does home-based counseling for The Crisis Team, an agency that provides crisis counseling. Between the two agencies, he has done home-based counseling for a total of two and a half years. Ryan said his juvenile justice program did not have formal training documents, but he produced a training binder he got when he started at The Crisis Team. He has experience working in a juvenile residential facility and a general counseling office. Ryan has been fully licensed for one year, so like Suzy, he started as a paraprofessional and accrued his LPC-Intern hours conducting home-based counseling [4]. Ryan graduated with his master's degree from a large university that he remembers focused on diversity and ethics [5]. Ryan said the main theory he uses is Cognitive Behavioral Therapy [6].

Ray. Ray is a White male in his late 50's who began his helping career as an LCDC ten years ago. After becoming an LCDC, he started working as a probation officer. He became an LPC three years ago and a Licensed Sex Offender Treatment Provider (LSOTP) one year ago [7]. Ray currently works in an inpatient psychiatric

facility, an office-setting with juvenile and adult offenders, and the home setting with juvenile offenders. In his position with the juvenile offenders, he has a group of teenagers for whom he serves as a probation officer and a separate counseling caseload [8]. He has done some form of home-based services for ten years. Ray did not get any training on home-visiting, so he did not have any home-based counselor training documents to provide[9]. In place of training documents, his agency's policies and procedures were reviewed, as well as the Ethical Codes for ACA, LCDC, and LSOTP. Ray graduated from a small university that provided general counselor training with focuses on assessment, psychopathology, and ethics [10]. In addition to his counseling roles, Ray teaches a class at a local junior college. Initially, Ray said his theory of practice is Cognitive Behavioral Theory, but as the interviews progressed, he noticed how much he talks about building relationships and amended his theory of practice to include Person Centered Therapy [11].

Hope. Hope, a Hispanic woman in her early 50's, has been an LPC for five years. She completed her master's internship hours and some of her LPC-Intern hours at a general counseling office, then finished her LPC-Intern hours at Children Inc., where she has worked for five years [12]. Hope provided the same training binder as Suzy but she started working at Children Inc. before the webinars were created, so she had not seen the webinars [13]. While working at Children Inc., Hope also operates a private practice where she conducts sessions in her own home or in her clients' homes. She subleases an office for when she feels uncomfortable meeting a client in a home-setting. She also works for The Crisis Team one or two nights a month [14]. Hope got her master's degree from a distance program with mostly online classes. She had a difficult time

remembering any particular focus of this program, but noted she attended during the program's first year of offering a counseling degree [15]. Hope stated that she frames most of her practice in Attachment Theory [16].

Jamie. Jamie is a White female in her early 30's who has been an LPC for six years. She started her counseling career with incarcerated juveniles and a family violence shelter. She worked at a substance abuse inpatient facility for about five years and now she works at Home Health, an agency providing a variety of home health services from various medical and mental health professionals. Jamie said she did a version of home-based counseling at the family violence shelter and the substance abuse facility, where she would go to clients' rooms to counsel in the event of a crisis [17]. She has done full-time home-based counseling with Home Health for two years and also has a small private practice, which is office-based [18]. Jamie submitted a large training binder that she received when she started at Home Health, which coincided with a week-long training course in another state. Jamie went to a large university's counseling program and remembers a focus on theories, abnormal psychology, ethics, and building relationships with clients [19]. Accordingly, she stated that the main theory guiding her practice is Person Centered Therapy [20].

Margo. Margo, a White female in her late 30's, has been a Licensed Professional Counselor longer than the other participants, having become licensed ten years ago. She got her LPC-Intern hours at a psychiatric inpatient facility, then worked at a mental health clinic for six years. Three years ago, she went to work for Children Inc. [21] in a different city than Suzy and Hope. She has the same training documents as Suzy, which consisted of a large training binder and webinars. Margo graduated from a large

University. She couldn't remember a specific focus of her counseling program, but said she enjoyed her play therapy class and remembers it the most [22]. Margo said she integrates from Cognitive Behavioral Theory frequently but also uses various family therapy theories and Supportive-Expressive Psychotherapy [23].

Context of the Researcher

I became interested in home-based mental health services in 2001 when I worked for a community agency that provided some of its services in the office, home, and in schools for children and adolescents with mental health diagnosis. I had obtained my bachelor's degree in psychology, was young and knew it all, and was out to change the world. The agency encouraged at least 70% of our visits to be in the family's home, yet there was no discussion of working in this environment. This did not strike me as odd until the day a mother answered the door in a negligee, invited me in, and sat down on the couch to talk. I suddenly felt unprepared to deal with the unpredictability of home visits.

Five years later, I found myself doing internships as part of my master's coursework for a Hospice program that provided services in the home. This time I had questions. How should I deal with important questions that come up during the session where there are no supervisors or coworkers around? How does culture reveal itself through the client's home and how should I address this? What would be the protocol for a client dying during one of my sessions? Especially if there is a Do Not Resuscitate Order? Thankfully, the issues never approached life or death; just questions of ethics and culture.

Five years after that, I completed coursework for my PhD and again found myself counseling in homes for children with behavioral problems. At this point, education had

taught me that I know nothing and questions about the process were abundant. I became interested in how other counselors feel about how prepared they are to practice counseling in the clients' homes and communities, which led me to the current study.

Restatement of the Research Questions

Traditional counselor training often follows the assumption that counseling services are being provided in a structured office environment, which is not the case for home-based counselors (Cortes, 2004). The provision of counseling in the clients' natural environments lends itself to myriad issues unique to home-based counseling, which counselors may be unprepared to handle therapeutically, therefore undermining treatment effectiveness (Macchi & O'Connor, 2010). This study sought to fill a gap in existing literature by examining how counselors experience home-based counseling, particularly in the areas of feelings of preparedness and ethics. Data were collected and analyzed to address the following questions:

- How do the participants perceive home-based counseling is experienced compared to office-based counseling?
- How prepared do home-based counselors feel to provide counseling in the client's home and community and in what ways do they feel their preparation program and place of employment did or did not prepare them for this form of counseling?
- What do the participants perceive about ethical dilemmas that occur in home-based counseling and how prepared do counselors feel to competently handle these situations?

The research questions are examined in light of the themes gained from the data, which are supported by direct quotes from the participants. Based on a content analysis of participant interviews and a thorough review of their training documents, the following themes emerged: (1) differences between home-based counseling and office-based counseling, (2) feelings of preparedness and preparation for home-based counseling, (3) ethical issues unique to home-based counseling, (4) handling ethical dilemmas, and (5) desired training, preparation, and support.

These five sections are further broken down into sub themes as follows. The difference between home-based counseling and office-based counseling section has the sub-themes of (1) chaos and lack of structure, (2) counselor discomfort, (3) knowing more information about the family, (4) relationship dynamic, (5) therapy in unusual places, and (6) safety issues. The preparedness and preparation section has three sub sections: (1) feelings of preparedness, (2) educational preparation, and (3) agency preparation. Seven sub themes were found for ethical issues unique to home-based counseling: (1) confidentiality, (2) informed consent, (3) boundaries, (4) duty to report abuse and neglect, (5) boundaries of competence, (6) multicultural competence, and (7) burnout. Handling ethical dilemmas is broken down into five sections containing four types of resources used: (1) colleagues, (2) supervisors, (3) counseling literature, and (4) agency policies and procedures; feelings of preparedness to handle ethical dilemmas is the fifth sub theme in this section. Finally, desired training, preparation and support is broken down into six areas in which counselors would like further training and support. The six areas of further training are: (1) topics specific to client population, (2) structuring sessions to minimize distractions, (3) building relationships on the clients'

turf, (4) handling the most frequent ethical issues, (5) case management, and (6) crisis management. Useful modes of preparation and experience participating in the study are also included in this section.

Analysis

Home-Based Counseling vs. Office-Based Counseling

The first and most prominent theme from the interviews matches a theme found in the literature, which is that home-based counseling can be experienced quite differently from office-based counseling (Christensen, 1995; Hicken & Plowhead, 2010; Macchi & O'Connor, 2010; Stinchfield, 2002). Participants in the current study were asked not about differences, but about how home-based counseling compared to office-based counseling and they noted that home-based counseling is like "night and day" [24] and "a whole other animal" [25] compared to office-based counseling. The main reasons why home-based counseling differs so greatly from office-based counseling can be broken down further into (1) Chaos and lack of structure, (2) counselor discomfort, (3) knowing more information about the family, (4) relationship dynamic, (5) therapy in unusual places, and (6) safety issues.

C*haos and lack of structure*. In a series of focus groups, Christensen (1995) found that home-based therapists found the home environment to be distracting and countertherapeutic, and many of them struggled to set therapeutic boundaries in their clients' homes. Participants in this study agreed that this can be a challenge and they elaborated on what they find difficult about the home environment.

> Ryan. First time I went out for the juvenile justice program, I was blown away. I was nervous to begin with. I sat down on their couch in their home with a bunch of kids running around, the TV is up and they're trying to play XBox and I was

> trying to do a counseling session. I was so blown away [laughing]. No one had ever told me what to do [26].
>
> Suzy. I think there's just different dynamics that happen in home based counseling, so in an office it's my space and it's the way I like it and it's quiet and it's comfortable and you know, there are places to sit and there's not children running around in the background and you know, all those things. So in the home there's not always….there's TV's in the background and there's brother running around and dad's sleeping on the couch and mom's cooking and typing on her phone and trying to talk, so there's a lot going on typically. Things that just wouldn't happen in an office. [27].
>
> Hope. I think there's a lot to be said for seeing the children in their homes and natural environments, but I also feel like it might be better for the counselors if we had an office and the families had to come to us because we spend a lot of time chasing them around and they're not there. 15 neighbor kids come running through and the phone is ringing and one of them is playing a video game…we don't really have their attention [28].
>
> Jamie. Not knowing who is in the back bedroom, clouds of marijuana coming out of the room when someone opens the door. Meeting somebody at some random place. We always go where they're at. Wherever they ask us to come. Maybe dad's house this week, a cousin's house next week. We have no idea sometimes the environment that we're walking into. No idea. So that's a major difference between the controlled environment and the uncontrolled environment [29].

All participants mentioned common distractions including TV, video games, extra people coming through the house during sessions, animals, bugs, and not having a clean place to sit. When talking about TV as a distraction during home visits, however, Jamie shared a revelation that altered the way she looks at this common distraction:

> Jamie. [The TV being on] bothered me a lot, a lot, a lot. I thought it was disrespectful. One day I was with this very young girl and we were talking about sex with her boyfriend. In the middle of this conversation, she gets up and turns the TV on and I was *pissed*! I thought, "What is wrong with you?" and then I realized that she didn't want anyone else to hear what we were talking about. And I was like, "OH! I get it! That is the mask! The noise!"…That was her way of making background noise so we could have a private conversation in a very un-private home. I think I got into my car and cried after that because I can't tell you how many times I have been annoyed with the TV. Sometimes it's just being disrespectful and not thinking, but sometimes there's a method to the madness. I had an epiphany that day [30].

Ryan and Jamie talked about how, over time, they have learned to better handle the many distractions within the home by setting up the idea of a therapeutic environment at the beginning of the counseling relationship, which entails talking to the family about home-based counseling and their role in controlling the therapeutic environment. Another solution was mentioning the distraction and asking for adjustments, like asking the family to turn down the TV so the counselor can hear them better. It is notable that Ray, Suzy, Margo and Hope talked about distractions but not what they do about them and all participants expressed that they have conducted sessions with major distractions without bringing it up to the family or asking for adjustments. This coincides and supports Christensen (1995) and Snyder and McCollum's (1999) research in which therapists had difficulty setting boundaries and asking for changes to the environment when they were on their clients' turf. There seemed to be great respect for being invited into clients' homes, sometimes to the detriment of helping prepare the environment to be conducive to productive counseling.

Surprisingly, although chaos and distraction was a common theme running through all interviews for all participants, training documents as a whole were silent on how to handle distractions during home-visits. Jamie's agency, Home Health, was the only agency that went into any detail on what distractions might be found in the home and how to deal with them, which might help to explain her relative comfort in handling distractions. An entire chapter of her materials is devoted to structuring home-visits and includes a discussion of how structure helps maintain boundaries and eliminate chaos, prevents the counselor from getting caught in a crisis cycle with a family, and helps

prevent professional burnout since home health employees and families know what to expect in each session [31]. A journal article at the end of her training binder suggests letting families know what to expect from home-visits, which could help the families be more cognizant of their role in minimizing distractions during therapy [32]. Although Ryan mentioned the greatest distraction of all, that dead bodies were sometimes in the room while he was talking to police and family members [33], his training documentation only mentioned contacting the supervisor after death calls to receive support, and said nothing about going to another place or otherwise handling this highly unusual situation [34].

Counselor discomfort. Some of the common distractions led to counselors feeling uncomfortable in clients' homes. Although participants said that most client homes in which they enter are clean and unremarkable, some homes make them very uncomfortable. Being in dirty environments, not having furniture to sit on, safety concerns, or the presence of dogs, rodents, and bugs play a large part in the collective discomfort. In comparing the home environment to the office in which her interview was taking place, Jamie shared:

> Jamie. The comfort level of the therapist in the home versus the comfort in the office. I have no issue with coming in here and sitting down and leaning back on the furniture and relaxing. Because there *is* furniture [laughing]. Sometimes there's not furniture [in clients' houses]. I've had to make a conscious effort to put my papers down, relax, and sit back and appear to be comfortable. That's not an issue in an office at all. If you're sitting forward like you're about to bolt at any moment, you've got the uncomfortable posture, that's not therapeutic…the environment isn't always clean and so…but that has an enormous effect on the therapeutic relationship if the therapist is obviously not relaxed and is uncomfortable. I can't even begin to think about what's going on in their mind about perceiving me but that's got to be a distraction to think, "Oh, she thinks my house is dirty" or, "She looks uncomfortable like she doesn't want to be here".

> That is *enormous* in what I do…being comfortable, appearing comfortable even when you're not. That's not an issue in office therapy [35].

Suzy and Ray discussed discomfort in clients' homes and related how unsanitary conditions make them feel as well as how they thought they should handle the discomfort.

> Suzy. Today I went and I'm hearing noises and I have just stopped looking around. I look at the kid and the mom and I just don't look. It freaks me out and I can't focus on anything we're doing. I'm panicked. I kept hearing something and so I looked today and there were 4 mice eating dog food out of the dog bowl. That was really bad. That was like 5 minutes into my visit and I don't feel like I should say, "I'm freaking out and I need to cut this short because I don't want to be here with mice". I don't feel like that's OK, so I'm thinking, "I can do this" [36].

> Ray. This one home I was talking about in [small county town], I go into the house and they have a dog, and it looks like she had her puppies like right in the living room, so it's kind of messy over there. It's cold and then you have a couch that the springs are…you have to be careful where you sit. I did sit down on that couch one time but it was such a…when you sat in it, it felt like someone was wrapping their arms around you. And trying to give the impression that you're accepting of their home and you don't want to say, "I can't sit down on your couch because I'm afraid of what might jump out from under it" so you have to act like you're OK with these surroundings even though they're just deplorable. Dishes, messy…so you tell yourself, I wonder if now is the time to talk about hygiene and what germs are but you can't do that until the family feels close enough to you to be receptive of your comments [37].

It was apparent that participants thought about trying to appear comfortable for the sake of building and maintaining the relationship and that they had great respect for being invited into people's homes. The typical response to discomfort in clients' homes was to ignore the difficult conditions unless they were easily changed, like turning down the TV, or if they posed a safety risk to children in the home. As previously stated in the section on handling distractions within clients' homes, most training documents did not address counselor comfort in homes or what to do if the home conditions are uncomfortable. Children Inc. had information on filing a report of abuse or neglect if the

home conditions are such that a child could be harmed from being in them [38] and Suzy said she did file a CPS report on the family with the mice since there were additional concerns about unsanitary conditions.

Knowing more information about the family. Entering a client's natural environment gives counselors abundant information about the client, his or her family, culture, daily routines and functioning (Hicken & Plowhead, 2010; Zur, 2007). Margo, Suzy, and Ray agreed with this theme from the literature and discussed how home visits make them privy to information a counselor would not be able to obtain in an office.

> Margo. I love doing home visits. I think it's just a really clear picture of what the family is going through. There's not a lot they can disguise when you're sitting right there in their living room [39].
>
> Suzy. You see a lot more…things that you know a mom might not think to tell you if she was to come into your office, I mean maybe she wouldn't even think were relevant like if grandma is in the background screaming at the kids or dad gives in to all older brothers' fits. You just see things that you wouldn't necessarily see or maybe not even touch on in an office if they weren't questions that you thought to ask [40].
>
> Ray. You notice that mother has some sort of respirator. You don't get to see that [in an office]. The house in itself…it was cold a couple of days ago. It's a very dilapidated home and it's freezing. You know what they're talking about when I come to the front door? How warm my coat looks. [laughs]. I was like, "Yeah. Do y'all need coats? There is a place in the city called Salvation Army. If you need anything, you can go there." They have a little heater, one of those little bitty oil-filled heaters and the way that they're circulating the heat to the rest of the living area is they have a cheap little fan that they have sitting behind the little oil heater. They're attempting to blow that warm air out into the house. You don't see those dynamics…if somebody is cold and hungry, do you think they really want to hear about the dangers of K2 [synthetic marijuana]? [41].

Consistent with Christensen (1995), Schwartz and AuClaire (1995) and Woods's (1988) statements that counselors can use the environment therapeutically, Ryan further

discussed how he uses information gained from the home environment to observe patterns of interaction.

> Ryan. Many times I've had to counsel with the TV blaring, with 15 kids in the same room while you know, the parents are yelling at each other. You're trying to maintain some structure, you know. I like to go in there and actually just watch sometimes to see what's dysfunctional here. Really you just have to sometimes watch the family to see what the dysfunction is and maybe tell them how they can start gaining some control if that's what they want. [42].

Suzy and Hope also talked about how what they observe in homes informs therapy and lends itself to the use of in-vivo interventions, which are interventions offered by the counselor and practiced by the parent and child at that moment and with immediate feedback. Both noted that this benefit can be negated by experiencing the same distractions that informed the therapy.

> Suzy. I think a lot of times, ideally, hopefully, in reality we're using whatever is happening to tie back into, OK, maybe this is why she's tantruming. Sometimes you can use it and sometimes it's just a distraction that makes counseling hard to do. It's hard to have a real conversation with somebody when there's 10 million things going on [43].

> Hope. Another plus for the counselors [to do office-based counseling] is the floor would be clean and there wouldn't be bugs crawling on them and tics from the dogs. I don't know for some of the children though, if the parent could take what we do in the office and apply it at home. I think they need to see how it's supposed to be done there [44].

A review of Children Inc.'s training documents showed that emphasis is placed on entering the client's natural environment as it is [45], which may imply to some that they should not change it, even if they thought the changes would benefit therapy. This could help account for their reluctance to ask families to change their environments by minimizing distractions like smoke, TV, and pets. Using information gained from the environment was not addressed in any of the other participants' training documents.

Relationship dynamic. When Snyder and McCollum (1999) asked Marriage and Family interns about what differences they see between office-based counseling and home-based counseling, many of them were struck by how casual and often social the process felt in the homes. Handling the balance of power between the counselor and client family can be difficult since the families have more control in their homes and the counselor takes on a guest role (Stinchfield, 2002). Suzy agreed with the casual nature of home-visiting:

> Suzy. I think the dynamics are different. For example, I text my families half the time when I'm on my way. You wouldn't do that if you were in an office, so I think that changes the dynamic of me being a professional and them being the client because you're in their space and their home and so I think it makes it more casual. Which is not necessarily a bad thing. It just changes the dynamic of the…it makes it feel more team-ish than professional-client [46].

Further, Hope talked about how basing therapeutic interventions around family routines like outings or meal times, which is common for her agency, can become confusing to both her and the families with whom she works:

> Hope: There's some families that we get very attached to each other and then they want me to come to the birthday parties and I go during the meal time to watch the kiddo eat and they want me to bring my food so we can all eat together. On the one hand, I could use that with the child, but on the other hand, I feel like that might be crossing the line [47].

Like the difficulty participants had minimizing distractions within the home, building a professional and therapeutic relationship while being a guest in someone's home was found to be a common challenge. Participants tended to use agency policies and guidelines and their Codes of Ethics to guide their interactions, but all of them said they would like more guidance in this area.

Jamie, who seemed to be the most confident in building relationships in her clients' homes, had a chapter in her training binder on building relationships that addressed how the home environment affects the relationship [48] and how the health professionals, most of whom are not counselors, may at times feel like a friend, family member, counselor, or social worker [49]. This chapter also covered the appropriate use of power, how setting boundaries positively affects the relationship, what over-involvement and under-involvement look like, and characteristics of a therapeutic relationship versus characteristics of a friendship.

Suzy, Margo, and Hope's training materials stressed that the family is the head of the treatment team and the number one decision maker, which attempts to equalize or change the usual power differential between counselor and client [50]. There was very little information on the relationship dynamic between home visitor and family besides a portion of a video webinar discussing common boundary issues like giving a family money to buy baby formula and the receipt of gifts [51]. This webinar was an addition to the existing training materials, so Hope had not seen it since she has worked at Children Inc. longer than Suzy and Margo, but it seems to indicate that challenges with the relationship dynamic is a common issue at Children, Inc. Ryan's training materials from The Crisis Team had very little information on relationship dynamic, possibly because counseling relationships are discouraged in favor of short-term crisis management and referral to more long-term resources. Ray said his agency does not offer much in terms of building relationships, but a review of his agency's policies and procedures revealed some discussion about accepting gifts and avoiding any relationship issues that would imply favor for a juvenile or family [52].

Therapy in unusual places. A theme that was not found in the literature review, but was found in the current study is all of the unusual places home-based counseling takes place. The supervisors interviewed in Lukenda (1997) reported that the most common topic brought up in supervision was handling issues that happen in a home but would not happen in an office, but this study did not go into detail about the unusual places therapy often occurs. Jamie talked about two different situations in which she conducted counseling in an usual setting, one in the substance abuse facility she worked at previously and one at Home Health.

> Jamie. Also there [in the substance abuse facility] I did some kind of crisis management out in the dorm areas…the barracks. Formal sessions were in the office but also lots of crisis, lots of [laughs]…I've done therapy with someone hiding under the bed, I've done therapy with someone hiding in the closet…I mean serious issues with severe anxiety, withdraw. Lots of walking therapy there, which wasn't so much in-home, but just, "I've got to get out of here" type of thing [53].

> Jamie. I've had to meet in people's bedrooms sitting on their beds. That's kind of a boundary for me. I don't know about ethical, but just…it's so intimate sitting on someone's bed. Oh [grimace]. Sometimes that's the only place with a heater. They don't have heat in the house except for the space heater in the bedroom and they have babies and I'm not going to sit in the living room and freeze out the babies so we go in the bedroom where the heater's at. There might be someone else in the bed. It's so weird! [laughs]. One time this girl had a couch bed and she was all covered up and everything and when I knocked on the door she said "come in" and she never got up, so I was sitting there on the couch bed and I had been there for like 20, 25 minutes and all of the sudden this guy pops out from under the covers and I was like, "What are you doing! Why didn't you say he was there!" It freaked me out so bad…So sometimes the ethical deal is you don't even know someone else is in the room listening to what you're saying [54].

Suzy did not mention doing therapy in unusual places during the course of her interviews, but during member checking when she reviewed the themes from all participants in the study, she added, "I think it's funny that it says, 'doing therapy in

community places most therapists wouldn't go or unusual places like on the clients' bed'. That happens all the time [laughing]. It's very uncomfortable. It's odd." [55].

Ray, Hope, and Ryan also talked about the fact that home-based counseling also occurs outside of the home in various community settings depending on the client's presenting problem or agency policies. For example, The Crisis Team goes wherever the client is, which may be an accident scene. Ray talked about going into schools or detention facilities to do sessions and Hope talked about how her agency encourages them to go wherever the child has a problem, which might be restaurants, parks, or daycares.

> Ray. You are always in the environment of the child whether it's school or home. With probation, we don't have the youth and family come in here [to the juvenile justice center] unless they're brought to detention. All of our stuff is done out on the front porch, out in the yard, in the house [56].
>
> Ryan. I think obviously with crisis, it's all home-based. When I say home-based, it might be in the ER, it might be out on the middle of an intersection at a wreck, you know somewhere like that, and so there is that therapy there that's the crisis intervention, so it may not necessarily be in the home [57].
>
> Hope. I had another family that we met at a Mexican food restaurant every week. And it was totally because the mother was freaking out. The child was not doing anything a normal child wouldn't do, but because mom was freaking out, he freaked out [58].

Hope's Children Inc. training documents supported the idea that the staff should conduct therapy anywhere the child has difficulty [59]. There was not any detail about the possible ethical issues this poses, such as confidentiality issues in public settings. Hope said she has run into instances where she conducted counseling in a public place with an adult from her private practice and other counselors told her this was a problem,

which seemed confusing to her since her agency encouraged the practice and she had become quite accustomed to meeting in the community.

> Hope. At one point, I had been seeing a lady at an office when I worked as a group, and because she didn't pay very much, they made me give up that timeslot so they could put somebody else in there and so I couldn't see her. I wasn't just going to tell her I couldn't see her, so we agreed to meet at a restaurant every Saturday morning at a specific time. The people in the group told me that's unethical [because] it wasn't confidential. I don't know what the deal was [60].

Ryan's training documents from The Crisis Team focused on entering a crime scene and the importance of leaving things untouched or reporting things that seem unusual to the officer on-scene. There was some discussion of confidentiality in general, but not how this relates to meeting in public. Jamie's Home Health training documents did not discuss any specifics about where they would counsel clients, but it encourages going wherever the client is and there is a brief discussion about contextual boundaries in which something might be wrong in some situations and right in others [61]. Her example of sitting on the clients' bed because that is where the heater is could be an example of a contextual boundary, as could Hope's example of meeting Children Inc. clients in public places but not meeting adult private practice clients in public.

Safety issues. It is notable that there was not a specific question in the interviews about safety, yet safety came up for all participants, usually in the process of discussing how home-based counseling differs from office-based counseling. Participants said they feel safe most of the time, but they talked about some instances where they feared for their own safety or that of the family they were visiting.

> Hope. I've been in the apartments where there have been shootings. I was late to one visit and if I had been on time, the bullet would have hit me where it came through the wall. My last visit in a certain apartment complex, they actually had 15-20 law enforcement officers come to the apartment just below the one we were

> in while I was there…hence another distraction from the home setting [laughs] [62].
>
> Jamie. I'm absolutely terrified that SWAT is going to come in sometime when I'm there. I pray to God they have surveillance that knows I come there with my big bag and name tag. I don't want to get caught in all that. I'm terrified of something like that happening because I have a couple of girls who live in the worst apartment in town. It's bad and the cops are there frequently and her door is like you can tell it has been repaired lots of times because it has been kicked out of the frame. I never know who's in that house when I go over there. It's always in the back of your mind, I guess. I can pretty much put it aside and focus on what I'm doing, but in certain places there's always a level of anxiety and it's not present in other places and it certainly wouldn't be present in an office. It wouldn't occur to those people to be afraid [63].
>
> Margo. There have been a few safety concerns and typically it's not the parents who don't want me there, that I don't feel safe. Some of them, probably the ones I felt most unsafe, have been just like when the family situation or something is going on in the family that is already volatile. I have a dad I was 99% certain was dealing drugs and mom and dad are separated, but he would just show up sometimes, and so you never knew if he was going to show up with a gun or with a gang, or whoever. It definitely was just…you were *on*. Your guard was up the whole time [64].
>
> Ryan. There was one situation we walked into…it was about 6:30 at night and it was getting dark and it was on the [high poverty side of town]. I didn't realize apartments like this existed in this town and it was so run down. There was no electricity and most of the apartments didn't have windows and you had a bunch of kids running around and dogs running around and we were talking to this guy who had schizophrenia. I was sitting there trying to talk to him in the dark with a candle with dogs and kids running in and out. I don't know this guy's history, you know, if he is violent and I don't know…I was getting anxious because it was getting really dark and we were going to have to walk back to our car with people standing around by the apartments [65].
>
> Ray. Some of the families that are involved in criminal activity, they don't want you in their homes. You will get bad vibes [laughs] [66].

Therapists in Stinchfield (2002) described having concerns for their own safety and those in Adams and Maynard (2000) feared for the safety of their client families but not their own safety, since they worried something could happen after a difficult family

discussion once the therapists leave. Christensen's (1995) participants reported fear for their own safety and for that of the families they visit.

The participants in the current study described varying levels of training relating to safety. Ray said the only safety information he got was to watch out for dogs [67]. Ryan's safety information was related to entering unstable situations and crime scenes and using police officers to assist with safety concerns [68]. Jamie's Home Health documents did not contain any information on safety, but she said they attended a safety training a year after initial training, after an incident happened with a Home Health employee in another state [69]. Children Inc.'s training binder had the most information on safety issues in home-visiting, with five pages dedicated to common concerns and related suggestions to guard family and personal safety [70].

Participants were readily able to come up with how home-based counseling differs from office-based counseling, but they had much more difficulty coming up with similarities between the two. Some examples of similarities that were mentioned were presenting problems of the clients [71], counseling theories and interventions [72], the importance of building a relationship with the clients [73], and having distractions in the office environment like intercoms and computers [74].

Preparedness and Preparation for Home-Based Counseling

The second research question posed in the current study asked how prepared do counselors feel to conduct home-based counseling. This theme is divided into three sub-themes that emerged, including (1) general feelings of preparedness, (2) how their educational institutions did or did not prepare them for home-based counseling, and (3)

how their agencies of employment did or did not prepare them for home-based counseling.

Feelings of preparedness. A common theme found throughout the literature on home-based therapists of all types (Christensen, 1995; Lukenda, 1997; Wasik & Roberts, 1994; Worth & Blow, 2010) matches a theme from the current study, which is that many counselors feel unprepared to conduct counseling sessions in clients' homes. Feelings of preparedness seemed to grow with time and experience and many of the participants expressed that they know where to go if they need help.

> Suzy. I don't know that I've always felt very prepared, but I always know what I can do if I have a question. So I always feel like there's lot of support as far as if I'm not sure how to handle something when it's happening, then I always feel like I have my supervisor to help me figure out what to do. [75].

> Margo. I think one of the things [my supervisor] told me when I first started was that there would be a one-year learning curve. You just need to know that up front. Doesn't matter how long you've been a counselor, there would be a one-year learning curve. I truly remember all through the first year, thinking "I feel like the dumbest person on earth". I would walk in some days and just be like, "I have no clue what I'm doing" because it's just very very different. You know? I mean I was like, "I know I'm a good counselor? I've been a counselor for a long time. But I truly felt like I know nothing today." I think as I've done home-based longer, the second year and a half was much easier than the first year and a half. It's much easier now. It really…I love it. It comes very natural [76].

> Hope. Well, I don't think there was any preparation for this type of counseling. I rode with a social worker, that's who I was taking her place. She was considered mental health, but she was definitely on the social work end of resources, and helping the families, rather than counseling. Like I said, [my position at the agency] was brand new, so there weren't a lot of veterans to go to to talk with [77].

> Ray. I don't know…if somebody asked me how well do you feel you're equipped to do home therapy, I'd be like, "Dang, I never even thought about it". I'm sure there would be some things I probably need to….once you do something for an extended period of time, you're not always conscientious about am I doing this right or wrong? There are gray areas. That's kind of one of the down sides is not having specific guidelines about what you should be doing [78].

> Ryan. The first couple of sessions I was getting comfortable with it [working in the home environment]. I walked out and said, what on earth am I doing? With [the juvenile justice program] I just thought, there is no way. I definitely knew it was home-based counseling, but I loved when I was going to meet the student in school. I knew at that point at least I had an office and I could control the environment, so it definitely takes some getting used to [79].
>
> Jamie. I'm not sure that anything can prepare you for home-based counseling [laughs]. They needed a course on dogs and vermin [laughs]. Had they had that, I might have felt a little more prepared…I wasn't prepared to have to deal with all of the other relationships that come into play when you're doing therapy in the home and the unpredictability of chaos and people and this is just out of your control. It's completely out of your control. [80]

When talking about how prepared they feel to counsel in homes, Hope and Jamie commented that it is difficult to understand the home environment until they were in it and actually facing the challenges that come with that setting. This was a small, but important sub-theme that will be further discussed in the conclusions chapter of the study, as it likely has implications for how to prepare a home-based counselor.

> Hope. As far as knowing how people interact and work in their own homes, knowing what to watch for, what to watch out for, but I'm not sure that's something I could be told all of that. I think until you get in there and start getting the feel of it, I don't think you can grasp it. It's like being told what it's like to be married or have a child; you can read all the books and everyone can tell you but until you do it, it's not real [laughs] [81].
>
> Jamie. How could you prepare somebody for stuff that's just not in an office? No one has scary dogs or smokes in an office. Nobody has weird food smells [laughs]. Seriously. Stuff that distracts you from what you're doing. You're like, "what *is* that?" Like holes in the floor, garbage everywhere. It's like no one can prepare you for the personal reaction that you have to some of these things. You can tell somebody, "You're going to see a lot of garbage and smell some weird stuff," but until you're sitting there trying to listen to somebody and you're thinking, "What am I sitting in? There's something wet on the couch! Is this people pee? Is this dog pee?" and she's just yak yak yak and I'm like, "What? I'm sorry, I lost my thought process." What do you do? Say, "Oh, my god, there's something wet on your couch?" You don't have to worry about this stuff in an office. There's no way to prepare someone for the stuff you encounter in someone's home [82].

The main ways counselors were prepared to conduct counseling in clients' homes was through experience, basic counseling principles learned in their counselor education programs, and what their agencies taught them. The next two sections address educational preparation and agency preparation.

Educational preparation. Sinchfield (2002) found that one out of ten of her study's participants had heard of home-based counseling during their graduate training program. In accordance with this, when asked about what kind of training participants received from their educational programs to conduct counseling in homes, responses varied from "none" [83] and "never" [84] to a couple of chapters on home-based counseling in a family counseling class [85]. Some participants simply could not remember if their educational programs discussed home-based counseling. Suzy pointed out that she did not know home-based agencies even existed, so she would not have missed the training or known to ask questions about it [86].

> Hope. Home-based wasn't introduced at all during the program. So there was no special preparation for that. They took us on tours of prisons and state hospitals, and talked to us a lot about that and had professionals come to talk about areas they were working with, but none of it ever pertained to home-based [87].

> Jamie. As far as preparation goes, moderating a discussion in an office is not the same as moderating a discussion in a home. So preparation for that…no. I don't think that dynamic was ever really brought to light about how much the environment can change what you're doing and how comfortable people feel in reacting in one places versus the other. So no. I don't feel like the environment was ever really discussed and how much that affects the therapy relationship [88].

> Ryan. We did a portion of, I believe it was family counseling class…there was only maybe a couple of chapters over home-based counseling…I don't feel like there was a whole lot of attention put towards home-based counseling [89].

Participants talked about general counselor training that has been helpful to them in their home-based role, like building client relationships, using different theories of counseling, working with diverse populations, and handling ethical and legal issues in general.

None of the participants were able to submit documents like syllabi from their counseling courses, so a document review to support this discussion was not possible. In place, counseling literature was reviewed including the ACA Code of Ethics (2005) and the Council for Accreditation of Counseling & Related Educational Programs (CACREP) standards (2009), which accredits counseling programs and provides learning standards. Four of the six participants graduated from CACREP accredited programs, and two came from smaller universities that are not accredited.

CACREP standards (2009) do not specifically address home-based counseling, nor any other specific environment, but the standards do allude to understanding an array of practice settings in which counselors might practice. In the Clinical Mental Health Counseling section, under knowledge it says, "Understands the roles and functions of clinical mental health counselors in various practice settings…" (p. 30). Similarly, the Marriage, Couple, and Family Counseling section states, "Knows the roles and functions of marriage, couple, and family counselors in a variety of practice settings and in relation to other helping professionals." (p. 36) Diverse settings are also brought up in the Doctoral Standards for Counselor Education and Supervision section, "Demonstrates an understanding of case conceptualization and effective interventions across diverse populations and settings." (p. 57).

A CACREP standard that addresses the roles of the client's support systems who might be involved during home-based counseling states, "Recognizes the importance of family, social networks, and community systems in the treatment of mental and emotional disorders." (p. 31) Further standards encourage recognizing professional limitations and seeking supervision when needed (p. 32, 37, 41), as well as being able to effectively link clients with community resources (p. 32, 38), which were themes that emerged in the current study.

The ACA Code of Ethics (2005) also does not directly address home-based counseling, but some ethical responsibilities in the code shed some light on issues commonly faced by home-based counselors and will be further examined in the Ethical Issues section following this section.

Agency preparation. Five of the counselors in the current study received the bulk of their preparation on home-based counseling from their agencies of employment, and Ray stated he did not get home-based training from his school or agency. The agencies had very different amounts of training, ranging from sparse or non-existent for Ray to months-long training before getting their own clients. The difference in the amount of training is quite stark between Ray and the women at Children Inc., but according to Suzy and Margo, more training was not always effective training.

> Ray. Our department has never even said, "here…if you go into homes, this is what you should do." The only one we ever heard was "watch out for the dogs". [laughs] [90].

> Suzy. It was tons of paperwork. *Tons*. And it was tedious and dumb. So I was playing music in the background because I didn't have to engage and think. I'm just being honest. And then I would just fill out the sheets. And I would meet with the trainer and we would go through it and check off did I get 70% of them correct so I could move on. It was horrible [91].

> Margo. It was not effective at all. I don't remember any of it. It would go through all these modules and it would say, like, you know, on line B in section 173, you know, how…I don't remember, but all this law stuff. It applies to our kids, but it does not apply to my job. It does apply in the state capital, but it doesn't apply here. Ten minutes later you don't remember any of it. You're just looking for an answer. It was so menial [92].

It was noted that Suzy and Margo are at different Children's Inc. sites in different cities, but they went through the same training. Hope started at Children's Inc. when training was about a month long and consisted of a 260-page training binder. Since Suzy and Margo started, another month of video webinars was added to the training. It appears that the webinars address some of the topics that were absent or inadequately covered in the binder, for instance, the binder has only two paragraphs on boundaries in the home, and now there is an entire webinar devoted to the most common ethical issues, one of which is boundaries. The binder makes very few references to ethical issues in home visiting and the webinar collection contains two ethics webinars, one on common ethical issues and making good ethical choices and one on ethical decision-making. Consistent with what Hope, Suzy, and Margo reported, the Children Inc. binder seemed to cover policies, procedures, laws, and paperwork processes the most, with much less information about how to conduct oneself in the home, how to handle distractions or structure visits, or common issues faced during home visits.

One area in which participant report did not coincide with the review of their training documents was in the area of case management. The women at Children Inc. reported feeling insufficient in their case management skills, and case management was the second most extensively covered topic in their training materials, with 66 pages

dedicated to it in the binder and additional information in the webinars. This could be partially explained by Suzy:

> Suzy. The most common case management things that I deal with are local issues like how do I get my kids into Head Start or where do I get clothes or where do I get a turkey for Christmas? Those are local things, not something to put in a state resource. Not like 66 pages of whatever [93].

Even with a minor in social work, Jamie felt unprepared to link clients with local resources and she stated this is an area in which she would love more preparation and ongoing training.

> Jamie. I was not prepared for the social work aspect of it. It is absolutely impossible to escape that. I say that, within this line of work with people that are in poverty, it's impossible to do that. I wasn't prepared for that. This is odd because my minor is in social work [laughs]. Just knowing the resources and how to get to them has been really challenging for me [94].

While the overall training process at Children Inc. was not deemed to be very helpful in handling dynamics in the home, participants did find observing co-workers during ride-alongs to be helpful. This was done during the first two months of their training, both before they got their own caseload and while they slowly built up their own caseload.

> Margo. There was lots of shadowing, which was really really helpful…For me that's always the biggest help. You're not going to do it exactly like the other person but you'll have an expectation of what it can look like [95].

> Hope. The observations we have to do…we had to go out with and do so many hours with other people that were already [counseling in the home]…so I guess that's where we get how to handle this and that [96].

Observations seemed to be a common training practice for all participants except for Ray, who did not have anyone else to observe. Ryan said he did a couple of ride-alongs with established counselors when he started The Crisis Team, and now they

always work in pairs [97]. Jamie said she even had an observation as part of her interview with Home Health, which she thought was really helpful to give her an idea of what the job would entail. She expressed regret that Home Health no longer allows this practice, as observations are only allowed once the home health professional has been hired [98].

Jamie seemed the most satisfied with her training, which was an intensive week-long training in another state that covered the history of her program, the theories behind their practices, how to structure visits, how to build therapeutic relationships, how to handle common ethical issues, and where to seek help if needed.

> Jamie. It was the best training I've ever had, honestly, I mean as far as for a job, you had to fly to [another state] and spend an entire week for training. It was awesome. I think they did a really good job preparing me for what poverty entails and meeting people where they're at and understanding that not only is this their home, but this is the way they're used to living. I felt like they helped me understand that that was important and integral to being successful…was to be able to successfully navigate relationships and build relationships with the people in the home [99].

Unlike other participants' training documents, Home Health's training binder focused heavily on practical information, building relationships, and maintaining professionalism in clients' homes. This seemed to be reflected in Jamie's overall presentation, which appeared confident and thoughtful of the processes of home-based counseling. Jamie said one area in which she felt she should have had more training was safety [100], which was noted to be absent from her documents. Additionally, confidentiality issues were not covered much in her training, such as having extra people in the house during sessions or travelling with client charts. She said she got general HIPAA training relating to confidentiality of medical records and they discussed

confidentiality issues at her weeklong intensive training, but she still finds confidentiality issues to be challenging [101].

Ryan said that his training at the previous employer, the juvenile justice home-based program, consisted entirely of weekly supervision and case consultation. His supervisor there led by case examples and role play, but there were no training documents to follow. Ryan said that supervisor suggested some books on home-based counseling, but he could not remember what they were. Ryan had positive things to say about his training with The Crisis Team.

> Ryan. [My supervisor] prepared us for any scenario that we were going to be involved in. He said he had 500 cases, you know, and there were 500 different ways he handled it. He prepared us no matter where we are or where the location is, it's the same thing we'll be doing. We'll be providing assistance to someone in crisis. Crisis intervention at the time, diffusing the situation and helping them realize what they're going through is natural feelings, but also helping them through some of the process [102].

Ryan also had a training binder, which had information on entering a crime scene, working with police officers, maintaining personal safety, keeping in touch with the supervisor, crisis management, and providing community resources and referrals to the victims they served. Things that were noted to be missing from this training document were common ethical issues, handling distractions or chaos in the environment, and practicing within boundaries of competence. The minimum requirement to work at The Crisis Team is a bachelor's degree [103], so not all of his coworkers are counselors, and there was little distinction between what the paraprofessionals and counselors could provide. There was also no information about multiple roles, which might be pertinent since most of The Crisis Team staff also work somewhere else and they could run into a client from their other agency while on shift for The Crisis Team.

Ethical Issues Unique to Home-Based Counseling

Bryant, Lyons and Wasik (1990), Strom-Gottfried (2009), and Wasik and Bryan (2001) argue that home-based counselors face common ethical dilemmas experienced in unique ways by leaving the safety and structure of traditional counseling offices. One might conceptualize it as mapped landmines in an office, where the counselor knows what ethical issues she is likely to face, and unmapped landmines in the home, where the counselor cannot know who will be there, what will be going on, or what will come up [104]. This theme, found in the literature, was supported by participants in the current study as they shared their most common and most difficult ethical dilemmas. The issues that came up the most during interviews were (1) confidentiality, (2) informed consent, (3) boundaries, (4) duty to report abuse and neglect, (5) multicultural competence, (6) practicing within boundaries of competence, and (7) burnout.

Confidentiality. Confidentiality was one of the most commonly mentioned concerns due to often having extra people in the home during sessions like other family members, neighbors, and friends. Often counselors in the study did not even know who the extra people were because it was quite common for many extra people to be there during the counseling hour. Sometimes the participants felt like people in other rooms were listening in, which prevented them from discussing potentially uncomfortable topics, which is also described in Hicken and Plowhead (2010) and Zur (2007). Jamie wondered if she should say anything about the extra people, and whether she even had the right or authority in clients' homes to ask people to leave.

> Jamie. You're not in a secure environment and you're not in a structured environment. Confidentiality kind of goes out the window when somebody's uncle is asleep on the couch. Weird things going on. You never know who is

> going to listening, which is insane. Navigating between, "Do I ask these people to leave? Do I have the authority in this home to ask them, 'could you give us a few minutes alone?'" Perhaps this is a different kind of setting because maybe it's understood in other counseling, but this is our time and I'm coming to your home and this is supposed to be between us, and that's not the case at all [105].

In a later interview, she revisited the topic when discussing not knowing how to handle this situation:

> Jamie. It's not something you can make a list of things we can or can't talk about in front of this person or that person. It's not something you can prepare for. It just happens sometimes. There's a sensitive nature to a lot of the stuff we talk about…birth control, domestic violence, so that's…yeah. It sneaks up on you, I guess, is why it's so difficult. It comes up at inopportune times or awkward times and there's nothing you can do to prepare for it. They'll just change the subject. Or I redirect to the child. Something safe [106].

Ray had a similar problem with confidentiality at juvenile probation. He raised the additional issue of being the only counselor at his agency, so his confidentiality standards are different from those of his coworkers.

> Ray. Breaking confidentiality, you can get too lax working at probation, you think you are probation and you think can do things that other people may not do, there have been many times when I have gone to houses where they have friends, brothers, or other people from some other county or state and they happen to be in the home and I don't even mess with it. If you want to sit in and participate that's fine. And then when you leave you don't have any release to, or anything, to talk with them [107].

Suzy, Margo, Hope, and Ryan also described having people in the home besides the client family, and none of the participants expressed having any training from their agencies on how to handle this almost daily issue. They seemed aware that this could pose a problem, but agency policies seemed to be at odds with confidentiality norms. For example, Jamie said she is encouraged through her agency to work with whoever is in the home and her training documents instruct her to greet everyone present and include them in the session [108]. Children Inc. recommends providing services wherever the client

has a problem in their daily routine, which is often in public places like grocery stores, restaurants, parks or schools [109]. One of Children Inc.'s webinars focused on the importance of confidentiality, including being overheard in public, but this seemed to be more in reference to talking to coworkers about a client in public [110]. Ray [111] and Ryan's [112] documents had just a few lines telling them to guard confidential information but not offering additional detail.

An additional confidentiality issue unique to home-based counseling is the presence of travelling records, in which counselors must carry their clients' charts with them throughout the day and either leave them in their car or bring them into a clients' home (Bryant, Lyons & Wasik, 1990; Roberts, 2006). Additionally, it is customary to carry cell phones and laptops that often carry client information within. Ray and Hope admitted to having concerns about this issue, but not having a good solution.

> Ray. I also think about do you take information like charts with you when they can be taken or lost or…I don't know [113].
>
> Hope. That bothers me. If I have a wreck, I have files in my car and they're going to blow over all creation, but I can't not have them because I have to have them. It's a requirement [114].

The ACA Code of Ethics (2005) speaks to the security of records saying, "Counselors ensure that records are kept in a secure location and that only authorized persons have access to records." (B.6.a., p. 8). This is an example of an ethical expectation being modified to fit the environment, since many agencies require taking a client's chart to their home visit and counselors cannot return to the office to switch out charts between visits. Accordingly, home-based counselors might need to make modifications to assure security of client records like carrying a lock box in their locked

car trunk or password protecting phones and laptops. The participants' training documents were largely silent on this issue with Jamie's agency being the only one to very briefly mention guarding the security of travelling records and talking to their supervisors about agency policies regarding records security [115]. While her training documents did not show much discussion of confidentiality, she said they talked about it at length at her agency after the initial training [116].

Informed consent. Informed Consent is a process in which the counselor informs the client about the therapeutic process and relationship, thus helping the family make informed decisions about counseling (Freed & Drake, 1999). All participants agree that home-based counseling is very different from office-based counseling, yet it was rare that they talked to their families about these differences, which may help to prepare the home environment to be more therapeutic and productive. Most of the participants talked about informed consent only in relation to confidentiality and its limitations including duty to report abuse, neglect, or harm to self or others.

> Ryan. First off, when we get there we first tell them who we are, what our purpose is there, we make sure that they understand that we are not there as an investigator but as a crisis counselor. When we show up I want them to know that. I also want them to know that if they tell me something I have to report it as a crime. If they tell me that yeah they killed this person it is my duty to report that to the officers. [117].

> Ray. I just tell the clients up front that you can speak in hypothetical terms but the things that we talk about, there is no client privilege between you and me, the Feds can come in at any time. When we do staffing, they want to know what you're doing. So then I leave it up to them [118].

The informed consent process was agency specific and none of the counselors in the study mentioned having their own informed consents for counseling. This is problematic for two reasons. First, the ACA Code of Ethics (2005) has specific

information that should be included in an informed consent and it is not likely that this information would be included in an agency consent that also covers non-counseling professionals:

> "Counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor's qualifications, credentials, and relevant experience; continuation of services upon the incapacitation or death of a counselor; and other pertinent information. Counselors take steps to ensure that clients understand the implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements. Clients have the right to confidentiality and to be provided with an explanation of its limitations (including how supervisors and/or treatment team professionals are involved); to obtain clear information about their records; to participate in the ongoing counseling plans; and to refuse any services or modality change and to be advised of the consequences of such refusal." (A.2.b, p. 4)

The second issue involving the absence of doing an informed consent is losing the opportunity to set up the home-based counseling experience, including letting families know what to expect, how they can contribute to an effective therapy experience, and the unique limitations to confidentiality involved when there are additional people in the home or the session is taking place in a public place. Banach (1999), Klass (1997), and Knapp and Slattery (2004) add that the informed consent process also helps to set and maintain boundaries, which is another common ethical difficulty encountered in home-based counseling.

Boundaries. A theme commonly found within home-based literature is difficulty maintaining boundaries due to the intensity of services and social feel of going into someone's home (Banach, 1999; Bryant, Lyons & Wasik, 1990; Christensen, 1995; Lauka, 2012; Macchi & O'Connor, 2010; Snyder & McCollum, 1999). Families are accustomed to offering food and drink to visitors, and many use food or drink to show

their appreciation. Snyder and McCollum (1999) and Knapp and Slattery (2004) maintain that boundaries in home-based counseling need to be redefined from traditional office-based counseling due to the contexts being so different.

Clients offering food and gifts was the most frequent boundary issue experienced by participants in this study.

> Jamie. Food [laughs]…food and drinks, trying to feed you, gifts. I've had more than one client tell me, "You're part of our family". They send me pictures of their children randomly on their phones. These people…they do treat me like family and I'm in their home, so a lot of times we do visits in bedrooms and places where other people wouldn't be invited, which is awkward and weird and uncomfortable [119].

> Ray. When you go to their house, I started seeing them several months ago in the summer…so she brings all this squash from their garden and she's like, "I brought you some squash!" I told her we're really not supposed to take gifts from probationers and their families. The policy we have here is you can't take it yourself but you can say you'll take it and distribute it at detention or with the co-workers. So they use some back there. OK. Once you take something from somebody, they're like, "Ah. Ray. He's our friend." Then they begin to treat you differently…I've gotten everything from like peaches, to pecans, to squash…wanting to give you a puppy [laughing] [120].

Besides being offered food and gifts, Hope said additional boundary issues she faces are resisting the urge to provide things for the children that are not related to their therapeutic goals like clothing, being invited to birthday parties, and being contacted via social networks like Facebook [121]. A few participants talked about the families sending texts and pictures long after the child had left services, mostly to let them know how the child is doing, which could also occur with office-based counselors.

All of the participants said their agencies had policies about the receipt of gifts, which usually involved avoiding gifts with monetary value or over a certain amount of money, taking the gift to share with the office, using personal discretion, and taking

culture and motives into account, which matches ACA's (2005) ethical code regarding examining the context surrounding the giving and accepting of gifts.

Ray said that in most areas, he did not get much training, but in the area of boundaries, he did have policies and memos from his agency regarding holding boundaries for the family's sake and to avoid the appearance of favor to one particular probationer [122]. Ryan's agency training did not focus on boundaries, perhaps because his position does not require or encourage long-term counseling relationships since they are crisis counselors.

Children Inc.'s training binder had only two paragraphs on boundaries, which mentioned the intense nature of going into people's homes, feeling needed, and maintaining professional distance [123]. One of the ethics webinars that was added later covers boundaries in more depth including receipt of gifts, maintaining professional distance, and treating all families the same. An example is used of a family asking their Children Inc. therapist to be their child's god parent, illustrating the process she went through to decide not to do this [124].

Jamie's Home Health training contained the most information on boundaries. Types of boundaries covered are absolute boundaries like physical or sexual abuse, boundaries set by agency policy like transporting clients, and contextual boundaries, which might be right in one situation and wrong in others [125]. Characteristics of a therapeutic relationship are compared to characteristics of a friendship and detail on how to structure visits to maintain boundaries is delineated [126]. Specific information on giving and receiving gifts is covered, including a discussion on considering the impact of

acceptance or denial on the therapeutic relationship. Finally, a decision tree is offered to help Home Health professionals decide if their behavior is ethical or unethical [127].

Duty to report abuse and neglect. Counselors are mandatory reporters and therefore have a duty to report suspected abuse and neglect to law enforcement or Child Protective Services (CPS). Participants in the current study were familiar with this requirement, but many of them struggled with when to report and when to try to help the family with the issue, whether or not to tell the family a report was made, and feeling pressure from their agency not to report.

> Suzy. I think the most common ethical issue I face is whether or not to call CPS if they're not already involved. I've got three [cases] right now that, you know, it's just a really hard….hard decision on whether or not to involve them [CPS]. For a couple of different reasons, one…I'm just being honest…a lot of times they [CPS] don't do what they're supposed to do, so then you lose the family and the family doesn't benefit. So they hold on to families it doesn't seem to make a whole lot of sense and they let go of families you would think they would really want to be involved with. It could be that you'll lose the family and the kids won't get the services they would get if they stuck with my agency, so you don't have a chance to help them. But it's also a law to report when there's abuse and neglect. [128]

> Hope. One home had like 16 dogs and I got tics on me from being in the home. It was a CPS case and I just want to know why the worker wasn't seeing what I was seeing. Another one was that there were roaches crawling everywhere and the CPS worker was going out [to the house] because my mother lived with her sister and her sister had an open case and I'm wondering, "Can't she see that? And do I need to report it because she's already in there?" [129]

> Jamie. There's been an issue where let's give the example of suspected drug use in the home. I don't know for a fact, so that's an ethical dilemma, do I report to CPS on something I'm not quite sure of? How much evidence do I have to have of this before I report it [130]?

Suzy and Margo brought up feeling like they have to get permission from supervisors to report suspected abuse and neglect.

> Suzy. I think that there are times when it's hard to report, because if it was me, I would just call and report but I feel like we have to jump through hoops in order to do that, I feel like I have to justify why it's neglect or abuse and sometimes I'm passively told to help change the situation instead of reporting something I feel like is abuse and neglect, which goes against the law or my education, so that's an interesting dynamic too [131].
>
> Margo. If it's something I have no question about…if I know I can't lay my head down at night and not wonder if this kid is OK if I don't call CPS, I'm just going to call them even if the supervisor says not to [132].

Suzy added that there's an additional concern unique to home-based counseling, which is going into the client's home after reporting, possibly posing a safety risk if the client knows she reported. Speaking of a situation that happened the day of the interview in which she intended to file a CPS report, Suzy said, "This is really bad. I'm afraid for my safety if we report. I definitely think we'll lose the family and I don't know that anything will be done to help them." [133].

Worth and Blow's (2010) participants relayed some difficulty knowing how to handle when families were already on probation or involved with CPS and violating their terms of probation or safety plans. Ray gave a similar example of going to a home to see a client and marijuana smoke coming out when the family opened the door. The family said the teen client was not there, so Ray left wondering if that was something he should report since he was not sure his client was there or not [134]. Therapists in Tracy, Bean and Gwatkin's (1992) study found reporting abuse and neglect to be one of the highest areas of stress since they could be personally involved in a child's removal from the home.

All of the participants had some form of training on reporting abuse and neglect. Ray's Juvenile Justice Professional Code of Ethics (2010) includes an admonition not to

be designated as a perpetrator of abuse or neglect but it does not speak to reporting suspected abuse or neglect [135]. Ryan's training documents made multiple references to not only reporting abuse and neglect, but also being responsible for reporting confessions of crime since he is often working at crime scenes [136] . The Children Inc. training binder had one page devoted to mandated reporting and consistent with Suzy and Margo's report, the policy is to first talk to their supervisor before reporting. One of the webinars expanded on this with the ultimate message that it is not up to the employee to determine if abuse or neglect is present, just to report if there is any suspicion [137]. Jamie's training binder did not address reporting abuse and neglect, but she felt like her educational program provided thorough training on this common ethical issue [138].

Practicing within boundaries of competence. Professional competence and practicing within professional scope are discussed in home-based counseling literature as being challenges for numerous reasons. Fuller (2004) and Macchi and O'Connor (2010) explain that home-based counseling requires different training and intervention skills than traditional office-based counseling, which counselors may or may not have when they start practicing this specialty. Additionally, home-based counselors may be asked for assistance in areas outside of their area of expertise (Bryan, Lyons & Wasik, 1990; Levenstein, 1981) and feel compelled by the families or even their agencies to assist in these areas. Hope and Margo talked about doing a general educational service usually provided by bachelor's level paraprofessionals and being asked to work on issues outside of their training like fine motor skills or speech. Margo said she dislikes doing this particular service, which is not counseling-based.

> Margo. It's not what I'm trained to do. It's not what I got licensed to do. It's not what I enjoy. It feels ambiguous when you are just thrown into it when the parents are saying, "Oh he's great, he is fine." It's hard to help them identify needs when they don't see there are any needs [139].

Hope also talked about providing this general educational service and working on fine motor skills, gross motor skills, and speech. When asked if she had training in these areas, she said:

> Hope. Just what I've seen occupational therapists doing [laughing]. A lot of times I just say, "I'm not the speech person but I have seen them do this with other kiddos," or "I'm not a physical therapist but I have seen them do this." [140].

Suzy also mentioned providing this general educational service, but when she started at Children Inc., she was a paraprofessional and was hired into that role. Because of this, she did obtain general training in the areas of motor skills and communication, which could explain why she was more comfortable with this dual role [141].

Working outside of the boundaries of competence was not unique to Children Inc.; Jamie talked about how most of the employees at Home Health are in the medical profession, yet the Home Health training focuses heavily on therapeutic processes that seemed to be counseling specific, "Oddly there is some instruction in being a counselor without being a counselor in this program because no one else, none of the other health professionals are therapists as well." She said she is assigned most of the clients with known mental health issues and staff often bring up counseling issues during their weekly case consultation meeting. She and her coworkers refer to other counselors if the mental health problem seems to be out of Home Health's boundaries of competence or program focus. [142]

The ACA Code of Ethics (2005) cautions counselors to seek "appropriate education, training, and supervised experience" (p. 9) before practicing in specialty areas new to them to protect clients from harm. This seems to address home-based counseling as an area of specialty and working on issues outside of their areas of expertise. This may preclude counselors from working on specialized non-counseling issues like motor skills and speech unless they have gotten specialized training in these areas from their agency and are being supervised by an occupational therapist, physical therapist, or speech therapist. Alternatively, counselors may choose to refrain from working on these issues and instead refer to the specialized therapist working in those areas.

Training documents were largely silent on the issue of practicing within the boundaries of competence. The only reference found to this was in Children Inc.'s ethics webinar, which listed this as one of the top five ethical concerns for this agency. They gave an example of a Children's Inc. employee suggesting a multivitamin when a child seemed to be getting sick, which resulted in the child forgoing a trip to the doctor and becoming sicker [143].

Multicultural competence. Entering into a client's home gives counselors a glimpse into the client's culture and what the family finds important. Being sensitive to cultural norms in a client's home and cultural differences between clients and counselors is an imperative listed in the ACA Code of Ethics (2005). Very few studies in the home-based counseling literature contained discussions on multicultural competence in home-based counseling. While researching what counselors think is important for home-based therapy, Stinchfield (2002) found that participants deemed cultural competence to be one of the areas that was important. Lukenda (1997) studied preparation in six categories, one

of which was cross-cultural competency. Forty-three percent of the participants rated their multicultural education as inadequate. It is possible that 15 years later, counselors are getting more education in multicultural counseling, and indeed Hope, Ray, Ryan, and Jamie remembered a focus on multicultural competence in their master's programs.

A review of their training documents showed that multicultural knowledge, awareness, and skills were mentioned at least briefly in the Home Health documents and The Crisis Team documents. Children Inc. was the only agency that had sections devoted to this topic. Children Inc. had one page in the original training binder devoted to cultural awareness that talked about respecting other cultures, acknowledging our own culture and how it affects how we see the world, and striving for unconditional positive regard [144]. With the addition of the webinar series, cultural competency was covered in more detail with a webinar on the topic. This webinar stressed that culture impacts the way families see healthcare and seek assistance. Encouraging cultural competence, the webinar asked the audience to consider thinking about their own origins, reflecting on stereotypes, biases, generalizations, and value sets, and considering cultural differences in communication. The webinar wraps up by reminding the audience that every family is unique and comprised of many cultural elements [145].

Home Health had a small section for multicultural competence, and comments were dispersed throughout the rest of the binder urging awareness of various cultures, especially the culture and cycle of generational poverty. Specific cultural issues like taking off one's shoes when entering the home or eye contact are brought forth for reflection, as is maintaining awareness of personal biases and prejudice [146]. What

stood out in this training is the emphasis on generational poverty more than emphasis on different ethnicities and races.

Within Ryan's training documents, any discussion of multicultural competence was limited to a few pages at the end that covered suicide in various populations like the elderly, Hispanics, African Americans, youth, women, and the Gay/Lesbian/Bisexual/ Transgendered community [147]. A reference to Ray's Juvenile Justice Professional Code of Ethics (2010) showed two lines about performing duties impartially and without regard to "race, ethnicity, gender, disability, national origin, religion, sexual orientation, political belief, or socioeconomic status" [148], which seemed to be more about not discriminating than being culturally competent.

In the current study, multicultural competence was not a frequent theme, but Jamie and Ray did speak to maintaining awareness and knowledge about cultural values and norms when providing counseling interventions in homes.

> Jamie. Another snafu that we've run into is respecting the matriarchal figure in the home, whoever that is, getting in good with them and making a relationship with them. Not even the primary client, but having to navigate relationships with whoever is in the home and being respectful of that because people…you talk about some hard-earned beliefs when it comes to child-rearing. Old-school mamas…you don't cross them with things like that, so you have to be *super* super careful and skilled at challenging those myths about what they believe [149].

> Ray. I remember one time at one of our practicum hourly meetings during school… it was a Hispanic family and what was mentioned was cultural issues because the dad was doing all the talking. It was dad, wife, son. I don't know…we were talking about enabling or co-dependency and I asked him, "Can your wife speak for herself?" and that just totally insulted him and his wife and he told me, "You know what? You obviously know nothing about Hispanic culture." And I was like, "You're absolutely right!" [laughs]. That was her role in the family that they had been used to for years and in her family. They did not look at the concept of enabling. It was good nurturing the way she saw it [150].

In talking about how culture affects boundaries, Ray and Jamie said:

> Ray. Some people, Hispanics in particular, when you come to their home, you begin to be looked at as a friend. It's hard to be confrontational or challenge them because they see you differently [151].

> Jamie. Usually with just food I accept it. To me, it's more of a cultural thing that would be insulting for you to be like, "No. I don't want that or no thank you," or "I just ate" because it's their way…most of the time they have very little so that's something that they have to share. Food. So I would feel bad telling them no when it's a very generous gesture on their parts [152].

Burnout. The intensity of home-based services, nature of the population served by home-based agencies, and unpredictability of the therapeutic setting can lead to counselor burnout (Adams & Maynard, 2000; Christensen, 1995; Tracy, Bean & Gwatkin, 1992; Wasik & Bryant, 2001). The only study found that focused on burnout was Tracy, Bean and Gwatkin (1992). While participants reported feeling satisfied with their jobs overall, the group as a whole displayed moderate to high emotional exhaustion. Overall, burnout was not a frequent theme seen in the interviews in the current study, however it was quite evident in Hope. After many comments indicating some level of demoralization and burnout, she was asked outright if she was suffering from burnout, to which she replied:

> Hope. I'm burned out with that job. Absolutely. I love working with the kids and some of my families and I guess this is true with anything, you have the one or two out of 20 that are really helped and that's what you have to focus on [153].

In a previous interview, she had talked about the cyclical nature of at-risk families and how this contributes to her feelings of hopelessness.

> Hope. Most of them are lower socioeconomic families. Uneducated. Really street smart because they have to be. They can lie like the best of them [laughs]. Sometimes I just feel like it's so hopeless for me to try to do anything with that child because of the environment he's being raised in and that's what's going to shape him. All five uncles went to jail, and dad went to jail, and my brothers went to jail…now it's my turn [154].

Hope said that most of her caseload consists of clients from CPS who are mandated to attend counseling, both at Children Inc. and in her private practice [155]. This is not the case for all counselors at Children Inc., which may account for why Hope expressed burnout and Margo and Suzy did not. Hope also said her agency requires evening visits and vast amounts of paperwork and employees are told to do the paperwork in the homes with the clients. She thought spending time doing paperwork during clients' sessions takes away from the counseling time and negatively impacts the counseling relationship. While discussing burnout she lamented, "The demand on the hours and the demand on the paperwork. I understand why they're doing it, but it's just not realistic." [156].

Suzy also talked about the stressful nature of the paperwork and some demoralization stemming from this.

> Suzy. I feel like there's so much focus on how paperwork looks and that paperwork looks great and especially in intake and other assessments and nobody ever asks, "Are your visits working?" [laughs] "How's therapy?" That's not often a focus. I came home one day and I had only made like four visits that day, it had been a slow day, and I called one of my coworkers and told her, "I had really good visits today" and she laughed and said, "Nobody ever asks about that, huh?" and I was like, "No, they don't." It's more, "Is my paperwork on time and does it look good and was it signed nine million times where it was supposed to be." There's no focus on did you have any quality visits this week [157].

Children Inc.'s training materials contained two pages on managing stress, which acknowledged that the therapist may have too many responsibilities with not enough time to get it all done. Suggestions are offered on avoiding burnout including utilizing support systems, maintaining professional boundaries, and practicing safety precautions during home visits [158].

Some ethical issues were found in the literature but were not brought up by participants in this study. Some of these ethical issues are coerciveness and intrusiveness relating to families feeling forced to accept services or have their child placed, and termination issues like having to discontinue services before the family or counselor is ready. It is possible these particular issues did not come to mind for participants during the interviews, are not commonly experienced, or are not perceived to be ethical issues.

Handling Ethical Dilemmas

During the literature review, four studies were found that focused on ethical issues in home-based counseling (Blass, Rye, Robbins, Minder, Handel, Carroll et al, 2006; Lauka, 2012; Roberts, 2006; Worth & Blow, 2010). However, none of them provide detail about comfort with ethical situations as they are experienced in the home, ethical decision-making processes, or resources accessed by home-based counselors.

A search of general counseling literature revealed two studies that explored what resources counselors, social workers, psychologists and marriage and family therapists found useful to deal with ethical dilemmas. Pope, Tabachnick, and Keith-Speigel (1987) found that colleagues, internships, and ethical codes were the most commonly utilized resources. A duplication of this study was done in 1993 by Gibson and Pope and once again colleagues and ethical codes were found to be the most utilized resources, but in addition, participants reported finding ethics committees, journals, and state licensing boards helpful.

In the process of discussing the most common or difficult ethical issues, participants in the current study were asked to talk through the process of how they handle ethical dilemmas including what resources they found useful. Consistent with

Pope, Tabachnick, and Keith-Speigel (1987) and Gibson and Pope (1993), colleagues and supervisors were the most common resources participants used when facing an ethical dilemma. Behind consultation with colleagues and supervisors, participants referenced the ACA Code of Ethics (2005) or other ethical codes, and consulted other counseling literature like textbooks or websites. Resources that came up in the current study that were not mentioned in the literature include checking agency policies and procedures or utilizing materials or knowledge gained from ethics training required to maintain LPC licensure.

Colleagues. The most commonly cited avenue of handling ethical questions and dilemmas was talking to counselor colleagues, both co-workers and friends in the profession from other agencies. This is generally done in two main formats: scheduled case consultation meetings as a team and informal consultation. Jamie's agency, Home Health, had the most frequent case consultation meetings, with meetings every other week to discuss difficult cases and resources [159]. Both Children Inc. sites have monthly group case consultation meetings, but Suzy and Hope said much of that time is spent discussing policies and procedures and they would like more case consultation time to discuss cases. They noted that they could ask for time during this meeting if something urgent was happening, but Hope said she hesitates to do this for fear of taking more than her share of time [160]. Ryan's agency, The Crisis Team, has formal group staffings every three months and Ray said he does not have counselor staffings at juvenile probation since he is the only counselor there.

Informal or unscheduled consultation with colleagues or friends who are counselors seemed to be a more common method of solving ethical dilemmas.

> Suzy. I'm really lucky. My husband is a counselor, so we talk about that in our free time [laughs]. We sometimes are like "No more work!" So I've found almost everything…as far as situations I don't know how to handle…he's been counseling for years so I'll talk to him about what he would do and how he would handle that [161].
>
> Hope. When we have an issue we just call each other and say, "What do you think about this?" "What do you think about that?" It's not like structured supervision [162].
>
> Ray. I know several therapists that sometimes will get together or just knowing them through friendship if you really have something you can throw it out there. They're pretty good about giving you feedback [163].

Margo, in talking about why she more frequently consults colleagues, noted that her supervisor is not a counselor, which was the case for all but one participant.

> Margo. I'm going to talk to other counselors because our supervisors aren't counselors. I'm going to talk to other counselors just because the different disciplines handle situations differently [164].
>
> Jamie. Yeah, mine is a nurse...She has absolutely no [counselor] education….no idea in the ability to build that therapeutic relationship with us. It's not there. It's very unfortunate. It could be very effective. It's built in to be so effective [165].

S*upervisor*. Ryan was the only participant whose supervisor is also a counselor. He stated that the Crisis Team employees stay in constant contact with their supervisor on an individual basis, especially after responding to any calls in which a death has occurred, which is intended to help with burnout and personal impacts of the job.

> Ryan. We can always if we have a call-out, we communicate with him how it went, what do we need to do for next time, what we learned from the case, so we've got that supervision [166].

Even though the rest of the participants were not being supervised by counselors, they still used their supervisors as resources when faced with an ethical dilemma.

> Suzy. I always feel like there's lot of support as far as if I'm not sure how to handle something when it's happening, then I always feel like I have my supervisor to help me figure out what to do [167].

Margo. We've got great supervisors, I'm going to talk to one of them [168].

Some reported having the option of asking their supervisor to go on home visits with them or periodic supervisory observation is built into their program model. Supervisor ride-alongs were mentioned for situations in which participants needed guidance or if there were safety concerns [169].

Jamie is the only participant who reported a negative perception of supervision. She said she does not benefit from supervision because her supervisor is not a counselor and therefore is not versed in counseling issues and her supervisor uses supervision time to discuss her own personal issues. Jamie found this unfortunate since she liked the idea of weekly supervision and having the opportunity to staff cases, but she said this was usually not how her supervision time was spent [170].

C*ounseling literature*. The most common counseling literature counselors in the current study utilized was their Codes of Ethics. It was noted that Codes of Ethics never came up immediately when participants were talking about resources; it seemed like more of an afterthought after consulting colleagues and supervisors.

> Ray. Well I generally try and follow the guidelines of ethics between probation and LPC and LCDC [171].
>
> Suzy. There have been situations where I have gone back and read our LPC code of ethics. Then times when I've gone back and read, you know, when are we required to report things, so I guess the literature that's there for that [172].
>
> Ryan. I always refer first back to the code of ethics, the ACA Code of Ethics, and always have that in the front of my binder, so I always refer back to that [173].

Hope, bringing up the Code of Ethics as an afterthought, explained why she does not often refer to it: "The little ethics thing….The Code of Ethics. I *could* refer to that

[laughs] but it's so much easier to talk to another counselor." [174]. She also mentioned occasionally consulting materials she was given at an ethics training she took to maintain her licensure [175].

Margo and Ryan brought up looking at websites like ACA's website or websites specific to her client population to find information and guidance [176]. Jamie is the only participant who brought up the legal hotline that is available to malpractice insurance holders, which indicates that it may be an underutilized resource overall, it may not immediately come to mind when considering helpful resources, or it may not be available due to not having malpractice insurance.

> Jamie. I've never utilized it before, but I know the ACA's hotline is there to talk to them about any legal or ethical issues that you might have. That's always a resource. I've never had to used it before but I know it's there if I needed it for protection or my own guidance [177].

Jamie also discussed referencing counseling textbooks to make sure she's on the right track with specific clients, revealing what her thought process is when considering boundaries of professional competence.

> Jamie. I consulted a specific textbook for sexual abuse with a chapter on incest to make sure I was on the right track because it [the clients' history of abuse] was so, so deep. So I guess maybe the ethical thing was am I prepared for this, am I OK to do this, is this something I can treat and so in that case I made sure it was aligned with what was recommended as far as this book goes [178].

Consulting agency policies and procedures. Ryan and Jamie expressed referencing their agency's policies and procedures when wondering what to do about something. Ryan, especially, had an abundance of policies since he was often working within crime scenes and it was very important for him to follow specific protocols. Jamie admitted that policies and procedures only function as a general but useful guideline.

> Jamie. I guess the roundabout answer is that I have to look to the protocols that I've been given in order to make some of the ethical decisions and some of them aren't so clear-cut. Some are more of a subjective nature, I guess [179].

Feelings of preparedness to handle ethical dilemmas. Research shows that counselors often feel unprepared to handle ethical dilemmas, regardless of their setting. Pope, Tabachnick, and Keith-Speigel (1987) surveyed office-based psychologists about their ethical beliefs and behaviors and found that there were many instances where they were unsure about the nature of ethical dilemmas. In Neukrug and Milliken's (2011) study, counselors were given a list of ethical situations to rate whether each instance was ethical or not ethical and 25-50% of the respondents could not agree on whether 40% of the items were ethical or not, showing that uncertainty was fairly common. Research on ethical preparedness in home-based counseling is rare, but two studies that were found present somewhat conflicting information. Lauka (2012) compared home-based counselors to office-based counselors and found no differences in perceptions of ethical issues between the two. Consistent with the results of the current study, Roberts (2006) found that home-based counselors had more difficulty with confidentiality and boundaries than office-based counselors. Neither study delved into how prepared home-based counselors feel to conduct counseling in clients' homes.

After discussing the most common and most difficult ethical dilemmas and resources they use to solve ethical dilemmas, participants in the current study were asked how prepared they feel to handle ethical issues in the home. Responses varied from pretty prepared to not prepared. The participants who seemed to feel the most prepared were those who have counseled the longest and had more extensive training.

> Margo. I have felt pretty prepared. I think a lot of that is, I don't know I would have 10 years ago. A lot of that is experience and exposure and it gets easier. I have a pretty clinical background and faced lots of pretty true mental health issues and the whole thing is that's definitely given me a good foundation. And then like I said I've got great friends who are counselors and just good support [180].
>
> Jamie. I think well prepared. Maybe not with the training I got through the agency but through my experience and through my education. I felt well prepared to make those decisions. I felt confident in my ability to ask for help if I don't know. I know where to look to find the answers [181].
>
> Hope. I didn't *not* feel prepared. I guess I didn't even think about it until an issue came up. It wasn't that I didn't feel prepared, it was just something I probably couldn't have prepared for. So…I felt fine with it I guess [182].

The participants who expressed feeling less prepared were Ray, who reported having no home-based training and no counselor colleagues at his agency, and Suzy and Ryan, who have both been licensed for about one year.

> Ray. I don't know, probably once you get to talking about it you think "I probably don't feel all that…I feel OK doing it but I'm sure there might be some things I could do a little differently if I'm getting off track with goals or objectives." With people's families who come in that you don't have releases for, what do you do. A lot of stuff comes up that you're not really prepared for. But overall, I guess I hadn't really thought about it that much [183].
>
> Suzy. I don't know that I've always felt very prepared, but I always know what I can do if I have a question. So I always feel like there's lot of support as far as if I'm not sure how to handle something when it's happening, then I always feel like I have my supervisor to help me figure out what to do [184].
>
> Ryan. Probably not well prepared just because it was easier for me to define…ethics generally is pretty easy to define doing no harm, things like that, but it seemed a little different in the home because it was less controlled in the home and it seemed like there were more opportunities for ethical problems to come up. Ethically I felt really prepared to work in an office setting but I don't feel like ethics is brought up in the context of a home counseling service [185].

Training documents from all participants made references to ethical issues like confidentiality, boundaries, and duty to report abuse and neglect, but only documents from Children Inc. and Home Health contained sections on how to utilize ethical

decision-making models. While participants from these agencies did not specifically voice that they use decision-making models that have been presented to them, exposure to these models may have increase their comfort with ethical decision-making.

Home Health's training binder contained a decision-tree meant to help the practitioner through a reflective practice. The three main reflective questions asked the participant whether the action would meet a clearly defined treatment goal of the client, if the action follows standard of practice, and if the participant would want their behavior to become public knowledge. Other questions for self-reflection include does the client need to learn to do the action in question herself, who is benefitting from the action more (home health provider or client), will the action cause role confusion, is there a company policy regarding the action, and is the agency aware the counselor is doing this action [186].

Children Inc.'s original training binder did not contain any detailed information about ethical issues or decision-making, but two webinars were added that address how to think through ethical dilemmas. One webinar suggests the following steps: Recognize the dilemma, consider options while consulting ethical codes and supervisors, develop a plan, follow through with the plan, and reflect on the decision while thinking about possible choices [187]. This model is consistent with ethical models used in the counseling field (Rae, Fournier & Roberts, 2001; Tarvydas, 1998).

The second Children Inc. ethics-based webinar presented a more abstract model of ethical decision-making including embracing the ethical dilemma, avoiding judgment of the dilemma, being as professional as possible, considering your ethical and moral principles, and letting things go. The presenter of this webinar, a contracted individual

with no experience with the agency, gave examples of these ideas that were vague, containing many platitudes, and difficult to tie to the principle being discussed. He seemed to go from main idea to examples that did not fit the home-based situation with no explanation of the main ideas in between [188]. When compared side-by-side to the other decision-making process presented by the agency, they appear to contradict each other. One encourages the home-visitor to consider options and consult while the other suggests avoiding the passing of judgment. One suggests reflecting on the process and what could be done next time and the other encourages letting things go. The presenter brought up "agency drama", employees not agreeing with agency policies, and "communication breakdown", so it is possible he was referring more to strife within the agency than ethical issues like confidentiality and duty to report [189].

Desired Training, Preparation and Support

At the culmination of all three interviews, participants were asked what would be helpful to make them more effective home-based counselors. The main training topics suggested by participants were (1) topics specific to the client population, (2) how to structure the home environment to achieve maximum therapeutic value, (3) how to build relationships on clients' turf, (4) how to handle the most frequent ethical issues, (5) case management, (6) crisis management, (7) case consultation opportunities, and (8) useful modes of preparation.

Topics specific to client population. Participants said they would be interested in any ongoing training on topics specific to their population, such as working with mandated clients including those involved with the juvenile justice system [190] and children in foster care or the Child Protective system [191]. Working with these

populations often leads to experiencing concerns for personal safety and encountering duty to report more often since the counselor can see home conditions and violations of the terms of probation or protective safety plans (Bryant, Lyons & Wasik, 1990; Freed & Drake, 1999; Roberts, 2006; Schwartz & AuClaire, 1995). Additionally, Suzy gave the example of wanting to learn about interventions that have been proven effective for specialized populations, like attachment issues for children in foster care [192].

The culture of poverty and the cyclical nature of at-risk behavior was brought up by Hope, Jamie, and Ryan [193] as being issues they faced daily, so how to intervene in the cycles of incarceration, abuse, neglect, and violence would be useful to many home-based counselors. Jamie's training documents were the only ones that addressed the culture of poverty and staying self-aware to views and messages projected onto the client about their living situation and choices [194].

Common diagnoses encountered by the agency and evidenced-based interventions for those diagnoses were a theme noted by the Children Inc. counselors, particularly in the area of Autism Spectrum Disorders.

> Suzy. [I would like training] on specific issues related to like children and behavior. Specific things like kids with autism or kids with challenging behaviors [195].

> Margo. The autism stuff is always good for me, I feel like it's my weakest area and part of that is personal and its emotionally very hard for me so I think that I have some emotional resistance, so that's always helpful just to get more information where I feel more equipped in that setting [196].

How to structure the counseling session to minimize distractions. Christensen (1995) and Lukenda's (1997) participants expressed that they would like more preparation in how to handle the home environment. The most pervasive theme in the

current study was how unstructured the home environment is and how many distractions are present in the home compared to an office. Like the participants in Christensen's and Lauka's studies, one of the greatest challenges counselors in this study face is maintaining concentration amidst distractions like TV's, dogs, home conditions, and extra people in the home during sessions. Participants seemed unsure if it was appropriate to ask the family to change the environment while they are guests in the clients' homes. All participants expressed difficulty with this issue, but Ryan and Hope explicitly expressed a desire for more training in this area.

> Ryan. I would like to have a little more training on in-home counseling because to me it's the hardest. It's much harder working in their territory and not the controlled environment so it seems like there would be need for more training, like how to learn that structure and aligning with the parents, things like that [197].
>
> Hope. Chaos is so big. Man, just a little bit of training in that would have been so helpful [198].

Jamie also thought a discussion about the realities of providing services in the home is warranted for new hires so they can decide if they are a good fit for this modality and if they get hired, they might feel more prepared to handle the challenges of home-based counseling.

> Jamie. A very frank discussion about…and not in a horrific way, like, "Oh, my god, you're not going to believe the things you'll see", but more like talking about the things that take away from your ability to concentrate first of all and secondly the ethical and confidentiality issues that come up with just not being in control of the environment. Nobody talks about that. I'm not sure why. The last person that we hired before they stopped the shadow visit…they let us do a group interview with her and we kind of broke it down for her, like, "This is no joke. It's nasty sometimes". Not in a horrific way, but just to not sugar coat it [199].

Most training documents were silent on the issue of maintaining structure in the home or handling chaos. A theme found throughout the training documents of Children

Inc. was that the home-visitor needs to fit into the client's natural environment and routines, which may give new home-visitors the impression they should not change this environment. Home Health is the only agency that explicitly discussed how to set and maintain structure in homes by following a general visit structure and dealing with distractions upon entering the home [200].

Building relationships on the client's turf. Participants felt like the dynamic of the client-counselor relationship is different when counseling occurs on the client's turf. Coinciding with Snyder and McCollum (1999) and Stinchfield (2002), this study's participants wanted more information on how to establish rapport, pace with the client, and navigate the unique balance of power between client and counselor. Additional challenges are the more casual nature of home-visiting, helping clients who might be suspicious of the help-giving system feel accepted and not judged, and increasing client's comfort level with having a visitor in their home. Ray directly spoke to this:

> Ray. What do you do to make people feel more receptive to your presence in their homes, which is their safety, their security? I always wanted to bring them a little gift or something and say, "I brought something" [laughs] [201].

> Ray. The people that we serve have trust issues to begin with and a lot of them are impoverished and underserved so their homes are not…sometimes they're kind of embarrassed about their living situation and maybe just how to make people be more receptive. How you could present yourself to be someone who's more appreciated in their homes. To maybe break down that wall of resistance where they don't mind you coming [202].

Jamie's agency was the only agency with training on how to build relationships within homes. Ray's agency, Juvenile Probation, focuses on intervention and criminal justice, not counseling, so it is not surprising his materials did not address relationship building. Ryan's agency focuses on short term crisis intervention, so again, relationship

building would be much less emphasized in this role. The Children Inc. documents were largely silent on the issue of relationship building, but like all of the agencies in the study, not all of the employees of the agency are counselors, so the materials are not written with therapeutic relationship-building in mind.

Handling the most frequent ethical issues. The most frequent ethical issues found in the current study were confidentiality, setting boundaries, and duty to report abuse and neglect. Suzy and Jamie talked about wishing they could have more training in these areas.

> Suzy. There are times when I'm not sure where the line is between I'm offering services in the home so I'm seeing things that are unsafe and when it's my business to say something and when it's not. So if they were coming to an office, it wouldn't be things I would be seeing, so I have a hard time of you know, I don't want to offend families by saying, "There are roaches all over your house", but then sometimes that's a safety concern when kids are picking them up. So maybe more training on those situations where things are uncomfortable and trying not to offend but also offer help [203].

> Jamie. Maybe a little bit more training on how to set boundaries with each individual client as far as having a conversation about who is present in the house and having a genuine talk about sometimes we talk about things in here that are sensitive and I want to make sure I always respect your privacy and is it safe to talk about these kinds of things in here [204].

Both Suzy and Jamie's agency documents reveal that some training in these areas was included when they started at their agencies. One of the ethics webinars at Children Inc. discussed what the most common ethical issues are for that agency and how to deal with them, but Suzy did not remember this webinar. She had complaints about the way the webinars were presented that affect her ability to remember important information: "I think a lot of it is presentation. It didn't seem relevant or useful. It felt like tedious things to check off a list so I could say I was finished." [205]. Jamie remembered receiving

training on common ethical issues and when talking, she showed knowledge of helpful ethical thought processes. Home Health's training materials have references to ethical issues throughout and an ethical decision-making model is provided. Nonetheless, Jamie also felt like more preparation in this area would be warranted.

Case management. Participants in Adams and Maynard (2000) and Lukenda (1997) listed case management as one of the areas they would like more training. The at-risk nature of the usual home-based clientele demands that home-based counselors be familiar with helpful resources, possibly more so than office-based counselors. Jamie and Suzy listed how to case manage and find local resources for their families as areas in which they would like additional training.

> Jamie. [Case management] is something the national office can't teach you, it has to be something more local because they're local resources [206]
>
> Suzy. That would be really helpful for ten minutes of every staff meeting to talk about a different resource we could use for our families [207].

Besides knowing about local resources, Jamie talked about fundamental goals behind case management, which are to teach the families to find and access resources on their own. This part of her training seemed quite valuable and should be part of the recommended case management training for all home-based counselors.

> Jamie. Not to problem solve for them and not to take away the drive to do for themselves. That's another fine line too…to navigate, which I think prepared me. I was prepared in training to begin to understand how my relationship can either empower them or help them self-sabotage. Really relying on other people instead of learning those skills to do it yourself. The difference between making the phone call and handing them the phone and letting them make the call while you're sitting there. Those nuances are enormous when you're doing home-based counseling and you're helping them become more assertive [208].

The largest section in Children Inc.'s 260 page training binder was case management, with 66 pages devoted to insurance and assistance programs, case management documentation, what is billable and what is not, collaborative relationship with the client family when case managing, and how to find local resources. When discussing this content, Suzy said, "That's not the case management things I think our families actually need help with. They need resources they can access." [209]. She was interested in learning more about the details of local resources and how to access them than processes of case management. Margo and Hope did not express difficulty with the case management role, so they may have benefitted more from the provided training, had enough experience to feel comfortable, or simply did not think of case management when discussing desired preparation.

Home Health's documents did not discuss case management and finding resources. With a social work minor, Jamie would have gotten more education that most of the participants in case management, yet she still felt uncomfortable and overwhelmed with this role, indicating that this might be an area of ongoing training to constantly stay knowledgeable about available resources [210].

Similar to Children Inc., The Crisis Team provided detailed training on case management but it had more emphasis on local resources. One of the main roles of the crisis counselor is to provide resources for ongoing assistance after the crisis [211], so its focus on resources fits with this role. Ryan seemed comfortable overall with his case management role and knowledge of resources, possibly indicating that his training and frequent experience with resources was of benefit.

Crisis management. Participants in Adams and Maynard (2000) felt like they had training in their educational programs on how to handle crisis, but they were not sure how the things they learned translated to the home environment. Jamie, Hope and Margo talked about facing many crises with their clients, but Margo and Hope explicitly said they wanted additional training on how to handle common crisis.

> Margo. And then there wasn't much practical…just what do you do if you have never done this before. What do you do when you go into a home for the first time, the parents get in a fight in the next room, what do you do? [212]

> Hope. Crisis and chaos…training on that because even though now I'm experienced, I'm sure there's more I could learn without having to experience it to learn it [213].

Notably, Hope contracts on the side with The Crisis Team and has gotten pretty extensive training on how to handle crisis. She may have been alluding to this when mentioning her experience, but nonetheless, she would be interested in more training on crisis management as it relates to the Children Inc. setting.

Case consultation opportunities. Jamie expressed how much she gets out of bi-monthly group case consultation meetings. Hope and Suzy wished they had more opportunities to go over their cases, whether it was individually with a supervisor or in a team format with colleagues. Hope said she would like individual supervision once or twice a month in addition to the monthly counselor meeting, where she did not feel like she had time to staff her cases [214]. Suzy lamented that she misses case consultation time, which used to be included in the monthly counselor meetings.

> Suzy. I used to think our counseling staffings were awesome when the former supervisor was leading them. I felt like we got a lot more information as far as learning new things and I felt like we did more discussion about particular kids and what to do with kids that we weren't sure about. There were times when people brought videos of kids. I don't know if it's a change in staff or in the

> agency as a whole that there's just so much other politics to talk about. Like legalities and work related things not related to counseling [215].

Lawson and Foster (2005) examined supervision frequency and satisfaction for home-based therapists and found that 74% of their participants were unhappy with their level of supervision. Almost one fourth of the counselors received one hour or less of supervision per month and about one fifth received one hour or less of group case consultation per month. Wasik and Roberts (1994) surveyed almost 2,000 home-visitors and found that 92% got individual supervision and 72% had group supervision. These supervision sessions ranged from weekly to quarterly.

The participants in this study were cases of feast or famine in the area of supervision. Ryan and Jamie were in weekly contact with their supervisors to discuss cases. Margo said her Children's Inc. site had a monthly group case consultation time and optional individual supervision as needed [216]. Hope and Suzy had no individual supervision and had one monthly meeting that no longer contained case consultation time. Ray had no opportunities for supervision or case consultation and he added that his supervision during his master's program and while obtaining licensure were "lax and not much of an educational process" [217], leaving him feeling completely unsupported. These findings coincide with Lawson and Foster's (2005) and Wasik and Roberts' (1994) call for more supervision to assist in feelings of stress, burnout and under-preparedness.

Useful modes of preparation. Various methods of presenting and teaching were discussed when participants talked about what kind of preparation they would like. Ryan said he would have liked to have had guest speakers who conduct home-based counseling come to his classes during his masters preparation to talk about what home-based

counseling is like, benefits of working in the clients' homes and other natural environments, and common challenges [218]. Both Ryan and Ray thought conducting role plays where one counselor plays the client and one plays the home-visitor would be helpful [219].

Suzy talked about getting to do observations and co-visits, where two therapists can conduct therapy together, as part of her initial training when she first started at Children Inc., but once the counselor is trained, observations and co-visits are discouraged. She said she would love the opportunity to continue learning through her peers by watching how they handle the home environment and what interventions they find effective.

> Suzy. I don't know that it would even be possible, but it would be really helpful, like I would love to go observe visits with counselors who have been doing this a lot longer than I have. If we were less concerned about hours and numbers, that would give us freedom to do more of those things, not that we're going to changing that any time soon [220].

Ray said he has never had anyone to observe, so he, too, would be interested to learn from other counselors in similar situations. As mentioned previously, readily available supervision and group case consultation staffings were also mentioned as helpful modes of preparation and ongoing support.

Experience of participating in the research study. During member checking, all participants agreed with the themes gained from everyone's interviews that were presented at their final interviews. Ryan and Ray expressed appreciation for the universality of themes and common experiences between all participants during member checking and reviewing the themes of the study. Ryan said, "I felt like these were just mine" [221] and Ray agreed, "I thought these are all the ones I was thinking about, but

these are everyone's! They're pretty similar across the people." [222] Ray, particularly, expressed enjoyment participating in the study since he does not get to hear about any other home-based counselors' experiences and he was interested to talk to someone else who does home-based counseling. The questions and discussions that came up as a result of the interviews gave him some ideas he wanted to incorporate into his visits.

> Ray. You have put a level of being conscientious in my mind and when I do this, I am going to be more aware of…just by the fact that we talked about it…Maybe I might even ask. That's a wonderful idea. What I will do the next homes I'm in, I'll ask them how they feel about home-visits. Is there anything that could be revamped to make this a more positive experience and get feedback from them. Now that would be like another level [223].

Summary

The results of the current study offered insight into the experiences and perceptions of home-based counselors. This chapter presented data gathered from three transcribed interviews per participant as well as a review of the six participants' training documents and ethical codes. Emergent themes relating to the initial research questions became evident and include: home-based counseling is experienced to be quite different from office-based counseling, feelings of preparedness and what types of preparation participants had to conduct home-based counseling, ethical issues unique to home-based counseling, how participants handle ethical issues, and desired training and support. These themes were overall consistent with existing literature on home-based counselors. The findings are discussed in the following chapter and a conclusion is presented.

Chapter V

Summary, Implications, and Recommendations

In this chapter, results are summarized and examined in accordance with the research questions of the study. Further, the results are presented using the theory framing the study, Brofenbrenner's Ecological Theory of Human Development (1979, 1989, 2005), and implications for home-based practice are delineated. Suggestions for future study are discussed in the further inquiry section, and how this study has affected my home-based counseling practice will conclude the study.

Examination of Results

This study was conducted to explore the perceptions of home-based counselors, including how they perceive that home-based counseling is experienced compared to office-based counseling, how prepared they feel to provide counseling in the client's home and community and in what ways they feel their educational program and place of employment did or did not prepare them for this form of counseling. Additionally, I examined what participants perceive about ethical dilemmas that occur in home-based counseling and how prepared they feel to competently handle these situations. Unique contributions of the study are that it addresses areas not found in the literature such as details into what kind of training participants received to conduct home-based counseling, what resources they use to solve ethical dilemmas, and what kind of training or preparation they think home-based counselors should get.

Participants consisted of six Licensed Professional Counselors (LPCs) who conduct at least half of their counseling sessions in client's homes. Participants were

obtained from five different agencies in the Southwestern United states to gain a variety of experiences. Four are female and two are male, with five of them being Caucasian and one Hispanic. Their ages ranged from late 20's to late 50's. Two had been licensed for one year, and the one who had been an LPC the longest was licensed for ten years. One had worked in home-based counseling as a Licensed Chemical Dependency Counselor (LCDC) for ten years, but had only been an LPC for three years.

The perceptions of home-based counseling and preparedness are divided into five themes: home-based counseling vs. office-based counseling, preparedness and preparation for home-based counseling, ethical issues unique to home-based counseling, handling ethical dilemmas, and desired training, preparation, and support.

Home-Based Counseling vs. Office Based Counseling

For the first theme, participants were initially asked how home-based counseling compares to office-based counseling. Participants easily discussed many examples of how they differ, but they had a difficult time thinking of similarities. Some of the basics of counseling were cited as similarities, like counseling theories, building relationships, basic ethical practice, multicuturally sensitive practice, and techniques. Differences were broken up into six sub-themes, which consisted of losing therapeutic opportunity due to chaos and lack of structure in the home, counselor discomfort in some homes, knowing more information about the family due to being in their natural environment, different counselor-client relationship dynamic, conducting therapy in unusual places, and safety issues.

Regardless of how long participants had been conducting counseling in homes, they had a difficult time maintaining structure and dealing with distractions such as loud

TVs, animals, and extra people being in the home during sessions. This is consistent with other research on the experiences of home-based counselors (Christensen, 1995; Snyder and McCollum, 1999), whose participants also had difficulty requesting changes in the home. Ryan and Jamie were the only two participants who expressed making changes to the environment to make it more conducive to therapy. Many of them expressed a respect for being invited into the clients' homes, as well as a feeling of being a guest, which contributed to them feeling like they should not tell the clients what to do in their own homes even if it would help maximize therapeutic benefits. Related to this, many of them also remained silent when they were in uncomfortable environments; that is if the house was dirty, furniture was missing, or mice or roaches were crawling around.

One of the stated benefits of conducting therapy in clients' homes was gaining more information about the family in areas such as living conditions, who is in the home, neighborhood safety, and how the families handle daily routines. This topic was found in one study on home-based counselors (Christensen, 1995), but was included in many theory or thought piece articles such as Hicken & Plowhead (2010), Schwartz and AuClaire (1995), Woods (1998), and Zur (2007). Suzy said she learned things she would not have even thought to ask about if they were in an office, and Ray noted it is helpful to know about the living conditions of the client, which sometimes explains their lack of engagement in therapy if they are more worried about meeting basic needs.

The therapeutic relationship dynamic was found to be different in home-based counseling due to how casual and social counseling visits often seemed. Like participants in this study, Snyder and McCollum (1999) and Stinchfield (2002) found this guest role difficult to navigate. It was common for participants to be offered food, drink, and gifts or

to be invited to the child's birthday party. Participants in this study agreed with Snyder and McCollum and Stinchfield's participants that the balance of power shifts to the client when counselors enter the clients' homes, which has implications for the therapeutic relationship and process. One of these implications relates to another sub-theme, which involved distractions in the environment. Clients have the ultimate control over the therapeutic environment, so unless they are made aware of this, they may not think to adjust the environment to help therapy be as productive as possible.

Therapy occurring in unusual places and public places was a sub-theme found in the current study, but not in the literature. Participants reported having conducted therapy on client's beds, while clients were in the closet, at restaurants, schools, front porches, yards, and street intersections. This supported the idea that home-based therapy occurs not only in client's homes, but also in other natural environments in the community.

Participants shared that they usually felt safe while in client's homes, but occasionally they feared for their safety or that of their clients if difficult topics came up during therapy. Stinchfield's (2002) and Christensen's (1995) participants also had concerns for their own safety and Adams and Maynard's (2000) and Christensen's participants feared for the safety of their clients after sessions, revealing that this is a common concern for home-based counselors.

A review of training documents showed that for all agencies, very little information was presented on how to handle chaos and distractions within the home. Jamie's agency was the only agency that even made brief mention of handling potential distractions when initially entering the home. The training documents also were silent on using information gained from the home environment. Jamie's agency was the only

agency to address therapeutic relationships in the home, with an entire chapter devoted to this topic and information on relationships dotted throughout the whole training document. Children Inc.'s and The Crisis Team's training documents were the only ones to discuss meeting the clients wherever they're at and working within public settings, but neither addressed resulting ethical issues. Safety issues were addressed in Children Inc.'s documents and The Crisis Team's documents, but Home Health's documents did not have any information about safety while home-visiting. Jamie said this was given later as an addendum, but she would still like more information on safety. It is surprising how little safety information was provided to participants, as they all had at least occasional concerns for their safety and that of their clients.

Preparedness and Preparation for Home-Based Counseling

A variety of responses were gathered when discussing how prepared participants feel to enter clients' homes to conduct counseling. As would be expected, the counselors who had been working in homes and licensed the longest felt the most prepared, and in fact, all of them expressed feeling more comfortable and prepared as they gained experience. An interesting and unexpected idea presented itself through the participants: perhaps it is difficult, if not impossible to truly prepare someone for home-based counseling. Jamie pointed out that even if someone is told what to expect, he or she still might have a strong reaction when faced with something unusual. This has implications for training which will be discussed in the implications for practice section.

Much like Stinchfield's (2002) participants, five out of six of this study's participants do not think home-based counseling was brought up in their educational programs, and one participant thinks it was mentioned in his family counseling class.

Most of them admitted they may not remember home-based counseling being talked about even if it was because it would not have been relevant at the time or they went to school too long ago to remember. General topics that were covered in their educational programs that have been helpful to their home-based practice were building relationships, theories of counseling, multicultural counseling, and handling ethical issues, but not as they relate to the home.

As would be expected, the bulk of participants' training on home-based counseling came from their agencies. Amount of preparation varied widely, with Ray receiving no agency preparation, Jamie and Ryan getting a week of intensive training, Hope training for a month, and Margo and Suzy having about two months of full-time training and observation before getting their own client caseloads. Notably, amount of training did not seem to affect how prepared they felt to do counseling in homes. Suzy and Margo discussed how their training was more tedious and mind-numbing than practical or helpful, so amount of training did not translate into feeling more prepared for them. Jamie and Ryan, with one week of training, were more satisfied with their preparation than the rest, possibly because their training focused more on practical issues as evidenced by their report and review of their training documents. They also had the most frequent supervision and case consultation opportunities, so this may also affect their perceptions of overall preparation. What participants said they did find helpful from their agency training was riding with other counselors and observing how they structure sessions and the home environment as well as what interventions the other counselors use.

The review of training documents generally correlated what participants reported about their training. Jamie's Home Health documents were heavy on practical issues and she said she loved her training and thought it was very beneficial. Children Inc.'s documents focused heavily on laws, policies, and procedures and were scant on practical information on things like how to structure sessions or handle common challenges in the home. Ryan's documents from The Crisis Team were heavy on policy and procedures but also had a lot of information about how to conduct crisis counseling and find local resources for the victims' longer-term mental health needs. Ray, who had no home-based training to speak of, at times expressed uncertainty, which may be related to his lack of training or isolation as a home-based counselor. An area in which participant report did not match training documents was case management. Ryan, Suzy, and Jamie wanted more training on case management, but all had received training through their agencies or educational programs and the document review showed information on case management and resources for their agencies. The distinction, according to Suzy and Jamie, is their training covered case management in general but not specific resources in their cities of employment, which they thought would be helpful.

Ethical Issues Unique to Home-Based Counseling

All counselors face ethical dilemmas and must be mindful of ethical issues in counseling, but this study supported that home-based counselors experience common ethical issues in uncommon ways. This finding is supported by research by Bryant, Lyons and Wasik (1990), Strom-Gottfried (2009), and Wasik and Bryan (2001). The most common ethical issues faced by counselors in the current study were confidentiality

issues, informed consent, boundaries, duty to report abuse and neglect, multicultural competence, practicing within boundaries of competence, and burnout.

The most common ethical issue mentioned throughout the study was confidentiality issues stemming from having additional people in the home during sessions, the likelihood of being unintentionally overheard by people in other rooms, and the practice of travelling with client records. Participants seemed unsure about how to handle these confidentiality issues, and agency documents were silent on the issue. Home Health encourages its employees to greet and include everyone present and Children Inc. encourages going wherever the client has a problem with daily routine, even if it is in a public place. These agency policies seem to contradict counseling norms about conducting counseling in front of others who could overhear. The ACA Code of Ethics (2005), however, does suggest that all clients are notified about confidentiality and its limitations, so meeting in public or in front of other people the client chooses to have present could be limitations discussed during the informed consent process. Home-based counselors must also take measures to safeguard travelling documents, such as password protecting phones and laptops, not leaving briefcases with charts in them unattended and locking charts in a lock box in a locked trunk when travelling.

Another common ethical issue was going over a detailed informed consent specific to home-based counseling. All participants' agencies had some kind of informed consent, but they were vague and did not address the mandatory requirements given by ACA (2005). This appears to point out a missed opportunity to discuss with families how home-based counseling differs from office-based counseling, how the family can contribute to a therapeutic environment, and how to navigate common ethical pitfalls like

professional boundaries, limitations to confidentiality, and the duty to report suspected abuse and neglect.

Banach (1999), Bryant, Lyons and Wasik (1990), Christensen (1995), Lauka (2012), Macchi & O'Connor (2010), and Snyder & McCollum (1999) discussed the difficulty of maintaining boundaries in the more casual home-based counseling relationship. Participants in the current study agreed, and talked about being offered food, drinks, and gifts, as well as being invited to the client's family gatherings, getting requests to connect on social network sites, and providing material items for families in need instead of linking the families to resources. Participants' training documents varied on how much information was provided on boundaries. Ryan's documents did not have any references to therapeutic boundaries. Ray, Margo, Suzy, and Hope had some training on boundaries in terms of gifts and maintaining a professional and not personal relationship. Jamie had the most training on boundaries, with information throughout her training binder on how to set and maintain healthy boundaries. Home-based counseling literature focusing on boundaries (Klass, 1997; Slattery, 2005) suggest that boundaries are indeed different in clients' homes due to the counselor being in a guest role in clients' homes. Both Klass and Slattery recommend that home-based counselors discuss what their role is with their clients at the beginning of the relationship and throughout, as well as monitor for role slippage and ensure that the focus always remains on the client and what is best for the client.

Reporting issues surrounding suspected abuse and neglect were difficult for participants in this study and for those in Tracy, Bean and Gwatkin (1992) and Worth and Blow (2010). Participants knew they must report abuse and neglect, but many situations

seemed to fall into gray areas, such as being encouraged by their agencies to work on the issue with the family instead of reporting it or not knowing at what point a house is dirty enough to file a report. Additionally, if CPS was already involved and conducting home visits, some participants did not know if they were supposed to file an additional report. Suzy also brought up safety concerns regarding filing a report on a family, then going back in to the home not knowing if the family would know she had called. Training documents contained a surprising dearth of information on this common issue.

The three counselors from the two Children Inc. agencies brought up the issue of practicing within boundaries of competence and being asked to work on issues outside of their training such as communication and fine motor skills. Conversely, Ryan and Jamie had coworkers who were not counselors but who essentially served in the same capacity as the licensed counselors. Ironically, Children Inc. was the only agency that discussed not practicing outside of one's boundaries of competence in its training materials, yet participants from this agency felt like they were often encouraged to do so.

Cultural competence was mentioned by two participants, Jamie and Ray. They told of situations in which they became aware of how important it is to maintain self-awareness and knowledge of other cultures, including the culture of generational poverty. Training documents from Home Health, The Crisis Team, and Ray's Juvenile Justice Professional Code of Ethics (2010) had anywhere from a few lines to a few pages about multicultural awareness, knowledge and skills. Children Inc. had the most training on this topic, including a webinar on cultural competence. It is difficult to ascertain whether the topic just did not come up for the other four participants or they did not consider being culturally competent as a common or difficult ethical issue.

Burnout or demoralization was the final sub-theme expressed by two of the study's participants to some extent. It was included in the current study because it was a pervasive theme for Hope and burnout is a common theme found in the literature (Adams & Maynard, 2000; Christensen, 1995; Tracy, Bean & Gwatkin, 1992; Wasik & Bryant, 2001). Suzy did not talk explicitly about burnout, but some of her comments expressed demoralization and stress. Hope talked about how the intense nature of working with mandated clients immersed in generational poverty and family violence has taken a toll on her, as has her agency's focus on paperwork and billing goals. It is interesting that level of burnout did not correlate with how long they were counselors or how long they had served in a home-based role. Hope was in the middle of the participants as far as how long she had been a licensed counselor and Suzy was at the beginning of her counseling career. What is notable, however, is they come from the same agency in the same city, so their demoralization could be more related to problems at their agency and not their home-based counseling role. Burnout is minimally addressed in Hope and Suzy's training binder with two pages on managing stress.

Handling Ethical Dilemmas

After discussing the most common and most difficult ethical dilemmas, participants were asked to talk through how they solve ethical dilemmas and what resources they find helpful. Consistent with Pope, Tabachnick, and Keith-Speigel (1987) and Gibson and Pope (1993), who studied office-based counselors, consulting colleagues and supervisors was the most common response to facing an ethical dilemma, followed by referencing the ACA Code of Ethics (2005) or other ethical codes they fell under such as the LCDC Code of Ethics (2010) or the Juvenile Justice Professional Code of Ethics

(2010). An additional resource this study's participants used to guide ethical decisions which was not found in the literature was agency policies and procedures, especially for boundary issues. Colleagues were consulted more than supervisors because colleagues were more likely to be counselors and all but one of the participants were supervised by someone from another profession like physical therapy or nursing. There seemed to be a difference between what participants knew they could use and what they actually used. Jamie, for instance, brought up the legal hotline through ACA, but said she had never used it. None of the participants brought up ethical decision-making models as a resource for solving ethical dilemmas.

Training documents from Home Health and Children Inc. contained ethical decision-making models. They were both similar to Rae, Fournier and Roberts (2001) and Tarvydas (1998), which suggest defining the problem, referencing ethical codes and policies, consulting with supervisor or colleagues, making a plan of action, following through and reflecting on the process.

Participants who had been counseling for the longest amount of time seemed to feel the most comfortable with how to solve ethical dilemmas. Margo and Jamie pointed out that this comfort had come with time and experience. Hope said she did not feel unprepared but that she usually did not think about ethical issues. Similarly, sometimes Ray said he felt pretty prepared and sometimes he reflected that he might not be that prepared once he really thinks about it. Ray also pointed out that he practices in relative solitude and had very little training on home-based counseling, which may have contributed to not feeling as comfortable with ethical issues in home-based counseling.

Ryan and Suzy felt the least prepared and have both been licensed for about a year, the shortest amount of time compared to the other participants.

Desired Training, Preparation, and Support

Participants were asked towards the end of the last interview what would be helpful to make them more effective home-based counselors. The answers took on many different forms including what they wish they would have had when they started, what kind of training they want now, and what kind of training they would recommend that new home-based counselors receive. Participants wanted ongoing training in topics specific to their populations, for instance on specific diagnosis or interventions. Training on navigating the home environment such as how to structure visits, how to build relationships on the clients' turf, and how to handle the most common ethical issues was desired by all six counselors in the study. Participants commonly faced having to provide case management and crisis counseling to families, and five out of six of them wanted more training in these areas. It was noted that most of them had received some training in case management, but they wanted more training focused on local resources and how to access them, rather than how to case manage in general or laws regarding linkage to services. This also supported the theme that practical information was perceived to be lacking in their agency training, and this is what they would find helpful.

Group case consultation time with colleagues was also viewed as desirable or helpful. Jamie and Margo were the only participants with regular group case consultation meetings, and they expressed how helpful these meetings were. Hope and Suzy said they would find it very helpful to have a consistent case consultation time to discuss their clients. They said they theoretically had this time carved out once a month, but in reality,

their agency used the time to discuss administrative issues like policies, procedures, and billing or productivity issues. A relevant suggestion found in Wasik and Bryant (2001) is that administrative supervisors be separate from clinical supervisors so that case consultation and individual supervision time retains its focus on clinical issues and not administrative ones. Ryan reported having group case consultation every three months but he was in contact with his direct supervisor after every shift and his agency rides in pairs so he did not seem to miss group meetings. Ray had to look outside of his agency for peer consultation, which he said he did, supporting the idea that he also found consulting with colleagues to be a helpful avenue to get feedback on professional challenges.

Ryan and Jamie were the only two participants with regular individual supervision and Margo said it was available to her upon request. Ryan and Margo were satisfied with level and type of supervision. Jamie said the frequency of weekly supervision was good but that the quality of her supervision was unsatisfactory for reasons related to her supervisor's personality and the supervisor not being a counselor, and thus being unable to assist with counseling issues. Hope expressed that she would like to have individual supervision once or twice a month. Ray and Suzy did not have regular supervision, but they said they could contact their supervisors, who were not counselors, whenever they needed. Neither Ray nor Suzy mentioned wanting individual supervision, but as stated above, they both wanted group case consultation opportunities.

In summary, two participants were completely satisfied with their supervision and four were not. The participants with group case consultation opportunities valued this time and the ones without case consultation time wanted it. These findings are consistent

with Lawson and Foster (2005) and Wasik and Roberts (1994) who found that most of their participants wanted more supervision and case consultation opportunities. It is unclear why many home-based counselors do not get the desired amount of case consultation and supervision. Hope and Suzy mentioning that their case consultation time was replaced by administrative issues that directly relate to billing and financial sustainability for their agency, making it appear that the economic climate may have an impact on the availability of free time for supervision or for more focus on financial sustainability over clinical issues.

Participants discussed helpful ways of learning about home-based counseling which might be informative to University programs and agencies. Guest speakers who could talk about home-based counseling and topics specific to the client population were highly sought after. Observations and co-visits with other counselors were methods of training most of the participants experienced when they were hired and they found this to be extremely helpful. Once they met their training requirements, their opportunities to observe other counselors were eliminated though Suzy and Hope still wanted to do this. Ray never had the chance to observe another home-based counselor and he also expressed that this would be helpful. Again, financial sustainability might be one reason co-visits and observations are not encouraged in the long run, as insurance companies typically will not pay for two therapists to conduct therapy at the same time. Ray and Ryan mentioned that role plays might be helpful in masters-level classes like techniques or practicum, but the lesson of working amidst chaos and distraction would be lost unless distracting elements were brought into the classroom. Turning on a TV, having the client periodically leave the room, and eating during sessions could make classroom-based role

plays more closely simulate a home environment. Further information on using role plays and other training methods to prepare home-based counselors is included in the recommendations section in Implications for Practice below.

Implications for Theory

Bronfenbrenner's Ecological Theory of Human Development (1979, 1989, 2005) is often used to frame home-based counseling because of its focus on the interaction between people and their environments. This theory is often used as it relates to clients and their environments but the theory is also relevant to the counselors who provide home-based counseling. It is not objective reality, but perception of the environment that is of utmost importance (Bronfenbrenner, 1979). This focus on perception makes this theory an appropriate framework for the current study, which examines counselors' experiences and perceptions in their various environments. Bronfenbrenner's five concentric structures (1989, 2005) that comprise the ecological environment that systematically affect a person's development will be discussed using this study's results as examples.

The most immediate and directly influential structure affecting a counselor's development and experiences is the microsystem, which consists of relationships, activities and roles experienced by the participant (Bronfenbrenner, 1979). Microsystems examined in this study include elements of participants' training and daily interactions at work and at home. At their agencies of employment, co-workers, supervisors, working with clients in their homes, the agency office, and even the participants' cars, which serve as travelling offices, would be considered microsystems that directly affect participants' experiences. The presence or absence of supervision or case consultation or training on

how to handle a chaotic home environment is part of the microsystem that affects home-based counselors' development and perceptions of their professional roles. Both personal and professional roles are examples of microsystems and in this study, participants mentioned being counselors (some both home-based and office-based), private practitioners, instructors, case managers, crisis workers, trail blazers, coaches, and friends.

The interrelation of microsystems makes up the mesosystem. One notable mesosystem from the participants' experiences is the interrelation between training gained in educational programs versus their agencies. Participants seemed to have gotten most of their information about ethics, diversity, and theories from their masters programs and most of their home-based information from their agencies. An area in which contradictory information was found is confidentiality. Hope gave the example of her educational program teaching that she would never counsel in public places where she could be overheard and her agency encouraging her to meet wherever the family wants to meet, which sometimes includes public places. On the same note, the relationship between agency policies and ethical codes was sometimes at odds, for instance trying to counsel families about suspected neglect versus reporting it to CPS. Additionally, one counselor could have one set of expectations for home-based counseling and a different set of expectations for office-based counseling, especially in the areas of boundaries.

Exosystems are broader communities and systems that more indirectly influence the developing person. Helping systems more indirectly involved in home-based counseling could be examples of exosystems, such as juvenile probation, Child Protective

Services, the police department, victims services, or the health community. The safety of the neighborhoods in which participants counsel in is an exosystem that affects them daily since for some participants, it related to feelings of overall safety and stress.

Macrosystems are comprised of attitudes, laws, values, and customs of the culture or subculture. This study has a particular focus on the macrosystems of home-based counseling, as they are quite influential to the overall experience of home-based counselors and come from many levels. On the state and national level, laws regarding helping children, such as educational laws and family preservation acts, influence how home-based programs run and whom they serve. Legislation affecting the security of home-based counseling programs would be another state or national-level macrosystem. Decreased funding affects daily life of home-based counselors by increasing billing requirements, thus making the job more stressful, or even worse, shutting down home-based agencies entirely. Agencies also have their own values and customs, which was evident among the five agencies represented in the study. An example of different agency values is apparent when one compares juvenile probation and The Crisis Team, which are intended to serve a purpose and move on without building a relationship, with Home Health and Children Inc., which focus on building longer term therapeutic relationships to meet their ultimate goals. Agency values and customs regarding the training and supervision of its counselors is another macrosystem related to the study. Suzy and Hope felt like their agency had replaced group case consultation time with administrative tasks and topics focused on productivity, which affected their attitudes about their agencies and their roles as home-based counselors. Another part of the participants' macrosystem is the ACA Code of Ethics (2005) and published material such as ethical decision-making

models, which express the values of the counseling field and guide counselors in their practice.

The fifth system is the chronosystem, which addresses the impact of time, life and historical events. A noticeable chronosystem example is that four of the six participants gained full licensure while in a home-based counseling role. Their full licensure resulted in a decrease in supervision and guidance and an increase in job responsibilities and independence. The increased comfort and knowledge gained as a result of experience and time in the home-based role was also evident in the study. Over time, Hope and Suzy saw their case consultation time change to policy and procedure meetings possibly as a result of legislation that affected funding, which affected productivity and billing goals set to keep the agency afloat. This, in turn affects some internal chronosystems such as burnout and demoralization, which were evident in two of the participants. Incidents and successes experienced by the participants and how these affected their overall perception of home-based counseling self-efficacy over time are also notable chronosystems. Ray's comments about participating in the study show the affect his participation had over time, which he said was a decreased feeling of professional isolation. This was the result of talking to another home-based counselor and having the opportunity to reflect on his practice and how he deals with common ethical issues.

One can note the interaction of these systems in the previous examples and see how they affected daily practice and overall perceptions of the home-based counselors in this study. Many strengths and resources were identified that participants used to build relationships with their clients, build their home-based practice skills, and solve therapeutic challenges and ethical dilemmas. The study also identified areas for possible

improvement and underutilized resources that could be of benefit to both current and future home-based counselors.

Implications for Practice

The conclusions reached in this study support the existing research's stance that home-based counseling is experienced quite differently than office-based counseling and home-based counselors need training specific to counseling in homes and communities (Christensen, 1995; Cortes, 2004; Lawson & Foster, 2005; Macchi & O'Connor, 2010; Mattek, Jorgenson & Fox, 2010; Stinchfield, 2002; Wasik & Roberts, 1994). One recent study (Worth & Blow, 2010) found that half of the home-based counselors were unsatisfied with their training and supervision, but half of them were satisfied. Two participants in the current study, Jamie and Ryan, were satisfied with their training and overall support, so recommendations for training and support are gained from the two participants who were happy in this area and from the four who were not satisfied with their preparation and support. This provides a balanced picture of what is working well for the satisfied home-based counselors and what is desired by those who felt unprepared or unsupported in their home-based roles.

Recommendations

Suggestions to improve home-based counselor training, support, and practice are discussed in the following six sections: recommendations for educational programs training graduate-level counselors, agency preparation, agency support, recommendations for building the home-based counselor-client relationship, home-based counselor support, and recommendations for the counseling profession.

Recommendation 1: Educational Programs should include homes and community settings as possible locations in which counselors-in-training may provide services and discuss the implications of practicing in these settings.

Educational programs serve to give counselors the fundamental skills they need to be effective helpers and provide a glimpse of the types of counseling that exist and may be encountered in counselors' professional careers. Home-based counseling can be introduced and discussed in any counselor education class, such as an introduction to counseling class, theories, techniques, family therapy, ethics, multicultural counseling, or practicum and internship. For instance, the family therapy class could include topics like how to handle family dynamics in the home and commonly used home-based counseling theories. The ethics class could discuss how ethical situations differ once a counselor leaves a typical office setting. Likewise, the techniques class could allow for home-visiting role play opportunities. The basics of home-based counseling should be discussed, including how it differs from office-based counseling, benefits, and common challenges. How to solve ethical dilemmas, seek resources, and problem-solve are valuable to counselors regardless of professional setting.

Modes of training that could be helpful include class lectures, discussions, reading assignments, guest lecturers, and role plays (Gould, 2000; Gerace, Tiller, Anderson, Miller, Ward & Munoz, 1990; Woodford, Bordeau & Alderfer, 2006). Gerace et. al. (1990) suggest starting with class lectures and reading assignments, then having a home-based counselor speak to the class. It would be beneficial if the home-based guest lecturer could be involved in role playing activities to help increase relevance and accuracy by suggesting common scenarios. The role plays could address entering the home, dealing

with any distractions present, responding to offers of food and drink, and ending a session. Props could be used to provide distraction such as radios, televisions, other people talking, and food. Taking the role play experience further, Gerace et al. suggest planning a home-based assignment where pairs or small groups of students meet at one of the students' house to practice. They would be encouraged to pay attention to the contextual environment and what it tells about the home owner, such as cultural artifacts, what's important to the home owner, and neighborhood resources. Students could be encouraged to write a reflective paper on the process, what they learned, what seemed helpful to the therapeutic process, and what seemed difficult.

Recommendation 2: Agency training should include practical issues faced by home-based counselors, information about common ethical issues, and how to solve ethical dilemmas.

Most home-based training and preparation comes from the agencies specializing in home-visiting once the counselor is hired (Macchi & O'Connor, 2010; Wasik & Bryant, 2001). Before employing a new counselor, home-based agencies should describe the benefits and challenges of home-based counseling and give scenarios specific to working in clients' homes as part of the interview process (Bryant and Wasik, 2001). For instance, what would the interviewee do if there were extra people in the home or if a child was about to do something unsafe? Gould (2000) recommends screening potential employees for flexibility, willingness to leave their comfort zone, and good interpersonal skills to make sure they would be a good fit for the home-based agency.

As stated by counselors in the current study and Gould (2000), agency training should include more practical issues in their training process such as building

relationships on the clients' turf, working with different cultures in their homes, and utilizing theories specific to home-based counseling. Additionally, teaching how to handle distractions and chaos and how to "control the interaction without having control of the environment" (Gould, 2000, p. 160) would be helpful, with detail about when it is appropriate to ask for changes in the environment and how to structure sessions.

An aspect of agency training that five of this study's participants received and found extremely helpful was observing more experienced home-based counselors conduct sessions. They enjoyed seeing how these counselors structured the visit, how they handled distractions and other challenges, which interventions they used, and even practical issues like which gas stations had the cleanest restrooms. Even after a year of home-based practice, Suzy wished she could still observe other counselors so she could learn new skills, styles, and interventions, so observations need not be reserved for newly hired home-based counselors.

Common ethical issues unique to home-based counseling should be an important part of training, and they should include issues like using informed consent to set up the environment and notifying the family about limits to confidentiality, including how confidentiality changes when the client chooses to have visitors in the home during sessions or to meet in a public place. Boundary issues should be discussed including the intimate nature of long-term services in the client's home, accepting food and other gifts, and receiving invitations to client family gatherings. The duty to report abuse and neglect, as well as the duty to report to governing agencies regarding observing violations of terms of probation or CPS safety plans should be taught to home-based counselors, including how to handle going back into the home after reporting a family.

Finally, how to conceptualize and resolve ethical dilemmas is an important part of training. Presenting ethical decision-making models and applying them to common home-based situations, particularly those involving families with whom they have already worked or observed, would likely be more memorable that just presenting the model without applying it to their own situations. Jamie, Margo, and Suzy had been exposed to ethical decision-making models on paper, but none of them explicitly expressed knowing about or using them in practice, possibly because the actual models faded from memory. How the models affect the ethical thought process, however, was apparent in the way Jamie talked about thinking through dilemmas, and it was evident that she had applied the model to her own experiences because she had written personal examples in the text box provided for the activity.

Recommendation 3: Agencies should provide continuing support and resources to home-based counselors.

Considering how specialized home-based counseling is and the often intense and stressful nature of the job (Adams & Maynard, 2000; Christensen, 1995; Wasik & Bryant 2001), it is imperative for quality practice and the wellbeing of both the counselor and agency that support is continuous and consistent. Ongoing training is one way in which agencies can support their counselors. Participants in the current study wanted ongoing training on topics specific to their agencies, for example specific diagnoses, interventions, parent-child interaction problems, and handling crisis. Agencies should also ensure that counselors are kept abreast of local resources and how to access them. Measures intended to protect counselor safety must be provided, like cell phones, safety tips and a buddy

system if needed. Agencies could also offer small lock boxes for counselors to carry in their trunks to secure travelling records and guard against unintentional loss or exposure.

Participants in this study listed colleagues as their most commonly used resource, so colleagues should be utilized by agencies to provide ongoing support by setting up peer teaching and mentoring systems and maintaining regular group case consultation opportunities. Group case consultation provides counselors with the opportunity to staff difficult cases, bring videos of home visits for group feedback, support each other, exchange ideas and resources, and monitor each other's wellbeing and self-care. This time was greatly appreciated by Jamie and Margo, the only participants with group case consultation opportunities, and it was missed by Suzy and Hope, whose case consultation time was replaced by agency policy meetings.

In addition to group case consultation, individual supervision is recommended for home-based counselors (Gould, 2000; Lawson & Foster, 2005; Macchi & O'Connor, 2010; Wasik & Bryant, 2001). Wasik and Bryant added that supervision should be provided by a clinical supervisor and not an administrative supervisor in order to keep the focus on clinical issues and avoid fear that things brought up in supervision could put their jobs in jeopardy. Individual supervision could give counselors an opportunity to reflect on their performance, discuss interventions, and work through boundary issues, transference and countertransference. Ryan and Jamie had regularly scheduled individual supervision and Margo had it available upon request. All three thought this was a good idea. The other participants knew they could talk to their supervisors whenever they needed but Hope, who expressed experiencing burnout, said she would love regular individual supervision once or twice a month. This is consistent with Lawson and Foster

(2005) and Wasik and Bryant's (2001) participants, who wanted more supervision and felt generally unsupported in their home-based practice.

Recommendation 4: Home-based counselors should utilize the informed consent process with their clients to help set up the therapeutic environment and talk about ethical issues in home-based counseling.

In addition to being an ethical imperative (ACA, 2005), the informed consent process can be extremely useful to initiate and maintain conversation between the counselor and client about the process of home-based counseling. Counselors can use the informed consent process to explain how home-based counseling works, how it differs from office-based counseling, what the expectations are for both counselor and client, and how the client can control and adjust the home environment to protect his or her own confidentiality (Knapp & Slattery, 2004). Other topics typically included in the informed consent are potential risks and benefits of home-based counseling, fees and billing arrangements, the complaint process, the right to refuse services or treatment modalities, and the termination process (ACA, 2005). Additionally, a focus on how ethical issues are experienced in unique ways could be conveyed in the informed consent, along with information to the client about how these issues are navigated. Examples could be how having neighbors and friends in the home or meeting in public affect confidentiality, the agency's policies on accepting gifts, duty to report abuse and neglect, and staying within one's scope of professional practice.

Many agencies have a consent for services, but these consents may not comply with all of the items mandated to be included by ACA (2005), so it is suggested that counselors add a personal informed consent specific to the counseling relationship and

process if needed. This informed consent process should occur at the initiation of services and throughout the counseling relationship as needed (ACA, 2005) to keep the relationship and counseling process on track. Counselors can use this process to check in with clients about how things are going and to share concerns with clients and brainstorm solutions together.

Recommendation 5: Home-based counselors should seek support as needed and practice self-care.

Two of the participants in the study no longer had case consultation time and one participant had no counselor colleagues at his agency, so this section makes suggestions for counselors whose agencies do not or cannot provide the desired amount of support. For Suzy and Hope, whose agency had replaced group case consultation time with agency policy and procedure meetings, suggestions might include advocating for group case consultation to return by explaining its importance and benefits to productivity, quality of service provided to clients, and stress and wellbeing, which could improve employee retention (Tracy, Bean, Gwatkin, & Hill, 1992; Wasik & Roberts, 1994). Even if the agency does not provide regularly scheduled time for such meetings, interested employees could meet on a regular basis to support each other. For counselors like Ray, who practice in isolation, seeking out other home-based counselors in the community could be of benefit so they could provide support and ideas to each other. Staffing cases outside of one's agency, however, requires ethical considerations such as not using clients' names or other identifying information and letting the client know in the informed consent process that the counselor conducts such staffings.

Like all counselors, home-based counselors should practice regular self-care, establish healthy boundaries with their agencies and clients, and seek counseling for themselves as needed for demoralization and burnout. Additionally, home-based counselors should ensure that they maintain personal malpractice insurance policies and that their policies cover counseling practice in homes and other non-traditional settings.

Recommendation 6: Uniting organizations for home-based counselors are needed to provide consistency in training, information, regulations, and support.

There currently is no unifying national organization for home-based counselors providing core competencies, standards or resources (Hicken & Plowhead, 2010; Macchi & O'Connor, 2010). One state that has had success with a statewide partnership is Kansas, which contains the HBFT (Home-Based Family Therapy) Partnership (Macchi & O'Connor, 2010). Since 2006, the HBFT Partnership has provided training, credentialing for Medicaid reimbursement, and evaluation procedures for home-based therapists in Kansas. This program could serve as a model to other states striving to provide a uniting organization for home-based counselors.

The American Counseling Association could also consider creating a division or interest network for home-based counselors or specific divisions could incorporate more inclusion of home-based counseling such as the International Association of Marriage and Family Counselors (IAMFC) or the International Association of Addictions and Offender Counselors (IAAOC). This could be done by incorporating more information about issues facing home-based counselors in publications and presentations at national conferences.

Home-based counselors face unique challenges working in homes and communities and they would benefit from additional education and support. Educational institutions could introduce the home as a possible counseling setting and agencies of employment could provide more detailed and practical training on how to take full advantage of the benefits and how to navigate the challenges found in the home. Counselors also should seek support and provide for their own self-care and wellbeing so they can provide quality services and enjoy their positions as home-based counselors. The counseling field can contribute by creating a unifying organization to delineate core competencies, standards, and resources for home-based counselors.

Further Inquiry

Lauka (2012) called for research examining the training and supervision of home-based counselors and how this relates to perceptions of ethical situations. Among other things, the current study filled this gap by addressing feelings of preparation, how counselors felt they were and were not prepared to do home-based counseling, what ethical dilemmas were commonly encountered in home-based counseling, what ethical decision-making processes and resources home-based counselors use and what they believe would be helpful for the training and support of home-based counselors. Future studies could provide further detail about issues found in this study, other related home-based experiences of counselors, and the perceptions of families receiving home-based services.

Participants in the current study talked about common ethical issues found in the home environment. Pope, Tabachnick and Keith-Speigel (1987), Gibson and Pope (1987), and Neukrug and Milliken (2011) used variations of the same survey to study

how ethical or unethical therapists from various mental health backgrounds thought specific behaviors to be and how often they engaged in these behaviors. These studies could be duplicated using home-based counselors to compare their perceptions of ethical issues and practices with office-based counselors, since the current study shows that confidentiality and boundaries in particular are experienced differently outside of traditional offices.

Research conducted utilizing self-efficacy measures could also provide quantitative information on perceptions of self-efficacy home-based counselors have as a group or compared to office-based counselors. An additional area which this study merely touched on, but which warrants further investigation, is multicultural competence in home-based counseling. Such a study could use multicultural competency scales or case study examples to discuss multicultural issues in home-based counseling and counselors' awareness, knowledge and skills in this area. Burnout was expressed by one of the study's participants and demoralization by another one and these issues are also addressed in passing in the literature (Adams & Maynard, 2000; Stinchfield, 2002; Wasik, Bryant, & Lyons, 1990). The only study found that focuses specifically on stress, demoralization, or burnout in home-based counselors was conducted in 1992 by Tracy, Bean, Gwatkin and Hill. Further exploration could shed light on what contributes to burnout and demoralization and factors that serve to protect against burnout and demoralization.

An area of interest and possible further study came up during Ray's final interview. Discussing his perceptions of home-based counseling made him wonder how clients perceive home-based counseling. I had been wondering the same thing throughout

the study, therefore future qualitative research could focus on the perceptions of clients receiving counseling in their homes. Areas to explore could include how therapy fits into their home lives and environments, their perceptions of the balance of power during sessions, how they perceive boundaries and confidentiality, and the informed consent process, including how much counseling in the home environment is explicitly discussed by their counselors. This could provide important insight for counselors to help them improve the home-based experience for their clients.

The Study's Effect on my Home-Based Practice

The idea for this study evolved at the same time I began full-time home-based counseling, a birth of its own sort, so I have had the privilege of growing as a home-based counselor with my study, which has informed my practice every step of the way. Because I was reading books and research studies about home-visiting in addition to the training I received from my agency, I was afforded unusual amounts of knowledge and insight into home-based practice, yet I was still taken off-guard by situations in homes on a regular basis. Knowledge about home-based practice helps, but as Jamie and Ryan stated, nothing can completely prepare anyone for all of the situations that can occur in what I affectionately call the Wild Frontier of counseling. As I approach my third birthday as a full-time home-based counselor, like Margo, Jamie, Hope, and Ray, I feel more competent to handle surprises and I find that a sense of humor goes a long way when someone answers the door wearing no pants or a mouse crawls up my back during a session.

Hearing the participants' stories was deeply touching, humbling, and amusing, and I felt like both they and I benefitted from openly reflecting on the process of home-

based counseling. Through all of the wild and wacky things that happen in homes, participants expressed a love of what they do and a deep respect for being invited to be a part of clients' lives and homes. Home-based counseling can be a very isolated practice, and uniting with other home-based counselors made me feel like part of a bigger picture.

Some of my home-based practices have changed over time, as I now openly discuss the home-based process at the initiation of the relationship and throughout the course of counseling. My informed consent has changed to be reflective of the home-based process and I have found that this does help to make clients more cognizant of managing the environment to be more therapeutic. Much like I do not know information about their child unless they tell me or show me, they do not inherently know how to get the most benefit from the home-based process unless I tell them.

Finally, this research started with enough interest to conduct a study on home-based counselors, but it has turned into a passion to help prepare home-based counselors. I voluntarily serve as a trainer and mentor to new counselors at my agency and I became certified as a Continuing Education Provider so I can help other home-based agencies and counselors learn about how to get the most benefit out of the home environment and tackle common challenges ethically and with grace and humor.

Conclusions

The current research study supported the premise that home-based counseling is indeed experienced quite differently from office-based counseling. While general counseling skills were deemed helpful, advanced knowledge and skills specific to navigating the unique home environment were desired. Building and maintaining professional relationships as well as structuring sessions and handling distractions within

clients' homes were practical skills deemed necessary by participating home-based counselors. Since common ethical issues were experienced in unique ways by participants, ethics training specific to home-based counseling would also benefit counselors providing services outside the relative safety of traditional offices. This specific training would not only benefit counselors providing home-based services, it would also ensure that families receiving these services have prepared, well-informed counselors.

This research gave home-based counselors a voice in sharing how they experience the benefits and challenges of counseling in clients' natural environments and what or who supports them through these challenges. It was evident in interviewing Suzy, Hope, Margo, Ray, Jamie, and Ryan that they have learned a lot about their clients, the counseling process, and themselves as they grew as home-based counselors. Their respect for the families and the process of being such an intimate part of their clients' lives was evident and inspirational, illustrating that even if one does not know how to handle all challenges that occur, a sense of humor, respect, and flexibility go a long way.

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APPENDIX A

EMAIL SCRIPT ASKING FOR PARTICIPATION IN THE STUDY

Dear Counselors,

My name is Rachelle Berg Ritter and I am a doctoral student in Counselor Education at Texas Tech University. I am currently recruiting home-based counselors to participate in my dissertation study. To be a participant, you must be a Licensed Professional Counselor (LPC) and conduct at least a portion of your sessions in clients' homes. In this study, I am examining the experiences and perceptions of home-based counselors, particularly how prepared counselors feel to conduct counseling in clients' homes and how ethical issues are experienced in this role.

Participation in this study will include two interviews over the span of about two months and submitting training documents from your agency or academic institution that directly address home-based counseling and ethics for me to review. These will be returned to you in their original condition. Meetings will be scheduled at a time and place convenient to you, including nights or weekends. Interviews will be audiotaped to ensure accuracy and completeness of information. Research participation is completely voluntary and confidential and great care will be taken to maintain your anonymity in the final study report. You will be given an opportunity to attend a voluntary ethics training given by me that is geared towards ethical home-based practice that is grounded in the literature and includes useful resources gained during the study.

This research has been approved by the Texas Tech Institutional Review Board. This board protects the rights of people who participate in research. You can ask them questions at 806-742-2064. You can also mail your questions to the Human Research Protection Program, Office of the Vice President for Research, Texas Tech University, Lubbock, TX 79409. The study is being supervised by Dr. Loretta Bradley in the College of Education. She can be reached at 806-742-1997 x 263, Loretta.bradley@ttu.edu, or COE Box 41071, Lubbock, TX 79409-1071.

If you are interested in participating or have questions about the study or participation, please contact Rachelle Berg Ritter at berg.ritter@gmail.com or 806-577-1512.

Thank you for your consideration,

Rachelle Berg Ritter, LPC
Doctoral Candidate
Texas Tech University

APPENDIX B

INFORMED CONSENT FOR PARTICIPATION

What is this project studying?
The study is called "Counselors' Perceptions of the Home-Based Counseling Experience: Preparedness and Ethics". The purpose of this study is to examine how prepared home-based counselors feel to provide counseling services in clients' homes and communities.

What would I do if I participate?
You will be asked to participate in three interviews about your background as a counselor, training you have had, and your experiences in counseling clients in their homes. These interviews will be audiotaped to ensure completeness and accuracy of information. You will also be asked to provide training materials you were given by your university or place of employment. These will be returned to you in their original condition.

Can I quit if I become uncomfortable?
Yes, absolutely. Dr. Loretta Bradley and the Protection Board have reviewed the questions and think you can answer them comfortably. However, you can stop answering the questions at any time. You can leave any time you wish. Participating is your choice.

How long will participation take?
The first two interviews will take about one hour each and the third one will take 30-45 minutes.

How are you protecting privacy?
Every effort will be made by the researcher to preserve your confidentiality including the following:

- You will choose a pseudonym that will be used throughout the study. Notes, interview transcriptions, and any other identifying participant information will be de-identified with this pseudonym and kept in a locked file cabinet in the personal possession of the researcher. Audiotapes will be destroyed after they are transcribed.
- Your place of employment and graduate school will not be identified, only the general population with whom you work. Participants from multiple agencies and cities will be gained to further protect anonymity.
- Each participant will get a transcribed copy of his or her interviews and the opportunity to add to the information or choose for specific statements to be deleted from the study.
- Participant data will be kept confidential except in cases where the researcher is legally obligated to report specific incidents. These incidents include incidents of abuse, suicide risk, and professional conduct that has harmed or is likely to harm a client.

How will I benefit from participating?
A list of the resources gained throughout this study will be sent to you upon completion of the study and you will be given the opportunity to attend a voluntary training in ethical home-based practice.

If I have some questions about this study, who can I ask?

- The study is being run by Dr. Loretta Bradley from the Counselor Education Department at Texas Tech University. I you have questions, you can call her at 806-742-1997 x 263 or email Loretta.bradley@ttu.edu.
- TTU also has a Board that protects the rights of people who participate in research. You can ask them questions at 806-742-2064. You can also mail your questions to the Human Research Protection Program, Office of the Vice President for Research, Texas Tech University, Lubbock, Texas 79409.

Signature _____ Date _____

Printed Name: _____

This consent form is not valid after September 30, 2013

APPENDIX C

DEMOGRAPHIC INFORMATION FORM

Chosen Pseudonym:

Age Range (circle one): 20-25 26-30 31-35 36-40 41-45

46-50 51-55 56-60 61-65 66-70 70+

Gender:

Ethnicity:

Highest degree obtained:

How long have you been a fully licensed LPC?

How many years have you worked as a home-based counselor?

What is your primary theory-base when conducting counseling?

APPENDIX D

INTERVIEW ONE PROTOCOL

*Review informed consent to participate in research study, obtain participant signature and give participant a copy for his or her records. Explain purpose of audiotaping and that after they are transcribed, tapes will be destroyed.

*Ask the participant if they would be willing to bring training documents to second interview.

Questions:

Talk about how you decided to become a counselor.

Tell me about your educational preparation to become a counselor.

Describe the agencies you have worked for including the one where you currently work.

What kind of training did you get in your educational program to do home-based counseling?

Describe the training your agency provided on home-based counseling.

Tell me about the supervision you receive to do home-based counseling and how satisfied you are with this level of supervision.

In what ways do you feel your educational program did or did not prepare you for this form of counseling?

In what ways do you feel your agency of employment did or did not prepare you for this form of counseling?

*End by thanking the participant for his or her time and ask if I can contact them for a second interview.

APPENDIX E

INTERVIEW TWO PROTOCOL

*Review consent procedures (verbal review, no new consent signed)

*Gather training documents brought by participant and ask if they need them back right away or at third interview.

Questions:

Compare home-based counseling to office-based counseling.

Describe a typical day that involves home visiting.

Tell me the general characteristics of the clients/families you counsel in the home.

Tell me about the most common ethical issue you face while counseling in the home.

Describe the most difficult ethical issue you face while counseling in the home.

Talk me through the process of how you have handled some of these ethical dilemmas.

What resources did you feel were useful to handles these issues?

How prepared have you felt to handle ethical dilemmas in home-based counseling?

APPENDIX F

INTERVIEW THREE PROTOCOL

*Review consent protocol (verbal review, no new signature)

*I will share themes derived from document and record review and check for accuracy or any other document or records they may have forgotten or that may have surfaced since the beginning of the study.

*Return documents to participant unless he or she has asked to have them returned sooner.

*Review transcripts from first two interviews and themes that have emerged from the data analysis.

*Ask for clarification on anything that came up from previous interviews or during analysis of transcripts.

Is there anything you would like to add to what you have already talked about?

Is there any part of what you have said that you would like revised or excluded from the study?

What would be helpful to make you a more effective home-based counselor?

What else would you like for me to know about your experiences counseling in the home?

*Thank her or him for participating in the study

- Ask if she or he would like to be contacted for a voluntary training with results of study and resources gained throughout the study.

APPENDIX G

INTERVIEW SCHEDULE

Participant	*Interview #*	*Date*	*Length of Interview*
Suzy	1	11/9/12	18 minutes
Suzy	2	12/7/12	28 minutes
Suzy	3	2/1/13	62 minutes
Hope	1	11/16/12	35 minutes
Hope	2	12/14/12	34 minutes
Hope	3	2/2/13	51 minutes
Margo	1	11/17/12	33 minutes
Margo	2	12/7/12	26 minutes
Margo	3	2/4/13	26 minutes
Ryan	1	12/5/12	23 minutes
Ryan	2	12/21/12	36 minutes
Ryan	3	1/16/13	25 minutes
Jamie	1	12/27/12	26 minutes
Jamie	2	1/10/13	21 minutes
Jamie	3	2/1/13	45 minutes
Ray	1	12/28/12	34 minutes
Ray	2	1/11/13	45 minutes
Ray	3	2/8/13	23 minutes

APPENDIX H

AUDIT TRAIL

Reference #	Participant/ Agency	Interview/Document	Page #	Line #s
[1]	Suzy	Interview 1	1	44-46
[2]	Suzy	Interview 1	1	33-35
[3]	Suzy	Demographic page	1	9
[4]	Ryan	Interview 1	2	11-34
[5]	Ryan	Interview 1	1	37-46
[6]	Ryan	Demographic page	1	9
[7]	Ray	Interview 1	3	32-36
[8]	Ray	Interview 2	3	26, 45
[9]	Ray	Interview 1	7	35
[10]	Ray	Interview 1	2	13-16
[11]	Ray	Interview 2	2	18-21
[12]	Hope	Interview 1	2	7-24
[13]	Hope	Interview 3	9	21-22
[14]	Hope	Interview 3	7	18, 31-35
[15]	Hope	Interview 1	1 2	16-23, 28-31 1-3
[16]	Hope	Demographic page	1	9
[17]	Jamie	Interview 1	2 3	45-46 1-46
[18]	Jamie	Interview 3	2	3-12
[19]	Jamie	Interview 1	1 2	32-46 24-26
[20]	Jamie	Demographic page	1	9
[21]	Margo	Interview 1	1 2	42-46 1-24
[22]	Margo	Interview 1	1	27-37
[23]	Margo	Demographic page	1	9
[24]	Ryan	Interview 2	1	6
[25]	Jamie	Interview 2	2	6-7
[26]	Ryan	Interview 3	1 2	45-46 1-3
[27]	Suzy	Interview 2	1	11-20
[28]	Hope	Interview 2	1 2	43-45 1-2
[29]	Jamie	Interview 2	1	36-42
[30]	Jamie	Interview 2	5	14-19, 25-29
[31]	Home Health	Training binder	71-94	n/a
[32]	Home Health	Training binder	3	13-56

		Appendix		
[33]	Ryan	Interview 1	8	15-21
[34]	The Crisis Team	Training binder	5	19-20
[35]	Jamie	Interview 2	1	17-32
[36]	Suzy	Interview 3	3	30-36
[37]	Ray	Interview 2	2	28-38
[38]	Children Inc.	Training binder	5.8	1-11
[39]	Margo	Interview 1	2	18-21
[40]	Suzy	Interview 2	1	30-36
[41]	Ray	Interview 1	6	33-42
[42]	Ryan	Interview 1	5	1-9
[43]	Suzy	Interview 2	3	28-31
[44]	Hope	Interview 2	2	13-16
[45]	Children Inc.	Training binder	2.16 2.17	11-40 29-36
[46]	Suzy	Interview 1	4	40-44
[47]	Hope	Interview 2	5	22-26
[48]	Home Health	Training binder	123-135	n/a
[49]	Home Health	Training binder	28	28-30
[50]	Children Inc.	Training binder	2.4	16-31
[51]	Children Inc.	Making Decisions Webinar	3 7	20-36 14-17, 26-30
[52]	Juvenile Probation	Code of Ethics	3	10-12
[53]	Jamie	Interview 1	3	33-38
[54]	Jamie	Interview 3	3 4	38-46 1-5
[55]	Suzy	Interview 3	6	1-3
[56]	Ray	Interview 1	6	6-9
[57]	Ryan	Interview 1	7	23-26
[58]	Hope	Interview 2	7	10-12
[59]	Children Inc.	Training binder	2.16	18-33
[60]	Hope	Interview 3	2	16-24
[61]	Home Health	Training binder	131	19-23
[62]	Hope	Interview 2	6	28-32
[63]	Jamie	Interview 3	5	26-36
[64]	Margo	Interview 2	2	13-19
[65]	Ryan	Interview 3	2	20-27
[66]	Ray	Interview 1	9	6-7
[67]	Ray	Interview 1	7	35-36
[68]	The Crisis Team	Training binder	5	9-15
[69]	Jamie	Interview 3	6	22-26

[70]	Children Inc.	Training binder	7.10- 7.14	n/a
[71]	Suzy	Interview 2	1	40-42
[72]	Margo	Interview 1	5	40-41
[73]	Margo Jamie	Interview 1 Interview 2	5 2	40-41 1-2
[74]	Ray	Interview 3	6	34-37
[75]	Suzy	Interview 2	6	44-46
[76]	Margo	Interview 1	6 7	14-20 29-30
[77]	Hope	Interview 1	6	23-26
[78]	Ray	Interview 1	9	16-21
[79]	Ryan	Interview 3	2	11-15
[80]	Jamie	Interview 1	5 9	5-7 17-20
[81]	Hope	Interview 1	7	31-36
[82]	Jamie	Interview 2	12	4-14
[83]	Hope	Interview 1	2	27, 29
[84]	Ray	Interview 1	7	26
[85]	Ryan	Interview 1	2	43-46
[86]	Suzy	Interview 1	2	31-33
[87]	Hope	Interview 1	6	9-12
[88]	Jamie	Interview 1	9	37-42
[89]	Ryan	Interview 1	2	43-46
[90]	Ray	Interview 1	5	28-29
[91]	Suzy	Interview 1	3	15-18
[92]	Margo	Interview 1	5	8-14
[93]	Suzy	Interview 3	8	18-21
[94]	Jamie	Interview 1	9	14-17
[95]	Margo	Interview 1	3	1-5
[96]	Hope	Interview 3	11	7-9
[97]	Ryan	Interview 1	5	26-28
[98]	Jamie	Interview 3	5	5-9
[99]	Jamie	Interview 2	6 7	36-39, 45-46 1
[100]	Jamie	Interview 3	4	25
[101]	Jamie	Interview 2	7	2-9
[102]	Ryan	Interview 1	8	1-7
[103]	The Crisis Team	Training binder	2	2-5
[104]	Ritter	Researcher's Journal	14	12-15
[105]	Jamie	Interview 1	7	24-31
[106]	Jamie	Interview 3	7	2-9
[107]	Ray	Interview 2	5	9-14

[108]	Home Health	Training binder	75	8-10
[109]	Children Inc.	Training binder	2.16	26-33
[110]	Children Inc.	Making Decisions Webinar	7	18-20
[111]	Juvenile Probation	Code of Ethics	2	31-33
[112]	The Crisis Team	Training binder	4	23-25
[113]	Ray	Interview 3	6	1-2
[114]	Hope	Interview 3	10	38-39
[115]	Home Health	Training binder	91	9-11
[116]	Jamie	Interview 3	5 6	42-46 1-6
[117]	Ryan	Interview 3	3	15-23
[118]	Ray	Interview 2	6 7	44-45 1-2
[119]	Jamie	Interview 1	5	14-18
[120]	Ray	Interview 1 Interview 2	6 1	12-18 38-39
[121]	Hope	Interview 1	4	12-14
[122]	Juvenile Probation	Code of Ethics	3	8-14
[123]	Children Inc.	Training binder	5.4	11-26
[124]	Children Inc.	Making Decisions Webinar	3 7 5 6	20-36 14-17, 26-30 10-46 1-46
[125]	Home Health	Training binder	131	14-22
[126]	Home Health	Training binder	134 84	5-10 14-16
[127]	Home Health	Training binder, appendix	8 11	7-24 1-24
[128]	Suzy	Interview 2	4 5	38-46 1-4
[129]	Hope	Interview 2	5	31-35
[130]	Jamie	Interview 3	9	21-24
[131]	Suzy	Interview 2	6	1-5
[132]	Margo	Interview 2	5	16-18
[133]	Suzy	Interview 3	3	17-19
[134]	Ray	Interview 2	8	1-4
[135]	Juvenile Probation	Code of Ethics	3	17-21
[136]	The Crisis Team	Training binder	4 6	15-16, 30-31 20

[137]	Children Inc.	Making Decisions Webinar	3 7	4-11 21-25
[138]	Jamie	Interview 1	5	7-14
[139]	Margo	Interview 3	2	2-7
[140]	Hope	Interview 3	5	36, 41-42
[141]	Suzy	Interview 1	2	19-20
[142]	Jamie	Interview 1	7	43-45
[143]	Children Inc.	Making Decisions Webinar	3 4 7	36-38 1-2 31-33
[144]	Children Inc.	Training binder	2.31 2.32	1-37 1-5
[145]	Children Inc.	Culture Webinar	2 3 4 5 6	31-45 39-52 1-3 8-31, 51-52 1-17
[146]	Home Health	Training binder	75 76 124 125 126	16-25 1-8 4-7, 15-16 1-25 1-14
[147]	The Crisis Team	Training binder	54-61	n/a
[148]	Juvenile Probation	Code of Ethics	3	1-2
[149]	Jamie	Interview 1	5	25-32
[150]	Ray	Interview 1	8	18-28
[151]	Ray	Interview 1	5	36-39
[152]	Jamie	Interview 3	3	21-24
[153]	Hope	Interview 3	1	32-34
[154]	Hope	Interview 2	4	11-15
[155]	Hope	Interview 2	4	33, 37-38
[156]	Hope	Interview 3	1	45-46
[157]	Suzy	Interview 3	7	35-42
[158]	Children Inc.	Training binder	5.3-5.4	n/a
[159]	Jamie	Interview 3	7	8-9
[160]	Hope Suzy	Interview 2 Interview 3	1 1	16-22 20-27
[161]	Suzy	Interview 2	6	21-27
[162]	Hope	Interview 1	5	30-31
[163]	Ray	Interview 3	9	25-27
[164]	Margo	Interview 2	5	24-26
[165]	Jamie	Interview 1	11	2-4

[166]	Ryan	Interview 1	5	14-16
[167]	Suzy	Interview 2	6	44-46
[168]	Margo	Interview 2	5	23
[169]	Hope Suzy Ray	Interview 2 Interview 3 Interview 1	1 4 9	21-22 38 40-42
[170]	Jamie	Interview 1	10	7-16
[171]	Ray	Interview 2	2	16-17
[172]	Suzy	Interview 2	6	36-39
[173]	Ryan	Interview 3	8	9-10
[174]	Hope	Interview 2	7	44-45
[175]	Hope	Interview 1	4	2-6
[176]	Margo Ryan	Interview 2 Interview 2	5 8	34 11
[177]	Jamie	Interview 3	9	34-36
[178]	Jamie	Interview 2	10	7-16
[179]	Jamie	Interview 2	9	4-7
[180]	Margo	Interview 2	5 6	44-46 1-4
[181]	Jamie	Interview 2	13	26-29
[182]	Hope	Interview 2	8	8-13
[183]	Ray	Interview 3	1	26-31
[184]	Suzy	Interview 2	6	44-46
[185]	Ryan	Interview 2	8	16-23
[186]	Home Health	Training binder Appendix	11	6-7, 10-24
[187]	Children Inc.	Making Decisions Webinar	5 6 7	2-46 1-46 1-2
[188]	Children Inc.	Conceptualizing Ethics Webinar	4	1-46
[189]	Children Inc.	Conceptualizing Ethics Webinar	4	9-11, 23, 44
[190]	Ryan	Interview 1	6	9-12
[191]	Suzy Margo	Interview 3 Interview 2	5 4	22-30 8-11
[192]	Suzy	Interview 3	4	27-30
[193]	Hope Jamie Ryan	Interview 2 Interview 1 Interview 2	4 6 3	11-15 37-43 2-14
[194]	Home Health	Training Binder	75 124 125 126	17-20 1-16 1-14 1-14

[195]	Suzy	Interview 3	5	21-22
[196]	Margo	Interview 3	2	34-37
[197]	Ryan	Interview 3	1	12-15
[198]	Hope	Interview 3	11	2
[199]	Jamie	Interview 3	5	1-8
[200]	Home Health	Training Binder	73 75	1-25 9-10
[201]	Ray	Interview 3	3	12-14
[202]	Ray	Interview 3	2	34-38
[203]	Suzy	Interview 1	5	29-35
[204]	Jamie	Interview 3	4	33-40
[205]	Suzy	Interview 3	9 10	33 12-13
[206]	Jamie	Interview 2	11	18-19
[207]	Suzy	Interview 3	8	32-34
[208]	Jamie	Interview 1	7	14-21
[209]	Suzy	Interview 3	8	25-26
[210]	Jamie	Interview 1	9	16-17
[211]	The Crisis Team	Training binder	17-20 1	n/a 5-8
[212]	Margo	Interview 3	4	41-44
[213]	Hope	Interview 3	11	26-27
[214]	Hope	Interview 1	5	33-34
[215]	Suzy	Interview 3	1	20-27
[216]	Margo	Interview 1	4	10-15
[217]	Ray	Interview 1	3	37-43
[218]	Ryan	Interview 3	1	42-43
[219]	Ryan Ray	Interview 3 Interview 3	1 4	43-45 14-15
[220]	Suzy	Interview 3	5	36-41
[221]	Ryan	Interview 3	5	22
[222]	Ray	Interview 3	6	18-20
[223]	Ray	Interview 3	5	7-13