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Post-print. *Family Journal: Counseling and Therapy for Couples and Families*, Volume 18, No. 2 (April 2010), DOI: 10.1177/1066480710364316. Used with permission.

Home-Based Therapy for Young Children in Low-Income Families: A Student Training Program

By Ryan J. Mattek, Elizabeth T. Jorgenson, and Robert A. Fox

The purpose of this project was to develop an internship training program that offered in-home therapy for young children with significant emotional and behavior problems. The children lived in single-parent, low-income homes in unsafe neighborhoods of a large, urban area. A year-long, training and supervision program was implemented with 10 second-year, graduate students enrolled in 5 different university programs that prepared mental health professionals. Students received specialized instruction in working with diverse families living in poverty and in an evidence-based treatment program. They initially observed veteran counselors implementing the treatment program in homes and gradually assumed responsibility for conducting sessions on their own. Students' scores on a measure of counseling self-efficacy improved significantly from pre-to post-internship. Students reported high levels of satisfaction with the training program and significantly improved confidence levels in their counseling skills at the conclusion of their internship experience. The limitations of these preliminary outcomes for this pilot program are discussed along with the need for more research in this understudied area.

Internships are the traditional vehicle for providing supervised, hands-on experiences for students in graduate training programs in the mental health field. This training is designed to refine student skills in listening, reflecting clients' feelings, implementing established diagnostic, assessment, and treatment practices, clinical writing, identifying and correcting professional weaknesses, and working with diverse client groups (Bradley & Fiorini, 1999). Normally, students must obtain approximately 600 hr of supervised clinical experiences over two semesters as an internship requirement of their master's program in counseling. Typical internship settings include community mental health clinics, university counseling centers, hospitals, inpatient psychiatric settings, and substance abuse centers (Brems & Johnson, 1996). In addition to these traditional mental health settings, graduate students can also receive supervision and training experiences through unconventional settings such as in-home family therapy programs (Yorgason, McWey, & Felts, 2005).

There are a number of advantages to using in-home therapy, particularly for families living in poverty. Home-based therapy eliminates some of the barriers to conventional office-based treatment faced by low-income families such as a lack of transportation or an

inability to find childcare (Woods, 1988). Evidence suggests that families receiving home-based instead of office-based services have higher attendance rates and are more engaged in treatment (Slesnick & Prestopnik, 2004). In addition, by providing services in the family's everyday environment, the clinician is more likely to get an accurate picture of how family members interact (Woods, 1988).

However, there are inherent challenges to in-home therapy, which can make it a less-than-desirable environment for training. For example, the clinician may become more involved with the entire family and community, creating potential boundary issues and anxiety over the clinician's role (Stinchfield, 2004). Additionally, there are distractions in the home, which can make it more difficult to manage sessions (Snyder & McCollum, 1999) and there may be potential safety concerns for clinicians entering homes to do treatment in unsafe neighborhoods (Adams & Maynard, 2000). These difficulties represent potential obstacles for any mental health professional and can be especially daunting for students.

There currently is a paucity of literature to guide internship programs that include home-based therapy as one of their training options for students. Snyder and McCollum (1999) conducted a qualitative study of the personal experiences of three master's-level therapist interns who were learning to provide in-home therapy to families after having been previously trained in a clinic setting. The interns used a solution-focused therapy model and worked with low-income families concerned with their child's behavior problems. The interns reported feeling an increase in anxiety and a decrease in confidence due to the limited applicability of their clinic-based training. Additionally, the interns reported struggling to reconcile their existing clinic-based views of the therapeutic relationship (e.g., boundaries, confidentiality, and timing) with the reality of working in the clients' homes. Adapting to being on the client's ''turf,'' accepting the fact that the session may feel out of their control at times, dealing with other individuals overhearing or interrupting a session, and establishing a realistic expectation for session pacing and timing were experiences that the interns felt unprepared for as a result of their clinic-based training and experience. However, all the interns reported that over time they began to redefine their concept of therapy, develop new strategies to manage challenges, and accept the unique difficulties of providing home-based therapy.

Likewise, Christensen (1995) conducted a study in which 10 family therapists from a clinic setting discussed their experiences implementing family preservation services in the home. The therapists reported that they felt ineffective in providing in-home therapy as their training had been geared toward therapy in a clinic setting. This clinic-based training did not equip the therapists to address home-based issues such as dangerous clients (e.g., a client's abusive

boyfriend who makes a pass at the therapist), safety precautions (e.g., traveling in pairs, not going into the house of a sex offender alone), and unexpected distractions (e.g., visitors, phone calls, and television). Furthermore, most of the therapists in this study reported feeling both ineffective and dissatisfied due to these inherent challenges of working in the home. The author acknowledged the difficulty of providing in-home therapy and suggested that specialized training should be provided to supervisors and to therapists to address the unique issues that may arise in such an environment.

Lawson and Foster (2005) conducted a study investigating the ego development, the conceptual complexity, and the supervisor satisfaction of 120 home-based counselors. The authors found that the nature of home-based therapy (e.g., highly unstructured environments, numerous and simultaneous cognitive and interpersonal strains) demanded more in terms of ego and conceptual development from counselors in a home setting than from counselors in a clinic-or a school-based setting. The authors suggested that these higher demands warrant specialized training to prepare counselors for the unique challenges of in-home counseling. Furthermore, the study found that most in-home counselors felt undersupervised and under-supported. Working in such settings puts counselors in the homes of the most severely troubled families in the community and also assigns them the task of coordinating treatment among multiple services agencies. Counselors who felt that they were receiving good supervision (26%) saw strengths in their clients more so than weaknesses and were better able to establish rapport and help them navigate the community services networks. Counselors who felt dissatisfied with their supervision (74%) tended to see their clients as laden with problems and were less likely to effectively collaborate with the family and outside agencies. The authors posited that specialized training and enhanced supervision were necessary for in-home counselors to develop and subsequently provide more effective services to families.

When reviewing the literature regarding counselors' experiences doing in-home therapy, four themes emerged: (a) doing in-home therapy was especially challenging and demanding (Christensen, 1995; Lawson & Foster, 2005; Snyder & McCollum, 1999); (b) counselors trained to do clinic-or school-based therapy often felt ineffective and unprepared to do in-home therapy (Christensen, 1995; Snyder & McCollum, 1999); (c) rigorous and specialized training was recommended to equip counselors for the unique challenges of in-home therapy (Christensen, 1995; Cortes, 2004; Lawson & Foster, 2005); and (d) regular supervision can positively affect a counselor's experience in a home-based setting (Lawson & Foster, 2005). Yet, despite a clear call for specialized training programs that have consistent and high-quality supervision, the current literature contains no clear description of what such a program might look like (Cortes,

2004). More research is needed to explore models for preparing and training students for the unique challenges of doing therapy in the home.

The purpose of this project was to develop a year-long training program for graduate-level internship students conducting in-home therapy with young children with significant behavior and emotional problems from low-income families in a large urban area. This article describes the training program that incorporated important elements identified in the literature (e.g., need for specialized training beyond that provided in traditional clinic-based, graduate programs; provision of regular and high-quality supervision). In addition, preliminary data were collected from the participating students to assess their professional growth and satisfaction with an internship experience using home-based therapy.

Student Training Program

Participants

Participants included 10 students who were beginning their second year of a graduate program in community counseling. As part of their program requirements, students were required to complete two consecutive semesters of supervised internship in a community-based clinic. These 10 students were from 5 different university programs and chose to meet their internship requirements through a clinic offering specialized, in-home therapy for young children and their families. These programs offered similar classes during the first year (e.g., personality theory, development, research methods, individual counseling, and ethics) and no programs required any face-to-face contact with clients during that time frame. The internship included a specialized and comprehensive training program in conducting home-based therapy with young children and required a time commitment of 20 hr each week for a total of 600 hr for the academic year. In addition to providing direct clinical services to the children and their families, students were required to participate in weekly individual and group supervision sessions for 1 hr each. Moreover, ongoing consultation with staff on clients was always available and routinely provided. Students also attended a separate weekly internship seminar at their local institutions. Of the 10 participants, 9 were female and ages ranged from 23 to 34 (M = 25.50, SD = 3.31). Nine of the participants were Caucasian and one was Hispanic.

Behavior Clinic

The Behavior Clinic provides in-home mental health services for children less than 5 years of age with significant emotional and behavior problems that often are complicated by developmental delays (Fox, Keller, Grede, & Bartosz, 2007). The clinic is housed within a

community-based, Birth-to-Three agency that provides a variety of clinical services (e.g., speech therapy, physical and occupational therapy, and special education) for a culturally diverse population of children, the majority of whom come from families who live below the poverty level (95%). The agency serves over 1,400 children each year in a large, urban city in the Midwest. Children are referred to the Behavior Clinic for behaviors such as severe tantrums, destructiveness, aggression, oppositional behaviors, and less frequently for internalizing behaviors such as separation anxiety and reactive attachment disorders. Children who completed services from the clinic during this study ranged in age from 1 to 5 years (*M* = 2.66 years, *SD* = 0.74 years) and 70% met criteria for a developmental delay. Primary caretakers of the children were typically their biological mothers (84%), 62% of whom were unmarried, most of which had less than a high school education (*M* years in school = 11.92, *SD* = 2.59), and 84% of whom were receiving one or more sources of public assistance indicating that their income fell below the federal poverty level (Fox & Holtz, 2009).

Clinic's in-home therapy model. The clinic used child management therapy (CMT) with the families to affect positive changes in their children's behaviors (Eyberg, Nelson, & Boggs, 2008). An evidence-based, child management program designed specifically for parents of very young children (Fox & Nicholson, 2003) was used and included five components: (a) nondirective play to strengthen the parent–child relationship; (b) teaching parents to thoughtfully interact instead of emotionally overreacting to their child's challenging behaviors; (c) teaching parents to establish appropriate developmental expectations for their children; (d) increasing the child's prosocial development through the use of strategies such as positive reinforcement, establishing home routines, and giving clear, appropriate instructions; and (e) reducing the child's challenging behaviors through the use of limit-setting techniques such as redirection, ignoring, natural consequences, and time-out. Within the context of the CMT program, each parent was provided with a treatment plan developed specifically to meet their child's needs. Treatment plans included two goals identified by the parent and clinician: (a) increasing a specific prosocial behavior such as listening and (b) decreasing a specific challenging behavior such as severe temper tantrums or physical aggression. Plans outlined the strategies to be used to meet these goals. For example, a treatment plan focusing on using time-out to decrease physically aggressive behaviors included a step-by-step, time-out procedure for the parent to follow. The student explained and modeled all of the treatment techniques for the parent and provided any materials necessary for treatment such as instructional handouts, child rewards (e.g., stickers or fruit snacks), and child safety gates for time-out. At the end of each session, the

parent received a behavior plan that outlined specific steps of the treatment plan to practice before the next session. The behavior plan might list items such as (a) play with your child for 15 min every day after lunch; (b) give your child five simple requests throughout the day such as ‘‘put on your coat’’ or ‘‘give me the toy’’ and follow with an immediate edible reward and praise; and (c) give your child a 2-min time-out every time they hit their little sister. The plan included space for the parent to indicate whether each step was implemented every day. Treatment sessions also included a parent coaching component during which the parent practiced the treatment techniques while the clinician observed and provided immediate feedback. Treatment sessions typically lasted from 60 to 90 min. Families who completed the CMT program participated in an average of 12.76 weekly, in-home sessions (*SD* = 5.30) over a mean of 4.91 months (*SD* = 2.57), with an average attendance rate of 79.2% (*SD* = 14.99; Fox & Holtz, 2009).

Student internship training program. Students began their internship at the Behavior Clinic with varying degrees of experience with children and parents. However, because of the unique population (i.e., children with severe behavior problems from families living in poverty), the unique setting (i.e., in-home therapy in unsafe neighborhoods), and the unique demands placed upon clinicians (i.e., handling multiple distractions in session, working with multiple caregivers/extended families, knowing when to leave an unsafe situation, or dealing with frequent cancellations), all students underwent the same rigorous and specialized training program at the Behavior Clinic. Students received training in three modules: (a) information on working with diverse families of young children who live in poverty and on maintaining personal safety when working in an unsafe urban setting; (b) early child development knowledge and clinical skills needed for interacting with young children such as following the child’s lead during play; and (c) evidence-based treatment procedures and data collection. Students received 20 hr of didactic instruction that included information on poverty, working with diverse cultures, and early child normal and abnormal development, the theoretical underpinnings and therapy procedures comprising the CMT program, and training videotapes of veteran clinicians implementing the CMT program with children and their families. Additionally, students were given the opportunity to practice the required skills in simulated exercises with other clinicians. Students were also required to spend a few hours each week for 4 weeks interacting with young children in special therapy classrooms in the Birth-to-Three Agency that housed the Behavior Clinic. This component was included to increase students’ comfort levels in working with very young children. Next, students began field training by accompanying experienced clinicians on home visits to observe treatment sessions. Once they were comfortable with the skills in a

particular module, students were supervised as they began implementing portions of the treatment with children and their caregivers in their homes. Supervisors documented students' adherence to specific treatment criteria that addressed the clinical skills needed to function independently as a clinician such as interacting with families in a culturally sensitive manner, demonstrating an understanding of the treatment rationale, effectively explaining and modeling treatment techniques at the parent's level of understanding, providing appropriate feedback to parents, and writing sound treatment plans. When students met these criteria, they were able to operate independently in the homes carrying a regular caseload of five to seven families. However, students normally continued to conduct home visits in pairs for two reasons: (a) it allowed one student to work with the child while the other student was working with the parent and (b) it provided better safety for both students. One hour of both group and individual supervision were required for students each week throughout their entire training and internship experience. In addition, supervisors were available in person at the clinic, via phone, and via e-mail to maximize student access to supervision. An on-call supervisor was available for all home sessions.

Preliminary Student Outcomes

To begin to assess the impact of the in-home therapy training program on students, an adapted version of the Counselor Activity Self-Efficacy Scales (CASES) was used (Lent, Hill, & Hoffman, 2003). The CASES assesses clinicians' level of confidence and self-efficacy in their counseling skills and abilities and includes 6 subscales: Exploration (attending to the client, asking open questions), Insight (making interpretations or giving information), Action (role-playing, assigning homework), Session Management (responding with the best helping skill, given a client's particular need, remaining aware of your intentions during session), Client Distress (working with a client who is depressed or manipulative), and Relationship Conflict (working with a client who demonstrates manipulative behavior in session). For the current study, the CASES was adapted to be more appropriate for use with in-home therapy for young children. Eight items that were less relevant for the CMT used in the homes (e.g., helping a client to talk about their concerns at a ''deep'' level) were replaced with 11 items that captured the same underlying constructs but were more appropriate for in-home therapy (e.g., making appropriate referrals to outside agencies, addressing safety concerns in the home, and working with a client who lives in the inner city). Additionally, minor wording changes were made to better represent the specific situations the students would encounter (e.g., working effectively with a client who differs from you in major ways was changed to working with a client who differs from you in

culture). Using a 10-point Likert rating scale (0 = *no confidence* to 9 = *complete confidence*), students rated how confident they are in their ability to do each counseling task with clients. Subscale scores were calculated by summing all item responses with higher scores indicating higher clinician confidence in using the skills of a particular subscale. The following coefficient as were computed for the adapted CASES based on the 10 students' pretest scores: Exploration = .78; Insight = .59; Action = .90; Session Management = .93; Client Distress = .90; Relationship Conflict = .70; and CASES total = .97. The adapted CASES was completed by students during the first and final weeks of the internship.

A 7-item survey was used to assess student satisfaction with the training program. Using a 7-item Likert rating scale, students were asked to rate: the quality of the clinical experience (1 = *poor* to 7 = *excellent*), the quality of the training program (1 = *poor* to 7 = *excellent*), the degree to which their treatment knowledge improved (1 = *not at all* to 7 = *a lot*), the degree to which their clinical skills improved (1 = *not at all* to 7 = *a lot*), if they would recommend the internship site to other students (1 = *no, definitely not* to 7 = *yes, definitely*), their level confidence at the beginning of the training program (1 = *not at all* confident to 7 = *very confident*), and their level of confidence at the end of the training program (1 = *not at all confident* to 7 = *very confident*). For the current sample, the coefficient α for these items was .72. Students completed this survey anonymously at the end of their internship.

Student Findings

Repeated measures, multivariate analyses of variance (MANOVA) were used to assess pre-and post-internship changes in the students' scores on the adapted CASES. Univariate *F* tests were used to determine the source of the significance in significant MANOVAs (Table 1), and partial η^2 was used to determine the effect size. The first MANOVA showed significant improvement in students' Exploration and Insight scores, suggesting an increased ability to comfortably explore client issues, interpret clients' statements, and provide feedback. Students' scores on the Action and Session Management subscales also increased (second MANOVA), which suggests they were more comfortable with using directive counseling skills, guiding treatment sessions, and keeping clients on track. The third MANOVA showed students scores improved significantly in Client Distress and Relationship Conflict, which indicated that students felt more confident in dealing with difficulties arising in therapy with both parents and children. Finally, a two-tailed t test showed a significant increase in students' total scores on the CASES from pre-to postinternship [$t(9) = 10.10$, $p < .001$].

All 10 students anonymously completed the satisfaction survey. Students rated both the

quality of the clinical experience (M = 6.60; SD = 0.51) and the quality of the training program highly (M = 6.40; SD = 0.96), indicating that they viewed the training received as good to excellent. Students reported that the program improved their clinical knowledge (M = 6.60; SD = 0.51) and improved their clinical skills (M = 6.80; SD = 0.42). They also indicated that they would be very likely to recommend the internship site to others (M = 6.8; SD = 0.63). Students retrospectively reported a relatively low level of confidence in their ability to work in a home-based setting with a low-income population at the start of their internship (M = 3.8; SD = 1.14), but at the end of the program, they felt a higher level of confidence in their ability to work with a similar population in the future (M = 6.6; SD = 0.51); this change in confidence from pre-to postinternship was significant [$t(9) = 7.20$, $p < .001$].

Discussion

This study described a year-long training program for graduate students whose internship experiences emphasized in-home therapy with low-income families and their young children. The literature recommended that specialized training for conducting therapy in this unique setting was required above and beyond the instruction provided in university graduate programs (Christensen, 1995). The current project adopted this recommendation and included 20 hr of didactic training in providing therapy in the homes of young children living in poverty. In addition, students had frequent opportunities to observe veteran clinicians in the home setting and received ongoing training as they gradually assumed the role as lead clinician for a child. The literature also endorsed the importance of regular supervision for improving counselors' satisfaction with conducting in-home therapy (Lawson & Foster, 2005). Students in our internship received weekly individual supervision sessions that dealt with counseling issues they faced in the homes as well as the impact of these experiences on their own personal development as mental health professionals. During supervision sessions, students regularly expressed that they were able to resolve frustrations that they had experienced in a timely manner when families were inconsistent in attending or following through with their recommendations, when therapeutic progress was slow, and when their university classes did not provide answers for in-home challenges that they routinely faced. Students also attended weekly group supervision that helped normalize their clinical experiences with those of other students and staff. In our experience, and consistent with the findings of Snyder and McCollum (1999), students were able to successfully adapt the training and skill development offered through their university programs to in-home therapy. However, the training process was not an easy one. Most students did not start taking a lead role in the home sessions until the end of their first semester of internship. By

the end of their second semester, students felt confident leading in-home therapy sessions. Most of these students continued to provide in-home therapy at the Behavior Clinic following the completion of their internship through summer stipends; four were hired as part-time or full-time family counselors at the Behavior Clinic following the completion of their master's degrees.

By the end of their internship experience, students' scores on the adapted CASES improved significantly when compared to scores obtained during the first week of their internships. Although it would be expected that students should report higher levels of counselor self-efficacy after two semesters of internship, this may not always be the case (Christensen, 1995; Deal, Hopkins, Fisher, & Hartin, 2007). In their review of the literature, Larson and Daniels (1998) found the relationship between counselor self-efficacy and training was unclear. Moreover, in support of the finding that not all training programs will produce positive outcomes, Hill, Sullivan, Knox, and Schlosser (2007) reported that less than half of their students enrolled in a prepracticum course made gains in self-efficacy on domains as measured by the CASES.

Students in the current project reported a high degree of satisfaction with their internship. Although the quality and intensity of the project's training and supervision program may have contributed to these positive findings, the unique population we served through in-home therapy also may be a factor. The specialized nature of addressing mental health issues in very young children may be particularly well suited for in-home therapy. Working directly in the home provides a unique opportunity to put immediately into action the tenets of CMT and to see firsthand if they are being implemented correctly. For example, a time-out area can be created for a child who is aggressive, in a small apartment with limited space, kitchen cabinets can be fitted with locks for a child who is destructive, and distracting items can be put out of the reach and sight of a child who has attention problems. Furthermore, students discovered that young children's challenging behaviors could be significantly reduced in a relatively short period of time if they could successfully engage the parents in consistently following the evidence-based treatment program. Reading about the successful outcomes obtained for families who completed the treatment program (Fox & Holtz, 2009) certainly bolstered student confidence in the treatment program. However, observing changes in children that were the direct result of the students' intervention efforts may have had an even greater impact on their confidence. Students also recommended the Behavior Clinic as an internship site for other students. Currently, we receive three to four times the number of student applications for internships than we can accommodate.

The findings of the current project are preliminary in nature. The results for students are based on a pre-and posttest research design without a control or comparison group. As such, we

cannot attribute the changes in the students' CASES scores or their positive evaluations to our training program. Other factors such as the normal expected student growth in an internship, students responding to self-report items in a socially desirable manner, and the uniqueness of the younger population may have contributed to the findings. In future research, more comprehensive data collection (e.g., supervisor ratings) within a more rigorous research design is needed to determine what training program elements are important for obtaining positive outcomes and whether these elements will be transferrable to programs that train students to work with other populations using in-home therapy.

Authors' Note

The authors acknowledge the support of Penfield Children's Center, the Birth-to-Three agency that served as the site for this project, and the graduate students who provided mental health services for the young children and their families.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interests with respect to the authorship and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research and/or authorship of this article: This research was supported in part by grants from Brighter Futures of Milwaukee, the Assurant Health Foundation, the Charles D. Jacobus Family Foundation, the Exchange Clubs of Greater Milwaukee Charitable Foundation, Inc., the Helen Bader Foundation, the Stackner Family Foundation, and United Way.

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Appendix

Table 1: Student Outcomes Based on Pretest and Posttest Counselor Activity Self-Efficacy Scales (CASES) Scores

	Pretest		Posttest				
	M	*SD*	*M*	*SD*	*F*	*df*	η_p^2
Exploration	32.60	3.34	39.10[a]	2.60	453.19	1,9	0.98
Insight	21.50	1.78	28.90[a]	2.02	80.92	1,9	0.90
Action	23.00	5.23	31.00[a]	2.87	1031.26	1,9	0.99
Session management	78.20	13.61	105.50[a]	7.26	49.36	1,9	0.85
Client distress	65.90	9.59	93.80[a]	7.96	387.45	1,9	0.98
Relationship conflict	30.00	2.62	39.20[a]	2.15	81.67	1,9	0.90

[a] Significant change ($p < .001$) from pretest to posttest.