2021

Helping in the Home: Counselors' Experiences Providing Clients With In-Home Services

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Walden University
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Abstract

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MA, University of Illinois at Springfield, 2006

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Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

Counselor Education and Supervision

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Abstract

Counseling is an essential service that helps individuals work through struggles and live their best lives. Such service now includes providing counseling in clients' homes. Counselors may require specific training or education to prepare for counseling in a home environment. This need for training and education is due to a lack of knowledge of the lived experiences of counselors providing services in the home. Transcendental phenomenology was used to guide a qualitative exploration into the lived experiences of counselors providing services in clients' homes. Participants were 7 professional counselors, 5 female and 2 male, having met minimum state licensure requirements and having at least 6 months of in-home counseling experience. Data were collected from semi structured interviews, comprised of self-created open-ended questions, to obtain insight into the clinicians' experiences of providing in-home counseling services. Phenomenological reduction, systematic content analysis, and bracketing of the data resulted in three major themes: (a) counselor preparation and support, (b) therapeutic relationship, and (c) environmental factors. Two subthemes identified were (a) barriers and (b) comfort. These themes and subthemes that arose from the data collected may lead to future research on the preparation and education needs of counselors providing services in clients' homes. The results of this research may lead to the development of new training for current counselors providing in-home counseling and new practice model or educational courses or programming for future counselors. Such program development will help counselors follow evidence based best practices; ensuring a more positive and beneficial experience for counselors and clients.

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Dedication

I dedicate this work to my son Brady. He has been on this journey with me from day one and I hope he sees that determination and hard work will help him accomplish any dream he desires. The world is at his fingertips, and I cannot wait to watch him grow and be there to support him through life's challenges—just as his many hugs and smiles have supported me along this journey. I love you forever and ever, Brady!

Acknowledgments

First, I must take a moment to acknowledge my family. Their love and support have been unwavering. A special thank you to my parents, Joyce and Dave Schmidt and Clay and the late Cheryl Nath, for raising me to be the stubborn, determined, heartfelt, and passionate person I am today. Next, I must acknowledge that I would not have made it through this process successfully without the support of my friends. Thank you for the late-night talks, listening to my venting sessions, and supporting me when my emotions took control. From the friends I have known for years to the new friends I have met through Walden, your friendship and support are priceless. Lastly, I must thank my committee for their steadfast commitment. With their support, I was able to navigate tumultuous times and accomplish this lifelong goal.

I am forever grateful to all of you.

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Chapter 1: Introduction to the Study

Helping professionals have historically established care for clients in office-based settings, requiring clients to come to them for services. Although the research is dated, there has been a documented shift in the helping professions to enhance access to services and care in a way most convenient for the clients (Adams & Maynard, 2000). However, Adams and Maynard (2000) identified that a central challenge is determining how training programs can be revised to best prepare therapists for working off site or out of the clinical setting. Friedman (2017) reported that medical personnel and social service workers have offered services in the homes of the clients and received payment from governmental waivers as far back as 1981. One significant reason for this shift is that traditional office-based services are not always as effective for clients with multiple environmental, social, and personal needs (McCain & Day, 1999; Oser et al., 2013; Stinchfield, 2004). McCain and Day (1999) found that home-based services and office/clinic-based services occur in very distinct locations and, in turn, create differing needs for the client and the counselor. Adams and Maynard (2000) also mentioned this lack of understanding, noting "the skills required to provide home-based services have not been directly examined" (p. 41). Hammond and Czyszczon (2014) explored the shift from traditional office-based care to home-based services and found the same lack of professional understanding of this process, identifying a need to explore the phenomenon further to professionalize the services and to offer training and education to counselors wanting to work in client homes.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards (2016) established the criteria for counseling and counselor education programs and include guidelines for teaching basic clinical skills to counselors through coursework and professional experiences. Section 3 of these standards includes the direction that students must complete preprofessional clinical experiences in practicum and internship through an identified clinical site with a site supervisor (CACREP, 2016). While CACREP (2016) established the requirements for accreditation, it did not specifically define *site* or dictate exactly how a program may meet the standards. Instead, CACREP (2016) promoted program innovation while using the standards as guidelines for program development. These guidelines prepare counselors for careers in "mental health, human services, education, private practice, government, military, business, and industry" (CACREP, 2016, p. 4). Counselor education programs have historically interpreted *clinical site* in such a way that preprofessional experience is conducted within an established brick-and-mortar agency or institution with a supervisor present on site. This is evident through practicum and internship course descriptions and requirements through university websites, such as the University of Illinois at Springfield ("Human Development Counseling," n.d.). Additionally, Walden University (2019a), an online institution, used this practice until spring 2019 when it implemented a new home-based counseling practice and protocol for students entering internship. These practices are consistent with research findings showing historical academic practices to focus on the building of clinical skill regardless of location (Adam & Maynard, 2000).

Continually preparing counselors for practice in an office setting may be putting them at risk. Oser et al. (2013) reported counselors providing clinical services in clients' homes have higher rates of burnout and report needing additional training and support for working out of the office. Currently there is not a concrete understanding of the experiences or needs of counselors providing services in clients' homes' homes (Adams & Maynard, 2000). Obtaining this knowledge and expanding training and education on in-home counseling will allow the counseling profession to adhere to evolving best practices and uphold ethical responsibilities. Minimal research exists on proper training procedures for in-home counseling. However, the American Counseling Association (ACA) has established a code of ethics to outline best counseling practices to better serve and protect clients. Counselors have a professional responsibility to practice only within the boundaries of their training (ACA, 2014). Given the historical experiential practices of internships being designed for office-based settings and evolving best practices suggesting a greater understanding of home-based services (Adams & Maynard, 2000), counselors are ethically bound to obtain training and supervision for this new practice before proceeding (ACA, 2014). Given the safety and burnout risks of in-home counseling (Lauka et al., 2013), it is important to consider the unique needs of counselors who provide in-home counseling and how the code of ethics and CACREP standards are to be interpreted when home-based counseling services are provided.

In this chapter, I explore the concept of in-home counseling and provide an outline for this study. Information includes a brief background on in-home counseling, a study problem statement, and the purpose of this study. I also outline the study by

providing the research question, definitions, assumptions, limitations, and a description of the qualitative approach. This research serves as the first step leading to a more in-depth exploration of specific training needs for counselors who provide counseling services in the home. I end this chapter with an explanation of the significance of the research.

Background

A defining moment for home-based services occurred in 1980. At that time, the Federal Adoption Assistance and Child Welfare Act became law and required child welfare workers to put forth additional efforts to help children remain in the home (Adams & Maynard, 2000). One such effort was to provide in-home services to families involved with child welfare. Although this was not the first documented in-home service, it was a pivotal point for the future of all social services as the creators of the Federal Adoption Assistance and Child Welfare Act set guidelines and a standard of practice to provide the best care for clients despite their ability to travel to an office for services (Adams & Maynard, 2000).

Nearly two decades after this monumental decision, research has been underway to examine the differences and outcomes in providing services in an office setting versus providing services in a home-based setting. McCain and Day (1999) reported home-based and office/clinic-based are distinct locations, thus resulting in a different experience and different needs for the client and clinician during therapy (Bowen & Caron, 2016). These differences are rooted in the fact that counselors working in an office can account for potential safety risks and distractions to promote progress during the therapeutic session (Bowen & Caron, 2016). On the other hand, counselors working in the home have no

control over the setting, and the environment presents potential safety risks and multiple distractions that could hinder client progress. However, despite the risks and distractions of in-home counseling, McCain and Day (1999) found that home-based services are more accessible for clients living in rural populations compared to clients in more urban populations, thus allowing rural clients the opportunity to obtain services otherwise unavailable when held in an office setting. Oser et al. (2013) discovered that clients needing home-based services face increased challenges compared to clients seeking services in office-based settings. These increased challenges include a "lack of reliable transportation, caregiver mental or physical health problems, difficulty setting and keeping regular appointments, employment, or school commitments, and obtaining and affording childcare" (Tate et al., 2014, p. 371) Traditional office-based counseling is not always effective for individuals with these higher needs and increased challenges (Stinchfield, 2004).

Additional challenges exist for in-home counselors compared to traditional in-office practices. Bowen and Caron (2016), Lauka et al. (2013), and Walker (2016) found that in-home counselors often feel inadequate and ill prepared for the work they are providing due to safety concerns, environmental influences, feelings of isolation, and increased feelings of burnout and secondary trauma. Within the home, counselors tend to see a more intimate and personal side of clients, including family interactions, which, mixed with the emotional experience of counseling, may create extreme emotional reactions or troubling situations that a counselor is not prepared to handle (Lauka et al., 2013). Furthermore, engaging in personal counseling in the client's home allows the

counselor to immerse themselves in their environment but may also cause lines to blur between the participant roles (Lauka et al., 2013). This may occur with a simple dinner invitation at the end of a session or a request from a busy parent asking the counselor to pick up the client from school before coming to the house. While these requests may not appear to be troublesome, they do create the potential for the counselor to take on a more personal role within the family, creating a nonprofessional relationship for the counselor and client. The ACA's (2016) code of ethics dictates that counselors should avoid entering into nonprofessional relationships with client and former clients. Lauka et al. (2013) reported that these environmental and personal changes cause increased risks for counselors, such as decreased safety, environmental distractions, and heightened emotional reactions from clients when providing therapeutic services to clients in their homes.

The purpose of this study was to develop an understanding of the experiences and needs of counselors providing services in the home. Studying the lived experiences of counselors working in the home has potential to affect social change significantly in the way counselor educators and counseling training programs prepare counselors to provide in-home counseling. Furthermore, the results of this study increase the overall knowledge of the counseling profession regarding the potential risks and needs involved with in-home care. The findings from this study may inform areas of needed advancement to meet the needs of clients and improve best practices for both counselors and clients involved in home-based services.

Problem Statement

The practice of providing therapeutic services in the home is a growing area of the helping profession (Crespi & Generali, 1995). In-home counseling is used to provide services to a variety of clients, many of whom suffer from multiple challenges and/or barriers to receiving services (Lauka et al., 2013). These client barriers include life commitments such work and school and needs such as transportation and physical and mental healthcare (Tate et al., 2014). In-home counseling can have many benefits for clients, including cost effectiveness and a reduction in barriers to obtaining counseling services, such as eliminating the need for and cost of transportation (Lauka et al., 2013; Tate et al., 2014). Despite many benefits to the clients of in-home counseling, there is a high level of burnout and turnover among professional clinicians in these roles (Hammond, & Czyszczon, 2014; Lauka et al., 2013; Tate et al., 2014). Crespi and Generali (1995) and Tate et al. (2014) addressed the scarcity of research in exploring experiences of those involved or competencies necessary for effective care. Minimal research has led to a lack of understanding of the true experiences of counselors providing in-home care (Lauka et al., 2013). Providing in-home services with minimal environment-specific training leaves counselors facing risks they are ill prepared to handle.

Counselors have reported feeling ill prepared for the family dynamics and potential nonprofessional relationships they face when providing care in client homes due to undertraining for the unique environment (Lauka et al., 2013). Oser et al. (2013) also found in-home counselors had safety concerns. Despite these concerns and struggles,

counselors hesitate to report them to supervisors for various reasons including job security (Czyszczon, 2014). At times, this lack of reporting may also be due to counselors feeling their safety is sufficient if an agency puts safeguards into place (Adams & Maynard, 2000). While the current literature presents substantial support for the experiences of in-home care providers of other professions, there is a lack of significant research on the specific support and training for counselors providing in-home counseling services. The paucity of support, training, and experiential understanding puts in-home counselors' safety at risk and opens the door to increased burnout and compassion fatigue (Hammond, & Czyszczon, 2014; Lauka et al., 2013).

Overall, a lack of understanding of and preparation for in-home counseling experiences contributes to increased rates of counselor burnout, employee turnover (Hammond, & Czyszczon, 2014; Lauka et al., 2013). The increase of counselor burnout and employee turnover may lead to a lack of staff and, in turn, a reduction of resources for those in need of in-home care. Due to the negative effect of this lack of knowledge, it is imperative to acquire an understanding of experiences of in-home counselors. This phenomenological, qualitative study involving semi structured questioning of counselors providing in- home therapeutic services provides necessary information on lived experiences of these counselors. I sought a purposeful sample of counselors from social service agencies that provide in-home counseling services. These counselors were able to tell their own experiences and stories, thus providing crucial information and insight into both positive and negative aspects of in-home counseling. These insights may allow for development of additional theories and training models to best support counselors,

minimize burnout, minimize turnover, increase service providers, increase service options, and best serve clients.

Purpose

The purpose of this transcendental phenomenological study was to understand the lived experiences of professional counselors who provide in-home counseling services. Current research identifies increased risks for counselors providing in-home services and a need for further training on working within the home environment. Following this study, counselor educators may be better able to understand the lived experiences of counselors and their needs when working in clients' homes. This newfound understanding may allow educators to expand training programs or educational course work to best prepare current and future counselors for in-home work.

Research Question

What are the lived experiences of counselors providing counseling services in clients' home environments?

Theoretical Framework

Husserlian phenomenology was the guiding philosophy for the theoretical framework of this research. I used Husserl's transcendental phenomenological theory as a guide (TaipaLe, 2015). However, before discussing transcendental theory, it is important to explain the philosophical approach associated with Husserl.

Edmund Husserl's phenomenological approach began through his work in the early 1900s, when his beliefs developed from the works of Hegel and Descartes (Moustakas, 1994). Hegel provided the basic belief that an individual's experience or

"knowledge" of an event or situation comes from their different senses (sights, sounds, feelings/emotions) and conscious awareness during the actual experiencing of the event (Moustakas, 1994, p. 26). Husserl further refined his philosophy using Descartes' concept of removing doubt or preconceived notions, thus allowing an individual to use their inner experience to assign true meaning to a situation (Moustakas, 1994). Having the ability to understand the true meaning of an experience provides the opportunity to develop or grow a particular phenomenon. Husserl refined this concept through the development of his transcendental phenomenology (Moustakas, 1994).

Husserl developed transcendental phenomenology to explore the experiences of the individual participants (Patton, 2015). He believed much information is lost when we form knowledge of events without considering the conscious experience of the individual (Gutland, 2018). By allowing an individual to explain their own experiences, including their conscious knowledge and physical experiences of what they know, perceive and sense, we gain a more complete interpretation of the event (Husserl, 1931, 2013). Husserl (2013) explained that events or situations encompass the factual events as well as the conscious experiences of the individual involved. Researchers may then take this information and bracket off key concepts from information gathered, while also bracketing away their personal beliefs or biases that arise (Husserl, 2013). These key components help provide insight into the commonalities between research participants within a given situation.

When applying transcendental phenomenology to a research study, researchers examine participants' lived experiences within the phenomenon or situation (Ravitch &

Carl, 2016; TaipaLe, 2015). Husserl suggested that exploring the experiences of the individual to the phenomenon would provide a more in-depth and richer understanding (TaipaLe, 2015). Murdoch and Franck (2012) and Novak (2011) found success using this phenomenological approach to explore experiences of different populations related to training for in-home work.

Significant research related to counselor experiences providing counseling services in an office-based environment exists. However, the counseling profession knows little about the experiences of counselors who provide in-home counseling services (Hammond & Czyszczon, 2014). Using a transcendental phenomenological approach allows for the acquisition of firsthand knowledge regarding the experiences of counselors working in a home environment and will highlight key concepts of this experience.

Nature of the Study

There is a high level of burnout and turnover in the in-home counseling field (Hammond, & Czyszczon, 2014; Lauka et al., 2013). Currently, little research exists exploring experiences of the counselors involved or competencies necessary for effective in-home care (Crespi & Generali, 1995; Tate et al., 2014). Using a transcendental phenomenological approach allows researchers to grasp a broader understanding of the counselors' experiences of working in clients' homes. Without using this approach, researchers would be making decisions based solely on their external observation, which eliminates the true essence of the experiences by the participants (Gutland, 2018). Furthermore, without the knowledge gained from this study, counselor preparation and

training may remain the same, which has been proven to create high levels of burnout, stress, and turnover for those clinicians working in clients' homes, throughout the counseling profession (Hammond & Czyszczon, 2014; Lauka et al., 2013). No attempt to change these high levels of burnout, stress, and turnover may also lead to an even greater shortage of clinicians to work in both the office and home environments.

The primary goal of this transcendental phenomenological study was to explore the lived experiences of counselors providing in-home clinical services. Husserl believed that the true way to understand a phenomenon is to study it through the eyes of the individuals experiencing the phenomenon (Husserl, 1931). This understanding comes from observation of the participants' lived experiences or through an interview with the participants regarding their lived experiences. In turn, transcendental phenomenology allows a researcher to gain insight into the lived experiences of a counselor working in the homes of clients. To obtain information on counselors' lived experiences, I conducted open-ended, semi structured interviews with counselors who have experience providing in-home counseling services. I selected a transcendental phenomenological approach to seek out the lived experiences or perceptions of the participants and not a causal relationship of the phenomenon (Ravitch & Carl, 2016). While a quantifiable or causal relationship may provide some insight, I did not believe it would provide the depth of knowledge necessary to best prepare counselors for providing counseling services in the home. Husserl developed transcendental phenomenology to learn of the true nature and real-life experiences of individuals (TaipaLe, 2015). Employing the transcendental approach to this research allowed me to gather information-rich experiences to provide

the counseling profession a true understanding of what it is like to work in clients' homes, thus providing an opportunity for development of training and education for current and future counselors.

Definitions

In-Home Services: Various home services, including but not limited to, therapeutic (counseling), medical assistance, and rehabilitative work provided to a client in their home or place of residence (Holm et al., 2017).

Counseling: The ACA (2019) defines counseling as a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals ("Professional Counselor and Clinical Professional Counselor Licensing and Practice Act," 2012).

Professional Counselor: An individual who has completed an academic master's degree level program and who has or is now eligible to practice counseling ("Professional Counselor and Clinical Professional Counselor Licensing and Practice Act", 2012).

Graduate Intern: A student in a master's degree level counseling program who is enrolled and participating in their required internship course. CACREP (2019) refers to internship as entry-level professional practice in which students receive supervision, including formative and summative evaluations of their skill.

Assumptions

I have assumptions relating to the inclusion criteria being appropriate to answer the research questions and the honest participation of each individual counselor in this study. First, I assumed that all participants would explore their experiences with in-home

counseling. Second, I assumed that the information participants reported would be honest and accurate. Seeking an understanding of counselors' lived experiences of in-home counseling, it is crucial for participants to be willing and able to express their experiences. Finally, I assumed participants, based on self-report, have provided counseling services in the home for a minimum of 6 months. Without in-home experience, counselors would not have the knowledge or information necessary to answer the questions in this study.

Scope and Delimitations

The focus of this research includes gaining an understanding of lived experiences of counselors who provide in-home counseling services. Participants must (a) be a licensed professional counselor or master's degree level counseling graduate intern and (b) have provided counseling services to clients in their homes with a minimum of six months' experience. While various approaches are available to obtain the necessary information to answer the research question, the focus to use transcendental phenomenology ensures the ability to gather information-rich details from each participant. Analysis of this information allows for successful study of the research question and potential development of future studies and training.

Limitations

Limitations to this research study begin with the inclusion criteria and are as follows: (a) population is limited to professional counselors and graduate interns and (b) participants must have at least 6 months' experience providing counseling services in the home of clients. Limitations related to methodology include (a) dependability, while

researchers may repeat the study, the participants' responses may vary; (b) transferability and dependability due to varying responses from participants, which may be in response to a participant's inability to articulate their experiences; and (c) confirmability limitations, including the need to ask participants the same questions in a similar way.

Personal limitations in this study include my close relations to the social services industry in the geographic area the study took place and any potential obligation the agencies or workers may feel to participate. I addressed this by recruiting participants from agencies across the state of Illinois—not just the area of the state I am familiar with—and by including snowball sampling to potentially bring in participants from across other states. I also limited participation to professional counselors and graduate interns to minimize crossover with my personal contacts, who are mostly clinically licensed professionals. Another personal limitation is potential bias due to my 4 years of prior experience as an in-home counselor for children in specialized foster care. I have chosen Husserl's transcendental phenomenology as it provides a framework for interviewing and data analysis processes that account for and attempt to eliminate researcher bias.

Significance

In 1980, the U.S. government created the Federal Adoption Assistance and Child Welfare Act (Adams & Maynard, 2000). This act states that social service workers must put forth effort to help children remain in the homes with their biological families. One effort developed to help the children remain in the custody of the biological families was to begin providing counseling and case management services to the troubled families in

their homes instead of having them come to the office for mandatory meetings (Adams & Maynard, 2000). Following this monumental change in service provision, the family counseling field took nearly a decade before there was research into training for counselors facing these new in-home settings (Adams & Maynard, 2000). This was despite increased challenges and risks involved with providing home-based services (Hammond & Czyszczon, 2014; Matte et al., 2010). Various challenges include decreased safety, unplanned family involvement, lack of crisis protocol, and dual relationships (Adams & Maynard, 2000; Czyszczon, 2014; Matte et al., 2010). Given the increased challenges, it is essential to learn more about the experiences of in-home counselors, both licensed and graduate level, to develop new training and educational programs focused on in-home or home-based counseling services (Van Iersel et al., 2018).

Researchers have studied the experiences of alternative in-home services from noncounseling professions (Ferguson, 2018; Hsu et al., 2018; Mauridis et al., 2019; Mendes, 2018). When studying these experiences, Hsu et al. (2018) found that using in-home services for nursing, medical, and rehabilitation services allowed for a reduction in costs for the clients. Mendes (2018) explored the concept of in-home nursing and risks of patient suicide. The findings indicated a need for an increase in support and training when working in the community and homes for this population. Furthermore, Ferguson (2018) began with researching the lived experiences of family social workers providing services in the home. Obtaining this base-level understanding of working in the home allows for the identification of support and training needs for social workers. Mauridis et

al. (2019) expanded this study to include training on increased self-care to counter the risks experienced when providing in-home care to clients. Following the implementation of the self-care training, Mauridis et al. (2019) showed a positive correlation between the application of training and the decrease of experienced risks.

While researchers have explored the benefits, experiences, and trainings for in-home care in noncounseling professions, these same explorations have been minimally existent in the field of counseling (Lauka et al., 2013). Ferguson (2018) reported that researchers overlook the importance of service location in the providing of clinical care. Hammond and Czyszczon (2014) studied in-home family work to identify it as an accepted practice but did not explore what needs exist for supporting the work as a profession. Tate et al. (2014) attempted to fully understand the needs of in-home workers by describing the experiences, analyzing the results, and theorizing the work as a whole (Ferguson, 2018; Tate et al., 2014). While this research begins to attempt to understand the professions providing in-home care, it fails to gather a complete understanding of all aspects of providing in-home counseling services. Using a phenomenological approach to seek the lived experiences of counselors allows for the consideration of the different needs among the counseling professionals providing in-home care.

Understanding the experiences of professional counselors and graduate interns who provide in-home counseling services could inform counselor education and supervision practices to prepare future counselors to overcome the various challenges of in-home counseling and to use best practices in serving clients. Exploring the lived experiences of counselors providing in-home services will help lay the groundwork for

social change in the training procedures and expectations of all counselor education programs through development of specific training and courses on the best practices of in-home counseling. Furthermore, this study and future research may inform legislative or ethical guidelines for best practices. Future implications of this study appear in Chapter 5 based on the outcomes of the research.

Summary

The rationale to study lived experiences of counselors who provide in-home counseling services to clients appeared in this chapter. This included an exploration of the background of the phenomenon, the problem statement, and the research question. To highlight the importance of and need for this study, the purpose was detailed. Finally, Chapter 1 covered the framework and nature of the study, including definitions, assumptions, limits, and the study's significance. This chapter served as an overall introduction to this research and showed the importance and need for the study, while addressing gaps in literature on in-home counseling.

Chapter 2 explores this phenomenon in more detail through a review of literature. This review includes the history of in-home services for counseling and related professions. Furthermore, Chapter 2 emphasizes growing needs of professional clinicians who provide in-home counseling services and how this study may address these needs and create a path for future research to support counselors.

Chapter 2: Literature Review

Currently, counselors provide home-based counseling to individuals who may otherwise not have access to counseling services (Myers, 2019). Providing home-based counseling services allows clinicians to go beyond traditional practice of care and meet clients' needs where they are—mentally, physically, fiscally, and environmentally. This shift has come with little consideration of the challenges that are present in the new environments and home-based settings (Czyszczon, 2014; Dudley, 2018). Home-based therapy's unique needs and challenges are not well-defined in the literature. This leads to an unintentional exclusion of training information on these unique needs and challenges when current practices dictate developing trainings based on basic clinical skill versus clinical location (Adams & Maynard, 2000; Christensen, 1995; Lauka et al., 2013). Having a lack of definition and minimal training for home-based clinicians increases their risk for burnout and compassion fatigue. Roughly 21%–67% of in-home counselors experience burnout because they lack appropriate training for working in the home environment (Myers, 2019). Furthermore, this lack of definition, training, and knowledge increases risks and leads to a need to professionalize the service of in-home counseling (Hammond & Czyszczon, 2014). Such risks include uncertainty of family dynamics, including who will be present for a session, potential dual roles, increased employee turnover, and minimal resources for those in need of in-home care (Stinchfield, 2004). Due to risks counselors face, burnout, and personnel turnover, it is imperative to acquire

an understanding of the experiences of counselors working with clients in the home (Oser et al., 2013).

This chapter begins with an explanation of the research strategy used to explore the topics of home-based services, counseling, and the chosen methodology. Following the explanation of research, I explore the theoretical foundation and then the key concepts of the study and approach. I then outline training and supervision needs in relation to in-home counseling. Finally, I explore academic preparation and clinical practice issues related to in-home counseling. The chapter concludes with a concise summary of the literature review for this study.

Literature Search Strategy

Walden University provides students access to a vast number of research databases through the online library. While completing research on the topic of home-based counseling, I used Walden resources and external sources. The resources used included Academic Search Complete, Cochrane Methodology Register, Dissertations at Walden University, ERIC, Google Scholar, ProQuest Dissertation and Thesis Global, SAGE, and Thoreau. Once I identified the databases, I sought to discover the best combination of words and phrases to find the information needed for a study on home-based counseling. Key word searches included variations of *home-based counseling, in-home counseling, lived experiences, rural counseling services, transcendental phenomenology, phenomenology, pedagogy, Husserl, counseling and laws, travel counseling, clinical training needs, counselor education, clinical interns, home-based therapy, in-home medical care, eidetic reduction, bracketing, constitution of meaning,*

burnout, compassion fatigue, clinical risks, clinical laws, social services in communities and *understanding counselor experiences*.

Beginning the research for this study, I aimed to identify a gap in the literature surrounding counselors providing services in the clients' homes . As I expanded my search, I quickly discovered a majority of research was on in-home services from different medical or helping professions and not counseling. There was conflicting information on whether to categorize counseling as a standalone topic or within the other in-home services. As the research question formed, my research refocused to identifying the current literature on in-home services specific to the topic of in-home counseling, as well as identifying the best approach for this study.

Theoretical Foundation

The overall focus of this study was to explore the lived experiences of counselors providing in-home counseling services through a theoretical lens of transcendental phenomenology as developed by Edmund Husserl (Husserl, 2013; Wesolowska, 2014). Transcendental phenomenology also guided the methodological choices of this study. The fundamental purpose of transcendental phenomenology is to attain a true understanding of a phenomenon from self-understanding and self-reporting (Patton, 2015). To gain this understanding, a researcher uses this theoretical approach to have participants describe personal experiences with the phenomenon under study; in this research that was in-home counseling (Hannah, 2014; Patton, 2015; Ravitch & Carl, 2016).

Husserl (1931, 2013) believed that true experience is comprised of individuals' perceptions of being among the phenomena. This includes how they interact and experience the world; as well as their physical, mental, and emotional reaction to this state of being within the phenomenon. Seeking to understand not only the phenomenon but also how the individual experiences the phenomenon required me to clarify and eliminate any assumptions I may have had throughout the study to prevent any bias in the reporting of the interviews (Wesolowska, 2014). Through transcendental phenomenology, Husserl directs a researcher to use different techniques to set aside personal bias and beliefs when conducting and analyzing research (Patton, 2015). The many components of transcendental phenomenology aid in a researcher's quest to learn the true essence of a phenomenon; this made it an ideal selection for studying the experiences of counselors providing counseling services in clients' homes.

The key descriptive factors of transcendental phenomenology are what researchers use to set it apart from other forms of phenomenology and from other forms of qualitative research. Lauka et al. (2013) used transcendental phenomenology as a theoretical framework to aid in their quest to identify the lived experiences of their subjects. When searching for home-based phenomenological studies or simply phenomenological studies, results were rare before the year 2000. Following the turn of the century, phenomenology appears to be a growing focus in much research (Lauka et al., 2013). For example, Crane et al. (2019) explored challenges of parents with children in oncology clinical trials and used phenomenological approaches to acquire a true understanding of the parents' experiences. Researchers outlined feelings of hopelessness

and running out of time, which is a description that may not have surfaced from other theoretical approaches. Similarly, Bowen and Caron (2016) and Lauka et al. (2013) provided research results that further support using a phenomenological approach when seeking to understand the lived experiences of counselors providing services in rural settings and in-home conditions. Bowen and Caron (2016) reported that using a phenomenological approach allowed them to learn the shared experiences of counselors providing services in the home and in turn develop policies and practices used to help guide agencies and educational programming. The experiences and findings further support the use of transcendental phenomenology in this research.

Transcendental phenomenology guides a researcher to focus on the experiences and needs of the participants, as opposed to the researcher's experience in relation to the phenomenon (Gutland, 2018; Hammond, & Czyszczon, 2014; Lauka et al., 2013) This approach allowed for the identification of future needs for counselors providing in-home services. Additionally, this study served as a foundation for potentially creating additional research studies that may lead to the development of training and educational programing for counselors providing in-home services as well as the development of new legislation and potential policy changes within ACA, CACREP, and state licensure guidelines.

Key Concepts and Variables

Medical professionals provide in-home patient care throughout history. Families began in-home care for the sick and wounded in the home for aging family members (Hsu et al., 2018). When there was only one doctor in an area, before hospitals, that

doctor would go to a patient's home to provide care. During the mid-1900s, as a result of the women-to-work movement during World War II, the United States experienced a significant shift in family lifestyles, which included more individuals going to work; fewer and fewer people were able to stay home to care for ill and aging family members (Hsu et al., 2018). During the mid-to-late 1900s, there was shift in focus of how in-home care was perceived from minimalizing the effects of an illness to recovery (Adams & Maynard, 2000). However, many individuals preferred to remain at home or were not able to travel to a care facility. Healthcare providers noticed this shift and the work of Jane Addams, founder of Hull House and leader in the development of social work practices led to the development of in-home case managers and the social worker profession, in hopes of helping individuals remain in the home and prepare for posttreatment (Adams & Maynard, 2000; Lengermann & Niebrugge, 2006). Developing in-home case managers and establishing the social work profession led to the expansion of in-home services for both medical and social/emotional care. This chapter encompasses a review of in-home services and the different factors involved in providers' experiences.

Medical Services History

A primary goal of and benefit of medical care is for patients is to remain in their own home as compared to a nursing home or rehab facility (Holm et al., 2017). Martinez et al. (2018) and Holm et al. (2017) reported one benefit of in-home care is to provide the lowest level of restriction with medical care, while also providing a continuity of care from what the patient would receive while placed in a treatment facility. Furthermore,

there are benefits to the family such as reducing the burden of familial responsibility and creating a cost-effective way to provide care for loved ones. Holm et al. (2017) found 73% of cases in which providing nursing care in the home had no end date attached to treatment, allowing the family to put the focus of care on the clients' well-being. In-home care also provides treatment to those patients unable to travel, to ensure their ability to receive person centered care and show significant improvement (Hack et al., 2015).

Social Work and Laws

Over the past five decades, growth of in-home care has been slow and consistent with the exception of times surrounding the passing of legislation (Mazier, 2015; Morris, 2003). Beginning with the passing of the Adoption Assistance and Child Welfare Act on June 17, 1980, social welfare providers attempted to refocus treatment to promote retention within the homes (Morris, 2003). Clinicians embarked on the task of studying the provisions of services in clients' home (Ware et al., 2008). Such research produced positive results showing a decrease in negative behaviors and an increase in child compliance, as well as increases in parents using positive reinforcement (Ware et al., 2008). Muzicant and Peled (2018) called in-home care an intervention that is unique and beneficial to clients. Despite the positive findings of the in-home care movement (Ware et al., 2008; Muzicant & Peled, 2018), current critics suggest that requiring in-home care, as seen in the Act of 1980, may require more involvement, legal and otherwise, than originally thought (Dudley, 2018).

Legal actions, specifically the Act of 1980, set a precedent in that social workers must establish guidelines and provide care for children involved within the child welfare

system. Since its inception, in-home care has overflowed into populations beyond children and the foster care system (Muzicant & Peled, 2018). Additional populations include but are not limited to, children and their families, elderly clients, home health, and hospice (Ferguson, 2018). As research continues, the need for additional in-home programs to serve a variety of clients rises.

Types of Programs

While many programs focus on aiding individuals and families involved in the social welfare system, it is important to remember that there are persons in need of help that are not involved with the system (Stuva et al., 2016). Cederna-Meko et al. (2014) surveyed parents and children and identified 60-plus risk factors leading them to seeking assistance with personal challenges in the home. Some instigating risk factors include, but are not limited to, parental history of academic trouble, substance abuse, legal record/jail time, and mental health diagnosis (Cederna-Meko et al., 2014). Cederna-Meko et al., (2014) expanded their research to look at child risk factors including poor academic performance, higher academic needs, grade retention, possible maltreatment, and medical needs. These extensive needs lead to a variety of systemic program interventions.

Crisis Work

Crisis intervention may be in the community or in the home. Stuva et al. (2016) identified a gap in literature and services regarding the lack of supportive responses to families seeking help, when not already involved in the social welfare system. Stuva et al. (2016) paired with Boy's Town in Omaha, Nebraska, worked to identify which

individuals, calling the crisis hotline for help, were not already receiving services. Stuva et al. discovered that 81% of the identified participants moved on to successfully meet goals and reduce initial risk factors.

Alternative in-home services established to help reduce risk factors and promote minimally invasive care include nursing, case management, and family and individual counseling. Bendixen et al. (2018), report that family members gain a sense of security when competent care occurs in the home. However, not all in-home workers had the same training or provided the same level of care. This lack of consistency caused increasing feelings of doubt and uncertainty for the family and client, as well as risks to the wellbeing of the client in the homes (Bendixen et al., 2018).

Research on In-Home Services

Risk of In-Home Care

An additional consideration includes the risks of in-home care. It is important to identify that there are two types of risks when providing in-home medical care: the known and the unpredictable (Schildmeijer et al., 2019). Known risks include that of medication management, where an individual staff member is solely responsible for the treatment; and communication challenges (Schildmeijer et al., 2019). Unknown risks include fragmented organization surrounding treatment, potential inability to balance patient autonomy, and environmental conditions that may arise while providing care (Schildmeijer et al., 2019). Despite not being able to account for 100% of risks prior to providing services, the benefits and success of in-home care far out weight the challenges

staff may encounter (Holm et al., 2017; Hack et al., 2015; Hsu et al., 2018; Martinez et al., 2018; Schildmeijer et al., 2019).

Academic Preparation and Training

The American Counseling Association (2014) developed the *Code of Ethics* to guide ethical and best practices for all counselors and counseling interns. Mazier (2015) acknowledges the benefits of counselors and interns providing counseling services in clients' homes but identifies a lack of training to prepare them for the challenges and risks of such work. Warren and Schwarze, (2017) studied the experiences of counselors-in-training and found that going into these new environments had a direct correlation to an increase of stress for the counselor. This correlation allows researchers to demonstrate the need to continue expanding counselor education and training to include new environments, such as the clients' home.

Bowen and Caron (2016) showed that study participants with experience providing counseling in a client's home setting report, "they would prefer that they receive trainings on best practice approaches for use in the home-based setting, as opposed to settings that they do not work in" (p. 132). Furthermore, Bowen and Caron (2016) suggested while counselor educational programs typically prepare future counselors for working in an office or structured work environment, they should also prepare students to work in home-based settings. It is important to use current and best practices for guiding counselor education programs to include components of community-based experience (CACREP, 2016; Stinchfield, 2004). Despite it being counselor educators' responsibility to prepare students for all situations, counselors

working in the home setting have not received appropriate training and education to encounter the specified challenges of working in this setting (Stinchfield, 2004).

Challenges include the unknown safety risks of entering into the family's home and engaging within the family system despite being there to treat an identified client (Mattek et al., 2010; Stinchfield, 2004). Establishing a therapeutic alliance with an identified client is challenging when the counselor and client are not the only two individuals in the home. Location in the home and individuals present may inhibit the ability of a client to establish a therapeutic alliance with an in-home counselor. Mattek et al. (2010) explored this phenomenon and implemented a training they developed to attempt to bridge this gap. This program included 10 second-year graduate students receiving training on working with the at-risk population and then observing experienced counselors implement therapy in clients' homes (Mattek et al., 2010). Eventually the intern took over and assumed the role of therapist. Mattek et al. (2010) found that counseling interns experienced increased levels of confidence and self-efficacy following training designed for providing services in clients' homes.

Protocols for Crisis Intervention and Supervision

When considering risk factors of providing services in clients' homes, one must consider how to respond to emergency and suicidal situations. Menendes (2018) discovered many employers have crisis protocol within their offices but not for when a staff member is operating in clients' homes. This is an extensive risk for the well-being of our clients and the staff members working in the homes. Furthermore, it is crucial that an identified supervisor provides therapeutic debriefing after a crisis occurs whether the staff

wants the debriefing or not (Menendes, 2018). Through this research, exploring the lived experiences of in-home counselors may provide further insight into the risks of in-home care, how to improve care provided in the home, and the desired supervision and training for in-home work.

Summary

Counselors work in a variety of settings and the growing trend since 1980 is to provide therapeutic services in clients' homes (Lauka et al., 2013). Much of the current research focuses on the experiences and benefits of different home health workers providing medical assistance and social work services (Cederna-Meko et al., 2014; Ferguson, 2018; Halvorsen, 2019). There is also research on the benefits of providing therapeutic services in the homes, but along with benefits for clients, we learn of risks for counselors providing those services (Lauka et al., 2013). To gain true knowledge of these risks, one must know how the individual internally experiences the situation including sights, sounds, emotions, and only the individual counselor providing services in the home can tell of this true experience (Moustakas, 2014). Bowen and Caron (2016) believed studying the lived experiences of counselors providing services in clients' homes could lead to potential practice and policy recommendations for counselors, professional organizations, and agencies. Identification of these concerns and successes could carry over to the development of intentional trainings and educational programming for future counselors and counselor education programs and CACREP.

Chapter 3: Research Method

Introduction

The purpose of this transcendental phenomenological study was to better understand the lived experiences of in-home counselors from the perceptions of the individual counselors themselves. It is important to gain an understanding of how counselors experience in-home counseling, as it is different from providing services in an office or other workplace (Bowen & Caron, 2016). Chapter 3 provides a description of this research, including research design and rationale, role of the researcher, and the chosen framework of transcendental phenomenology. Furthermore, Chapter 3 also explores the methodology of the research. This covers major decisions of the research process, including participant selection, inclusion/exclusion criteria, sample strategy, sample size, instrumentation, recruitment, data collection and analysis, trustworthiness, and ethical considerations. Much of this information may lead to better training and educational programming for in-home counselors. Above all, gaining insight on the lived experiences of in-home counselors will help in the preparation of individuals seeking to provide counseling services outside the traditional office setting.

Research Question

What are the lived experiences of counselors providing counseling services in clients' home environment?

Research Design and Rationale

In this research, I sought to understand the lived experiences of counselors providing counseling services in clients' home environments. The best way to understand

a phenomenon is through the experiences of the participants themselves. Husserl (1931) believed that using transcendental phenomenology allows a researcher to gain an understanding of the essence of the phenomenon through the counselors' lived experiences, which includes an account of all the counselor sees, hears, says, does, and senses. Due to the nature of the subject, it is critical to focus on the counselors' lived experiences, as the researcher is not able to be present for the counseling sessions in the home. Additionally, while alternative approaches are available, like hermeneutic phenomenology or narrative research, these approaches alter the focus of the research from the counselor's lived experiences to that of the researchers' perception or the chronology of the experiences. Neither of these approaches relate to the research question. This would prevent me from answering the main questions of the study and forgo the potential of developing new training to meet the needs of professional counselors and graduate interns. Overall, transcendental phenomenology is the most appropriate approach for this research because it provides the detailed descriptions needed to answer the research question.

Role of the Researcher

Within transcendental phenomenology, the researcher is the primary tool of data collection, evaluation, and assessment (Patton, 2015). I created the semi structured list of questions for the participant interviews. Once arranged, I then conducted the interviews in the role of an observer-participant. Due to the intimate and involved nature of the research, I also took on the role of main observer. As a part of the observer role, I kept a journal of the research process, my reflections on the research (particularly the

interviews), and any challenges that arose. This journal served as a sort of checks and balances as I reviewed the interview transcriptions and began writing the results.

An important factor in this research is my personal relationship to the research. This includes my prior work as an in-home counselor for a foster care agency and my interpersonal connections to the social service agencies and local graduate program in the area. To counter these relational concerns, I sought participants first from throughout Illinois and then from throughout the United States, via snowball sampling, to ensure equal opportunity of participation. As previously mentioned, I also maintained a journal to track my experiences and continuously evaluated potential bias. Finally, during appraisal and evaluation of the transcript interviews, I used a bracketing approach to help remove any potential bias and to scale down large amounts of data into common themes (Husserl, 2013).

Overall, I took care to build a trusting environment for the participants to feel free to speak their truths. I documented this process to explain any major shifts or changes. Furthermore, I continued documentation of my experiences throughout the research process to ensure minimal bias and compliance with all ethical guidelines.

Methodology

Husserl sought to identify the conscious experience or essence of a phenomenon (Moustakas, 1994). To do so, a researcher must be intentional in the decisions made for the research process. Following all processes, a researcher may be able to gain a true understanding of a phenomenon, thus allowing the research and academic world to grow.

In the following section, I outline the methodological approach to this transcendental phenomenological study.

Participant Selection

Patton (2015) and Moustakas (1994) suggested that the goal of conducting qualitative research is to gain an in-depth understanding of the chosen phenomenon. To do so requires a sample size large enough to reach data saturation in the interviews (Ravitch & Carl, 2016). Researchers obtain data saturation when participants' reports become repetitive and new information no longer arises during the interviews. Given the vagueness of what encompasses *data saturation*, there is no set participant number required, but it may often fall in a 6–10 participant range (Patton, 2015). I initially sought 6–10 participants, but had I not met data saturation, I would have continued interviewing participants.

I selected participant parameters to include professional counselors, identified as individuals meeting minimum state licensure requirements, and potentially counseling graduate interns, both male and female, who have provided a minimum of 6 months of in-home counseling services. Participants identified this information on the demographic information questionnaire (Appendix B). Tate et al. (2014) had multiple points of data collection but made sure to identify nine participants (ranging from individuals in training to directors) to reach data saturation. However, Schildmeijer et al. (2019) and Oser et al. (2013) both deemed it necessary to include between 20 and 28 participants to reach data saturation. An additional gap here is the study of an individual versus larger focus groups. Study participants were volunteers responding to a recruitment letter sent to agencies

providing in-home counseling services in Illinois. Second, participants were individuals referred through purposeful and snowball sampling methods from across the nation willing to volunteer. Participants signed a detailed informed consent letter as their agreement to participate in the research study.

Instrumentation

The data collection method consisted of qualitative interviews. I used a semi structured interview process with standardized open-ended questions and possible follow-up questions geared toward obtaining more in-depth information or data on the lived experiences of the participants (Hannah, 2014; Ravitch & Carl, 2016). As the researcher, I used a self-developed demographic questionnaire to determine eligibility (Appendix B). During the interview process, I used a self-developed, semi structured questionnaire (Appendix C) with each participant. To ensure credibility and that these questions would answer the study's research question, I used the essence of transcendental phenomenology to formulate the semi structured interview questions and based them on the gaps found during my review of current and historical literature. I also had the questionnaire reviewed by my committee for confirmation of the appropriateness of each question to answer the research question. Furthermore, I used predetermined follow-up questions during the interview to reach the depth of knowledge necessary to answer the research question completely.

Recruitment and Inclusion

I used purposeful sampling to seek participants meeting established criteria to provide information-rich cases related to the phenomenon of in-home counseling. I began

by electronically sending a recruitment letter to agencies identified within Illinois that offer in-home counseling services. Through purposeful and snowball sampling methods, I then sent the recruitment letter to individuals nationwide who were referred to me as potential eligible participants. Second, participants identified as professional counselors, counselors meeting minimum state licensure requirements to practice, or counseling graduate interns. Third, these participants self-reported experience with providing in-home counseling services on the demographic questionnaire (Appendix B). Finally, participants must also be willing to provide detailed descriptions of their lived experiences of providing in-home counseling (Patton, 2015). In preparing for possible emotional triggers, prior to exiting the interview, I provided participants with contact information for me and my dissertation chair, as well as information for counseling and other support options.

Following agency-based recruitment, I also used a snowball or chain sampling method to identify additional participants. Snowball sampling seeks the information-rich descriptions of participants' experiences that I hoped to gather (Patton, 2015; TaipaLe, 2015). Snowball or chain sampling begins with interviewing a few relevant participants, and then asking if they have referrals for additional participants meeting the inclusion criteria (Patton, 2015). Using this approach allowed me to ensure I reached my goal sample size of 6-10 participants, as it is the range of participants necessary for data saturation (Ravitch & Carl, 2016). However, if data saturation was not met with 6-10 participants, I would have recruited a larger number of participants to reach data saturation, as was required by Schildmeijer et al. (2019) and Oser et al. (2013). Both

deemed it necessary to go beyond minimal participation numbers and include between 20 – 28 participants to reach their data saturation (Oser et al., 2013; Schildmeijer et al., 2019).

Data Collection

In addition to data saturation, I considered the need for triangulation of data and sought three sources of data collection. The first form of data came from using phenomenological reduction while reviewing the transcriptions of the interviews with clients. As a second source of data, I kept a journal log detailing my experiences and summarizing my impressions of each interview. A third source of data was a demographic form completed by all participants. I gathered information on personal and educational history and their respective timelines. This information allowed me to see if any historical information may have contributed to or influenced the counselors' lived experiences with their clients.

Data Analysis Plan

As follow-up to my data collection, I also attempted epoche' or systematic content analysis, and reevaluate the interview transcriptions and my journal. Husserl sought the true essence of knowledge through allowing the subject to describe how they internally experienced a phenomenon and pairing that with the actual event to take place (Moustakas, 1994). Descartes developed the idea of epoche' or the removal of preconceived notions to get to the true meaning of a phenomenon (Moustakas, 1994). Once data collection was complete, I used an electronic program to transcribe all the interviews. I then read the transcriptions for accuracy and during a second or third read

through, I identified and removed any preconceived notions that may have prevented the true experience and meaning of the phenomenon from coming to the forefront of the research. I also kept the list of anything removed in my journal. Following this process, I then compared these findings with my initial transcript review to determine similarities, differences and to ensure no bias exists in my review.

To best organize and analyze the results of phenomenological research, Moustakas (1994) recommended systematic content analysis. This approach calls for the researcher to identify their experiences with the interview and research and then begin to code the transcripts (Yang et al., 2015). The systematic analysis and coding approach aligns with phenomenology as it acknowledges and sets aside the researchers personal bias and beliefs to focus on the lived experiences of the participants (Patton, 2015). Researchers focus on the participants' experiences by bracketing or coding the interviews through identification of repetitive quotes and themes in the interviews (Moustakas, 1994). I coded the interview transcripts by reading them and then writing repetitive or noticeable words and themes off to the side. Tufford and Newman (2012) reported the origin of bracketing to be Husserl's phenomenological reduction. Clinicians used grouping and reduction of topics to identify existing themes and potentially eliminate any "unacknowledged preconceptions" (Tufford & Newman, 2012, p.81) of the research being conducted. Following a thorough review of the transcripts, demographic information, and research journals, I wrote up all findings from this research.

Issues of Trustworthiness

Evaluating trustworthiness of a qualitative study requires consideration of the quality of data collected, evaluated, and summarized throughout the study. Moustakas (1994) reported that the data supports the value of the study, but one must consider multiple factors of trustworthiness, including confirmability, credibility, dependability, and transferability. Strengthening trustworthiness of data also establishes and increases the level of rigor in qualitative research (Rapport, Clement, Doel & Hutchings, 2015).

Credibility

Throughout qualitative research, it is important to establish neutrality in the reporting of research and findings (Walden, 2018). Ensuring credibility in research means making sure the voice of the participants shows through in the work (Patton, 2015). To support credibility of this research, I began interviews with semi-structured questions but also included follow-up questions to ensure the lived experiences of the participants shone through in the reporting and findings. I strengthened the credibility of the study by keeping a journal of the research process to identify any major shifts in the study and researcher involvement.

Confirmability

To improve upon this work, I worked to ensure confirmability. Confirmability is the extent to which the findings adequately reflect the participants' response instead of the biases of the individual researcher. I reviewed the transcripts of the interviews and used bracketing to eliminate potential bias from the researcher and to establish common themes between participants. Following this process aided in providing a depth to the

participants responses and increased the rigor and trustworthiness of this study thus establishing a base for future studies.

Dependability

Part of qualitative research is *dependability* or ensuring the outcomes of the process may be repeatable by future researchers and get the same results (Patton, 2015; Moustakas, 1994). Walden University has established a dissertation protocol that requires the written work and the researcher to go through a prospectus, proposal, IRB, and final approval processes (Walden, 2018). This process includes an internal audit of the research at multiple stages and required the researcher to explore similar phenomena through the literature review in Chapter 2 of the dissertation. Having these built-in checks and balances automatically supported the dependability of my research.

Transferability

A final part of qualitative research is *transferability* or the ability to apply research findings to similar populations or similar phenomena (Moustakas, 1994; Patton, 2015). Using the bracketing process allowed me to identify the similarity and consistency between participants from different areas, further strengthening the transferability of the data. Establishing the similarities and consistencies between participants allows researchers to apply these findings to varying individuals and to future research. Researchers application of this information will further the growth and quality of in-home services and the counseling profession.

Ethical Considerations

Clinical counseling professionals refer to the ACA *Code of Ethics* (2014) for guidance in all working situations. Through the course of qualitative research various situations may arise that require ethical considerations. ACA (2014) provides standards in section G of the *Code of Ethics* (ACA, 2014) to address best ethical practices in research. These standards guide researchers to minimize bias, respect diversity, and ensure all ethical and legal standards are followed (ACA, 2014). I ensured best practice standards by presenting all research plans to the Walden IRB, in proposal form for approval, by providing participants detailed study information in the informed consent form, upholding confidentiality, and destroying all data in the appropriate time and manner.

Walden IRB

Prior to the research phase of this study, I submitted an application and detailed proposal to Walden's IRB for approval. IRB reviewed the details of this study to ensure all aspects adhere to ethical practices for the well-being of the participants (Walden, 2019). Furthermore, I sent a copy of recruitment and informed consent letters to IRB for approval.

Informed Consent

Following ACA (2014) standards, all participants received a letter of informed consent. This letter covers research confidentiality, details, and interview procedures, including but not limited to the processes, risks, and benefits of participation. Participants signed this form as acknowledgement to the risks and their willingness to participate in the study. Participants received contact information to connect with me or my committee

chairperson if necessary. I submitted a copy of the initial informed consent to Walden's IRB board for approval prior to the active research phase of the dissertation process.

Confidentiality

This study had many unique situations where I had to consider and maintain confidentiality. I began by outlining confidential concerns in the informed consent letter. I then conducted interviews individually and reported the resulting data anonymously to maintain the confidentiality of each participant. Maintaining confidentiality of participants was incredibly important. Hammond and Czyszczon's (2014) reported that providers of home-based counseling services have many struggles but hesitate to report these for various reasons including job security. To ease participants' worries regarding confidentiality I assigned pseudonyms for each participant and used the pseudonyms when writing up the results of my interviews. To keep track of the assigned pseudonyms, they were listed only once, on the participants' individual transcript files stored on the external hard drive, of which only I have access to.

Interview Risks and Procedures

One of the largest areas of ethical concern surrounds the procedures for the interviews. I was intentional with all decisions regarding the interview process due to the potential of participants experiencing emotional distress. This began with offering a safe, agreed upon, virtual location, away from the participants' workplaces to conduct the interviews. This could include an office, or mutually agreed upon public location. Additionally, all participants had the option to select a virtual meeting using Zoom. These interviews should last approximately 60 minutes to ensure enough time for all the stories

and experiences the participants will share (Jacob & Furgerson, 2012). Depending on the interaction of the participants, some may go longer, and others may run shorter. Following the interview portion of our meeting, I provided participants with contact information for myself, my dissertation chair, and virtual therapeutic referral to a company called Better Help at www.betterhelp.com. I provided these resources as options for participants to reach out should they have any questions or experience distress following the interview.

Destruction of Data

Throughout the research process, when not in use, all data, journals, transcriptions etc. remained in a locked cabinet, kept in a closet in a room with a lock door, to which only I have access to. All electronic data is on a password-protected file on an external hard drive, also kept in the locked cabinet when not in use. Only myself and my assigned dissertation committee had access to the data collected. If a participant had chosen to discontinue their participation in the research, I would have destroyed all documentation for that participant immediately. Following completion of the study, I will keep all data for a period of seven years. At the end of the seven years, I will destroy or erase all data collected.

Summary

I provided a detailed exploration of this study's research method in Chapter 3. Including an explanation and rationale for the chosen research question, "What are the lived experiences of counselors providing counseling services in the clients' home environment?" Furthermore, I provided rationale for using a transcendental

phenomenological, qualitative approach. Once established, I provided a detailed explanation for the methodology chosen, including participant selection, interviewing procedures, data collection, and analysis. In this chapter, I also accounted for issues of trustworthiness and ethical considerations in the preparation of this study.

Moving on to Chapter 4, I discuss the research and participants in further detail. I also explore data collection and analysis to include my own observations from my journaling of the research process. Additionally, I explore my bracketing and coding procedures and results. Overall, it is paramount that I summarize the results of the research and its relation to the research question in this chapter.

Chapter 4: Results

Introduction

The purpose of this phenomenological study was to learn about the lived experiences of counselors providing counseling services in a client's home environment. According to Bowen and Caron (2016), there is a significant difference when providing counseling services in a home versus in an office or other workplace setting. This difference creates a need to understand the lived experiences of counselors providing services in clients' homes. Gaining such knowledge could fill a gap in research and provide a clearer understanding of potential benefits, needs, and/or challenges counselors face when practicing outside an office and in a client's home. Using transcendental phenomenology as a guiding force, I explored the research question: What are the lived experiences of counselors providing counseling services in clients' home environments? I explain the results of this study by first describing the setting in which the semi structured interviews took place. Second, I review the demographics of the seven participants to identify commonalities and differences among them. Third, I review the process of data collection and any effect it may have had on the study. Fourth, I explore the coding analysis and outcome of the data collected. Fifth, I evaluate the trustworthiness of the research process and findings. Finally, I summarize the resulting themes that arose from the data collected.

Setting

Given the broad range of participant locations, all interviews were held virtually via the teleconference software program Zoom. Using an online modality, such as Zoom,

for qualitative research has proven efficient in obtaining participants and information-rich data, as well as allowing greater diversity of participants by eliminating the physical proximity limitations found in face-to-face research (Woodyatt et al., 2016). Furthermore, using an online modality also increased the diversity of participants, as it allows participation for those who would not have agreed to an in-person meeting (Pszczółkowska, 2020). To provide additional protections in compliance with Health Insurance Portability and Accountability Act (HIPAA) regulations, I purchased a protected Zoom membership as opposed to the free, unprotected membership. Each participant was also directed to select a quiet and secure location to ensure their privacy. Coincidently, each participant joined the virtual meeting from their home. This could be due to the current global COVID-19 pandemic.

COVID-19 is a disease spreading across the globe caused by a severe acute respiratory syndrome coronavirus-2 (Jamous et al., 2020). The spread occurs when uninfected individuals come in close contact with infected individuals. “Common signs of infection include respiratory symptoms, fever, cough, shortness of breath, and breathing difficulties. In more severe cases, the infection can cause pneumonia, severe acute respiratory syndrome, kidney failure, and even death” (Priyadarshini et al., 2020, p. 148). The nature of this pandemic is requiring most individuals to remain in their homes and socially distance themselves by avoiding public interaction as much as possible, either by choice or by order from their government.

At the time of this study, the spread of COVID-19 was on the rise in Illinois and the governor implemented a five-phase plan dictating the level of social distancing

required by individuals, as well as which business/organizations could remain open and operational. Upon implementation, Illinois residents were ordered to shelter in place and only essential businesses could remain open with only essential employees working outside the home. The remaining population could leave their home for necessities, like food, medication etc., but it was encouraged that all remain home as much as possible. These restrictions limited access to participants for this study even further and reinforced the decision to use virtual interviews through Zoom.

The semi structured interviews were conducted to uncover the lived experiences of each participant providing clinical services in clients' homes. Experience was both current and historical. Technological challenges were encountered in two of the seven virtual interviews. In the first of those two interviews, the participant was hard to hear at times and appeared to fade in and out of our conversation. While I was able to understand most of their answers, I did paraphrase what the participant said and asked for confirmation of the information and intent of the participant's answers. During the second interview with technological challenges, the participant's internet connection kept freezing or skipping. This caused our conversation to be more robotic than most and hindered the flow of our conversation. However, both the participant and I confirmed understanding and accuracy with what we were hearing and responding. Overall, the virtual setting was a solution to the challenges of the COVID-19 pandemic but also posed some challenges with connection, clarity, and conversational flow. Despite these challenges, the participants' intended answers and experiences came across accurately in the interviews.

Demographics

Through observation, I gathered basic demographics and participants completed a demographic form (Appendix E) prior to participating in the study. For the purposes of providing a snapshot of participants, demographic data were converted to quantifiable data though percentages and totals *N*. Furthermore, length of clinical and in-home experience was graphed in years. In-home experience was also reported in number of months to align with participation criteria for this study.

Study criteria outlined a minimum of six to 10 participants (Patton, 2015) necessary to meet data saturation (Ravitch & Carl, 2016). Through following procedures outlined in Chapter 3, a total (N) of seven participants were recruited and interviewed. Participants included both male (n = 2, 28.57%) and female (n = 5, 71.43%) counselors, and included Caucasian (n = 4, 57.14%) and African American (n = 3, 42.86%) counselors. Gender and race information for the participants is presented in Table 1. Education and training information from the demographic forms is presented in Table 2.

Table 1

Gender and Race of Participants

Demographic	%	N
Total participants		7
Gender		
Male	28.57	2
Female	71.43	5
Race		
Caucasian	57.14	4
African American	42.86	3

Table 2

Counseling Level, Education, and Training Data for Participants

Demographics	%	N
Demographic forms completed		7
Counselor level		
Professional counselor	100	7
Graduate intern	0	0
Provided counseling in-home		
Yes	100	7
No	0	0
Education		
Master of arts degree	85.71	6
Master of science degree	14.29	1
Postgraduate training		
Yes	28.57	2
No	71.43	5

Participants also provided information on their clinical experience, education, and postgraduate training (Appendix E). All participants identified as professional counselors with a minimum of a master's degree and at least 6 months of in-home clinical experience, per study requirements. Furthermore, participants reported clinical experience ranging from 2 to 17 years. Only two participants reported any form of postgraduate training or education; only one of those included training related to working in the community, such as a client's home.

Data Collection

I began data collection after receiving IRB approval, 02-07-20-0578474, on February 7, 2020, through the Walden University's dissertation process (Walden University, 2018). I did not deviate from the data collection plan outlined in Chapter 3, but I did consider petitioning IRB to amend recruitment criteria to increase the potential

of obtaining my necessary six to 10 participants. In the end, seven participants participated in this research. I did not petition IRB for any changes. Below is the summary of the recruitment, data collection, and interview process.

Recruitment Process

Following guidelines set forth in Chapter 3, I began by electronically emailing my study invitation to agencies for potential participants. I then posted the study invitation on my personal Facebook page in hopes of gathering participants and potential referrals through the purposeful and snowball sampling method. Through the IRB application process, this study was also posted to the Walden University research portal, where students can participate in any study they meet requirements for. Upon confirming participation, individuals were provided a pseudonym to protect confidentiality. Pseudonyms were assigned alphabetically based on the chronological order the individuals participated. The first participant began with the letter A, the second participant began with a letter B, and so forth.

Data Collecting, Recording, and Tracking

In this qualitative study, the data collected come from the participants' information and experiences. Given the location of all participants, research took place virtually through electronic means of e-mail and video conferencing via the internet. Demographic information was collected electronically via email and the interviews were conducted over a Zoom teleconference; only the participant and I were present on the virtual call and each alone in our respective rooms. A total of seven interviews took place and spanned a 7-month period due to unforeseen and uncontrollable circumstances. At

the beginning of each interview, participants provided consent to participate and then the recording began. Once complete, I saved an audio only and video recording of each semi structured interview through Zoom. I only used audio recordings for transcription purposes. The video recordings were used only by me for reviewing the transcripts. I also kept a journal throughout this process to track the collection of data, interview timeline, and any anomalies that may have arisen throughout the interview process. I also used the journal and coding as a resource to ensure my prior experience did not sway data or create any bias during analysis.

Interview and Transcription Process

Following formal recruitment of participants, per guidelines in Chapter 3, a specific time was scheduled to meet with participants virtually via Zoom, a video chat platform. I obtained a paid membership that provided HIPAA compliance for users. Each interview began with discussions of consent, process debriefing, and participants were given the opportunity to ask questions. I then began the recording for the semi structured interview. In turn, recordings were shorter than full interview. Total interview times ranged from 20–42 minutes. Participants appeared comfortable and willing to speak on the subject at hand. However, while most participants maintained a calm demeanor, some participants responded with stronger emotions throughout the interviews.

Following the interviews, the audio recordings were transcribed using a computerized automatic transcription program called NVivo Transcription. Audio only files were uploaded to the program and transcription was completed within minutes. I then reviewed and listened to each interview to ensure accuracy and edit any mistakes.

Once complete, the interviews were emailed back to the participants, providing them an option to review and make any corrections necessary. No participants sent any corrections back to me.

Unusual Circumstances

I found, over time, how surprised I was, given our ethical code, the extent to which participants would agree to participate and then not follow through with participation, despite multiple attempts to connect. However, participants not following through was the least of my struggles during data collection and may have been due to the global COVID-19 pandemic. Five weeks into the data collection process, state officials in Illinois closed all nonessential businesses (including those agencies providing in-home counseling) and education facilities, and residents were ordered to shelter in place (mandatory quarantine) unless they were considered essential workers. The resulting effects of the shelter-in-place orders were an inability to reach agency workers who provide services in clients' homes and extending the collection time of my data until the state began opening up again. This resulted in a 7-month data collection process to obtain all seven participants.

Data Analysis

Data analysis was guided by the concepts of phenomenological reduction with bracketing or epoche and systematic content analysis (Moustakas, 1994). Husserl believed the true essence of a situation comes from the individuals' lived experiences. It was important to stay true to this intent during my coding and analysis of the transcripts, demographic forms, and my journal. The triangulation of the data from these three

sources helped ensure the coding process would be completed without any unintended bias (Moustakas, 2014; Patton, 2015).

Transcription

Upon completion of the interviews, audio recordings were transcribed using a computerized program called Nvivo Transcription. To ensure accuracy I listened to and reviewed each interview editing mistakes, as necessary. Once complete, the interviews were emailed back to the participants to review for accuracy. Participants did not send back any corrections.

Coding

To begin the coding process, I listened to the interview recordings while reading the transcriptions and followed systematic content analysis to identify my experiences with research and eliminate any potential biases present (Moustakas, 1994). To eliminate any assumptions or biased review during the interviews, I made sure to summarize participants answers if I felt unsure of what they were saying. As a second step of coding, I created an Excel spreadsheet with a row dedicated to each participant by assigned name, and a column for each of the interview questions. In step three, I reread and code each interview individually using bracketing and input the findings into the spread sheet, one participant at a time. Focusing on one individual interview, as opposed to one question for all interviews, allowed me to stay true to Husserl's vision of understanding the lived experience of the individual participant (Husserl, 1931). It also allowed me to continue systematic content analysis with each interview prior to coding. In step four, I used bracketing to further combine the codes into common groupings between the interviews.

Finally, these groupings were reviewed for experiential meanings and bracketed into major thematic content.

Through the bracketing process three major themes emerged, including two sub themes. These major themes included counselor preparation and support, therapeutic relationship, and environmental factors. Counselor preparation and support encompasses the need for additional educational programming and training to best prepare counselors for the unique environment and needs when providing counseling in clients' homes. It also includes the importance of having strong-well rounded supervision when providing services in clients' homes. The theme of the therapeutic relationship arises frequently and refers to the importance and strength of the therapeutic relationship developed between the counselor and client when providing services in the home and how this affects the experiences of both the counselor and client. The final major theme is the environmental factors which strongly influence the experience and success of the counseling provided in clients' homes. All participants experienced barriers that interrupted the therapeutic process, in addition to barriers the clients would experience when trying to obtain services. The *comfortability*, or varying level of comfort or discomfort, of the counselors and their clients emerged throughout the interviews. Each participant experienced varying levels of comfort for themselves, based on many factors, as well as the varying levels of comfort of the client during sessions. All seven participants highlighted each of the previously mentioned themes. One participant had a few discrepant opinions that were factored into the emergent themes and addressed for future consideration in Chapter 5.

Evidence of Trustworthiness

Strengthening trustworthiness of data within qualitative research helps increase the level of rigor of the study (Rapport et. al., 2015). While completing this study, ensuring trustworthiness is a concern. In turn the factors of credibility, confirmability, dependability, and transferability were considered and documented through notetaking, journaling and the established process of the research.

Credibility

Using semi-structured and follow-up questioning, as well as note taking during the interviews, I upheld credibility of this study and its results through coding and reporting thematic findings. All seven interviews were of similar length and had similar reporting, with few exceptions that will be reviewed in chapter 5. Within this process, it is important for the participants voices to shine through the results of this study (Patton, 2015). By notetaking after the interviews and journaling throughout this study I ensured the participants' voices would shine through during the coding and analysis of the data collected. Participants were also given the opportunity to review their interview transcript for accuracy of transcription and of their intent within their experiences.

Confirmability

It is important to ensure the participants' responses direct study findings instead of my thoughts or potential bias as the researcher (Patton, 2015). Offering participants the opportunity to review their transcript aided in this important variable of the study. I also reviewed each transcript to ensure all wording was accurate for myself and the participant. Once I ensured all transcription was accurate, I used a bracketing approach to

identify potential themes within the reported information and to eliminate any potential bias on my part as researcher. Approaching coding and reporting in this manor increased rigor of this study and ensured results could be a basis for future work.

Dependability

Dependability was naturally built into this study by following Walden University's established dissertation protocol of having the written work go through a review and approval process including the prospectus, proposal, IRB, and a final defense for overall approval (Walden, 2018). This provided an internal audit of the research throughout multiple stages and created a checks and balance system, thus supporting the dependability of the research. Furthermore, the detailed reporting and discussion of the research and reporting process within the study and with the committee chair added to the assurance that future researchers will be able to repeat this study and obtain similar results (Patton, 2015; Moustakas, 1994).

Transferability

Transferability of the results derived from this study will help support future researchers in works to promote growth in the counseling field as well as potential studies looking further into providing counseling in the home (Patton 2015). The bracketing of the transcripts further strengthened the findings and created a baseline of experiences for the participants. The similarities and consistency discovered between participants could influence the creation of new trainings, academic/educational materials, and potentially ethical guidelines guiding future clinical practice.

Interview Summaries

Using the transcendental phenomenological approach, the lived experiences of the study participants include an account of all that they have seen, heard, said, sensed and done (Husserl, 1931). To maintain consistency between interviews, I followed protocol established in Chapter 3. I began each interview by restating the purpose of the study and obtaining participants' verbal consent to participate and be recorded. I then started the recording and again asked for consent to participate. Once verbal consent was recorded, I asked the approved list of questions in order. Following all interviews, the audio recordings were transcribed via an automated computer program, NVivo Transcription. I reviewed the transcripts and compared them to the recordings for accuracy. Once accuracy was determined I sent every participant their transcript to review for accuracy of words, intent, and make sure there was no information they wanted added. No participant sent any changes to their transcript. To aid in a fuller understanding of the participants' lived experiences I am including a summary of each participant and their interview. I have given each participant a false name for ease of retelling their experiences and protect confidentiality. The order of everyone's participation determined their alphabetically assigned pseudonym.

Allen

Allen was a master's level professional counselor with 66 months of clinical experience, of which he spent 36 months providing services in clients' homes. Allen presented calm and collected, reporting he had participated in research studies previously and was happy to be able to help. After initial debriefing and confirming his consent to

participate the interview flowed smoothly with questions and answers between us. Allen provided detailed descriptions and examples for all answers. Allen believes providing services in the homes is a great service for clients and plans to continue for another 10–12 years or until he is physically no longer able to provide services while ensuring everyone's wellbeing. He continued to report that providing counseling in the home has been his best clinical experience because he is meeting clients where they are at and they truly thrive from that experience.

In addition to the client's optimal comfort level in their home, Allen described varying levels of comfort for the counselors. Often with adult clients he felt most comfortable and believed the best work took place. However, he did have some concerns working with children in the home due to other family members' presence:

> I find it a lot harder to work with the children in the home just because of the parent's involvement in the process …I have one mom who just hovers… She'll just come sit out in a session and, you know, interject when she feels like she needs to interject.

Allen believes these actions by family members may hinder the progress made by going into the home to meet child clients where they are most comfortable.

Despite believing in-home services are best for clients, Allen has concerns for the safety and wellbeing of the counselors, especially for newer or untrained counselors. Allen explained that prior to becoming a counselor he worked in child protective services and received training, He also received guidance from his supervisor regarding working in the homes of their clients. Both reportedly drilled in the importance of maintaining

safety in the homes. During this conversation Allen displayed hesitation and worry through his tone and expression, especially when he described dangerous situations that coworkers experienced, “having had guns pulled on them or who had knives pulled on them.” Being aware of the dangerous neighborhoods and potentially dangerous persons in the clients’ homes Allen asserted, “I don’t know if I had not had that experience [training], if I would have been comfortable enough to even say I’ll consider in-home [counseling]”.

Betty

Betty presented with a calm demeanor and an eagerness to participate in this study. She has over 15 years of counseling experience, of which 72 months have been providing in-home counseling. Betty described hands-on experience as her training, or lack thereof, for how to apply skills when working in clients’ homes. Supervisors provided feedback after the services were conducted but did not provide preparation or training prior to entering the homes. Despite this lack of training, she feels counselors wanted to be in the homes and still do to “provide more security for the clients, for the families so that they feel safer in the home setting to be able to work on their counseling”.

Betty recalled experiencing some client’s hesitation during in-home sessions due to the limited privacy from family members and potential stigma that surrounds receiving counseling services. Continually applying best practice counseling skills was her only way to learn how to work with the challenges of providing in-home counseling and adapting her skills to the environment. Betty’s experiences reconfirmed her belief that the therapeutic relationship was paramount to the success of counseling. However, she said

counselors need “a lot of additional skills when it comes to building rapport and engagement with clients, more so in the home setting”. She also recalled a need to be aware of surroundings and prepare oneself for any environment. Betty worked in homes in nice neighborhoods and not nice neighborhoods. She experienced concern, sadness and frustrations when working in clients’ homes but tried her best to maintain appropriate boundaries. She wants future counselors to remember that clients face a number of barriers that counselors are not used to. This is the clients’ norm and counselors cannot take their responses personally. New counselors need to make sure they truly want to work in clients’ homes before starting, as it is not for everyone.

Despite the challenges, Betty reported having a rewarding feeling towards providing in-home counseling. She said it is like being a part of the family and getting to work on family dynamics that also influence the needs and success of the clients. Keeping one’s boundaries allows for this successful exchange that she would not get in the office. She ended our interview stating counselors need to keep their eyes wide open when working in clients’ homes because even if a counselor is complete with grad school, the real learning for in-home counseling begins once the counselor is in the field working.

Carol

Carol’s interview started off with ease and familiarity as we crossed professional paths nearly 10 years ago. She described her experience as a positive one as she has spent 16 of her 17 years in social services providing services in the home of clients. However, it was not until the latter half of her experience that she earned her master’s and began

counseling. Carol's social work background working with parenting teens through Family Service Center is where she attributed her training for working in the home, not her counseling education. They focused on "what to expect from the clients that we work with and what not to expect and just some personal boundaries that we should keep as professionals."

As the years passed, it felt like Carol's clients preferred having her come to their home because it was the client's own space. Carol described a family being more comfortable and less worried in the home because if "the baby was running around in a pamper it was okay" but that would not be the same in the office. This connection is what Carol felt allowing the client to let their guard down and trust her, as their counselor, helped form a better therapeutic relationship. Carol also reported struggling in some situations when they felt too close to home. Carol displayed a variety of emotions as she discussed her experience growing up in foster care and how this knowledge has helped her relate to clients better but has also made her more aware of the boundaries she must keep.

After completing her master's degree and making the change from social work to counseling, Carol said she felt like she was "going to save the world." However, Carol began entering situations where she found herself focused on the environment and not the client. An urge to judge their situation arose, but Carol would remind herself that she is not one to judge and needed to maintain good self-awareness and boundaries with the clients. Despite this awareness, it did not stop the emotional response Carol experienced.

Often, after leaving a challenging home, Carol would just "sit in my car and debrief and sometimes I cry."

Carol's self-awareness leads her to urge new counselors to make sure they are open and maintain their own awareness to not judge the clients. Carol encourages new counselors to meet their clients where they are at and allow the client to discuss whatever they need. However, Carol said counselors must also be aware of their own safety when meeting clients in their homes. She reported facing safety concerns on a daily basis and making choices to not bring her purse in a home or making sure she was aware of the surroundings and being cautious. If Carol felt like she should not go into a home on a certain day, she would not go. Carol said she relied on her instincts to face those situations.

Dotty

Dotty's interview began the same way as all other participants, but I picked up on some hesitation or nervousness. I immediately began building a trusting and safe environment for Dotty and walked her through the informed consent again and the process of the interview. Dotty still chose to participate. She has been a counselor for 44 months and at least 36 months of that involved working in clients' homes for safety/well-being screenings and counseling. Dotty reported working primarily with children and some family members. When asked about what prepared her for this position, Dotty firmly stated she was not prepared. Dotty goes on to describe a lack of knowledge and having to learn as she worked. Dotty cited having had a great supervisor who had good intentions but mostly ended up being a person to vent to, but not actually learn what she

needed. Dotty felt unsafe and unsure of what she was doing. This uncertainty came across in her interview.

Dotty felt isolated and alone when working in the homes. Mentioning, “I wondered if anyone even knew where I was… but when in the office I was surrounded by peers and that was the safest place to be”. Dotty also reported that it was hard to go into the homes because the family did not want to counselors there and the kids did not want the counselors to see the truth of where they lived. Dotty felt as though the parents were trying to prove to her how great their home life was all while taking away from the session and impeding on the children’s privacy. Dotty’s biggest safety concern was when she had to respond to crisis situations alone. Dotty believes counselors should always have two people go into a home. She described a juggling act of having to manage to keep the child (client) calm but also deescalate the parent without setting off the child.

Despite the worry for her safety and if there were roaches or lice in a home, Dotty believes her experiences were humbling. Her voice became shaky as she described a memory of going into a trailer with younger children and witnessing the violence they lived with in the home. Their walls were virtually nonexistent due to the many holes put in the walls from the family violence.

> we’ll never even hear them talk about [the holes] because they’re not aware of them. They had grown up in a house with holes in them. They didn’t know it was it was different than anyone else’s. You know, that’s where they lived. And that’s, that’s what their world revolved around.

As we progressed through the interview, Dotty became visibly upset, the stated, “I haven’t thought about this for several years and it’s making me emotional”. Based on her experiences, Dotty believes counselors should only go into the home when they are with another person or they should just do all counseling in an office when others are present. She wishes she knew more about in-home counseling before she began because she could decide if she even wanted to do it in the first place. If given the opportunity, she would tell new in-home counselors to reconsider and to not do it.

Edward

Edward’s interview took many months to schedule due to his job transition and moving into a new home all during the COVID pandemic requiring transitioning to remote work for himself and remote schooling for his children. He was eager to participate in the study as he has provided in-home counseling for 24 of his 48 months as a counselor. Edward has a master’s in human development counseling and felt he had so many trainings on clinical skills that he could not remember them all, but none specifically on providing services in the homes of the client.

Edward described a very positive experience when providing services in clients’ homes. Through his experiences he felt it was more comfortable for everyone involved and allowed it clients to not put-up walls like they do in the office. Edward explained the stigma of a foster care office environment because many other [negative] situations occur in the office and going into it may trigger the parents or the children. By meeting the client where they are at in the home, Edward was able to avoid that stigma for the entire family.

While working in the home was more comfortable for the client and family, Edward reported multiple challenges including a lack of preparation. When asked about his training, Edward explained,

> …outside of, you know, how to just general counseling trainings and understanding and trauma training, those sorts of things that I don't remember there being a lot of specific in-home counseling, training that I did, it was kind of working with supervisors and then transferring the, you know, the skills and knowledge you had from, you know, office counseling and then working to transform those into a home environment setting.

Due to a lack of education and training on providing in-home counseling, Edward described trying to keep a close relationship with his supervisor. The supervisory relationship allowed him to discuss his concerns of how to maintain confidentiality for the client with their family being present during their sessions. Edward also struggled with safety, making sure he was aware of his environment and had an exit plan. Edward explained his concern for relational or environmental concerns such as maintaining a non-judgmental approach with parents when they have a bug infestation in the home. The other concern of entering a crisis situation that has escalated individuals and you're "needing to be aware of how to best deescalate the situation and manage everyone involved, whereas in the office it's normally just one person you're working with, and making sure you don't say anything to one person to de-escalate them, that could escalate another" person present. However, if he was able to get a handle on these challenges, while working with his supervisor, he enjoyed the experience.

Felicia

While following the protocol set forth in Chapter 3, Felicia reported on her demographic form that she had never provided counseling in clients' homes. My immediate reaction was to thank her for her interest and politely tell her she could not participate. However, I assumed there must have been a reason she was referred to participate. Through a phone conversation, it was discovered that Felicia had never been employed as an in-home counselor, but part of her in-home experience was psychoeducation and working with clients to find coping techniques to use with their diagnosis, all of which are very much part of counseling. In turn, we proceeded with the interview. Felicia reported only having 24 months of postgrad experience and as an intern she provided clinical services in clients' homes. We began the interview with her recounting her experience. Felicia remembered going into the homes to provide referrals for support services but also to work with clients regarding their diagnosis and treatment. Felicia described the core of her work as providing psychoeducation in individual sessions to help clients identify and understand their diagnosis and to help clients learn coping skills to manage their diagnosis.

Going into the homes brought with it many concerns and hesitations for Felicia. First, she described seeing clients with a variety needs and most clients not having connections to community resources and support. Even more so, many clients had no idea what their diagnosis was or what symptoms were associated with it. Felicia's experience with this lack of clinical knowledge made going into the homes feel unsafe. Not only could Felicia not predict the clients' behaviors, but she also had to be aware of

her surroundings and the current home situation. Some examples of the surrounding or home situation includes what mood, the client was in that day or what objects may be lying around the house. Felicia reported encountering these situations with every client and feels more training is needed in this area to help keep in-home workers safe.

Felicia described one situation with a client she had been working with for months on end and things were going well. Suddenly one session did not go so well. The client became aggressive and verbally irate and began pacing back and forth. She then began threatening Felicia stating, “Oh, you need to leave, or I’ll slice you (cut you)”. Felicia felt taken off guard/surprised and unsafe. Her work’s ‘safety protocol’ was to leave the area as soon as possible. As a response she left and spoke with a supervisor and did not return to working with the client even after the client reached out.

Moving forward, Felicia would tell new therapists that they should come prepared for any environment because not only are there safety concerns but there are also environmental concerns like the cleanliness (or lack thereof) of a home. Felicia stated these are all situations we may not like but we must remember we are in the homes to help our clients and need not judge the client for a situation that is safe and normal to them. Felicia provides another environmental example of other family member being present in the home trying to ease drop on the session. Felicia believes, “you really need to be aware that it’s their space and there may be random people walking through and you just get to trying to be able to roll with it because you don’t have control over that space.” In addition to being aware of client and environmental concerns, Felicia believes counselors need “Training on how the experiences can vary when providing services in

the home vs., in the in a clinic or in an office setting". Felicia reported her office had a safety protocol, but no training for these concerns, nor did she receive any specific training for in the home during her educational program. However, Felicia believes if this is provided and counselors can remember to not judge the client and focus on building a comfortable rapport with clients and environment for the sessions, the client can still get what they need from the sessions.

Gail

Gail is a master's level counselor with five years of experience. Three of those years were spent working in clients' homes. Gail was very willing to participate in this study but did explain her children were home, but not in the room, prior to starting the recording. I offered to find another time to meet, but like many during the global COVID-19 pandemic, there was not a possibility to meet when her children were not home. As we began the interview, I noticed a shift in her presence as she was able to talk about her experience working in the home. With a smile on her face, Gail described it as very interesting. She recalled being fully immersed in the homes as she provided psychosocial rehabilitation and counseling to the clients. Helping clients learn daily living skills and how to manage or overcome their diagnosis to be able to function in life. Gail recalled nothing being off limits and tells of one situation where she had to ask the client to get dressed/put clothes on before they could start their session. However, Gail said this is why counselors go to the homes, because clients need help where they are most comfortable and by going to the home and helping this specific client, she eventually was able to get up and get dressed before Gail even arrived.

Gail experienced clients' needs varying from home to home, but many surrounded basic needs of food, transportation, childcare etc. Gail said by going to the home we were overcoming that obstacle for the family and allowing them to get the help and support they needed in their home, where they are comfortable. For one mom Gail recalled, "we were able to work on a lot of her individual things, but also a lot of family things that were causing her symptoms to exacerbate and could have led to some pretty significant consequences had we not been able to meet where we met…". These moments of success and triumph helped Gail overcome the negative, sad, and heartbreaking emotions she encountered when helping clients in their home. She believes the success may not have happened if she were not able to be in the home and building the stronger bonds that are not built in an office.

When asked what training or supervision prepared her for working in the home, Gail reported there was nothing that prepared her, because back in her day they were told not to work in the home. Going into the home was a new and unpredictable world. Gail believes none of her prior training or education prepared her for this and it was " a fly by the seat of your pants kind of thing, asking your supervisor for help when there were any questions or safety or boundary concerns, especially [being] in a small town". Gail further reported any type of supervision was inconsistent and described it as more reactive than proactive.

For counselors, Gail believes there needs to be more training and education, and a level of comfort and understanding before going into the homes. She reported not knowing what she would encounter "whether it be a high crime area or it be homes that

have lots of bugs or are filthy". She said she had to come at it from where the families are at and not where she is from. Gail also reported trying to put work away at the end of the day for her own sanity, and not everyone can do that. Despite these challenges Gail still recalled working in the home as her favorite part of the work and the time when she could help her clients the most.

Reflection

Transcendental phenomenology focuses on the lived experiences of the individual. This framework was crucial to monitoring my interaction with the research to eliminate bias. Throughout the interview process, I stayed present with the participants and did not infer any information or make assumptions of meanings. After careful review of all transcripts, I determined that this was successfully completed. As I continued the bracketing and analysis of the transcripts for coding and documenting this process in my journal, I noticed many similar themes began to appear. As I bracketed from one level of coding to the next, I felt I was possibly losing or overlooking experiential information by generalizing and grouping too quickly. I took time to reflect and ensure my biases were not influencing my coding practices. As a precaution, I reviewed each transcript again to ensure I did not miss any repetitive words or themes within the interview. I did find a few repetitive words in one transcript that jumped out and those were added to the coding sheet. I then redid the remaining levels of bracketing and coding, first by individual and then by question between individuals. I found correct items were identified and grouped accordingly but thematic findings required rewording to accurately reflect the experiences of the individuals and not the conceptual ideas of the experiences.

Results

All major themes and subthemes were directly linked to the research question, "What are the lived experiences of counselors providing counseling services in clients' home environment?". These major themes included counselor preparation and supervision, therapeutic relationship, and environmental factors. The subthemes that emerged were barriers and comfortability. The themes provided great insight into the lived experiences of the counselors. Moving forward I will explore each major theme and provide details from the coding process and interviews that support each finding.

Counselor Preparation and Supervision

One major theme from interviews with all participants is counselor preparation and supervision. All seven participants reported no educational preparation for working in a client's home. When asked what of her personal training or supervision prepared her for the home, Gail recalled,

> Honestly nothing. There was none, cause usually back in the day, you're told you don't do services; you don't provide services in the home. You know, that's in the in your office. It's not in the park. It's not, it wasn't meeting where your families were at. So, there I, I, there was no clinical training. It was more of a little bit of fly by the seat of your pants. And when there were questions or boundary issues that are bound to come up, especially in small communities, when you're doing in-home therapy and things like that, I would go to my supervisor or the organizational president, be like, hey, how do I deal with this? So, it was more of

> an inconsistent thing in the moment versus any training or education through school or supervision.

Additionally, five of the seven participants reported no professional training from employers, and only some supervision for working in the client's home. Betty said she understands counselors need a lot of additional skills to work in clients' homes and further recalled her lack of training and minimal supervision saying,

> Well, you know, I've been doing this for a long time, just counseling, nothing, for training wise. Back like it's about 15 some years ago, it was a little different back then when it comes to supervision. I mean, there was some guidance and stuff, but a lot of it has to do hands on training and using the skills right there in sessions and stuff like that. So, past supervisors have given me a lot of input and feedback, which I appreciate to continue to be able to grow my clinical skills and how to apply better.

Two participants reported training for working in clients' homes from their initial professional positions as social workers. These two also agreed that they would not have been prepared for or as comfortable working in the homes had they not had this prior training. Carol says,

> "Well in the beginning we did have training because we were, when I worked with the teen parents our trainings were through (Social Service Agency name removed to protect confidentiality) and they did a lot of training with us, as far as going into the home, what to expect from the clients that we work with and what

> not to expect and just some personal boundaries that we should keep as professionals."

All participants reported the importance and need for training for counselors before sending them into the home environment and then positive supervision throughout the process. Dotty reported,

> In the beginning, I would say I was not prepared…I had very little understanding of actual interpersonal relationships and how they would form and what those would look like and then also how the setting was going to drastically change, how people behaved and sort of their comfort level. I did have an excellent supervisor at the time, but the budget allowed so that she met with us, was supposed to meet with us once a week. But we were lucky to have really an in-depth supervision maybe once, once a month. So, she tried as much as she could, but a lot of it turned into just kind of empathizing with me when things just felt really chaotic.

Dotty also stated that she wishes she knew more about in-home counseling before she began because she could have decided if she was comfortable enough or even wanted to do it in the first place. The subtheme of comfortability arose often when discussing prior training or preparation. Dotty was not comfortable working in the home in any capacity and preferred the office environment saying,

> One of the things that I struggled with going into the home, I guess, and felt the need, I guess, was just being alone. There were just times were going as an individual without, I don't know, I guess anyone there really looking out for me.

> There were times where I just didn't feel safe. Not that I ever threat, like felt immediately threatened but parents tend to be a little more open with their thought. So, when you're sitting in the home assessing their child vs. if you're in your office surrounded by your peers, so I didn't always feel like it was the safest environment to be in. That's one thing I felt like we needed to do was to be in pairs when we did counsel in the home. Whereas the remaining participants report the positives of working in the home because it was where clients were the most comfortable and able to truly be themselves. The participants also experienced that providing counseling in the client's home provided counselors a better insight into the client's world versus working with them in an office setting.

The isolation of entering each home alone was also a concern and noted risk factor for Felicia. Felicia described one such situation, in which her being alone in the home led to an unsafe situation:

> We would go to her house to provide services that included therapy and referral to services and community psychology, patient things like that. And there was one experience in which, like this patient, like, she became irate and it looked like it happened … out of nowhere, she just became irate. She just verbally like being verbally aggressive, pacing like back and forth and just out of nowhere, like she just told me, oh, you need to leave, or I'll slice you. Which that's like a term for physical harm. Which means cut. Yeah. And so, I was just like, well, this is this is out of nowhere, and before never had any issues like this from this patient before ever. Months and months of working with this patient. Then that happened, and of

> course, like there was safety protocols and everything in place [by agency]. And of course, like I removed myself from the situation I was in her home just removed myself, and I called my supervisor and let him my supervisor know and eventually that patient was transferred to someone else.

Given such experiences, it was no surprise that participants also discussed the need to learn how to separate their experiences working in the home from their personal lives or they would risk burnout and not being able to continue in the field. These findings align with Myers' (2019) report that 21% - 67% of in-home counselors experience burnout as they lack appropriate training for working in the home environment. They also support Hammond and Czyszczon' s (2014) research showing a lack of training and knowledge leads to a need to professionalize the service of in-home counseling. Carol mentions,

> I have to be careful with my transference because my, my childhood was very traumatizing, and I was involved with the Department of Children and Family Services myself. So, I have to keep that as a professional, keep that that transfers very you know, I have to balance that.

Further Carol mentions she needed to learn not to judge the clients or families and to leave it all behind when she goes home. Carols says,

> I would say, their homes may surprise you. Even if it's not to your standards or if it is to your standards. So, if it is to your standards, looking at this, looking at this family and they're involved with the Department of Children and Family Services, then you want to say, wow, how did that happen? And again, looking at

> this family, in their homes, does not meet your standards. You may say, I guess I can see how this happened. So, I'd want them too again, as much as they can, not to be judgmental. If you don't know the entire story. Of why they became involved or whatever their situation is, and it's hard for you to make a sound decision just to, you know, not to be judgmental, meet them where they are. So, yes…sometimes [after an appointment] I would just sit in my car and cry… to try not to bring it home.

Edward reported intentionally forming a good relationship with his supervisors to ensure he would have the support he needed to provide work in the homes despite his lack of training. He said,

> Training wise, I mean, outside of, you know, how to just general counseling trainings and understanding and trauma training, those sorts of things that I don't remember there being a lot of specific in-home counseling, training that I did, it was kind of working with supervisors and then transferring the, you know, the skills and knowledge you had from, you know, office counseling and then, you know, kind of working to transform those into a home environment setting.

These sentiments were echoed by most of the participants, but at least three of the seven specifically report the supervision they received was more reactive and failed to provide the support they needed upfront when working with challenging situations.

Therapeutic Relationship

A second major theme emerging from the interviews is the therapeutic relationship, which tied closely with the subtheme of barriers or in this case eliminating

them. Six of the seven participants felt meeting clients in their homes was positive for the therapeutic relationship with clients as it provided the opportunity to help eliminate barriers for the client and families. This paved a way for therapist to meet the client where they are at, physically and mentally. By doing so the client felt more secure and was more open to the counseling session, thus allowing for a stronger therapeutic relationship to develop. Felicia's experience was that by meeting clients in the home, they felt more secure in their home environment and were more willing to talk and engage in the counseling sessions which led to greater levels of therapeutic rapport and an overall stronger relationship. Felicia recalled,

> So, I believe that that is because it's more convenient. I also believe that it is because some clients, some patients they may feel more comfortable when working in the home are being provided. Services in their home may be more at ease. More willing to talk more willing to engage in services if it's like the convenience of their home, maybe they don't have to job if they don't have access to transportation. So, it's really, I believe, a convenience aspect, and then also just to put the clients at ease and then being in a comfortable environment.

This was echoed by Gail's experience of being able to meet clients where they are at and see exactly what is occurring in the home and being allowed to help not only the client but occasionally the family as well. These findings align with research from Bendixen et al., (2018), reported that family members gain a sense of security when competent care occurs in the home. In one portion of the interview Gail recalled,

> I would say you're going to love it. I think there's so much more to it to this the relationship to the progress you can make to the tools you find in a family's home that make the situation so much more beneficial. You've seen the families where they're at your I always got the sense that I was doing more good and helping more in those situations. So, I think it's. It's oh, it was great. Thing I love. That's always been my favorite part of any job is go into somebody's home.
>
> I think, overall, it was one of my favorite things I've done over the years. I think that that's [in the home is] where I saw the most success with the folks I worked with. The community, the hope, the families, the homes. It's such an integral part of who a person is and how they react to situations and what's going on in their world that I think when you're not doing service or providing services in those kind of settings [clients homes]. I think that it can to some degree be a disservice because you're not meeting folks, they're at."

Allen and Carol both experienced that much progress was made when there was a good relationship established with the client in the home. However, they also reported that counselors need to be aware of the differences between working in the office and in the home of a client. Betty felt it vitally important to provide services in the home but does believe counselors need "a lot of additional skills when it comes to building rapport and engagement with clients in the home setting". These experiences of needing to establish a good relationship and be aware of the surroundings were often due to the barriers or environmental factors present in the sessions.

Environmental Factors

A third and final major theme emerging from the interviews is environmental factors. It is important to note that this theme emerged neither solely positive nor negative but a combination of both. All seven participants reported their experience providing services in the client's home was very different from their experiences providing services in an office setting. Six of the seven participants felt it was a positive experience despite potential negative environmental factors. This finding aligns directly with the research finding that the benefits of providing services in the home far outweigh the potential risk factors encountered (Holm et al., 2017; Hack et al., 2015; Hsu et al., 2018; Martinez et al., 2018; Schildmeijer et al., 2019). This overall theme tied in repetitively with the subthemes of barriers and comfortability.

A major positive environmental factor was the location, in that counselors and clients were able to choose where the client was most comfortable to engage in their session instead of having to go to an office. Allen recalled,

> So, for me, it's all about the concept of meeting the client where they are and being able to have them in a place where they're comfortable, where they are able to be able to open up and discuss those difficult things in a comfortable setting. Whereas if they were here in my office or if they were, you know, you know in any other location, they would probably not be as comfortable to talk about certain things. Whereas if they're in their homes, they're probably the most comfortable and they're able to open up more, I believe.

Edward brought up an important factor in that the office often holds a negative stigma for families involved in social services, and primarily for those involved in foster care (as was his experience). He also recounts his experience of meeting the family in their home and then working with clients while playing basketball outside or going for a walk.

Another positive environmental factor is that by meeting clients in the home, counselors are helping eliminate barriers that previously prevented the client from receiving services. Five of the seven participants mentioned transportation as a significant barrier a counselor is helping clients overcome by providing services in the home. Additional environmental factors experienced by our participants as barriers, that are lessoned or overcome by providing services in the home are a need for childcare for relatives of the client, and socio-economic limitations. Gail recalled,

> Well, I feel like for me at the time I was meeting clients where they were, we had a lot of families who could not get to a counseling session. They didn't have a vehicle to come into the office. They didn't they couldn't afford the bus. We lived in a super small town, there wasn't really a bus. We had families who they didn't have childcare. So, an adult couldn't come in or, you know, that family had several children, and getting one kid to an appointment was really hard. But I also had families that getting out of their home on a daily basis, or even mostly my adult. Obviously getting out of their home to do anything was almost impossible. So, I think that's, you know, it was real important to meet them where they were where they were at.

An additional environmental factor for consideration is the familial environment. The familial environment includes the people present in the home during the session and the home structure. All participants mentioned one, if not both, of these factors as influential on the counselor's experience when providing counseling in the home. Dotty appeared most affected by these factors. She reported how overwhelming it was to be in the home and trying to focus on the session but couldn't because there were bugs crawling across her foot." Dotty continued to tell of another situation when she was unable to focus as her emotions were overwhelming because she was in a home where "there were virtually no walls because the family was so violent, they were covered in holes". Dotty continued on to say how sad this was because the kids had to live in this environment and they "had no clue" because it was what they were used to.

All participants mentioned some challenge being in an environment with other family members present. Allen recalled:

> Whereas when I'm working with children in the home and I don't really feel as comfortable because a lot of times with children, their parents are kind of hanging around and not really allowing me as a therapist to really engage the client. And I have a particular client that I'd go to his home and his mom is always hovering over the session. And that bothers me because it doesn't allow him to be open and honest about everything. And a lot of his issues deal with both his mom and his dad. You know, it doesn't really give him a lot of room to grow in those situations because he doesn't feel like he can be open with them. Open with me because his mom is lingering.

Dotty and Edward mentioned how the present of the family members is barrier for clients and a hindrance on their comfortability because they may be worried that the family member is going to listen to what is said, or they try to join or monopolize the conversations. Specifically, Dotty said,

> Like I said that additional training of just kind of the understanding of how environment changes. Counseling just like what we're going through now with the COVID-19. You know, I've been trying to do a lot of counseling, like on the computer and face to, face time and stuff like that. And it's just you miss out on so many different interpersonal levels that you get in the office. And then, and with that going into the home, things change to sort of the privacy for the child's not there. Whether you go into a room and you shut the door, the parents are listening. The parents are there. And the child fears that. And a lot of times when you're working with children and that's the one thing they don't want is for mom and dad to know what they're talking about. So, privacy is an issue when we're in the home. I would say that's probably the biggest roadblock for home counseling.

Gail recalled feeling unsure or unsafe walking into homes with other family members present because you never know what is going on with those individuals or what their needs are. In turn this could be a very unsafe situation for the counselor, and they must always be aware of what is going on around them. This led to discussion of needing more training for these encounters (as discussed earlier).

The final environmental factor that was mentioned by all seven participants was the potential physical location of the home. As Carol said,

> Sometimes they are in nice neighborhoods but sometimes they are in not so nice neighborhoods… for the physical part, be aware of your surroundings, know where you're going. Don't take your purse inside with you. Be very cautious. And if you have, if you feel like I don't think I need to go in there right now. Then don't go in there at that particular time. But as an in-home counselor, those are things that we have to face on a daily basis.

Dotty's experience led her to believe that counselors should not go into the home environment by themselves. Allen recalled being grateful for his social work training:

> …And before I was licensed, I did a great deal of work in the child welfare system as an investigator for CPS and with that experience in CPS, I think that kind of prepared me for working with families and individuals in their homes. Because a lot of the work that we did at CPS was dangerous. You know, it was sometimes in the middle of the night, you know, so it, um, it allowed me to gauge, I would say how to deal with individuals in their own home. So, I think with that CPS training, you know, the one thing that they really taught us was to pay attention to our surroundings. And I think that is what's really prepared me as a therapist to actually be able to go into a client's homes. I don't know if I had not had that experience, if I would have been comfortable enough to even say I'll consider in-home therapy.

Allen mentioned later in the interview,

> For me, my number, my number one priority is always safety. So that's, you know, being aware of the different types of neighborhoods that you're going in.

> You know when you're going into the neighborhoods, know when there is a higher chance of something happening in those moments, you know. So just being, you know, just being aware of the whole safety factor. For me, I don't know if there's any more needs of being safety just because, you know, when you're going into somebody's home, you know while they're comfortable. It's an unusual place for you, and, you know, you don't know if there's that weird uncle there who, you know, may be experiencing severe mental illness or, you know, if there's guns in the home, or there as pets in the home. So, you have to consider all of those things as well. Especially when you're dealing with someone who has mental health issues. You know, they could be you know, you could be an adult client and they could have some experiences with psychosis, you know. So, you have to consider those things as well. You know, definitely the diagnosis of the client and, you know, history of their violence would also be something else. But again, all of these things involve around safety. One thing that I do when I do go into a client's home; it doesn't matter if it's anxiety of its schizophrenia, I am always looking for the quickest exit. I'm not putting myself where my back is facing it with my back to the door, but I'm also, you know, not putting myself in a situation to where I cornered in either. Sometimes you have to make a quick escape. And that's something I learned while being an investigator with CPS.

Allen then described coworkers' experiences of running out of gas in an unsafe neighborhood, getting tires slashed while in a home, and another getting guns and knives pulled on them. Contrary to Allen's coworkers, our participants did not report any

situations in which they were harmed but did experience a lack of comfortability and safety due to the location of the homes.

Summary

In Chapter 4, I explored the research and participants of this study in further detail in relation to the research question, “What are the lived experiences of counselors providing counseling services in the clients’ home environment?”. I explained data collection and analysis processes and findings. I broke this down to explore my bracketing and coding procedures to reveal the major themes and subthemes emerging from the data. All themes were supported with occurrences and quotations as they occurred in the transcripts of the interviews.

Moving on to Chapter 5, summary and conclusions, I review my interpretations and findings from the research and relate to the literature. I proceed to identify the limitations of the study and provide recommendations for potential future research. Lastly, I review the implications of the research at hand and how it may relate to social change and progress.

Chapter 5: Summary and Conclusions

Introduction

The purpose of this study was to understand the lived experiences of professional counselors who provide in-home counseling services. Using a transcendental phenomenological approach allowed me to grasp a broader understanding of the true essence of the experiences of the counselors (Gutland, 2018). Furthermore, knowledge gained from this study may help advance counselor preparation and training and help decrease high levels of burnout, stress, and turnover for those clinicians working in clients' homes' homes, throughout the counseling profession (Hammond & Czyszczon, 2014; Lauka et al., 2013). The main research question guiding this study was: What are the lived experiences of counselors providing counseling services in clients' home environments? The major themes that developed were counselor preparation and supervision, therapeutic relationship, and environmental factors. The subthemes that emerged were barriers and comfortability.

In Chapter 5, I review my interpretations and findings from the research and relate them to the literature. I then identify the limitations of the study and provide recommendations for potential future research. Lastly, I review the implications of the research and how it may relate to social change and progress.

Interpretation of Findings

Prior researchers have exposed the lack of general understanding of what a counselor experiences during a counseling session in a client's home (Myers, 2019). This lack of understanding is shown to leave counselors potentially at risk, both in the physical

environment of the session and personally through mental and emotional well-being (Czyszczon, 2014; Dudley, 2018). Husserl (1931, 2013) believes to truly understand an individual's experience one must seek to learn the individual's perception of being among the phenomena, including their physical, mental, and emotional reaction to this state of being within the phenomenon. I gained these understandings using a transcendental phenomenological approach and asking participants to share their lived experiences providing counseling in clients' homes (Hannah, 2014; Patton, 2015; Ravitch & Carl, 2016). These understandings or findings are discussed in the following summaries by thematic topic.

Counselor Preparation and Training

Prior researchers have identified a need for proper training for counselors providing clinical services in clients' homes (Bowen & Caron, 2016; Mattek et al., 2010; Warren & Schwarze, 2017). The uniqueness of the environment has proven challenging for ill-prepared counselors. Five of the seven participants in this study reported a lack of understanding, when beginning services in clients' homes, due to no educational preparation or professional training on working in clients' homes' homes prior to providing in-home services. Furthermore, two of the seven received training when beginning positions in social services prior to providing counseling and reported not knowing if they would have been prepared for in-home counseling without the social work training.

In addition to confirming the need for professionalizing in-home counseling through training and preparations, the results of this study extend previously reported

knowledge by providing insight into what that education and training should entail. All seven participants reported a need to prepare counselors for the specific differences between providing counseling in the home versus an office setting.

Therapeutic Relationship

Muzicant and Peled (2018) reported that the home of a client provides a unique environment for services. Participants believed by meeting the client where they were at, barriers would be overcome and clients would be able to build a stronger therapeutic relationship with the counselor and have greater success. The stronger relationship was attributed to the lack of barriers and the increase in clients' level of comfort by simply being in their home. As cited in Chapter 2, Holmes (2017) also noted findings of greater successes when services are provided in clients' homes. While some hesitation exists for the strength of a therapeutic relationship when others are present in the home, six of the seven participants cited a stronger alliance in the home regardless of who was present at the time of the session.

Additionally, most participants reported that their therapeutic supervisory relationship was lacking. Participants indicated they believe this is because it was more reactionary and supportive versus the proactive and supportive approach needed for individuals beginning work in clients' homes. This confirmed previous findings discussed in Chapter 2 that a need exists for more formal training and supervision for counselors providing services in clients' homes.

Environmental Factors

Czyszczon (2014) and Dudley (2018) cited challenges for conducting counseling in clients' homes due to various environmental factors. The results of this study not only confirm a variety of environmental factors influence the counseling being provided in the homes but extend this knowledge by providing additional challenges and details to previously mentioned challenges. For example, Allen provided details on multiple situations in which the location of a session proved to be unsafe and his coworkers were put in unsafe situations where their tires were slashed while in a session with a client.

Another environmental factor causing concern was the presence of other family members in the home during therapy sessions. Multiple study participants reported interference by other family members and especially by parents when working with a minor child. Participants indicated that clients worry their confidentiality is compromised and that parents will hear what they are discussing. This is often concerning because many struggles for minor children often involve at least one of their parents/guardians.

Additionally, going into the homes of clients eliminates barriers for and increases access for the client but also has the potential to increase burnout for the counselor (Myers, 2019). By increasing the number of unknown environments, a counselor is entering on a regular basis, their risk for burnout increases as does their stress. All seven participants reported some level of stress when encountering new families and the various environmental concerns that arise. These experiences also align with the study results from Myers (2019) and Warren and Schwarze (2017).

Limitations of the Study

This study provides many insights into the experiences of counselors providing counseling in clients' homes. Despite the insight gained, limitations do exist. These limitations include the requirements for participation and the sole focus on the experiences of the counselors involved in in-home counseling.

The first limitation includes the requirements for participation. To participate in this study, individuals must have been either a graduate intern or master's degree level counselor (nonclinical/not clinically licensed) and have 6 months of experience working in clients' homes. I established the limit to focus the study results and to aid in minimizing potential bias with local participants. Furthermore, only master's degree level counselors participated and, had there not been a 6-month minimum, potential existed to obtain insight from graduate interns more likely. By gaining the insight of graduate interns and clinically licensed professional counselors, a more extensive understanding of the in-home experience for counselors of all training levels would be obtained.

The second limitation of this study was that I focused on the experiences of the counselors and excluded the insights and experiences of the clients and their families when receiving counseling in their homes. Husserl (1931) reported that gaining a true understanding of an experience is to study all seen, heard, and sensed. To this end, a true understanding of in-home counseling may include the experiences of the counselors, the clients, and their families. Including the experiences of all involved may provide a more in-depth report of the needs of those involved, allowing for greater understanding of what is needed for future progress.

Recommendations

The collective findings of this study provide solid insight into lived experiences of counselors providing services in clients' homes. However, additional questions remain unanswered. The insight I gained from this study guides my considerations and recommendations for future research.

The first recommendation is to consider a similar study and open up participation criteria to include counselors of all licensure levels as well as counselors in a larger geographical region. This new study should also consider eliminating the requirement of a minimum of six-months of in-home experience. While the current study provided much insight into the lived experiences of counselors providing services in the home, expanding inclusion criteria may provide a broader range experience. This expansion may also show if the experience of in-home counseling changes when an individual has a higher licensure or are in different geographical regions.

The second recommendation is to develop a study focusing on the cultural and background differences between counselors and how this correlates with their experiences providing services in clients' homes. Expanding this study's scope to include cultural considerations will provide vast knowledge into how individuals of different cultures experience the same situation. Especially when considering constructs of privilege and oppression. During the current study, different individuals had personal opportunities to take precautions such as a using a different car when going to a client's home in a not so good area. This may not be an option for all individuals. Furthermore, it

is wondered if counselors of different cultural backgrounds have differing needs when entering a client's home.

The third recommendation is to conduct a study exploring the experiences of the clients and families receiving in-home counseling. This study provided insight into counselors' experiences with the inclusion of interview questions regarding the needs of both the counselor and the client. However, knowledge of the clients' needs was reported from an observational standpoint. Exploring the needs of the clients and families may broaden our understanding of the home dynamics and possibly the experiences of the individuals receiving the in-home counseling.

The overall theme of counselor preparation and training arose throughout this study and demonstrated need for intervention prior to working in clients' homes. All participants expressed desire and need for better education and training. A possible solution, and fourth recommendation, is to conduct a study to determine the specific training needs for counselors prior to providing services in clients' homes. By conducting a study seeking specific training needs for providing counseling in clients' homes, a broader understanding will be obtained to allow creation of academic programing and professional training and a possible best practice model for providing these services.

Implications

Many insights arose during this study which led to positive implications for the general practice of in-home counseling. It also includes positive prospects for the individual counselor, the academic and professional fields of counselor education and supervision, and positive social change. Expansion of one's knowledge about in-home

counseling may increase the potential growth of the field and understanding of the inner workings of in-home services.

When considering general practices of providing in-home counseling, Mattek et al. (2010) referred to potential safety concerns present for counselors working in clients' homes. This study provided further clarity and definition of specific safety risks for the counselors. In turn, this knowledge provides opportunity for the counseling profession and more specifically the agencies providing in-home counseling to create new policies and protocol and training to increase counselor safety when in clients' homes.

The lived experience of this study's participating counselors is the lack of knowing what they were walking into when beginning counseling in clients' homes. As this study provides an in-depth look into those specific experiences, it provides an opportunity to educate counselors prior to beginning in-home work. This insight may affect an individual counselor's choice as to whether they decided to provide counseling services in clients' homes at that time or ever.

Gaining an understanding of the lived experiences of counselors providing services in clients' homes provides a knowledge base necessary to begin exploring appropriate preparation and training for counselors. Warren and Schwarze (2017) report high levels of stress for counselors providing services in clients' homes and a need for increased training. This study provides a base for future research and the potential development of training and supervision practices for individuals working in clients' homes. Such training and supervision have potential to decrease burnout and in turn increase retention of counselors providing such services.

Increasing awareness of counselors' experiences in the home and potentially creating protocol and trainings may lead to positive social change. Such change includes potential adjustments to how counselors prepare for practice in the homes and how they conduct services in the homes. By implementing such adjustments, we may improve counselors' experiences of working in clients' homes and increase their quality of care. A heightened level of care may lead to improved well-being of clients and their increased success in both counseling and in life.

Conclusion

Myers (2019) reported the ability and need to increase access to clinical services for clients by providing services in the homes of the clients. Warren and Schwarze (2017) agree with the increase in services but worry about the resulting increase in stress on a counselor and identify a need for additional training before going into a home environment. To understand the true experiences of counselors providing services in clients' homes, I used a transcendental phenomenological approach for the study. Results from this study confirm the need for in-home counseling services and a need for additional training and considerations. Results also include detailed descriptions and expand on the knowledge and needs of the lived experiences of counselors providing services in clients' homes.

From these detailed descriptions three major themes emerged including counselor preparation, therapeutic alliance, and environmental factors. Within these three major themes, two sub-themes of barriers and comfortability also arose. These themes accurately covered the many details of the lived experiences of counselors providing

counseling in clients' homes. Results from this data not only confirm findings in previous literature but also provide insight into the true experiences of the counselors and their respective needs. After review of the resulting data, further implications and recommendations also arose including consideration for changes in agency practices and protocols, and updates to new counselor education programming and training for when counselors provide services in clients' homes.

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Appendix A: Recruitment Letter

Greetings,

My name is Melissa Franzen, and I am a doctoral candidate at Walden University. In order to fulfill my degree requirements for a PhD in Counselor Education and Supervision under the supervision of my dissertation chair, Dr. Geneva Gray, I am requesting your assistance in identifying participants for a study called *Helping in the Home: A Qualitative Study of Counselors' Experiences of Working in Clients' Home*. Please note, should you also qualify, your participation in this study is much appreciated. The purpose of the study is to explore the lived experiences of professional counselors and/or graduate interns' experiences of providing counseling in the home. **You must be a master's level counselor or intern, operating under a limited license with supervision and have provided counseling services to client in their home of residence.** Participation requests that you complete a short demographic form, and a 45-60-minute individual interview. Participants may withdraw at any time during the course of the study.

I may be reached at Melissa.franzen@waldenu.edu with any questions or to confirm participation. My dissertation chair is Dr. Geneva Gray, and she may be reached at geneva.gray@mail.waldenu.edu. The study will be reviewed by Walden University's Institutional Review Board for approval (Approval #). The results may also be used in future publications, conference presentations, and future research.

Please also share this request with anyone else who may qualify for the study.

Thank you for your time and consideration,

Melissa Franzen, MA LCPC
Doctoral Candidate, Walden University.

Appendix B: Demographic Information

Questions	Answers
Are you a current graduate level intern student or a professional counselor?	
If a professional counselor, how many months of experience, post-graduation, do you have in counseling?	
Have you provided counseling to client(s) in their home?	
How long have you provided counseling in clients' homes?	
Please describe your educational experience	
Please describe any professional training you have received, post-graduation, regarding your clinical work and/or working in the home of clients.	
Would you be available for a follow-up conversation regarding this study's results? If so when would be good times to contact you?	
Please provide the name and contact information of another individual you know who may be eligible for the study	

Appendix C: Interview Questionnaire

Describe your experience working with clients in their home.

What about your training or supervision prepared you for this work?

What are your perceptions of why counselors provide counseling in clients' homes?

What are your perceptions of the needs of clients receiving counseling in their homes?

What are your perceptions of the needs of counselors providing services in the home?

Probe: What about your experiences lead you to feel this this way or believe this perception?

What of your physical experiences have led you to these beliefs?

What emotional responses have you had to your experiences of providing in-home counseling?

What would you say to another counselor who has never provided in-home counseling?

What else would you like to share about your perspectives on in-home counseling?

What else would you like to share about your experiences with in-home

counseling?

Appendix D: Gender and Race of Participants

Table 3

Gender and Race of Participants

Demographic	%	N
Total participants		7
Gender		
Male	28.57	2
Female	71.43	5
Race		
Caucasian	57.14	4
African American	42.86	3

Appendix E: Demographic Form Information

Table 4

Counseling Level, Education, and Training Data for Participants

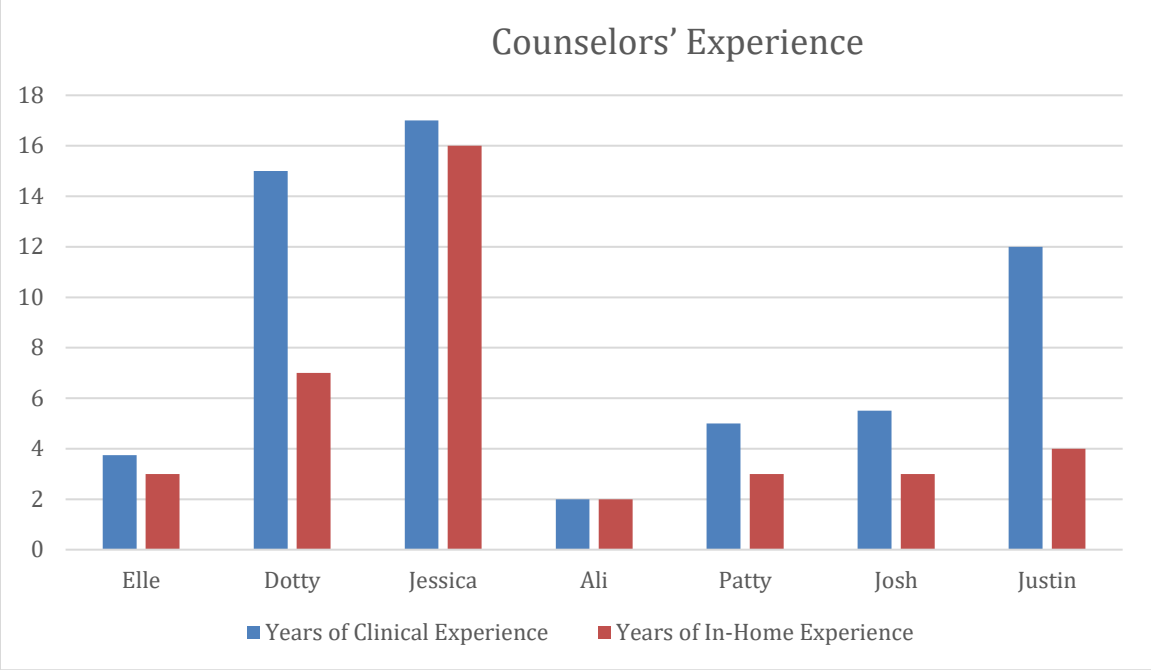
Demographics	%	N
Demographic forms completed		7
Counselor level		
Professional counselor	100	7
Graduate intern	0	0
Provided counseling in-home		
Yes	100	7
No	0	0
Education		
Master of arts degree	85.71	6
Master of science degree	14.29	1
Postgraduate training		
Yes	28.57	2
No	71.43	5

Table 3

Experience

Participant	Clinical Experience In Years	In-home Experience in Years (months)
Elle	3.75	3 (36)
Dotty	15	7 (84)
Jessica	17	16 (192)
Ali	2	2 (24)
Patty	5	3 (36)
Josh	5.5	3 (36)
Justin	12	4 (48)

Figure 1


Counselors' Experience
18
16
14
12
10
8
6
4
2
0
Elle
Dotty
Jessica
Ali
Patty
Josh
Justin
Years of Clinical Experience
Years of In-Home Experience