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The Perceptions and Experiences of Intensive In-Home Counselors Regarding Vicarious Trauma

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Walden University

College of Social and Behavioral Sciences

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Tara Ross

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Walden University
2022

Abstract

The Perceptions and Experiences of Intensive In-Home Counselors Regarding Vicarious Trauma

by

Tara Ross

MA, Liberty University, 2010

BS, Longwood University, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Social and Behavioral Sciences

Walden University

August 2022

Abstract

The purpose of the study was to explore intensive in-home counselors' perceptions and experiences with vicarious trauma when providing in-home services to children. The constructivist self-development theory was used to explain how helpers develop vicarious trauma after exposure to traumatic stories of clients. A generic qualitative inquiry was the methodology for this study because it focused on illuminating the participants' experiences, and offered a highlighted description of the participants' awareness, consciousness, and understanding, which explored those personal experiences. The study consisted of 10 adults between the ages of 31 and 62. The participants were all African American. Semi structured interviews were conducted and data were coded and analyzed for emergent themes. The themes that emerged from the study included perception of intensive in-home counseling, positive intensive in-home experiences, challenging experience to intensive in-home counseling, emotional experiences, and coping strategies to manage the emotional impact of intensive in-home counseling. The results indicated that all the participants experienced the emotional impact of providing intensive in-home counseling. This study offered implications for positive social change as it allowed the participants to shed light on their experiences through personal accounts. Through the shared experiences of their work inside the homes of at-risk children, they will continue to inspire social change as contributors in the communities they serve. These results may also help inform best practices and workplace training among counselors who provide in-home services and those who train and support them.

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Dedication

This dissertation is dedicated to God Almighty the creator. He has been my source of strength throughout this challenging process. This dissertation is also dedicated to my husband, Seon, who has been a constant source of support and who encouraged me most to finish my project. To my daughter, Kyla, I dedicate this dissertation to you. Although only 12 years-old, you always found the words to lift me up and motivate me when I was feeling defeated. To my son, Aaron, I dedicate this dissertation to you. As you prepare to enter graduate school, this project is an example of what you can accomplish through perseverance. I love you all.

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To Jeanette, my former colleague and friend. I want to acknowledge you because in my darkest moments, you prayed for me and kept me grounded in Faith. You always managed to encourage me when I could not encourage myself. Thank you.

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Chapter 1: Introduction to the Study

Mental health service providers, such as intensive in-home counselors, establish their careers by providing therapeutic services with the clients and families experiencing emotional, behavioral, and psychological challenges (Lauka et al., 2013; Marriage & Marriage, 2005; Moffett et al., 2018). Referrals to in-home services can be made through many community resources such as schools, counseling agencies, the Department of Social Services, Court Services Unit, Department of Juvenile Justice, and other community mental health agencies (Hammond & Czyszczon, 2014). Intensive in-home services are usually Medicaid funded, and the overall goal is to decrease the child's risk of out-of-home placement. The intensive in-home counselor spends, on average, 3–15 hours weekly, providing therapeutic interventions within the clients' home to improve family dynamics and interpersonal relationships between the family members (Moffett et al., 2016).

Some of the issues these counselors experience in the home environment are aggressive and oppositional children, chronic neglect, sexual abuse, self-harm, suicide attempts, and substance abuse (Hammond & Czyszczon, 2014). Each of these experiences might be classified as precursors to the development of vicarious trauma and other psychological issues such as posttraumatic stress disorder (PTSD; American Psychological Association [APA], 2018; Killian et al., 2017). Given the amount of time counselors spend working with at-risk children and families, counselors may develop vicarious trauma.

Chapter 1 includes background information, the problem statement, and the purpose of this study. Additionally, the research question is discussed in the constructivist self-development theory (CSDT) conceptual framework. Also, the nature of the study, definition of terms, assumptions, limitations, and delimitations of the study are included. Chapter 1 ends with a summary and the review of literature.

Background

Vicarious trauma develops over time. It can develop as a result of helping clients with challenging circumstances (Boulanger, 2018). Bowen and Caron (2016) completed a qualitative gender-specific study of home-based counselors' experiences by interviewing 12 counselors about their preparedness, professional development, and gender-specific experiences. Bowen and Caron found that the counselors' shared subjective experiences, such as isolation, ethical ambiguity, and high intensity of the job, led to feelings of vicarious trauma. The researchers stated that additional research was needed to understand the determining factors that cause some home-based counselors to leave their position within a few months of entering it and others to stay.

Furthermore, Bowen and Caron (2016) stated that more research is needed in areas related to retention rates as well as exploring and comparing the experiences of home-based counselors in urban areas with those in more rural localities. My research will differ as it will explore the experiences counselors might have with vicarious trauma in the home setting. Bowen and Caron's study focused on preparedness, professional development, and gender-specific competencies of home-based counselors.

Problem Statement

Many counseling professionals listen to vivid reports and observe clients' emotional and behavioral challenges (Foreman, 2018). Working with clients who have experienced trauma can negatively affect counseling professionals and place them at risk for developing vicarious trauma (Williams et al., 2012). Vicarious trauma is a form of secondary trauma that produces post-traumatic symptomology of invasive and avoidant symptoms, hyperarousal, and isolation, which can have harmful effects on the counselors (APA, 2018; Foreman, 2018). Additionally, vicarious trauma can contribute to impairments that threaten professional effectiveness and decrease the well-being of the professional providing the service (Foreman, 2018). Vicarious trauma is a human experience shared among counseling professionals and clients as the counselors may endure symptoms from their work with clients (Bell & Robinson, 2013; Miller & Sprang, 2017).

Many mental health agencies have recently expanded services to the home setting (Lauka et al., 2013). Intensive in-home counseling services have become a common approach in treating at-risk children with emotional and behavioral disturbances (Lauka et al., 2013). In-home counselors provide services such as crisis intervention and social support to promote stabilization and reduce their clients' risk for out-of-home placement (Lauka et al., 2013). Counselors working with clients in their homes can be affected by empathetic and emotional demands (Huggard et al., 2017). The in-home approach differs from out-of-home counseling because of its high intensity, which includes increased time in individual sessions, the number of family participants, and overall safety (Bowen et al.,

2016; Lauka et al., 2013). Increasing the understanding of this problem is vital because in-home counselors experiencing vicarious trauma symptoms might be unable to provide quality services in the best interest of their clients (Huggard et al., 2017; Williams et al., 2012).

Although there have been many studies on vicarious trauma and counselors, many of these studies focus on in-patient settings, clinicians who specialize in alcohol and drugs, licensed clinical counselors, professionals working with female victims of sexual trauma, school counselors, and others working in the field (Foreman, 2018; Honsinger, 2015; Huggard et al., 2017; Hunt, 2018; McCormack & Adams, 2015). Although, there is much research on vicarious trauma, I have been unable to find research specifically addressing the perceptions and experiences of intensive in-home counselors with vicarious trauma when providing services to children with emotional and behavioral disturbances. As such, further research is warranted to understand the experiences of counselors better when providing intensive in-home services to children in the home (Hammond & Czyszczon, 2014).

Purpose of the Study

The purpose of this generic qualitative study was to explore intensive in-home counselors' perceptions and experiences with vicarious trauma when providing in-home services to children. This study adds to the existing body of knowledge by exploring the experiences encountered by intensive in-home counselors when there is exposure to factors that might potentially elicit vicarious trauma, such as client trauma, personal

safety, family violence, family poverty, and child abuse (Foreman, 2018; Glebova et al., 2012; Hammond & Czysczon, 2014; Macchie al., 2014).

Research Question

I developed the following research question to guide this study: What are the perceptions and experiences of intensive in-home counselors with regard to vicarious trauma?

Conceptual Framework

The conceptual framework most appropriate for this study was the constructivist self-development theory (CSDT) developed by McCann and Pearlman (1990). The CSDT framework was developed to help others understand the psychological effects of treating clients with traumatic histories (Foreman, 2018). CSDT is a theory relevant to explaining how helpers develop vicarious trauma after exposure to traumatic stories of clients. Using CSDT as a conceptual framework will assist in exploring the experiences of in-home counselors. This framework was an appropriate choice for the topic of vicarious trauma among counselors because, according to CSDT, individuals construct their realities based on perceptions, previous experiences, and individuality (McCann & Pearlman, 1990). Based on seminal research, Miller et al. (2010) suggested that CSDT better explains how exposure to stressful and traumatic events can interfere with an individual's cognitive schemas. CSDT measures intrusive symptoms and the negative changes that occur for the counselor (Branson et al., 2013).

The settings in which the intensive in-home counselor and traditional office counselor performed their role is vastly different. The in-home approach involves a high-

intensity experience and an increased duration spent engaged with the client and family weekly, which exacerbate exposure (Bowen & Caron, 2016). McCann and Pearlman (1990) examined how individuals suffer adverse psychological effects for several years after completing work that exposed them to a traumatic issue, which has a way of complementing vicarious trauma. CSDT framed this specific research area through its blend of social cognition, psychology, and object relations. Moreover, this framework was useful in assessing the interaction and the experiences of the helper's therapeutic work, in this case, the in-home counselor.

Nature of the Study

This qualitative study utilized a generic approach, which focuses on interpretation and highlights the experiences related to human perception (Padilla-Diaz, 2015). With this approach, I attempted to understand the counselor's perceptions and experiences around vicarious trauma. I used a purposeful sampling method. Purposeful sampling is defined as deliberately selecting individuals able to communicate and interpret their experiences about a phenomenon (Ravitch et al., 2016). Ravitch and Carl described purposeful sampling as a term exclusive to qualitative studies that produce material-rich information from the participants selected and provides a deeper understanding of a study. Ravitch and Carl stated that purposeful sampling is responsible for providing comprehensive, impactful information regarding exclusive groups of people and locations. COVID-19 precautions did not allow for face-to face interviews; therefore, the meetings were completed virtually by video conference method as an alternative to a private office setting to ensure confidentiality of shared information (see Zhu et al.,

2018). Data about home-based counseling experiences were collected based on personal accounts of the work experience.

Definition of Terms

Intensive in-home counselor: Per Virginia standards, an intensive in-home counselor must qualify as a qualified mental health professional (QMHP) to provide intensive in-home for children, and this individual must have the designated clinical experience of at least a bachelor's degree in a human services field or special education from an accredited college and with at least one year of clinical experience with children and adolescents (Department of Behavioral Health & Developmental Services, 2018).

Intensive in-home services: Also known as home-based counseling, these services are designed for children under the age of 21, time-limited, and facilitated inside the clients' residence (Department of Behavioral Health & Developmental Services, 2018).

Secondary traumatic stress: A type of stress that impacts many in the helping profession who are indirectly exposed to the traumatic experiences of others (Sprang et al., 2018).

Trauma: An individual's response to a distressing event that creates challenges with the ability to cope (Boulanger, 2018).

Vicarious traumatization: A form of secondary trauma that produces posttraumatic symptomology of invasive and avoidant thoughts, hyperarousal, and isolation, which can have a harmful effect on therapists (APA, 2018; Foreman, 2018).

Assumptions

Assumptions are conclusions based on beliefs that may or may not prove true (Simon & Goes, 2013). One of the assumptions was that all participants would be honest and forthcoming in their experience with vicarious trauma (Simon & Goes, 2013). Another assumption was that all participants had experienced vicarious trauma. Finally, it was assumed that some in-home counselors have been trained to recognize vicarious trauma (Wargo, 2015).

Limitation and Delimitations

This study was not without limitations. The limitations specifically related to locality and the participants being limited geographically. A snowball sampling method was chosen, which is predicated on meeting specific criteria. To be eligible for inclusion in this study, the participants had to hold at least a master's degree, have 6 months to 5 years of practice experience with the target population, and be over the age of 21. Within most states, counselors possessing either a bachelor's or master's degree in a human services discipline meet the criteria for employment as an intensive home counselor under the supervision of a licensed behavioral health clinician. Intensive in-home counselors might be considered a unique sub-group that does not represent the in-home clinicians at large (Malterud et al., 2016). Therefore, this study's results might not be transferrable to other counseling populations (Robinson, 2014). My professional experience as a counselor in both private practice and a correctional setting might influence my preconceived opinion of vicarious trauma in counseling (see Wargo, 2015).

I controlled for this type of bias through member checking, bracketing, and reflexivity (see Charmaz, 2015).

Delimitations included the population intended for this study; intensive in-home counselors at least 21 years-old who are employed as home-based helpers. I chose to explore the perceptions and experiences of in-home counselors specific to their experience with vicarious trauma. I did not look at their experience through any other lens other than vicarious trauma. The CSDT theory provided a perspective that linked this population to their experience. Utilizing these delimitation components through generic inquiry assisted in my exploration of in-home counselors' experiences to address the intended research question.

Significance of the Study

With the emergence of nontraditional means of providing mental health counseling services within the confines of the client's home, it was important to explore the perceptions and experiences of unlicensed intensive in-home counselors regarding vicarious trauma and ways that treating children in the home might influence the counselor's susceptibility to vicarious trauma. Moreover, this research offered an original contribution to the existing body of literature because it brought attention to the limited research regarding the experiences if intensive in-home counselors. Much of the research literature has focused on other counseling professionals such as alcohol and drug clinicians, licensed clinical counselors, professionals working with female victims of sexual trauma, school counselors, and others working in the field (Foreman, 2018; Honsinger, 2015; Huggard et al., 2017; Hunt, 2018; McCormack & Adams, 2015). Gaps

in prior research were that the studies provided limited findings of home-based counselors' experiences of vicarious trauma. However, there was an abundance of literature on how vicarious trauma affects counselors working in in-patient clinics and therapists engaged in the profession of counseling. Studying vicarious trauma among home-based or intensive in-home counselors should be pursued because this remains an underdeveloped research topic, specifically addressing the experiences and perceptions of vicarious trauma when facilitating this service within the confines of the client's home.

Summary

In this generic qualitative study, I explored intensive in-home counselors' experiences with vicarious trauma when providing services to at-risk children. Bowen and Caron's (2016) qualitative gender-specific study of 12 home-based counselors' experience indicated that the counselors endured subjective experiences such as shared isolation, ethical ambiguity, and high intensity of the job. Finklestein et al.'s (2015) research on the phenomenon of vicarious trauma among mental health professionals and the risk factors associated with being exposed to a client's trauma narratives, such as psychological distress, supported the development of this research. McCormack and Adams's (2016) qualitative study on vicarious distress and complex trauma among four senior trauma therapists served as relevant background information for my study. The outcome of Adams study revealed that this population of counselors had experienced burnout and vicarious distress.

In Chapter 2, I discuss the literature on vicarious trauma, the conceptual framework, the emergence of intensive in-home services, and trauma as it relates to the

counselors' experience with vicarious trauma. The subjective experiences of in-home counselors were the focus of the study. The study included an exploration of their experiences of providing home-based services. I anticipate that the results of this study will be used to shed light on the practice of home-based counseling services through personal accounts. The findings of this study may contribute to the existing body of literature that may influence policy changes for intensive in-home standard of operating procedures, such as a reduction in caseload expectation and increase in clinical group supervision, and co-counselor support in areas with poor cellphone service. Furthermore, the research outcomes may influence others who will research a similar population or framework.

In Chapter 3, I discuss generic qualitative inquiry as the research design chosen for this study. In addition, the data collection process, participant selection, and recruitment are discussed. In Chapter 4, I provide more information on the participants, including their professional background, and on the themes that emerged and the findings. Lastly, Chapter 5 provides an overview of the study with emphasis on interpretation of the interviews, research limitations, and social change.

Chapter 2: Literature Review

Many counseling professionals listen to vivid reports and observe the emotional and behavioral challenges exhibited by clients (Foreman, 2018). Working with clients who have experienced trauma can negatively affect counseling professionals and place them at risk for developing vicarious trauma (Williams et al., 2012). The definition of vicarious trauma is a form of secondary trauma that produces posttraumatic symptomology of invasive and avoidant thoughts, hyperarousal, and isolation, which can have a harmful effect on therapists (APA, 2018; Foreman, 2018). The terminology was first identified in the early 1990s to describe the psychological effects of clinicians treating childhood sexual abuse survivors (Boulanger, 2018). The purpose of this generic qualitative study was to explore the in-home counselors' perceptions and experiences with vicarious trauma when providing intensive in-home services to children. After an exhaustive review of the literature, I was unable to find a significant amount of research focusing on these simultaneous concepts.

Moreover, this review of the literature centered around studies that investigated home-based counselors and vicarious trauma. In this literature review, I describe vicarious trauma and offer background information into this concept. Additionally, I provide insight into the CSDT as it relates to trauma, and include information about the emergence of home-based counseling and the counselor's experience.

Literature Search Strategy

This literature review was conducted by searching the Walden University Library, Google Scholar, and journal articles related to the study topic. Databases that I used

included ProQuest Central, SAGE Premier, PsycINFO, and PsycARTICLES. Keywords and terms searched included vicarious traumatization, secondary traumatic stress, secondary trauma, trauma, intensive in-home, home-based therapy, counselors, practitioners, clinicians, therapists, evidence of vicarious traumatization, narratives, and perceptions.

I researched foundational aspects of intensive in-home and vicarious trauma. The literature search also allowed me to review studies that focused on vicarious trauma among other professionals who work directly with victims of trauma and those who do not. Sources published between 2014 and 2019 were included to account for the historical knowledge relating to vicarious trauma and the emergence of home-based services. Various articles were incorporated into this study to provide a seminal background on vicarious trauma and the experiences of helping professionals. It was essential to include the historical context of intensive in-home and vicarious trauma concepts. All journal articles were from peer-reviewed journals, and the dissertations cited were only those approved by Walden University.

Conceptual Framework

The conceptual framework utilized for this study is CSDT. To understand the perceptions and experiences of intensive in-home counselors around vicarious trauma, it is relevant to include CSDT, which is the foundation for vicarious trauma (Williams et al., 2012). Using this approach provided an accurate exploration of the counselors' experience in the world of in-home counseling. This theory is foundational because it established an understanding of the social and behavioral disruptions associated with

exposure to trauma (Middleton & Potter, 2015). Developed by McCann and Pearlman (1990), CSDT was intended to explain the psychological effects of treating clients with traumatic histories (Foreman, 2018). McCann and Pearlman examined how individuals suffered adverse psychological effects for several years after completing work that exposed them to a traumatic issue, which has a way of complimenting vicarious trauma. CSDT is based on the concept that realities are constructed by individuals based on life experiences and personal schemas (Pearlman & Saakvitne, 1995). To understand the phenomenon of vicarious trauma, it was necessary to understand it as it was experienced (Neubauer et al., 2019). This framework was appropriate for the topic of vicarious trauma among counselors because individuals construct their realities based on perceptions, previous experiences, and individuality (McCann & Pearlman, 1990). CSDT is relevant to explaining how helpers develop vicarious trauma after exposure to traumatic stories of clients (Miller et al., 2010). Based on seminal research, Miller et al. (2010) suggested that CSDT better explains how exposure to stressful and traumatic events can interfere with an individual's cognitive schemas. CSDT provides a means for measuring intrusive symptoms and the negative changes that occurred for the counselor (Branson et al., 2013). McCann and Pearlman (1990) examined how individuals suffered adverse psychological effects for several years after completing work that exposed them to a traumatic issue, which has a way of complimenting vicarious trauma. CSDT framed this specific area of research through its blend of social cognition, psychology, and object relations.

Moreover, this framework allows researchers to assess the interaction and the experiences of the therapeutic work on the helper—in this case, the in-home counselor. Additionally, the CSDT framework focuses on aspects of the self, the ability to tolerate strong effects, and the ability to regulate expectations about self and others (APA, 2018). CSDT emphasizes how a person reacts to violence and trauma in areas of self-regulation, psychological needs, and how people perceived their own identity, including the world around them (Pearlman, 2013). Through self- development, the individual recreated those personal experiences and realities (McCann & Pearlman, 1990). This theory supports the concept that vicarious trauma can alter an individual's view of oneself and others and how they interact with others. Lee (2017) stated that CSDT exposes the practitioner to the client's trauma and causes the practitioner to question the motives of others, leading to challenges with the trust schema. Williams et al. (2012) stated that counselors, working with traumatized clients, effectively rebuild and reestablish their perceptions and realities based on their interaction with the client and the client's traumatic stories. After ongoing exposure to traumatic accounts, counselors adjust their belief systems, and worldviews establish meaning from these events (Williams et al., 2012, p. 135). The impact of vicarious trauma on mental health practitioners is an occupational hazard, and the exact number of practitioners affected by their experience is unknown due to the specific diagnosis of vicarious trauma (Williams et al., 2012), and a lack of research exploring the impact of engagement with client-related trauma stories (Lee, 2017).

Trauma

To understand vicarious trauma, it was important to have a grasp on what trauma is and means in the general literature. Pearlman and Saakvitne (1995) defined *trauma* as "a unique individual experience, of an event or enduring condition in which the individual's ability to integrate his/her emotional experience is overwhelmed, and/or the individual experiences (subjectively) a threat to life, bodily integrity, or Sanity" (p. 60). Trauma is an experience of being physically or emotionally overwhelmed with a subjective sense of threat or harm.

Trauma is contagious, and those individuals who have survived can infect others. This is where vicarious trauma comes in. For example, clinicians are susceptible to being affected by their clients' traumatic stories (Boulanger, 2018). Exposure to traumatic events is widespread in the United States, and few mental health practitioners receive adequate training in traumatic experiences (Ellis et al., 2019). Whether it is through hearing clients' narratives of abuse or contending with one's reminders of traumas, trainees and experienced clinicians alike are exposed to emotionally demanding work (Ellis et al., 2019). The lack of attention to the emotional, physical, and psychological needs of the clinician can create harm to both the clinician and client (Howard & Navaega, 2018). Carello and Butler (2015) and Finklestein (2015) stressed the importance of counselors recognizing issues related to trauma therapy, such as being indirectly exposed to the client's traumatic events. These researchers emphasized how clinical supervision and coping strategies are associated with lower levels of vicarious trauma, which might prevent client harm.

Vicarious Trauma

Definition of Vicarious Trauma

Vicarious trauma, a term created by McCann and Pearlman in 1990, refers to exposure to clients' trauma and the potential negative impact on the therapeutic relationship (Branson et al., 2014). It is a construct that denotes the negative impact of trauma treatment on helping professionals. The terminology was first used in the 1990s by professionals working with survivors of childhood sexual abuse (Boulanger, 2018). Hernandez et al. (2010) asserted that the length and intensity of traumatic stories would naturally affect therapists in negative ways, so *vicarious trauma* refers to the ongoing effect of working with traumatized clients, and bearing witness interferes with the natural and inner experience of the therapists. Cosden et al. (2016) explained vicarious trauma as the psychological responses of empathic engagement with survivor clients and their trauma material. It can include intrusive images, thoughts, and feelings experienced by helping professionals, which can last long after treatment has concluded (Branson, 2019). Vicarious trauma can negatively impact the counselor's well-being when performing trauma work and can manifest in the counselors' personal life (Branson, 2019). Additionally, vicarious trauma is a human experience. In some instances, it has been defined as a shared trauma among counseling professionals and clients (Bell & Robinson, 2013; Miller & Sprang, 2017).

Background Literature of Vicarious Trauma

Vicarious trauma develops over time. It is the result of helping many clients with challenging circumstances. Boulanger (2018) examined vicarious trauma and its history

by conducting a single case study interview with a retired military psychiatrist who shared his story of vicarious experience and ways the clinical engagement (joining) helped the psychiatrist and patient process traumatic material. Williams et al. (2012) examined personal trauma and personal wellness of mental health counselors, including ways traumatic stories and the counselor's display of empathy leaves the counselor vulnerable, causing impairments similar to those experienced by the clients (e.g., helplessness, nightmares, diminished psychological functioning), resulting in vicarious trauma.

Trauma begets trauma. Flint (2018) also acknowledged that disturbing dreams, isolation, hopelessness, and despair are common symptoms of vicarious trauma. Michalopoulos and Aparicio (2012) researched vicarious trauma among another class of helping professionals–social workers. The researchers determined that social workers without a traumatic history would be at a lower risk for developing trauma symptoms. Comerchero (2015) explained there are risk factors for experiencing vicarious trauma such as those who work with trauma survivors, personal trauma history, pre-existing anxiety, maladaptive coping skills, and a lack of professional support. Carello and Butler (2015) suggested that listening to trauma narratives is also a risk factor. Branson et al. (2014), who researched vicarious trauma as a hidden hazard of helping others, explained the occupational hazard that vicarious trauma poses for Behavioral Health Clinicians (BHCs), such as detrimental effects on the quality of personal life and interpersonal relationships. Branson et al. (2014) offered how clients' graphic disclosures can lead to symptoms of vicarious trauma. This study is relevant for a few reasons; it extends insight

into the significance of vicarious trauma, and the high turnover rate among BHCs. Researchers discussed how service delivery could be negatively affected when clinicians are exposed to trauma work.

Ethics are also critical to addressing vicarious trauma among counselors. Iqual (2015) suggested that counselors adhere to counseling ethics and exercise honesty about the impact of vicarious trauma, which included a responsibility to their clients' well-being and their own. For this reason, counselors are to adhere to ethical guidelines to protect their clients from harm and to recognize symptoms of impairment that may disrupt their ability to function professionally (American Counseling Association, 2014). Cohen and Collens (2013) researched vicarious trauma utilizing the CSDT framework to assess the impact of empathetic engagement and found that the clinician's schemas are changed when they are impacted adversely by their clients' trauma. Cohen and Collens utilized 20 published qualitative articles to conduct meta-synthesis research focused on vicarious trauma, posttraumatic growth, and vicarious posttraumatic growth to explore the growing evidence of the effects that trauma work has on therapists and the therapists who have been adversely impacted. The outcome of this research was the assertion that the impact of trauma work could potentially increase short- and long-term levels of distress. In terms of implications for future research, this work highlighted the need for a more cohesive view of trauma work rather than the traditional perceptions of either posttraumatic growth or vicarious trauma. The authors further suggested specific investigations into the nature and the development of vicarious posttraumatic growth. The

trauma workers reported experiencing professional growth as a result of their engagement and emotional distress with their clients.

Although vicarious trauma emerges over time, it can develop sooner, predominantly when a clinician responds to a traumatic situation that is challenging. Bell (2013, as cited in American Counseling Association, 2016) stated that mental health professionals experience increased risk of vicarious trauma through constant and continued exposure to clients' trauma material. Vicarious trauma symptoms are more challenging to identify, Bell maintained that it involves cognitive distortions and changes in one's beliefs, which substantiates the implementation of CSDT, which is useful in determining symptoms because it combines object relations theory, psychology, and social theory (American Counseling Association, 2016). Parker and Henfield (2012) completed a qualitative exploration of school counselors' perceptions of vicarious trauma by using a focus group of licensed or certified school counselors. Many of the counselors felt unprepared to address trauma work and believed their master's degree program failed in preparing them for vicarious trauma. Because many of the participants assumed burnout and vicarious trauma presented similar symptoms, the authors distinguished the difference between the two constructs. Participants pointed out that they utilized protective factors such as support groups, increased supervision, and conferences. Several participants agreed that once they became more settled in their profession, they were better equipped to deal with severe cases. Parker and Henfield's article benefit my study because it assesses intensive in-home counselors' awareness and perspective of vicarious trauma.

Similarly, Baker (2012) completed a qualitative research study of master's level trauma therapists enrolled in a doctoral program. Within this study, Baker assessed the students' personal history of trauma, defense mechanisms, academic training, and the number of trauma survivors assigned to their caseloads. Many of the participants reported experiencing difficulties with separating their client's stories from their own, which impeded them from providing the best clinical practice (Baker, 2012).

Further, Baker (2012) asserted that many therapists might be unwilling to disclose their experience with vicarious trauma to supervisors and are in denial and have no idea how they have been affected. Again, Baker emphasized the importance of the therapists' self- care when treating traumatized clients. Many of the qualitative articles discussed above have similar themes, such as assessing the training level and preparedness of the helping profession. Similarly, Williams et al. (2012) researched vicarious trauma by studying mental health counselors in urban, suburban, and rural areas of the Rocky Mountains to measure variables such as a history of personal trauma, personal wellness, workload inventory, and a supervisory working alliance.

Another example of exploring vicarious trauma in therapy is Bartoskova's (2017) qualitative study, which provided information on trauma work and factors leading to posttraumatic stress disorder (PTSD) in trauma therapists. The outcomes indicated that trauma therapists experience growth from their work, which contradicts prior studies on the impact of trauma work on therapists. Bartoskova identified various gaps, which included a lack of control across the caseload and clinical hours spent with trauma clients in comparison to the overall caseload (in terms of clients' symptoms presentation).

Bartoskova believed that this created confusion about the title "trauma therapists" being used based on participants' interest in trauma work. Bartoskova suggested that further studies would provide more information about the differences arising from varied working hours with trauma clients.

Many factors contribute to vicarious trauma. Dombo and Blome (2016) completed an exploratory qualitative study investigating factors that contribute to vicarious trauma in child welfare workers. Other researchers focused on the prevalence of vicarious trauma among physicians, social workers, child welfare workers, judges, law enforcement officers, EMTs, alcohol and drug clinicians, inpatient licensed clinical counselors, professionals working with female victims of sexual trauma, school counselors and judges (Foreman, 2018; Honsinger, 2015; Huggard et al., 2017; Hunt, 2018; McCormack & Adams, 2015). Nevertheless, they acknowledged that other professionals showed evidence of suffering vicarious trauma after exposure to traumatic stories and situations.

Stories, narratives, and imagery may also contribute to vicarious trauma. Likewise, Weigand and Keeler (2014) found that the clients' graphic disclosures can lead to symptoms of vicarious trauma. Finklestein et al. (2015) researched the phenomenon of vicarious trauma among mental health professionals, and the risk factors associated with being exposed to a client's trauma narratives such as psychological distress, this research supports the development of my research. Finklestein et al. incorporated a quantitative approach that consisted of 99 mental health professionals working in the community who are exposed to high levels of trauma. Implications for future research included using a

larger representative sample with a longitudinal design that compares the different groups of professionals, for example, social workers, psychologists, and psychiatrists. The results of the study indicated that MHPS working in more severely affected communities reported higher rates of subjective and objective exposure to PTSD and vicarious trauma symptoms. My research would offer a qualitative approach to exploring the personal narratives of intensive in-home professionals and their perception and experiences of vicarious trauma.

Intensive In-Home Counseling

Intensive In-Home (IIH) counseling, also known as home-based counseling, offers a unique benefit in that it provides more face- to- face mental health interaction than traditional outpatient service. IIHC is growing and becoming an essential way of delivering service to children and their families (Worth & Blow, 2010). On July 30, 1965, Medicaid was signed into law, and intensive in-home counseling services were established in the late 20th century. IIHC is a Medicaid program provided to low-income families that arose out of the child welfare /social work field (Hammond & Czyszczon, 2014; Moffett et al., 2018).

Home-based counseling emerged in 1974 under the Homebuilders model as a program designed for youth in the juvenile justice system and children demonstrating out-of-control behaviors (Moffet at al., 2018). Later, in the 1980s, the Adoption Assistance and Child Welfare Legislation Act of 1980 increased efforts of family preservation to include home-based case management and home-based family therapy services milieus such as communication skills and family counseling (Adoption

Assistance and Child Welfare Act, n.d.; Magellan Healthcare of Virginia, 2016). The purpose of the legislation was to empower families, maintain intact families, and reduce the number of out-of-home placements for children into foster care programs by increasing the family's coping skills (Strydom, 2014). This legislation led to the emergence of family preservation services. The idea was that this act would influence child safety and family reunification (Magellan Healthcare of Virginia, 2016; Strydom, 2014).

Intensive In-Home Services

This section will offer insight into intensive in-home service (IIH) within the United States, which is different than in home counseling. Around 2013, various behavioral health backgrounds, such as criminal justice, education, social work, psychology, and counseling, provide intensive in-home counseling services (Lauka et al., 2013). In 2008, the minimal requirements and qualifications consisted of an associate degree with 3 years of experience (DMAS, 2008). Today, the requirements to perform these services consist of individuals who meet the Department of Behavioral Health and Developmental Services (DBHDS) definition of a Qualified Mental Health Professional-C (QMHP-C) or Licensed Mental Health Professional (LMHP) (DBHDS, 2013). To qualify as a QMHP to provide Intensive In-Home for Children and the individual must have the designated clinical experience and must

> (1) Be a physician; or (2) have master's degree in psychology from an accredited college or university with at least one year of clinical experience; or (3) have a social work bachelor's or master's degree from an accredited college or university

> with at least one year of clinical experience with children or adolescents; or (4) be a registered nurse with at least one year of clinical experience with children and adolescents; or (5) have at least a bachelor's degree in a human services field or in special education from an accredited college and with at least one year of clinical experience with children and adolescents. (Department of Behavioral Health & Developmental Services, 2018).

Often utilized as a last resort, IIH is designed for children under the age of 21, time-limited, and facilitated inside the clients' residence. The goal is to keep the youth inside the home and reduce the risk of out of home placement. The individual clinician works with the family in their home at a time convenient to the family and provides a variety of interventions (Strydom, 2014). IIH is designed to improve family dynamics, provide modeling, improve interpersonal relations between family members in the home, and provide clinical interventions to help improve functioning. It also includes crisis intervention, 24- hour emergency response, care coordination with other required services, communication Skills, and family counseling (Intensive Family Preservation Services, n.d.). Agencies such as schools, courts, social services, and other state and local agencies such as the community services boards will often refer youth to intensive in-home services. This service has been considering cost-effective (Lauka et al., 2013), and offers evidence-based treatments for children and adolescents.

In-home counseling has emerged as an intervention for youth involved with the juvenile justice system, at risk for removal from the home due to abuse or neglect, and maladaptive behaviors that cannot be managed by the family. The weekly in-home

sessions vary between ten and fifteen hours weekly and extend over 4-6 months (Moffet et al., 2018). In most states, the intensity and length of service are determined by agency guidelines, the therapist's caseload, clients' needs, and funding sources. For example, a minimum of 3 hours per week of therapeutic intervention must be medically necessary for the member, with a maximum of 10 hours per week for 26 weeks annually. In exceptional circumstances, 15 hours per week may be provided. These services include case management, individual, and family therapy in areas such as trauma, crisis intervention, mental health disorders, substance abuse, domestic abuse and violence issues, conflict management and resolution, social skills, school-related concerns, and parenting (DBHDS, 2013).

Criteria for Intensive In-Home Services Eligibility

The focus of this service is on the family unit as well as the member; therefore, one parent or legal guardian MUST be willing to participate in the services (Magellan, 2016). Criteria for receiving intensive in-home services include: (a) the child is at risk for placement outside of the home or transitioning back to the home from placement due to high family disturbance or conflict; (b) difficulty establishing and maintaining relationships exists due to cognitive, emotional, or behavioral challenges; (c) evidence of significant emotional disturbance and/or behavioral health needs that have required multiple interventions by agencies such as schools, medical/mental health professionals, social services or the legal system; (4) and/or sufficient cognitive difficulty exists that the child is not able to consistently execute socially appropriate behaviors or comprehend threats to his/her personal safety (DBHDS, 2013; Moffet et al., 2018).

Experiences of Providing Intensive In-Home Counseling

It is not uncommon for children and adolescents receiving IIH to have been exposed to a family history of rape, personal victimization, emotional neglect, physical abuse, domestic violence, and substance abuse, which leaves many of these children with unpleasant memories. Counselors who provide intensive in-home clinical services to this at-risk population might be at risk for vicarious trauma. This is particularly true if the counselor is vulnerable to vicarious trauma based on their past trauma.

Families are often dysfunctional, and the living conditions are chaotic, and there can be challenges and complexities for the social worker. Specifically, this may mean feeling unwelcomed in a clients' residence. Many therapists have limited experience in providing therapy in the home. Glebova et al. (2012) examined the therapists' comfort level in delivering therapy inside the home. At times, the characteristics of the family's neighborhood might make it difficult for a therapist to remain calm and deliver successful treatment when they perceive the home environment as unsafe for themselves and their client (Glebova et al., 2012). Other challenges of providing intensive in-home counseling included personal safety (e.g., being injured by a client; Worth & Blow, 2010).

Preparedness and competencies are definitely important to successful care. Bowen and Caron (2016) completed a qualitative study examining the experiences of 12 home-based counselors by interviewing and asking them to describe their areas of preparedness, professional development, and gender-specific competencies. They posited that when providing home-based counseling, there is often a lack of a secure setting. The outcome of the study indicated that the counselors' endured subjective experiences such as shared

isolation, ethical ambiguity, and high intensity of the job. Additional research is needed to understand the determining factors that cause some home-based counselors to leave their position within a few months of entering it and others to stay. Bowen and Caron (2016) agreed that more research was needed in areas related to retention rates, exploring and comparing the experiences of those home-based counselors in urban areas with those in more rural localities. Although this article did not focus on vicarious trauma, my research will explore the experiences of the counselors and perceptions of vicarious trauma. It will also be interesting to determine if common themes exist amongst the participants of this study and my own.

License may matter, as well as experience. Moreover, Hunt (2018) completed a qualitative narrative study to explore the personal experience of licensed and non-licensed professionals working with female victims of trauma. Often, new therapists are vulnerable to vicarious trauma because of the challenges exhibited by the clients. This study suggests further research is needed on professionals' perception of vicarious trauma in other regions of the United States (Hunt, 2018). Researching the counselor's experience in providing home-based counseling allows an in-depth account of the counselors' experience of whether there are specific therapeutic challenges that contribute to vicarious trauma (Foreman, 2018). Boulanger (2018) examined vicarious trauma and the history of vicarious trauma, which is relevant to this study. Boulanger completed a single case study interview with a retired military psychiatrist who shared his story of vicarious experience, and ways the clinical engagement (joining) helped the psychiatrist and patient process traumatic material. This research captures the origination

of the term vicarious trauma and will serve valuable to the literature review section of my research. The author further explains that vicarious trauma is often unwelcomed or unintentional, which might be the experience of intensive in-home counselors.

Macchi et al. (2013) found that the negative emotional and psychological factors related to servicing multi-problem families impact home-based family therapist's quality of life. As future research ideas, they suggested evaluating the different theoretical approaches to supervision and common factors that underlie positive processes throughout that impact the professional's quality of life. Additionally, they suggested that future research should test whether varying types of self-care may yield differing results for the perceived professional quality of life. Also, they identified that studies are needed to explore situations and circumstances that may influence therapists' decisions and engagement in the use of self-care and clinical supervision.

Burnout and stress go hand in hand with vicarious trauma. In other studies, McCormack and Adams (2016) studied vicarious distress and complex trauma among four senior trauma therapists using a purposeful qualitative strategy, which served as relevant background information for my intended study. The outcome of the study revealed that this population of counselors had experienced burnout and vicarious distress. Additional research may seek to capture the impact that working within the medical model has on therapists and care professionals while detailing how a medicalized framework may impede or facilitate opportunities for personal growth following adversity. Furthermore, the data for this study came from females only; future studies might consider the responses of males performing the same work. My study will attempt

to understand the subjective experiences of both male and female intensive in-home counselors and their perception of vicarious distress while implementing clinical service in the clients' homes.

Other pertinent background articles included Hammond and Czyszczon (2014). They completed a study of Counselors in Virginia (paraprofessionals, non-professionals, and licensed professionals) performing home-based family counseling in areas of crisis, family violence reduction, abuse, and neglect to preserve the family unit. The outcome of this research focused on improved open discussion within the counseling profession. The authors suggested that future research is needed in several areas, such as a critical need to discover if organizations that serve families in the home are making use of formal, evidence-based models. Further, to address the gap, they suggested further research is needed to better understand the lived experiences of those serving consumers, and the experiences of the consumers themselves would benefit the field.

Background and social position may also play a role. Branson et al. (2014) found that vicarious trauma significantly contributed to a high turnover of Behavioral Health Counselors (BHC) is social positions and is associated with a decrease in sexual desire among this population. Future research included a qualitative study that would allow for the collection of subjective and individual explanations to assess a more in-depth analysis of the relationship between vicarious trauma and sexual desire or whether the possibility of vicarious trauma creates an increase in sexual desire.

More research was needed on counselor and therapist background and daily experiences. Foreman (2018) identified implications for future research to include

highlighting the importance of investing in one's wellness as a way to mitigate the impact of exposure to client trauma and guard against the negative effects of vicarious traumatization. The outcome of Foreman's article identified that exposure to client trauma when more than half of the clients are experiencing trauma was not observed to significantly influence the counselors' overall level of wellness, which contradicts the CSDT theory. My study included Master level in-home counseling practitioners as licensure of Intensive in-home professionals are not required in the state of Virginia. Also, the CSDT model was used within my research as a framework to support the psychological aspects of vicarious trauma based on individual perception and experience.

In addition, Hammond and Czyszczon (2014) completed a study exploring the lived experiences of in-home counseling services. Through this exploration, the researchers captured the parents' reflections on the in-home experience after the program. Moffet et al. (2017) examined the establishment of intensive home-based programs and only utilized experimental studies conducted in Hawaii, New York City, and Kansas. Many of the interventions used within the home setting are theory adapted and unique in that they are evidenced-based. The study showed no improvement in suicidal ideation, self-harming behaviors, feelings of hopelessness, or depression among the juvenile populations, but there was a greater reduction in suicide attempts. The researchers explained that when servicing children with severe emotional and behavioral disturbance in a crisis, the interventions being utilized are essential. In considering gaps in prior research, the literary information provided limited findings of home-based counselors' experiences and their perception of vicarious trauma; however, there is an abundance of

literature on how it affects counselors working in inpatient clinics and therapists engaged in the profession of counseling. Studying vicarious trauma among home-based or intensive in-home counselors was pursued because this remains an underdeveloped research topic, specifically addressing the experiences and perceptions of vicarious trauma when facilitating this service within the confines of the client's home.

Summary and Conclusion

Exposure to trauma in the course of providing treatment is inevitable, and the same applies to home-based counselors, as the service they provide has the potential to be both negative and positive. The literature review of this study found evidence that intensive in-home counseling is high intensity because the therapeutic experience is not like a traditional office or clinic (Bowen & Caron, 2016). The empirical literature review has shown consistent information in regards to vicarious trauma's definition and theories. There is a consensus that professionals such as social workers, school counselors, and child welfare workers with direct contact with children experience some form of secondary trauma, also known as vicarious trauma. The literature examined the experiences of other counseling professionals but did not simultaneously address intensive in-home counselors and vicarious trauma.

Therefore, a gap existed because the literature does not explore the perceptions and experiences of vicarious trauma among intensive in-home counselors. The research emphasized the importance of ethics when treating clients, and a counselor's emotional well-being is important in treating others with trauma-related issues, and when counselors are experiencing psychological distress, this can be ethically harmful to clients as there is

the risk of harming the client (Iqbal, 2015). Researchers who studied home-based (intensive in-home) counselors examined whether being personally involved in the family dynamics through direct observation and interaction increases the symptomology of vicarious trauma among this group of counselors. Further research is warranted that could better understand the experiences of counselors when providing in-home services to children in the home (Hammond & Czyszczon, 2014). In Chapter 3, I describe generic qualitative inquiry as the methodology used for data collection in this research study.

Chapter 3: Research Method

The purpose of this generic qualitative study was to explore the experiences of counselors regarding vicarious trauma after providing in-home services to at-risk children and adolescents. In this research, I addressed the documented social problem of vicarious trauma and explored ways in which the in-home treatment model might expose counselors to susceptibility to vicarious trauma. Examples of susceptibility might include exposure to client trauma, personal victimization, emotional neglect, physical abuse, domestic violence, family violence, and child abuse.

In Chapter 2, I provided a review of the recent literature, relevant research, and the conceptual framework guiding this study. In Chapter 3, I describe, in more detail, the methodology for this project. I discuss the chosen population and how they were selected for the study. I also explain the research design, a rationale for using this design, the sampling criterion for participants, the process for collecting and analyzing the data, the role of the researcher, and the ethical procedures.

Research Design and Rationale

A generic qualitative inquiry was the chosen design for this study. I chose this approach to explore the experiences of vicarious trauma with counselors who provide in-home services to at-risk children. The generic qualitative approach was designed to explore the participants' understanding and the meaning of their experience (Percy et al., 2015). The generic approach focused on illuminating those experiences, offering interpretation, and highlighting the experiences related to human perception (Padilla-Diaz, 2015). Luft (2011) discussed that generic inquiry relies on a person's awareness,

consciousness, and understanding, which unleashes the individual's personal experience. generic qualitative approach. Generic qualitative inquiry is a stand-alone approach that focuses on understanding how the participants individually construct, interpret, or make meaning of their experiences of providing intensive in-home services and their perception of vicarious trauma (Kahlke, 2014; Kennedy, 2016). In 2003, Caelli et al., described the generic approach as seeking to discover and understand people's perspectives (Kennedy, 2016). Percy et al. (2015) explained that generic qualitative inquiry aims to understand an individual's opinion, attitudes, beliefs, and descriptions of the experience. Theoretically, there is a link between the generic approach and social constructs that focus on how the counselors interpret their experiences and what meaning they attribute to and from those in-home experiences (Kahlke, 2014). According to Lim (2011, as cited in Kahlke, 2014) the generic studies approach aims to offer a rich description of a phenomenon under investigation. With this framework, I gained a deeper understanding of the counselors' perceptions and experiences of vicarious trauma.

In this study, a generic inquiry allowed for a description of the experiences and perceptions of counselors who provided intensive in-home services to at-risk children. Both generic inquiry and CSDT eloquently contribute to one's individual experience (Aagaard, 2017). Compared to other forms of qualitative inquiry, the generic approach is the most suitable inquiry to answer the research question because it emphasizes perception, feelings, and seeks to unwrap the individual meaning and perspective of a phenomenon. Whereas, a transcendental phenomenology approach focuses on the shared experience, and a case study approach focuses on an in-depth case. Other approaches,

such as narrative inquiry, grounded theory, and ethnography, would focus on the world view, gathering data through storytelling, or focus on specific cultural groups (Bellamy et al., 2016). Therefore, generic inquiry was appropriate for this study. It provided an informed description of the in-home counselor's experiences and perceptions around vicarious trauma.

Role of the Researcher

The role of the researcher in a qualitative study is that of the instrument. As the primary instrument of collecting the data for this study (Karagiozis, 2018), my role as the researcher entailed interviewing participants individually and I followed the semi structured interview protocol (see Appendix A). I actively participated in interacting and communicating with the participants and ensured participant protection from exposure, injury, or harm. The goal was to safeguard participants and their data and to ensure the study was conducted in a manner that did not violate ethical standards.

The participants were employed with behavioral health agencies that provide intensive in-home counseling. In a qualitative approach, qualitative researchers focus on how the participants interpret their experiences (Karagiozis, 2018). There were ways to manage researcher bias that did not compromise the credibility of the study. One way was by maintaining a position of neutrality and remaining opinion free (Galdas, 2017). I was mindful of any personal biases regarding the research topic, interview questions, collection, and analysis of data. Understanding personal perspectives and behaviors was essential to this research. Failure to recognize these issues might have cause unintended acts of engagement in discrimination, and the study may be affected (Karagiozis, 2018).

Reflexivity was a significant component of qualitative research. Reflexivity contributed to making the research process open and transparent (Palaganas et al., 2017). It allowed me to assess the topic by engaging in the subjective perception of the participants' experience contextually and promoting self-awareness. Utilizing reflexivity also allowed me to minimize any personal assumptions and biases when coding and sorting the collected data by allowing for an accurate representation of the phenomenon (Clark & Veale, 2018; Palaganas et al., 2017). Additionally, reflexivity articulates to the reader the reasons specific questions will be asked in the research and the ways data will be gathered (Sutton & Austin, 2015).

Along with reflexivity, I used bracketing as a preventive measure to reduce bias and to maintain objectivity. Bracketing was used to suspend judgment and preconceptions about the phenomenon and keep the focus on the participants' experience. I also used member checking to ensure the trustworthiness and quality of the data. It was conducted by sending a PDF copy of the interview transcript to each participant to confirm the data and allowed them to provide feedback and clarity of their responses (Hongjing & Hitchback, 2018).

Methodology

Participant Selection

The inclusion criteria for this study were that participants had to be licensed or nonlicensed intensive in-home community-based behavioral health counselors with at least a master's level degree. Recruitment was completed from agencies providing home-based counseling to youth and their family. I contacted directors/clinical supervisors of

these family services agencies to obtain their letters of agreement to recruit from their employee pool. The recruitment consisted of intensive in-home practitioners from diverse backgrounds, cultures, and ethnicities so that the study's findings are fair and unbiased. Participants had 6 months to 5 years of practice experience and were over the age of 21. Informed consent was established and signed before participation in the study. The participants included both licensed and non-licensed professionals with master's degrees in counseling, marriage and family counseling, social work, and other related counseling degrees supervised by a licensed clinician. Professionals not providing intensive in-home counseling were not considered for this study.

Verbal agreements were confirmed with two agency directors to post flyers within their agencies to allow staff to volunteer. I selected the participants for the research study based on the inclusion criteria. Once I received written approval by the institutional review board (IRB), the flyer was posted at each agency. Once participants responded to the flyer, I contacted each of them to determine whether they met the inclusion criteria. The participants meeting the criteria were emailed the approved consent form for review. After the review, each participant responded "I consent" in the email reply. Once this consent was received, I sent the participants meeting invites through the Zoom videoconferencing platform (https://zoom.us/) and interviewed them virtually. An additional informed consent form, specifically for teleconsent was discussed; however, this form did not replace the traditional informed consent, but rather was a solution to obtaining consent when face-to-face interviews amid COVID-19 were not an option for completing the research study (Welch et al., 2016). During the data gathering process, the

world had transitioned into a virtual platform, and videoconferences were seen as an efficient and convenient way to maintain communication (Zhu et al., 2018). Because COVID-19 precautions did not allow for face-to-face interview, the videoconference interview method served as an alternative in a private office setting to ensure confidentiality of shared information (Zhu et al., 2018). There would have been benefits utilizing the in-person approach, such as building rapport with the participants, clarifying answers, obtaining follow-up information, and allowing for the collection of systematic knowledge. Data were collected based on the participants' experiences in the client's home and how they are affected by the setting.

The sample size for the study included 10 participants, which is a typical sample size for a qualitative generic study (Clark, 2018). A type of purposeful sampling called the snowball sampling method was used for this research study. Snowball sampling refers to selecting participants based on knowledge about a phenomenon, and where existing participants recruit among their acquaintances. Tenhouten (2017) described snowball sampling in qualitative studies as having initial participants identify others who may have experience related to the study being investigated. Purposive snowball sampling is comprehensive and permitted impactful information regarding exclusive groups of people and locations (Ravitch & Carl, 2016).

Procedures for Recruitment

I recruited licensed and nonlicensed master's level counselors with degrees in counseling, marriage and family counseling, social work, and other related counseling degrees from agencies who provide in-home services. I recruited these individuals by

soliciting the support of agency directors or clinical directors located in behavioral health directories by letter to post flyers within their agencies. Another recruitment method utilized was to post the same flyer through social media. Each director received a phone call explaining the study, a follow-up email, and the approved flyer. I received both letters of agreement and verbal agreements granting me permission to send the flyer. The flyers were displayed at the agency in a location chosen by the director.

Instrumentation

Researchers using a qualitative approach often utilize various sources to obtain data such as interviews and focus groups (Rimando et al., 2015). In this study, I used a semi structured interview format to guide the process with the counselors. During the development of the questions, attention was given to experiences with vicarious trauma. A demographic questionnaire was included in the interview protocol (see Appendix). The demographic questionnaire I designed consisted of questions about gender, age, and ethnic identity, credentials, and years of practice experience.

Interviews

In qualitative research, interviewing is an interactive process, and the questions play a crucial role (Aarsand & Aarsand, 2019). In this research study, due to COVID-19 precautions, the videoconferencing method was used to collect data on the participants' experiences with vicarious trauma. The questions were developed to fully understand the intensive in-home counselors more generally by allowing the participants to express their experiences and perceptions to answer the research question. The chair and committee member also reviewed the questions. I obtained permission from the IRB to record each

participant. Each interview last approximately 60 minutes and was audio-recorded, with permission from each participant. A thank-you card and a $10 Amazon E-card was sent electronically to each participant for their time and assistance. I transcribed the interviews and completed member checking to ensure the trustworthiness and quality of the data. This member checking was conducted by sending a PDF copy of the transcript to each participant to confirm the interview data and allow them to provide feedback and clarity of their responses.

Transcription

Transcription provides a written record of my research. Sutton and Austin (2015) stated that in a qualitative study, transcription is a process of translating audio-recorded interviews to written form. I transcribed each interview shared by the participant for accuracy, meaning, and perceptions (Sutton & Austin, 2015). The transcription occurred within 24 hours after each interview to preserve pertinent words that might be stifled during audio recording. Bracketing was used to acknowledge nonverbal details (e.g., tears, head nodding, pauses) that cannot be detected through audio. Once an interview was completed, I listened and transcribed the recording verbatim. I used Microsoft Word software to identify themes and organize nonnumerical data by sorting and arranging information (see Predictive Analysis Today, 2016).

Data Analysis Plan

The research question guiding this study was as follows: What are the perceptions and experiences of intensive in-home counselors with regard to vicarious trauma? The elements of data analysis are the initial interview guide. The interview guide provided a

framework for analyzing and reviewing each source, particularly the content analysis, which refers to searching the text for reoccurring words or themes. Content (text) analysis was used with this approach and allowed me to capture the major themes related to the research question. The participants were sent the transcription of the audio recorded interview and allowed approximately 2 weeks to review their contribution to the research study. Once the member-checked transcription was returned to me, I analyzed the data to identify pertinent themes (see Percy et al., 2015). These themes were classified as aspects of the participants' experience. This task was performed manually to organize themes and keywords (Kahlke, 2014).

Issues of Trustworthiness

One way to address the problems of trustworthiness within this research study was to secure informed consent. Signed consent forms were obtained from each participant before the onset of the interview. Each participant was informed that their participation was entirely voluntary and would not impact employment. The informed consent included my contact information, disclosure of confidentiality, benefits and risks of participating in the study, the purpose of the study, written permission to audio-record, and the right to withdraw from participating. To ensure privacy and security, each consent form was maintained in a lockbox for which only I have the key.

Credibility

Credibility reflects the truthfulness of the study's findings, such as the data collected from interview responses, notes, and recordings from participants (Anney, 2014). To eliminate biases that could affect this research, I used the reflexivity technique

to prevent personal biases and beliefs and to maintain self- awareness about my role in the process to avoid preconceived assumptions (Korstjens & Moser, 2018). Credibility was maintained by comparing the transcribed interview responses with interview questions, member checking to share with participants the transcripts of their interview, and interpretation (Hongjing & Hitchback, 2018). Member checking and interpretation was accomplished by sending each participant a PDF copy of their transcribed interview to review for accuracy. In the email, each participant was asked to review the transcript and determine whether my interpretation seems representative of their perspective and experience (Anney, 2014).

Transferability

Anney (2014) defined transferability as the level at which research is transferred in context and explain the construct for similar data sources. Overall, this study was conducted in the central region of Virginia, where participants are employed as in-home counselors serving at-risk children and adolescents. Participants were recruited from agencies providing home-based counseling. The research question and the participants' experiences can be transferable to other intensive in-home counselors treating at-risk children in different geographical areas. In this study, transferability was accomplished by providing a full description of the participant's experience, writing notes from the interview, and recording the conversation to develop reliable reports (Korstjens & Moser, 2018).

Dependability

The importance of details in the data collection procedures (interviews), and the study is repeated across time, conditions, and cultures to gain the same results will show the study's dependability. Dependability was provided in this study by documenting all aspects of the study, including interview dates, time, and responses. Dependability was established by looking for mistakes made in collecting the data and interpreting the findings. Participants were allowed to evaluate the findings (Korstjens & Moser, 2018). Each study participant was provided a PDF copy of their interview approximately two weeks after the meeting via email to evaluate dependability.

Confirmability

Confirmability is known as an audit trail (Korstjens & Moser, 2018). An audit trail validates the findings' truthfulness and is a way to synthesize the data (Miles et al., 2014). Confirmability in research is the acceptance and accuracy of the study's results reflected by the participants (Anney, 2014). I ensured confirmability by being responsible for providing findings of the audio-recorded interviews and interview notes managing the data.

Ethical Procedures

Ethical practices included informing participants of confidentiality and explaining that their identity cannot be determined from anything said during the interview. Further, I explained that confidentiality will be established through assigning participants a pseudonym rather than using their names in the research study. Confidentiality was also completed by informing each participant what will and will not be done with the

information that is shared (Grossoehme, 2014). Within this research study, I did not reveal the participant's actual identity and pseudo names were provided. Informed consent was obtained from each participant before recording their voices for data collection (APA, 2018). Other ethical considerations practiced was that I did not conduct interviews until the Walden University IRB had granted approval. After IRB approval, each participant was provided the informed consent letter explaining the study's purpose and informed that all responses are confidential. I discussed with each participant that all written and recorded notes will be secured under the Health Insurance Portability and Accountability Act (HIPAA). The participant's information remains secured under a password-protected flash drive for a minimum of five years and kept in a lockbox, of which I am the only person with a key. After such a timeframe, the information will be destroyed (Lustgarten, 2015).

Summary

In Chapter 3, the research methods to complete this study was discussed. The essential components of Chapter 3 included the research strategy for answering the research question, data collection procedures, and analysis. Additionally, the description and explanation of the data procedures, the role of the researcher, and the sampling criterion for selecting participants for the study were disclosed. Chapter 3 entailed a detailed description of the intended data analysis plan, strategies to demonstrate trustworthiness, and ethical considerations. Chapter 4 discusses the study's findings from the data obtained from the participants' interviews and recorded conversations.

Chapter 4: Research Findings

The purpose of this generic qualitative study was to explore the experiences and perceptions of intensive in-home counselors when providing in-home services to children. The target population chosen for this study were masters level practitioners with degrees in a variety of fields under social and behavioral sciences who provided in-home counseling services to children. This study focused on the detailed experiences of counseling inside the home setting and each counselor's perceptions regarding vicarious trauma. The primary research question was as follows: What are the perceptions and experiences of intensive in-home counselors with regard to vicarious trauma?

During the interview, participants provided details of their experiences when working in the home setting. The discussions identified situations that generated an in-depth understanding of the research topic, which contributed to the emergence of seven themes under five categories. The findings of this chapter are focused on the research setting, demographics, data collection, trustworthiness of the data, data analysis, and results of the data. Each interview was completed virtually under my personal Zoom account which is HIPAA compliant.

Research Setting

Due to the COVID-19 pandemic, all interviews were conducted by via the Zoom videoconferencing platform. All interviews were conducted in my private practice office that has a sound machine located outside the door to maintain internal privacy. To my knowledge, all participants were interviewed alone in a private location of their choice. Two participants were interviewed in an office setting at their work location. The other

participants were interviewed in a home setting. Although the participants agreed to a 60-minute interview, many of the interviews were completed within 30–45 minutes.

Description of Participants and Demographics

A total of 12 participants volunteered for this study, but two did not meet the inclusion criteria. The participants in this study consisted of 10 master's level counselors. Nine of the participants were female, and one participant was male. Their ages ranged from 31 to 62 years. Each participant identified as Black/African American with a range of 1–10 years of experience as an intensive in-home counselor. Four of the participants (three females, one male) provided in-home services on a part-time basis due to being employed full-time in other social and behavioral health agencies. The participants described their educational backgrounds in clinical psychology, marriage and family counseling, educational psychology, professional counseling, and clinical health psychology. In adherence with the confidentiality outlined in the consent form, each participant has been provided a pseudonym (see Table 1).

Table 1

Participants in this Study

Pseudonym	Ethnicity/race	Age	Degree type/concentration	Years in-home counseling
Dave	African-American	59	MA-Educational Psychology	2
Eve	African-American	33	MA-Human Services	8
Raine	African-American	50	MA-Professional Counseling	1
Marian	African-American	50	MA-Marriage & Family	4
Amy	African-American	32	MA-Clinical Psychology	4
Renee	African-American	62	MA-Marriage & Family	7
Brittany	African-American	35	MA-Clinical Psychology	3
Trisha	African-American	41	MA-Marriage & Family	10
Sarah	African-American	31	MA-Clinical Health Psychology	3
Maggie	African-American	35	MA-Clinical Psychology	2

Data Collection

After receiving approval from Walden University’s IRB (Approval No. 08-09-21-0337663), I proceeded with participant selection and data collection. Due to COVID-19 restrictions, I emailed several agencies requesting permission to recruit through the use of flyers. I received letters of agreement from four agencies. In addition to this method, I placed flyers on the doors of five other community and family service agencies. I also received permission from Walden’s research center to post my study on the Walden participant pool to recruit study participants. The participants contacted me by both email

and telephone. I emailed each participant the informed consent form, and one participant signed giving her consent. The others responded back to my email stating “I consent.”

The data collection process included Zoom interviews with these 10 participants. Each interview was digitally recorded on the Zoom platform. Depending on the participant’s discussion of their experience and the depth of their responses, the interviews ranged between 30 and 60 minutes. After each interview, I listened to the recordings and began the transcription process. I sent each participant a PDF copy of the hand-transcribed recording to their email address. All participants agreed to the transcript by responding through email. Once the transcriptions were reviewed by the participants for accuracy, I read through each transcript and highlighted similarities in words and phrases to compare what the participants were reporting as it related to the research question.

Data Analysis

Within this generic qualitative study, the data were hand coded using both descriptive and in vivo coding. Coding was used to identify the participants’ descriptive perceptions and experiences. Williams and Moser (2019) explained that words, phrases, and patterns are used to develop themes in the data. Likewise, hand coding offered flexibility and was beneficial when the subject of analysis focuses on a social issue (Nelson et.al., 2021). Williams and Moser (2019) found that when using in vivo coding, the transcribed data are generated from the research question, and this method makes use of the participants’ literal words to turn them into an actual code rather than my interpretation. In-vivo coding method was used to organize and categorize the data. Data

were organized using sticky notes and colored pens. Utilizing this system made it easier to identify experiences and perceptions of the participants. Lastly, I used a reflective journal to help me keep track of my personal thoughts and participants' reactions during the interview process.

Results

In my data collection and analysis, I did note that only one participant seemed to have suffered vicarious trauma based on the definition and my assessment of her experiences. In Chapters 1 and 3, I described my population and selection criteria. Previous researchers had described instances of vicarious trauma among counselors. There was a gap in the literature with respect to understanding experiences of vicarious trauma among in-home counselors. As there is no way to clinically assess vicarious trauma prior to an interview and to use as a selection criterion, I did not and could not use this as a selection criterion for my participants. I aimed to explore counselors' experiences providing in-home care and understand instances of vicarious trauma for those who had experienced it. My first conclusion is that most of the counselors did not experience vicarious trauma.

The inductive approach was used to create the codes. I completed this process by reviewing the data line by line, looking for words and phrase patterns from the responses. Next, I created code labels. Some examples of the code labels created are as follows: assisting, success, safety, travel, worry, sadness, anxiety, self-care, and supervision. The categories and themes were derived from the responses provided by the participants. The following five categories were used to establish the themes developed from the

participants' responses to the interview questions: (a) perception of intensive in-home counseling, (b) positive intensive in-home experiences, (c), challenging experience to intensive in-home counseling, (d) emotional experiences, (e) coping strategies to manage the emotional impact of intensive in-home counseling. From these categories, I drew several themes:

1. Most counselors did not experience vicarious trauma.
2. Ability to assist families is key to success.
3. Personal gratification comes from experiencing successful outcomes.
4. Unreasonable work demands and resistant clients can lead to experiences of anxiety and worry.
5. It is easy to develop an attachment to clients.
6. Self-care techniques can help mitigate negative personal outcomes.
7. Maintaining a level of professionalism as a coping strategy.

Each participant discussed reasons they became an intensive in-home counselor. The primary theme that emerged was the ability to assist families.

Theme 1: Most Counselors Did Not Experience Vicarious Trauma

Although only the one participant indicated experiences of vicarious trauma, it is still important to understand and summarize the experiences and perceptions that these counselors *did* have, though many did not extend to the severity or implications of vicarious trauma. At times, there are factors occurring in the home that might place a counselor at risk for vicarious trauma. Each of the participants were asked if, from their

experience, there would be any factors occurring in the in-home profession that might put them at risk for developing vicarious trauma. Sarah stated,

> I was traumatized two months ago. I did not want to see my client for a little while after that because their trauma had been similar in some ways, and then the way I escaped my trauma was by telling my attacker that I had to be at work. I need to get to work, and that was that client I had to go see. So, my trauma is connected to their trauma in certain ways, and I didn't want to see them because I knew that I could not handle hearing about their trauma at that time.

Sarah described a separate incident and explained being physically attacked in the home by a client's sibling:

> I don't even think she knew what she was doing. But she was like trying to grab my stuff, and I'm holding on to it because if I let it go, she's gonna fall into a Christmas tree, and so she's like grabbing like kind of my arm different ways. I ended up having an arm wrist injury and had to do casting for a while, then physical therapy and stuff.

Whether it is through hearing clients' narratives of abuse or contending with one's reminders of traumas, trainees and experienced clinicians alike are exposed to emotionally demanding work (Ellis et al., 2019). Unlike Sarah's experience, the other participants did not perceive any risk that exposes them to vicarious trauma, but they identified other situations that might warrant exposure, such as the counselor experiencing someone that commits suicide in front of them in the home or maybe witnessing physical abuse in the home.

Theme 2: Ability to Assist Families is Key to Success

The participants were asked to share some of the reasons they became an intensive in-home counselor. Seven out of 10 participants identified that assisting families was a reason they pursued intensive counseling as a career. According to Marian,

> I love helping people and then, I love working with children as well. I try to give them some guidance, you know, some leadership. But that's mainly the reason. Sometimes kids find it difficult to talk to parents…basically, parents saying that they see the change in the child.

Similarly, Dave stated that he became an in-home counselor because it was important for him to "try to help the parents to figure out what techniques they can use to help their child." Brittany added that she became an intensive in-home counselor because of the positive experience as she stated, "I have seen people like transition. I have seen people say that this really helped me." Amy also discussed the need to assist families:

> I feel like most of the time people are really trying to access these services and they want a lot of convenience. Because for example, if someone has been undergoing trauma, and she's afraid of going out. You know, since she is not being able to like go for this appointment very often, so when I sacrificed myself and decide it's an in- home thing.

Likewise, Brittany explained,

> First, it's because later you'll be able to reach so many people. Second, it's because there's some people who really need these services, but they're not able

> to access them either due to fear or either because of their situation. And others feel like when you're going to a psychologist office, it's very expensive, so I wanted to do away with that notion.

Maggie shared her reasons for becoming an in-home counselor: "I felt like that was a niche that wasn't being filled very well, like getting counselors for younger children is also a challenge. Growing up we didn't have that. I didn't see that. So, I basically opted to join." Renee commented that her current working experience with the Department of Social Services was the reason she wanted pursue intensive in-home and to work with the families. She explained,

> I see so many kids that need in-home counseling. The kids need this because there is so much going on with all this bullying stuff. So, kids really need someone they feel like they can open up and talk to prior to family and parents.

Finally, Raine, explained,

> I wanted to get kind of an outlook on working with families and also clients that were having issues. So basically, assisting families in the home and finding better ways for them to learn skills to work with their child.

In other words, supporting the families and promoting parental involvement though skill teaching was essential to a successful outcome.

Theme 3: Personal Gratification Comes From Experiencing Successful Outcomes

The participants were asked what the most positive experiences in providing intensive in-home counseling had been. The themes that emerged from this question were personal gratification and experiencing successful outcomes. Five out of 10 participants

identified that personal gratification was the positive experience of providing in-home counseling. Raine discussed the experience of

> getting the feedback from the parents when they realize the stuff you suggest to them that work, and they see better behaviors from the child. Just the gratification of seeing the change in the client and also the parent realizing, ok, some of the stuff you suggest do work.

Trisha spoke some of her clients being in and out of services and shared how gratifying it can be seeing her clients make progress. As she stated, “just watching them grow and sometimes they master certain goals and objectives and sometimes they need more services in order to master others.” Finally, Brittany shared how rewarding it is to see her clients make the transition and people saying to her, “this really helped me.” In other words, this participant found gratification through the words of her clients. They acknowledged her for assisting them in overcoming challenging situations and the result was a positive change.

Six out of 10 participants identified that experiencing successful client progress was the positive experience of providing intensive in-home counseling. Dave agreed that successful outcomes are important. He explained,

> Some of the positives were seeing some growth, and how their relationship with their parents sometimes improved and working with their parents to show them some different techniques to help her or him with solving some of the frustrations with their child.

Marian offered a similar perspective as she discussed her positive in-home experience:

> That parents tell me that they see a change in their child, or kids tell me that they appreciate me coming and, talking to ‘em, helping them work through issues that they normally wouldn’t, or they felt they couldn’t get through.

Lastly, Renee discussed her experience of a successful outcome:

> I had a little girl that ... She … I was with her for about a year and a half and she got adopted to a permanent home and that really made me felt good because I felt like some of my counseling skills helped her to overcome her obstacles so she could get adopted by someone.

Renee’s experience seemed to suggests that gratification was achieved in her work by knowing that she assisted her client in establishing some form of stability necessary for a meaningful adoptive relationship.

Theme 4: Unreasonable Work Demands and Resistant Clients Can Lead to Experiences of Anxiety and Worry

The participants acknowledged that there are challenges and struggles associated with providing intensive in-home. The participants were asked what have been their challenging experience in providing in-home counseling. The participants offered a wide variety of challenges, but the dominant themes were unreasonable work demands and experiencing leading to anxiety and worry. Five participants identified unreasonable work demands. For example, Sarah stated,

> When I first started, which is the reason why I didn’t last long, I lasted six months the first time around, I had a client in one area, then another client was an hour away and had a third client that was another like 30 minutes or 40 minutes away

> and I was expected to work like every day so I could meet the needs, and I was like no.

Brittany also shared Sarah's view and discussed, "at times, you'll have to go to people who are a bit far away, which is a bit expensive." Marian provided details to the situations she determined unreasonable such as

> Some parents don't understand that I'm there as a mental health counselor. Like, I'm not the tutor, I'm not the big sister. So, I'm not the taxi cab, I'm not the bank. … the area that I'm in, I know a lot of people, so they try to use that to their advantage.

Five of the participants identified that they experience resistance from clients when providing in-home counseling. Renee discussed her experience with a female client and feeling ineffective: "She was afraid of everybody, and working with her one on one, you just couldn't get her to open up or really tell you how she was feeling." Renee further stated, "I think she had mainly been molested or something and she was just withdrawn from everyone." Brittany also discussed her experience of commuting to perform intensive in-home counseling and enduring a client who was not cooperative. She explained, "Sometimes you'll have terrible clients and they are not able to be very receptive." Lastly, Sarah explained that her experience has been that "A lot of families, you know, they want in-home, but they aren't really willing to change themselves, or they're not engaged in the process, Uhm, you implement things and then they don't follow through with it." Sarah's statements seemed to imply that at times, some families

vacillate in their dedication, which makes it difficult to work with families who fail in their commitment to the therapeutic process.

In response to the emotional impact associated with intensive in-home counseling, all participants discussed being emotionally affected in some manner. Five participants expressed feeling anxious and worried during their in-home experience. Trisha discussed feeling uncomfortable when there are too many people or when there is a male in the home. She stated, “I’ve experienced anxiety and had to kind of set up a different situation to meet the client somewhere.” Sarah explained feeling anxious when she was physically attacked during an in-home session by her client’s 5-year-old sister, resulting in an injury to her wrist that required casting, and physical therapy. Sarah discussed that while she was being attacked

> I was more so anxious, like, I don’t know what is the right decision to make. Am I not gonna get in trouble if I do this, or if I do that, and the mom is just sitting there watching it all. So, I swore, I would never do in-home again after that.

Lastly, Marian explained that she experiences anxiety when she feels her techniques are ineffective. She stated, “The anxiety that I have felt is when I actually couldn’t help somebody. I mean, when you’ve done all that you think you could have done for the person. The anxiety hits me when I can’t help them.” In other words, when Marian has felt defeated in the counseling process, and none of her interventions have shown effective, she experienced anxiety.

Theme 5: It is Easy to Develop an Attachment to Clients

Six out of 10 participants identified being emotionally attached to their in-home cases. For example, Trisha spoke of suffering grief when a client committed suicide a year ago by overdose: “It was very shocking to me and it just caught me off guard because she did not show any signs that she was depressed. She did not show any signs that she would attempt suicide.” Additionally, Marian believed she grieved when a now 15-year-old client suffered a traumatic experience at the age of 13 and 14 years old. Marian explained that this case was the saddest and most impactful because this client was a victim of sex trafficking and used all types of illicit drugs to cope. Marian shared being concerned for her client’s personal safety once the session has ended. She stated, “I meet with ‘em and as soon as I leave ‘em, I think about what are they doing now. …Like are they safe. They say you don’t get attached to them, but you really do.” Renee seemed to share in the same emotional impact as Marian. She stated, “I have gotten home and just sit there. When writing my notes all of this comes back to you, and you’re just sitting there just thinking like Lord, this poor child. What is this child probably gonna go through tonight?” It seemed that this participant is extremely concerned for the well-being of her client after the session. She is mostly impacted when completing the clinical report, and she uses her prayer as a super-natural protector.

When exploring further experiences of attachment, Renee mentioned getting emotional and feeling heartbroken while counseling a client whose parents allowed sexual abuse to occur. Similar to Renee and Marian, Trisha emphasized the attachment as she discussed details of a client diagnosed with PTSD and being molested from the age of

seven to eight. Trisha stated, “So you oftentimes take those things home to try to figure out what you can do to help that client overcome their trauma.” In other words, Trisha continues to educate herself on additional ways to support her client by researching strategies and interventions necessary to help her client overcome a traumatic experience.

Theme 6: Self-Care Techniques Can Help Mitigate Negative Personal Outcomes

The participants acknowledged that practicing coping techniques are essential to the counseling profession. Each participant was asked about coping techniques that assist them in managing the emotional experience associated with their work. The dominant themes were self-care and maintaining professionalism.

Nine out of 10 participants recognized that practicing coping techniques are essential when caring for others and when challenges exist within the in-home practice. The self-care modalities varied amongst the participants (i.e., psychotherapy, deep breathing, taking time off, and clinical supervision). Trisha discussed her coping techniques of deep breathing and also processing: “Because if you don’t process then you internalize and that can affect other cases that you have as a counselor even though we don’t oftentimes realize it. So, processing and deep breathing works for me.” Brittany explained that taking time off from work is a helpful coping strategy: “It helps me. It refreshes my mind and it gives me the right mindset when going to work as opposed to when you’re all stressed working throughout the year. It’s not productive.” Raine and Sarah mentioned seeking supervision as methods to managing challenging situations. In addition to supervision, Sarah discussed, how important self-care is when listening to the stories of her clients. She stated, “They eventually become a part of you, and no matter

how much you compartmentalize or separate from it, it still is going to affect you, so it's important to learn what it is that rejuvenates you." Sarah discussed being engaged in psychotherapy as a coping skill. She further discussed other techniques of binge-watching TV when the opportunity presents and spending a lot of time with family and friends: "A lot of that helps. That has never failed me." This evidence means that those interventions or those individuals who provide her with emotional supports are always there when she needs them.

Theme 7: Maintaining Professionalism as a Coping Strategy

All of the participants identified maintaining professionalism as a coping mechanism when performing intensive in-home counseling. Sarah offered insight into this theme and explained

> If you're doing it for the money, you're not gonna last. It's really important to be transparent with the client and the family and to build that relationship with them, and to be ethical because the family could also turn on you at any given moment.

Trisha shared that this experience has taught her not to take things personally. She explained, "Clients are gonna say things that are inappropriate. They're gonna say things that even may hurt your feelings at times, but you can't take things personal because the reason we're in the home is because they have an issue." Additionally, Marian suggested that patience with the clients is a huge component with this profession. She stated, "Be patient with your client. Be patient with the family you're working with and just keep trying different techniques." Dave explained the importance of flexibility and preparedness when working in this profession. He discussed that at times, things will not

go as planned and as a clinician, “you have to be able to adjust to their environment because you never know what will come out of the conversation with the family.” Amy concurred with Dave’s thoughts as she described her experience, “Be ready for anything. Be flexible. Be empathetic.” In other words, the participant was saying not to be complacent in the profession, be willing to walk in the client’s shoes, adjust and modify planned out sessions, and adapt to uncertainties.

Results Summary

It is important to highlight that only one participant suffered from vicarious trauma. In an attempt to understand in-home counselors’ experiences and perceptions with vicarious trauma, my main finding was largely that they do not experience it. At least, participants in my study did not. What I did summarize here was participants’ perceptions and experiences of their work and engagement with clients, though it largely did not extend to vicarious trauma. Further probing into this area of research is necessary to continue to understand the experiences of in-home counselors, especially in this environment of COVID-19.

Evidence of Trustworthiness

The participants described their experiences of working with at-risk children receiving intensive in-home services. All of the participants’ responses are credible and reflected through the truthfulness of the data source, such as the data collected from interview responses and recordings from participants (Anney, 2014). The following sections will discuss the credibility, transferability, and conformability of the study.

In this study, credibility was confirmed by comparing the audio-recorded transcribed interview responses with the interview questions. Each participant completed member checking, and interpretation was accomplished by sending each participant a copy of their interview to review for accuracy. In the email, each participant was asked to review the transcript and determine whether my interpretation seemed representative of their perspective and experience (see Anney, 2014; Hongjing & Hitchback, 2018).

Transferability of the context was accomplished by providing a full description of the participant's experience and transcribing the recording the conversation to develop reliable reports (Korstjens & Moser, 2018). The study was conducted in the United States where participants were employed as master's level intensive in-home counselors with a degree in a variety of fields under social and behavioral sciences. The research question and the participants experiences confirmed that the study's context could be transferable to comparable populations of counselors.

Dependability was presented within this study through details of the data collection process and evidence that data analysis occurred. The coding process was implemented to capture the accuracy of themes. Additionally, dependability was established by looking for mistakes made in collecting the data and interpreting the findings. All aspects of the study were documented including the interview dates and times. Participants were allowed to evaluate the findings for truthfulness (Korstjens & Moser, 2018).

Confirmability was ensured by the participant's reported personal experiences. Confirmability was achieved through acceptance and accuracy of the study's results

reflected by the participants (Anney, 2014). An audit trail was performed through synthesizing the data collected and an analysis of the interview questions that validated the findings' truthfulness (see Miles et al., 2014; Korstjens & Moser, 2018).

Discussion of the Findings

Vicarious trauma develops over time. It can develop as a result of helping clients with challenging circumstances (Boulanger, 2018). Vicarious trauma is a form of secondary trauma that produces posttraumatic symptomology of invasive and avoidant symptoms, hyperarousal, and isolation, which can have harmful effects on the counselors (APA, 2018; Foreman, 2018). The purpose of this generic qualitative research study was to develop a better understanding of the experiences and perceptions of intensive in-home counselors and situations related to the development of vicarious trauma.

All of the participants offered their perception of intensive in-home, discussed their positive and challenging experiences, reflected on the emotional aspects of this profession, and self-care techniques. Although there were aspects of the profession that impacted the participants, such as feeling sadness after an in-home session and suffering anxiety when engaged in an in-home session, many of the participants highlighted effective coping skills for example, self-care, therapy, clinical supervision, taking time off, and other methods. Sarah was the only participant who disclosed being in therapy and shared being diagnosed with ADD, anxiety disorder, insomnia and reported being prescribed medications. Many of her diagnoses were reported as historical and preintensive in-home related. Sarah stated,

> I was traumatized two months ago. I did not want to see my client for a little while after that because their trauma had been similar in some ways, and then the way I escaped my trauma was by telling my attacker that I had to be at work. I need to get to work, and that was that client I had to go see. So, my trauma is connected to their trauma in certain ways, and I didn't want to see them because I knew that I could not handle hearing about their trauma at that time.

Whether it is through hearing clients' narratives of abuse or contending with one's reminders of traumas, trainees and experienced clinicians alike are exposed to emotionally demanding work (Ellis et al., 2019).

Supportive literature explained that working with clients who have experienced trauma can negatively affect counseling professionals and place them at risk for developing vicarious trauma (Williams et al., 2012). The results of this study indicated that most of the participants did not reflect a connection to their in-home counseling to experiencing vicarious trauma.

Summary

In Chapter 4, I described how I conducted semi structured, audio-recorded interviews virtually that answered my research question. All participants engaged in the interview process and provided details of their experience as an intensive in-home counselor working with at-risk youth. The data collected answered questions regarding the participants perceptions about their ability to assist families, both positive and challenging experiences, the emotional impact, and the ways coping strategies are implemented to managing the emotional aspects of this work. A brief review of this study

is included in Chapter 5 along with interpretation, limitations, recommendations, implications for positive social change, and conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this generic qualitative study was to understand the experiences of intensive in-home counselors regarding vicarious trauma. Using semi structured interviews, virtual interviews were conducted with intensive in-home counselors aged 21 and over from diverse backgrounds, and from various social and behavioral health professions with 6 months to 5 years of in-home experience. The responses from the participants detailed an understanding of their subjective experience in providing in-home counseling services to at-risk children. The key findings in this study were as follows: (a) counselors working with at-risk youth in the home setting are exposed to professional challenges that results in various forms of emotional impact; (b) to cope with the challenges, professionals use various coping techniques; and (c) the perceptions regarding exposure to vicarious trauma varied among participants.

Interpretation of Findings

In concordance with the literature review, vicarious trauma is defined as exposure to clients' trauma and the potential negative impact on the therapeutic relationship (Branson et al., 2014). Vicarious trauma, as explained by Cosden et al. (2016), is the psychological responses of empathic engagement with survivor clients and their trauma material. It can include intrusive images, thoughts, and feelings experienced by helping professionals, which can last long after treatment has concluded (Branson, 2019). Vicarious trauma can negatively impact the counselor's well-being when performing trauma work, and it can manifest in the counselors' personal life (Branson, 2019). In some instances, it has been defined as a shared trauma among counseling professionals

and clients because the counselors may experience vicarious trauma symptoms from their work with clients (Bell & Robinson, 2013; Miller & Sprang, 2017). The findings confirmed that intensive in-home professionals encountered challenges when providing counseling in the home setting. However, they all did not experience vicarious trauma.

CSDT is a theory relevant to explaining how helpers develop vicarious trauma after exposure to traumatic stories of clients. The emotional experiences included anxiety, worry, and attachment. Previous research suggested that listening to trauma narratives is also a risk factor (Carello & Butler, 2015). The findings of my study, however, were that nine of the 10 (90%) participants in the current study reported being impacted emotionally; however, they did not consider being at risk for developing vicarious trauma. Baker (2012) asserted that many therapists might be unwilling to disclose their experience with vicarious trauma to supervisors and are in denial and have no idea how they have been affected. Although the experience of in-home counseling exposed the participants to emotional challenges, many of them provided information on ways they managed any risk of clinical impairment with coping strategies. Baker emphasized the importance of the therapists' self- care when treating traumatized clients. The importance of self-care was supported by the participants as they identified coping skills such as taking time off, clinical supervision, therapy, relaxing, maintaining professionalism, and spending time with family.

Weigand and Keeler (2014) studied how the clients' graphic disclosures can lead to symptoms of vicarious trauma. Finklestein et al. (2015) researched the phenomenon of vicarious trauma among mental health professionals and the risk factors associated with

being exposed to a client's trauma narratives such as psychological distress. The literature supported those professionals showed evidence of suffering vicarious trauma after exposure to traumatic stories and situations. Findings from the current study revealed that vicarious trauma influenced the professional work of an in-home counselor. For example, one participant acknowledged experiencing a personal trauma that impacted the ability to provide counseling services. She explained that when listening to the client's stories, they broke her, and the stories eventually became a part of her. She went on to state that, no matter how much she tried to separate from the experience, she was still affected.

Limitations of the Study

The limitations of the study specifically related to the sample size. Twelve participants showed interest in the study, but only 10 met the inclusion criteria. The study's selection criteria of focusing solely on master's level practitioners presented limitations regarding recruitment. The sample only included master's level degree in-home counselors. Additionally, there was an absence of ethnic and gender diversity. All of the participants identified as African American, and there was only one male participant. Another limitation is that the thematic analysis was completed by me versus a group of researchers. Utilizing multiple researchers might have enhanced the themes and findings. Finally, the use of teleconference software to conduct the interviews, as opposed to holding in-person interviews, limited the holistic view of body language and facial expressions as three of the participants only attended by audio.

Recommendations

This study was aimed at addressing the gap in the literature. There are several research studies conducted on mental health professionals and vicarious trauma; however, not many studies involve intensive in-home counselors. Previous research recommended further research that could lead to a better understanding of the lived experiences of counselors when providing in-home services to children in the home (Hammond & Czyszczon, 2014). The findings from this study revealed that all of the participants discussed the emotional impact of providing intensive in-home counseling, and based on the evidence, it is recommended that the in-home counselors continue to self-assess and educate themselves on the signs and symptoms of vicarious trauma and continue the practice of implementing effective coping strategies. Further, it is recommended that future researchers seek to address some of the limitations in this study, such as conducting an in-person qualitative case studies that encompasses additional ethnic groups and gender diversity which may generate other themes and findings. Finally, a quantitative approach is recommended to survey a larger population and utilize a survey to examine caseload size as a factor in developing vicarious trauma.

Implications and Social Change

This study explored the experiences and perceptions of counselors providing intensive in-home counseling to at-risk children. The findings in this study increased the awareness of the situations encountered in the home setting. The results of this study might inspire positive social change within the community of in-home professionals by encouraging more untold conversation amongst the counselors about the stories being

seen and heard that have the potential to reflect vicarious trauma in the work setting. The hope is that the discussions identify risks by promoting ways to maintain healthy therapeutic interactions. The findings of this study may be used as a resource for human service organizations to motivate transparency of the in-home experience and encourage strategies to minimize risks. The goal of this study was to fill a gap in the literature regarding the experiences of those counselors who work in the home setting. The information from this study provides pertinent details on the experiences of those clinicians who provide services to at-risk children. Several participants were enthusiastic about promoting an understanding of this experience.

Finally, the information obtained in this study offers implications for positive social change as it allowed the participants to shed light on their experiences through personal accounts. Through the shared experiences of their work inside the homes of at-risk children, they will continue to inspire social change as contributors in the communities they serve. Additionally, the findings of this study contribute to the existing body of literature and may continue to influence policy changes for intensive in-home standards, such as manageable caseload, an increase in clinical supervision, and ongoing clinical training to recognize vicarious trauma as a skill set needed in this profession.

Conclusion

This study explored the experiences and perceptions of intensive in-home counselors. The detailed discussions helped me understand situations occurring in the home that might place these professionals at risk for developing vicarious trauma. An analysis of their individual experiences revealed that although there is potential exposure,

the participants have found ways to manage risk to vicarious trauma. The findings from this qualitative study helped to close the gap in the literature. It addressed the experiences of these10 intensive in-home counselors. The participants in this study discussed being confronted with many situations during the in-home process, and what is clearer to me is that although minimal in number, the counselors did not perceive their work as being associated with the development of vicarious trauma.

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Appendix: Interview Guide

Interview Questionnaire

Introduction

Hi **________**, thank you for accepting my invitation to meet today. My name is Tara Ross, and I am a doctoral student at Walden University, researching the social phenomenon of vicarious trauma among counselors providing intensive in-home counseling. Also, I want to extend a thank you for completing and signing the informed consent form(s) today and thank you for agreeing to participate in this study. Today's interview will take about 30-60 minutes and will include 17 questions regarding your perception and experiences as an in-home counselor and vicarious trauma. I would like your permission to tape-record this interview so that I may accurately document the information. If you wish to discontinue the use of the recorder or the interview itself, at any time during the interview, please feel free to inform me. All of your responses are confidential. Your responses will forever remain confidential, providing there isn't evidence of illegal activity and/or proof of abuse or neglect. The purpose of this study is to develop a better understanding of the real-life experiences and perceptions of intensive in-home counselors and explore situations occurring in the home that might places counselors at risk of developing vicarious trauma.

For clarification, you have consented, certifying the agreement of this interview. Although you have consented to this interview, your participation in this interview is completely voluntary. If you need to discontinue this process or take a brief break, please feel comfortable letting me know. You may also withdraw your participation at any time

without consequence. After this interview and within 24 hours, you will receive one copy of the interview questions and transcript to review for accuracy. I will keep the original in a secure file, separate from your responses. There is a chance the findings of this study may be published; however, there will not be any information that can identify you as a participant in this study as you will be assigned a pseudo name. Do you have any questions or concerns about your privacy or confidentiality of the date before we begin? Then with your permission, it's ___________am/pm, may we begin the interview.

Demographic Information

What is your age? (Optional response)

What is your race? (Optional response)

What is your Ethnicity? (Optional response)

What are your Credentials?

What is your Master's Degree concentration- Counseling, Marriage and Family Counseling, Social Work, and other related counseling degrees?

The Number of Years in Practice?

Interview Questions

1. Can you tell me about your client population?
2. Can you share with me some of the reasons you become an intensive in-home counselor?
3. What have been your positive experiences in providing intensive in-home counseling?

4. What have been your challenging experiences in providing intensive in-home counseling?
5. In what ways have you been emotionally affected when listening to the client’s issues or problems?
6. Please share with me a time you have thoughts about a clients’ trauma when you were not at work.
7. Tell me about a time you felt any level of grief when working with a client?
8. What experiences have you had with feelings of anxiety while engaged in-home counseling session?
9. Tell me about a time you felt sadness after an in-home session with your clients?
10. Can you share with me a time you wanted to avoid an in-home client who had experienced trauma?
11. Tell me about your experience with constantly thinking about the trauma experienced by a client.
12. Tell me about a time you experienced difficulty sleeping after an in-home counseling session with a client.
13. What experiences have you had with difficulty concentrating on other tasks after an in-home counseling session?
14. When you experience these types of feelings, what do you do to manage them?
15. How does your technique(s) help, and for how long?
16. From your experience would there be any factors occurring in the in-home profession that might put you at risk for developing vicarious trauma?

17. When performing counseling in the home, tell me something you believe future counselors need to know about this experience?
18. Tell me about anything else you think I should know to understand your experience and perception as an in-home counselor.

Closing: I appreciate you taking time out of your busy schedule to participate in this study. Your role as a counseling professional is crucial. Before we conclude, is there anything else you would like to add? Again, my name is Tara Ross, and I am the responsible researcher. If, after this interview, you have any questions concerning the research, please contact me at 434-xxx-xxxx We will meet again at a time convenient for you____________________(date/time) to review your interview information to make sure it is correct.

Appendix B: Letter to Agency with Flyer

Dear Agency Director or Clinical Supervisor,

My name is Tara Ross, and I am a doctoral candidate in Human Services with Walden University. I am contacting you to obtain your permission to post a flyer at your agency to seek volunteers for a dissertation study (See Attachment)

The focus of my study is Intensive In-Home clinicians. The purpose of this study is not to gather information about the content of the sessions, therapeutic outcomes, therapeutic modalities, or anything related to therapy skills. Instead, this dissertation study will focus on how the In-Home Clinician makes sense of the perceptions and experience of vicarious trauma when there is exposure to factors that might potentially elicit vicarious trauma, such as client trauma, personal safety, family violence, family poverty, and child abuse when providing services inside the home setting.

I would like to conduct a face-to-face interview or video conference with Intensive In-home staff to learn more about their experiences. The interview will take between 30 to 60 minutes. As a licensed clinician and doctoral student, I am aware of the ethical mandates to protect client identity, to do no harm, to elicit voluntary engagement from potential participants', and the need to ensure study participants' engagement without coercion. I assure you that all precautions will be implemented to protect each participants' identity, the name of your agency, and any data linkable to any participants' identity by using pseudo names. Additionally, I will follow all of Walden University's Institutional Review Board (IRB) criteria for ethical recruitment and treatment of study participants. A copy of the study's informed consent is attached to this letter for your reference as well.

Once I have transcribed the interview, I will ask each participant to check the transcript for accuracy and to participate in a member check. This means that they agree to review my interpretations of the interview to make sure that an accurate meaning was extracted.

I am grateful for your time and consideration. I hope you will be able to accept my invitation and allow me to post a flyer at your agency (See Attachment). Volunteers interested in participating in this study may contact me by phone or e-mail within the next seven days to confirm their willingness to participate. Once I receive a response, I will schedule the interview and will do my best to accommodate any volunteer's schedule.

Sincerely,
Tara Ross, MA, LPC
Walden University
Doctoral Student in Human Services

See Attachment

Attachment

Master's Level Participants with A Degree in Human Services Needed for A Dissertation Research Study

Exploring Children Intensive In-Home Counselors Perceptions and Experiences of Vicarious Trauma

Description of Research: This research is part of a Walden University dissertation project that seeks to understand your experiences regarding Vicarious Trauma.

Your participation in this study is entirely voluntary and confidential. Each participant will receive a Thank You Card & $10 Amazon Gift / E-Card for their time and assistance.

To learn more, contact the Researcher of the study, Tara Ross, at Walden University.

This research is conducted under the direction of Dr. Tracey Phillips, Dissertation Chair, Walden University at ________________

This research study has been reviewed and approved by Walden University Institutional Review Board. If you have concerns regarding this study or questions regarding your rights as a study participant, please contact The Walden University Research Participant Advocate at 612-312-1210. ***PLEASE RESPOND BY: SEPTEMBER 30, 2021.***