10-1-2014

In-Home Counseling for Young Children Living in Poverty: An Exploration of Counseling Competencies

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Accepted version. *The Family Journal*, Vol. 22, No. 4 (October 2014): 371-381. DOI.

In-Home Counseling for Young Children Living in Poverty: An Exploration of Counseling Competencies

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Abstract: Home-based counseling is increasingly an alternative mode of providing counseling services for children and families, reduces barriers to accessing traditional counseling services, and has also been shown to be effective. As such, the purpose of this qualitative study was to explore and describe the competencies needed to provide such counseling services. This study yielded five categories of competencies—*necessary knowledge sets,case conceptualization, counseling behaviors, flexibility in session,* and *professional dispositions and behaviors.* We also outline implications for counseling practice, counselor education, and public policy.

The Family Journal, Vol 22, No. 14 (April 2014): pg. 371-381. DOI.

Keywords: in-home counseling, counselor competence, case conceptualization, barriers to counseling, family counseling

Home-based counseling is increasingly an alternative mode of providing mental health services for children and families (Stinchfield, 2004). It provides increased access to mental health services for young children living in poverty (Fox & Holtz, 2009), which is important given the often unmet, complex mental health challenges faced by young children in the United States (Mellin & Pertuit, 2009). Further, children living in poverty are often from traditionally marginalized racial/ethnic groups (e.g., African American and Latino) and are more likely to face mental health risk factors such as single-headed households, exposure to violence, child abuse, systemic discrimination, and difficulty accessing community resources (Canino & Spurlock, 2000). Home-based counseling reduces barriers common to this population including lack of reliable transportation, caregiver mental or physical health problems, difficulty setting and keeping regular appointments, employment or school commitments, and obtaining and affording child care (Adams & Maynard, 2000; Thomas, McCollum, & Snyder, 1999). Additionally, conducting counseling in a child's home offers a unique window of opportunity to observe and interact with children and their families in their natural, everyday context (Worth & Blow, 2010), thereby increasing the likelihood of change for the child and the family system (Cortes, 2004). Finally, in-home counseling has yielded positive mental health outcomes for children and their caregivers (Fox, Mattek, & Gresl, 2013; Gresl, Fox, & Fleischmann, in press).

There are also challenges to providing in-home counseling services. Counselors who have provided in-home services expressed concerns about their clients' and their own safety (Adams & Maynard, 2000; Christensen, 1995; Worth & Blow, 2010), the myriad of concerns/problems that inevitably arise within each family, and their ability to emotionally cope with high levels of crisis and lack of resources that many of their clients were facing (Adams & Maynard, 2000). On a procedural level, counselors have expressed concerns about professional and clinical boundaries, maintaining confidentiality (Snyder & McCollum, 1999; Worth & Blow, 2010), and effectively managing the time/pacing of counseling sessions in the midst of various distractions that occur while working in clients' homes (Christensen, 1995; Snyder & McCollum, 1999; Worth & Blow, 2010).

Surprisingly, there is little research about the counseling competencies involved in providing effective in-home counseling for this population (Mattek, Jorgenson, & Fox, 2010). Lawson and Foster (2005) posited that effective in-home counselors should have a high level of ego development (e.g., tolerance for ambiguity) and conceptual abilities (e.g., ability to see and integrate multiple

perspectives). Cortes (2004) suggested that in-home family counselors should be skilled in noticing and navigating the myriad of information and distractions in the home environment, balancing family problems with a focus on family strengths/resources, setting and maintaining appropriate boundaries, and making ethical decisions about issues of client and counselor safety. Some studies have addressed training needs (Adams & Maynard, 2000) and general categories of competencies needed for effective in-home counseling (Stinchfield, 2004), but a comprehensive, detailed description of such counseling competencies is lacking. As such, the purpose of the present study was to explore and describe the competencies needed to provide effective in-home counseling for young children living in poverty.

Method

This study was conducted using an exploratory, qualitative approach. The data sources for this study included interviews, observations of counselors working in clients' homes, and a counselor training manual. These data were collected in the context of an in-home counseling clinic (Fox, Keller, Grede, & Bartosz, 2007) that has proven the effectiveness of its services for young children living in poverty (Fox, Mattek, & Gresl, 2013; Gresl, Fox, & Fleischmann, in press).

The Behavior Clinic

The data for this study were collected through speaking with and observing counselors working in a home-based counseling program in the Midwest. This clinic provides mental health services for a diverse population of children, the majority of whom come from families who live below the poverty level (95%; Fox, Keller, Grede, & Bartosz, 2007). The clinic uses an individualized format of the Parenting Young Children (PYC) program for young children (Fox & Nicholson, 2003). The PYC program includes four main treatment elements: (a) strengthening the parent–child relationship through nondirective play and increased nurturing activities; (b) helping parents maintain appropriate developmental expectations for their child and learn cognitive strategies to avoid emotionally overreacting to their child's challenging behavior in a negative manner; (c) using techniques to strengthen the child's prosocial behaviors such as positive reinforcement, establishing home routines, and giving good instructions; and (d) employing limit-setting strategies to reduce the child's challenging behaviors such as redirection, ignoring, response cost, and time-out. A significant number of these children referred to the clinic have serious emotional and behavior problems that often are complicated by developmental delays and are usually referred to the program for externalizing

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behaviors (e.g., severe tantrums, destructiveness, aggression, self-injury, and oppositional behaviors) as well as separation anxiety, attachment and trauma issues, and posttraumatic stress disorders. This program receives referrals for services from over 60 community-based agencies in addition to pediatricians, public health nurses, social workers, and parents themselves. The age of children who receive services from this program ranges from 1 to 5 years, and the majority meet criteria for a psychiatric diagnosis at the time of intake (e.g., oppositional defiant disorder; American Psychological Association, 2003). The vast majority of the families receive at least one source of public assistance, indicating that their income falls below the federal poverty level. Finally, this program has a structured training of program wherein students from master-level counseling programs complete internships under the supervision of the program staff. This is an important factor in regard to this study, as such experience training counseling students provides the staff with a unique perspective on the competencies that their counselors and interns need in order to work effectively in this context. Most importantly, this site was chosen because the counseling model employed by this program (Fox & Nicholson, 2003) has proven its effectiveness in providing in-home counseling for young children living in poverty (Carassco & Fox, 2012; Fox, Mattek, & Gresl, 2013; Gresl, Fox, & Fleischmann, in press), which is quite important, given the goal of this study is to explore competencies for effective counseling in this context.

Researchers as Instruments

Given the inherent subjectivity involved in qualitative research (Creswell, 2012; Hays & Wood, 2011; Strauss & Corbin, 1990), it is important to discuss the researchers' backgrounds, given the possibility this may affect the results of this study. The first, second, and fifth author of this article served on the research team (the third and fourth author of this article did not participate in the collection or analysis of data but contributed to the writing of this manuscript). The first author, and primary investigator, is an assistant professor in a counselor education program, who identifies as a White male. His research has focused, in part, on counselor competence as well as issues of cultural difference and systemic oppression. He has practiced counseling in community and university settings with adults for 8 years. His only affiliation with the behavior clinic was his role as a faculty member in the same department as the director of the clinic. The second author is an undergraduate student who identifies as a Hispanic female. She is majoring in psychology and has participated in research teams investigating the cultural adaptation process as it relates to mental health outcomes. She had no affiliation with the behavior clinic. The fifth author is a master-level counseling student who identifies as an African American female. She has 1 year of counseling

experience with underserved adults and has participated in research teams investigating the psychosocial needs of underserved populations. Her only affiliation with the behavior clinic was as a student in the department where the director of the clinic worked as a faculty member. None of these three researchers have experience providing counseling services to young children or with providing in-home counseling services.

Participants and Data Collection

The data collection process was guided by theoretical sampling of data sources within the clinic (Creswell, 2012; Hays & Wood, 2011) and involved multiple sources including the training manual for the program, a focus group with program staff who provide in-home counseling, in vivo field observations of senior-level counselors providing in-home counseling services, follow-up individual debriefing interviews with the counselors who were observed in vivo, and theoretical memos created after each of the interviews and observations. Several sources of data were used in order to maximize the ability to understand the phenomenon of interest (i.e., counselor competence) in a rich, complex fashion (Strauss & Corbin, 1990). All of these data sources were subjected to analysis, as noted in the Data Analysis section to follow.

Training manual

The behavior clinic has an extensive training manual used to guide the training of new counselors and student counselor trainees. The manual was read by the research team, and statements that directly related to competencies needed for work in the clinic were extracted for analysis. For example, the following are reflective of the types of statements extracted from the manual. It is important that a trainee "understands and effectively communicates the rationale for using various treatment techniques (e.g., nondirective play, ignoring, time-outs, etc.)" and "establishes good rapport with caregivers from diverse backgrounds and who live in poverty." All such statements were compiled into a single document for analysis.

Focus group

A focus group (Rubin & Rubin, 2012) was conducted by the first author with staff members who provided in-home counseling through the program. Participants in the focus group included the clinic director, a senior-level psychologist, one clinical supervisor, two senior-level family counselors, three family counselors, and one research assistant/family counselor. Eight of the participants were White and

one identified as White/Asian. Participants had a mean of 7.4 and median of 6 years of experience providing in-home counseling for children aged 0–5 years, with a range of 2–30 years of experience. A semistructured interview format was employed to explore the competencies, skills, and qualities that are required for effective in-home counseling with young children living in poverty. Two general questions were explored during the focus group: (a) "What does it take to be a competent counselor when working with your client families?" and (b) "When you are training new counselors and counseling students, what do you see that tells you they are becoming competent in working with your client families?" As the focus group members responded to the questions, the first author took notes on a whiteboard that was visible to all group members. Participants were asked and encouraged to verify or correct what was being recorded there in an effort to increase the dependability of our data collection process. These notes from the whiteboard were transcribed in electronic format for later analysis. Additionally, the focus group was audio recorded and transcribed verbatim for later analysis.

Field observations

Field observations of counselors providing in-home counseling were conducted in order to gain a behavioral perspective of what competencies in this context look like in practice (Mulhall, 2002). A typical session for the Behavior Clinic begins with a counselor coming to a family's home at a predetermined time, and a client family stays with one full-time counselor for the duration of their engagement with the clinic. It is also common for senior counselors to bring a new counselor or counseling student with them to family's home for training purposes. The initial session with a family involves extensive assessment and intake procedures, but sessions thereafter begin with a brief assessment of the family's experience since the last session. Sessions vary considerably after the initial session depending on the presenting issues for that child and family, but common practices include counselors intervening in various ways with the child (e.g., conducting nondirective play with a child) as well as with parents/caretakers (e.g., modeling and supporting a parent during a "time-out session" for a child having a tantrum). Two senior-level counselors were observed in vivo providing such in-home counseling services to three different client families. These counselors were referred to the researchers by the clinic director as highly competent, effective, senior-level counselors. One of these counselors was a 28-year-old White female with 5 years of experience providing in-home counseling, and the other counselor was a 26-year-old White female with 6 years of experience providing in-home counseling. Both counselors were trained in the behavior clinic's counseling model, and each provides similar counseling interventions based on this model. Researchers consulted with these

counselors to choose appropriate families for observations. Criteria for selecting families included choosing families that already had an established relationship with the counselors, had previous experience with trainees observing their counseling sessions, and who represented typical presenting concerns for the clinic. As stated earlier, these were the assigned counselors who had worked with the families since engaging with the clinic. The observations were conducted by the first author. Before the observation began, the family was asked for their permission for the observer to sit in on the session. All families consented before the observations began. In order to minimize distraction, only one counselor and the researcher were present for the field observations. During the observations, field notes were taken by the researcher. Specifically, the researcher created notes about behaviors and conversations that occurred throughout the session as well as patterns in process and content that emerged as the session progressed.

A total of three field observations were conducted. Two were conducted initially, and then a third was conducted to further enrich and refine the results of this study (see data analysis section for further detail on this issue). The first field observation was with a 41-year-old White mother. This was the third time that the counselor had met with this family. Her son was the identified client and was referred due to temper tantrums, aggression, and destructiveness (diagnosis of adjustment disorder with mixed disturbance of conduct and emotion). The mother had a history substance abuse, and family concerns included a history of domestic abuse in the home and multiple life changes. The second field observation was with a 28-year-old White mother and her 4-year-old son. This was the fourth time the counselor had met with this family. Her son was the identified client and was referred due to concerns regarding temper tantrums, aggression, and oppositional behavior (diagnosis of adjustment disorder with disturbance of emotions). The mother had a history of anxiety and depression, and there was a history of multiple family moves and life changes. The third field observation was with a 27-year-old Puerto Rican mother, her cohabiting African American boyfriend (not the father of her children), her 4-year-old son (identified client), and 2-year-old daughter. The client was referred due to aggressive outbursts and emotional reactivity (i.e., severe temper tantrums; diagnosis of oppositional defiant disorder and attention-deficit hyperactivity disorder). This final observation was conducted to collect data specific to cultural issues. As such, a family was chosen that the counselor believed would reflect the practice of such competencies. All sessions took place in the clients' homes.

Debriefing interviews

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Debriefing interviews with the counselors followed all three observations and occurred immediately after each one. Using the observation notes taken during the sessions as a guide, the researcher asked the counselors to talk through their thought process during the counseling session. This approach was used to both clarify and enrich the data that were collected during the observations (Charmaz, 2006; Rubin & Rubin, 2012). These interviews were recorded via note-taking on the same pages that the field notes were taken. This was done to maintain a connection between field observations and the counselor's thought processes that paralleled these observations. These notes were transcribed to an electronic format for analysis.

Theoretical memos

After each of the field observations and the focus group, the researcher created theoretical memos (Charmaz, 2006) to document ongoing, emerging patterns and connections within the data. In other words, these memos were not simply a recounting of past occurrences but rather theoretical postulations about how the data were beginning to coalesce into categories and subcategories of competencies. These memos were included in the data analysis process.

Data analyses

The data were analyzed using open coding procedures as outlined by Strauss and Corbin (1990). The researchers used open coding because this method allows for an exploratory view into a new area of study, which fits with the exploratory nature of this study. Specifically, the goal of this study was to develop a rich understanding of the categories and subcategories that describe in-home counseling competence within one particular counseling clinic that has proven the effectiveness of its services. The data analysis process took place in two stages.

The first stage of analysis began with each researcher reading the data independently and making notes of emerging patterns and themes they perceived in the data. Additionally, the researchers kept an ongoing log of theoretical memos (Charmaz, 2006) as they began to make efforts to create categories and subcategories that best described the data. These memos were used in both individual and team work to guide the analysis process. Over the course of several meetings, the researchers brought their notes and memos to a group discussion and worked toward consensus identification and descriptions of categories and subcategories for the data. For example, when analyzing the focus group transcripts as a team, the team (first individually and then as a group) developed

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an initial list of descriptors that summarized the data. An illustration of one such descriptor was "the ability to understand child's behavior in context of the natural environment." This was a summary of a segment of the focus group, which was focused on counselors' ability to use the home environment as a source for conceptualization. Further discussion and analysis of this transcript segment by the team resulted in refining this to "the ability to understand child's behavior in context of real-time family interactions and the physical home environment." Such descriptors were then organized into larger categories and subcategories. For example, an initial category titled *managing boundaries* was used to capture data that referred to counselors' ability to decide who was involved in the counseling session and how to ethically engage such individuals. Later, this category was left behind and such data were folded into the category titled *flexibility in session.* As the analysis process unfolded, a constant comparative approach was used (Strauss & Corbin, 1990), wherein researchers compared new data and patterns to the ones that had emerged in previous meetings and data sources. This analysis process was repeated for analyzing the data from the training manual, focus group, the first two field observations (including notes from debriefing interviews), and theoretical memos created after the focus group and observations.

At the end of this first stage of the process, the team had developed five categories that closely resembled the final results found in this article but felt that there was a lack of depth in these categories. Specifically, the research team believed that more data should be collected in regard to cultural competencies. This leads to a second round of data collection and analysis. The second round of analysis was conducted through conducting a third field observation (only two were conducted before this stage). This observation was specifically targeted at gathering data about cultural competencies needed to conduct in-home counseling with families living in poverty. As such, the third field observation and debriefing interview were focused on this issue. The research team then analyzed this new set of data using the same method described earlier. This second round of analysis resulted in adding cultural aspects to each of the five categories found in the final results of this study.

Triangulation

In order to increase the dependability of the results that emerged from this analysis, the results were subjected to a triangulation process (Creswell, 2012; Denzin, 2012). The results of the researchers' analysis were sent to counselors/staff who participated in interviews and observations. These individuals were asked to review the categories and subcategories and to provide feedback in terms of needed revisions and additions that should be made. Specifically, an

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electronic form of the initial list of categories and subcategories was sent to the clinic's staff (i.e., those who participated in the focus group and field observations), and that staff added their suggestions and feedback to this form. For example, upon reviewing the research team's initial category related to competence in case conceptualization, the clinic director suggested changing the title of a subcategory from "conceptualizing sources of clients' problem behaviors" to "conceptualizing sources of clients' referral concerns (i.e., behavior and emotional problems)." This was indicative of the feedback given by staff, in that this feedback helped to refine and correct subtle mistakes in the representation of the participants' perception of what constituted competent counseling in their context. This feedback was analyzed and incorporated into the final results of this study.

Results

There were five categories of in-home counseling competence with young children living in poverty that emerged from the data analysis—*necessary knowledge sets, case conceptualization, counseling behaviors, flexibility in session, and professional dispositions and behaviors*. All categories were further organized into subcategories in order to give a more nuanced description of the data. A full summary of these results can be found in Table 1. The analysis also revealed competencies that were quite particular to the specific assessment and treatment model used by the program from which the data were collected. Given that the purpose of this study is to investigate general in-home counseling competencies rather than the specific competencies involved in using the program's specific treatment model, only the competencies that are not specific to the program will be reported here. Finally, although it is not possible to fully illustrate all of the subcategories, the examples provided will illustrate characteristics of each category that seem particularly relevant to in-home counseling with young children living in poverty.

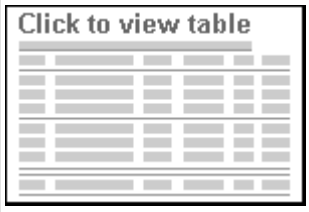

Table 1. Counseling Competencies for In-home Counseling With Young Children Living in Poverty.

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Categories & Subcategories	Properties
Necessary Knowledge Sets	
Knowledge of early childhood development	• Normal childhood development • Developmentally appropriate behaviors • Developmental delays and disorders • Attachment theory
Culture-specific knowledge	• Knowledge of what it means to be White in a community highly segregated by race/ethnicity • Knowledge of what it is like to be of a particular race-ethnicity, living in poverty and in an inner city context • Knowledge of common cultural values associated with the clients being served • Understanding of client family's cultural views on gender roles • Understand family's reality-based concerns of safety in community • Understand family's perception of counselor as agent of public/governmental system • Understanding the common impact factors such as institutionalized discrimination and the chaotic schedules client families have on the life choices families make
Case Conceptualization	
Conceptualizing sources of clients' referral concerns (i.e., child's behavior and emotional problems)	• Biological/physical factors • Daily schedule • Home environment • Community environment • Clients' experience of trauma and/or abuse • Family membership, structure & relationships • Client and/or caregiver psychopathology and current services being received (if any) • School/daycare experience • Clients' functioning levels (e.g., social skills, developmental delays)
Methods of conceptualization	• Rating non-directive play sessions • Observing "in vivo" the home environment and the activity therein • Formal assessment methods (e.g., intelligence screening) • Caregiver interviews • Client self-report instruments (e.g., parenting styles; child behavior scales; trauma checklists)
Conceptualizing the treatment process	• Assessing ongoing quality of therapeutic relationship • Identifying family members who may or may not participate in treatment • Understanding caregivers' conception of acceptable change for client (e.g., parent goals) • Consistent focus on conceptualizing and incorporating client and family strengths • Identification of treatment barriers that counselor may or may not able to address • Mapping of behavior patterns and triggers throughout the treatment process • Effective prioritization of behavioral symptoms and sources
Conceptualizing culture-specific factors	• Impact of client's specific cultural context (e.g., race/ethnicity, poverty, educational background, gender, age, and geographic location) on the presenting issue • How systemic issues (e.g., institutionalized racism) impact clients' presenting issue • How poverty is affecting entire family experience
Counseling Behaviors	
Forming and maintaining effective professional/therapeutic relationships	• With children under six years old • With caregivers of children • With other family members involved in clients' lives (e.g., grandparents, siblings, aunts, uncles, cousins) • Maintaining ethical boundaries between with client and family members • With other professionals and agencies in the community
Effective use of directive interventions	• Program model is a directive, psychoeducational model • Skill in being directive while maintaining therapeutic relationships • Balancing empathetic concern with a directive approach
Skill in collaborating within and across disciplines	• Collaboration and consultation with fellow counselors and staff • Due to being part of a larger service system, need for collaboration with social workers, physical therapists, psychiatrists, occupations therapists, etc.
Case management	• Organizational skills (follow through in a timely manner) • Clinical writing skills (well-written reports)
Self-care	• Maintain effective work-life balance given high stress nature of the setting • Attentive to, and actively addresses, emotional distress resulting from work in this setting • Prepared to accept high dropout and no show rates
Basic cultural competence skills	• Culturally competent communication skills • Ability to address and navigate cultural differences between counselor and client families
Advocating for clients' and families basic needs before beginning treatment	• Knowledge of, referral to, and education about relevant community resources (e.g., pediatrician, public health nurse, dentist, counselor, public and private schools, summer programs, after school programs, day cares, Bureau of child welfare, etc.) • Encouraging families to follow through with referrals
Treatment planning	• Systematically addressing biological, psychological, cultural, and contextual factors in plan • Clearly communicating about plan with clients and families
Flexibility in Session	
Balancing the implementation of the BC model with a focus on in-the-moment events	• Balancing directive interventions with an empathetic connection to caregivers • Adapting the model to what has been working for the client between sessions • Using in-the-moment client behaviors to illustrate and implement the model and provide feedback • Prioritizing types of treatment model interventions based on what is happening in session • Being creative when typical model techniques are not working • Changing treatment goals in session when they are not working for client
Managing multiple relationships and events in session	• Ability to multitask between several topics or activities • Maintaining concurrent, meaningful communication with multiple parties in session • Effective session management and maintaining composure in the midst of unplanned events (e.g., new parties entering room during session or caregiver unexpectedly disengaging during session)
Transitioning between widely varying and challenging physical spaces	• Adapting to settings with little or no furniture and/or space for treatment activities • Ability to focus in settings that are uncomfortable or aversive (e.g. insects in the space) • Ability to adapt to the unique factors encountered in an urban, inner city context
Adjusting and accounting for cultural diversity	• Implementing model, but adjusting based on family's culture and context • Adjusting communication and interventions based on educational level of family • Respecting caregivers' disagreements with treatment model values, and adjusting treatment accordingly • Ability to address conflicts in values between counselor and caregivers when cultural values of clients have possible negative outcomes for client
Professional Dispositions & Behaviors	
Tendency to have positive attributions about clients and families	• Strengths focus • Lack of judgment about lifestyle and decisions made by family that are not illegal or harmful to child
Openness to critical feedback	• Awareness of inherent limitations of counselor as an individual • Seeks out feedback • Incorporation of feedback into work with clients • Awareness when mistakes are made in sessions, and learns from such mistakes • Views supervisor input/interruptions in session as a learning experience
Emotional maturity	• Balanced emotional regulation when under stress • Able to process difficult sessions and re-center for future sessions
General professionalism	• Behaves in an ethical and honest fashion • On-time to session and with paperwork • Ability to communicate effectively via paperwork and writing • Professional appearance
"True Grit"	• Tendency to persevere through difficult events in session • Focus on social justice and need for services being provided • Dedication to improving the lived experience of clients
Culture-specific dispositions	• Comfort working in inner city, urban environment • Respectfulness of cultural differences • Comfort working in-home, in widely varying cultural, familial and physical contexts • Comfort working in homes that are different from one's own culture and background

[View larger version]

Necessary Knowledge Sets

The first category was necessary knowledge sets and was defined as types of knowledge that are a necessary foundation for competent practice in this setting. For example, in the focus group it was pointed out that "you have to have a solid foundation in early childhood development…these knowledge sets aren't usually covered in sufficient detail in traditional counseling programs." Evidence of the *culture-specific knowledge* subcategory was observed in a field observation and then further elucidated in a follow-up interview. The researcher observed a counselor talking to a male caretaker of a young boy about the use of violence. The male caretaker expressed his desire for the boy to "not back down" when confronted, and the counselor validated the reality that, unfortunately, self-defense is sometimes needed to maintain safety in dangerous circumstances. In a follow-up interview about this session, the counselor stated that she was aware that, in the

context of the inner city in which she works, "knowing how to use self-defense in the right way" is an important survival value and skill for many of her clients and families.

Case Conceptualization

The second category was case conceptualization and was defined as the quality of counselors' conceptualization of their clients and clients' families as well as the process by which these conceptualizations are formed. For example, in regard to the subcategory conceptualizing the treatment process, in the focus group it was noted that effective counselors "know that if certain dads aren't going to be involved, they're not going to be involved. Then you don't beat your head against the wall, to get someone involved who just has no interest." This statement was evidenced in a field observation wherein, after several unsuccessful attempts to engage a male caretaker in a program-specific intervention (nondirective play), the counselor continued on with the session without this person being involved. In a follow-up interview about this interaction, the counselor stated that she realized it would have been counterproductive to the treatment goals to "keep trying to pull him into the session." Another comprehensive example illustrative of this category as a whole emerged from the individual interview. She stated:

We talk about how behaviors are symptoms…so what are the main underlying causes that are contributing to why this kid is having these behaviors?…We always want to rule out physical causes…We are looking at developmental delays…We are looking at if there is any kind of trauma, any kind of abuse, any kind of underlying emotional concerns, adjustment problems…We are looking at the family structure…with our kids who are in foster care, what's their relationship like with their biological parents…we are looking at their school, how they are doing in daycare or school? How do they relate to other kids?…and then there are the environmental factors too…what does this kid's home look like? What does their street look like? What does their schedule look like? What does their room look like? Where do they sleep? What does their day look like? Is it kind of a free-for-all, are they allowed to kind of do what they want, is there any structure?…Is [the house] clean? Is it chaotic? Are there a lot of people around? Is it open, is it shut in?

Counseling Behaviors

The third category was counseling behaviors, which was defined as counseling behaviors that are necessary for competent treatment in this setting. An

example involving the *treatment planning* serves illustrative of this category. During the focus group, a discussion among group members highlighted the need to be able to assess and address basic needs within the treatment plan.

Group Member 1:

Well [group member name] you went into a house that basically had two boxes of cereal right?

Group Member 2:

Yep.

Group Member 2:

No furniture.

Group Member 1:

Not having the basic needs met…being one of those barriers and having to work through those before you can move forward with any of our treatment

Group Member 3:

So meeting the basic needs before even being able to start the therapy.

In regard to *forming and maintaining effective professional/therapeutic relationships* and *effective use of directive interventions*, a field observation illustrated these subcategories. The counselor, who was working with a mom to use time-outs with the identified client (4-year-old), also went on to help the mom use the same intervention with the client's younger sister (2-year-old) who was not an identified client. During both of these interventions, the counselor balanced direction about the intervention with empathetic reflection about the difficulties involved in hearing these children have a long and emotional tantrum.

Flexibility in Session

The next category that emerged was flexibility in session and was defined as the ability to balance the application of the program's evidence-based treatment model, in-the-moment events, multiple individuals participating in sessions, and

unexpected events/distractions. An illustration of the subcategory *managing multiple relationships and events in session* was found in the focus group data.

Group Member 1:

You have to have a pretty good sense of time management when working in home. You don't have that nice clean cut 50 minute therapy hour. You gotta be sure that you get stuff done in a timely way. It's sometimes difficult to do in the home environment when there are so many distractions

Group Member 2:

So you have to be willing to go longer than an hour.

Group Member 3:

But also sometimes you got the television on and the dog over here and the kids over here. Like a million things going on [and still] being able to redirect the client.

This ability to manage multiple relationships in session was also seen during one of the field observations. During one part of a session, a counselor was engaged in therapeutic play with two children, maintaining substantive conversation with the mom and intermittently engaging a male caretaker (boyfriend of the mom) in the counseling process. She maintained these multiple relationships for almost half of the session.

A field observation also revealed an example of *adjusting and accounting for cultural diversity*. Building from the example given earlier about the male caretaker who expressed his desire for the client to "not back down" when confronted, the counselor adjusted the typical approach of suggesting absolutely no violence at all. Rather, she affirmed the need to sometimes defend oneself but suggested that the young child (4-year-old) may not be able to discern when the right time for violent defense might be. Further, she pointed out that the client had been expelled from day care for aggression already, and the goal was to help him reach out to adults to determine how he should respond in circumstances where he might act violently. The male caretaker agreed with this adjusted suggestion.

Finally, in the focus group a participant reflected on the issue of *transitioning between widely varying and challenging physical spaces*:

I sat next to a pile of garbage yesterday. Like they were trying to clean before I got there but like it hadn't made its way to the garbage can. So they had nowhere to sit because they had just moved. [name] was with me and we just sat on the floor next to the pile of garbage. Going in a house with a ton of bugs and getting hassled when going to your car by some drunk guy. Sometimes you are faced with situations that you just have to…that you really can't prepare for.

Professional Dispositions and Attitudes

Another category that emerged from the analysis was professional dispositions and behaviors and was defined as counselors' attitudes and personality traits that contribute to success in this setting. During the focus group, a participant reflected about the subcategory *tendency to have positive attributions about clients and families*

I think that another part of being nonjudgmental is…making positive attributions about the choices that people make and not assume. Trying to, when possible and appropriate, to assume the best about a caretaker's decisions.

This tendency toward seeing the positives was also seen in a field observation wherein the mom of a client told the counselor she felt very guilty about allowing her child to witness her ex-boyfriend physically abuse her. The counselor normalized and validated this feeling but redirected to a discussion of the positive action of mom removing her child from a violent situation. The counselor then went on to reflect on the positive changes that have occurred with her child as a result of being committed to the counseling process.

A rich illustration of *culture-specific dispositions* emerged from an individual interview with a senior counselor:

[an aspect of] cultural competence is, I think, with that disposition of, um "Though I come from a different culture and though…I come from a home that looks different from this home, I can be comfortable sitting in your home with you for an hour or two" and with that means that I walk into a home, and there's no furniture, that I will sit down on the floor and say "I can be here with you today and that is fine"…and I think that's…an important disposition to hold is like "Nah, I'm cool with this, This is fine, you know, what's good enough for you is good enough for me."

Discussion and Implications

Family Counseling Practice and Training

Several implications for family counseling practice and counselor training emerged from this study. As the competency area necessary knowledge sets indicates, a strong knowledge base in early childhood development and mental health treatment for young children is necessary to ensure that counselors are prepared to provide in-home therapy to young children and families living in poverty. Given the increasing awareness of the complex, unmet mental health needs of young children (Mellin & Pertuit, 2009), and previous research that has reached similar conclusions about training (Adams & Maynard, 2000), counselor education programs should consider including such topics into their curriculum. Further, practicing counselors providing in-home counseling for young children may need to acquire additional knowledge regarding early childhood development and related appropriate mental health services through continuing education opportunities, specialty certifications, and on-the-job training. Such counselors should also seek observation and supervision opportunities from those who are skilled at providing this type of counseling, given the unique skill set needed to provide such services. Consistent supervision is also necessary to ensure that specific professional dispositions and behaviors (as outlined in Table 1) are fostered on a continual basis. Previous research has indicated, for example, that in-home counselors who receive adequate supervision and "feel well supported" are more able to maintain a strengths focus and to work in collaboration with families (Lawson & Foster, 2005, p. 159). Moreover, given the breadth of culture-specific knowledge and factors influencing case conceptualization in this context, even highly competent counselors should seek supervision and consultation when conducting in-home counseling with this population.

Second, cultural considerations permeated the competencies that emerged from this study, which is consistent with the larger counseling profession's standards (Roysircar, Arredondo, Fuertes, Ponterotto, & Toporek, 2003) as well as research and theory about providing in-home counseling (Lawson & Foster, 2005; Snyder & McCollum, 1999). For example, counselors providing in-home counseling for children living in poverty should always strive to be aware of the impact of their own cultural context, implicit biases, and the effect of the in-home context on their case conceptualization and treatment plans (Cortes, 2004). Further, given the complex constellation of cultural factors involved in working with children and families living in poverty, in-home counselors should be culturally competent in regard to this population. This is more complex than the cultural competencies needed for working in traditional settings, as counselors must navigate the home context. For example, counselors should know a family's cultural norms related to

gender when attempting to include male and female caretakers in to the counseling process. Counselors may also benefit from researching the cultural history of the geographical location in which they provide in-home services. For example, the program described in this study is located in a highly segregated urban context wherein people tend to live in particular geographic areas based on race, ethnicity, and income level. Understanding the history and sociopolitics of such contexts is important when considering the presenting issues of clients (Martín-Baró, Aron, & Corne, 1994). The results of this study also suggest, given treatment success may be impeded by the many barriers present in an urban, low-income setting (Adams & Maynard, 2000; Thomas, McCollum, & Snyder, 1999), counselors should be familiar with community resources that address clients' basic needs that may need to be met before effective counseling can begin and be ready to assume an important advocacy role.

Finally, the category of flexibility in session seems to be a unique competency set needed for providing in-home counseling for young children living in poverty, which is an echo of previous claims (Adams & Maynard, 2000; Cortes, 2004; Lawson & Foster, 2005; Snyder & McCollum, 1999). Counselors must be prepared to address complex, unforeseen situations that may arise in an environment that cannot be controlled by the professional. In-home counseling sessions can be most productive when the counselor views these environmental circumstances as opportunities to gather valuable information about the lived experience of the family and to provide immediate feedback based on in-the-moment observations and experiences. However, counselors should remain aware of their own professional limitations within the role of in-home counselor, as families with multiple challenges may inevitably bring up concerns that fall outside of a counselor's competence. For example, there may be structural limitations to home counseling environment (e.g., lack of furniture or space for interaction with children) or unsafe conditions in the community at large. In this instance, counselors should be able to identify what they are able to change and what cannot be addressed by a counselor. Counselors should therefore be prepared to refer to additional resources when necessary and to seek additional supervision regarding these issues. Further, such instances may provide the counselor with opportunities for advocacy with and on behalf of their clients (Lewis, Arnold, House, & Toporek, 2002)

Public Policy

Providing mental health services to an underserved population is a social justice issue, and as such there are implications for public policy that flow from this study. Specifically, the need for practices that form the competency area flexibility

in session may conflict with an agency's need for reimbursement in an era of counseling wherein many treatment planning decisions are influenced by insurance companies and policy makers (Braun & Cox, 2005). In-home counseling cannot always be limited to a 50-min clinical hour (Snyder & McCollum, 1999; e.g., drive time of the counselor and advocacy activities). As such, counselors' full service provisions may not be reimbursable by insurance companies. This is problematic, given the research that shows providing mental health services in the home setting reduces substantial barriers to accessing treatment (Adams & Maynard, 2000; Cortes, 2004; Thomas, McCollum, & Snyder, 1999), is effective and appropriate for addressing mental health needs of young children (Fox, Mattek, & Gresl, 2013), and provides information that is valuable to the conceptualization and treatment planning process (Christensen, 1995; Cortes, 2004; Lawson & Foster, 2005; Worth & Blow, 2010). For these reasons, providing in-home services may not be a sustainable option for many established counselors or agencies unless policy and budget changes are made to address the mental health needs of very young children.

Increasing access to mental health services for very young children living in poverty also requires early identification of children with mental health problems. Several of the in-home counseling programs described in the literature are available to children and families who are already involved with child protective services (Adams & Maynard, 2000; Lawson & Foster, 2005; Snyder & McCollum, 1999). Similarly, funding for in-home services is many times limited based on systemic issues. For example, some state legislation restricts services to children and families who meet specific criteria for severe emotional disturbance (SED; Department of Health and Family Services, 2007) that may not apply to very young children. In this example, the definition of SED includes a specification that the child is already receiving services from two other service provider systems, which may not be an option for this population. In such instances of systemic barriers to treatment, community outreach, and partnerships among mental and physical health providers may be necessary to identify families with young children in need of mental health services who are not already connected to other service providers.

Limitations of this Study

The limitations of this study are related primarily to the limited scope of data collection. By focusing on one clinical setting, it is difficult to discern what is or is not particular to competent counseling practice through this particular program's model. As such, the results of this study should be considered exploratory and a foundation for more wide-ranging analysis of competencies needed for in-home counseling with young children living in poverty. Further, the participants in this

study were predominately White and female. Although these professionals seem to demonstrate high levels of counseling competence as evidenced by the effectiveness their work (Carassco & Fox, 2012; Fox, Mattek, & Gresl, 2013; Gresl, Fox, & Fleischmann, in press), this imbalance in racial/ethnic and gender diversity may have biased the results of this study. Finally, this was a study conducted using qualitative methods, which inherently include the subjective judgments of the researchers conducting the analysis.

Areas for Future Research

Given that this study was designed as an exploratory study, future research might use these results as a foundation for further study of competencies needed for in-home counseling with children living in poverty on a larger scale. More specifically, researchers might use these results, along with other data, to build a theoretical model using grounded theory (Strauss & Corbin, 1990). Such data would need to be collected from a variety of sites to justify the transferability of such a theory. Another consideration for future research is the need to study the connection between the competencies revealed in this study and their differential effect on client outcomes. Such research would provide an understanding of how to weigh and/or prioritize such competencies in training and supervision of in-home counselors. Further, this would allow counselors providing such services to focus their skill set, given a particular type of client or presenting issue. This type of research would provide a first step toward sorting through the complexity of clients' strengths, presenting issues, and home context as they relate to the diverse set of competencies needed to work effectively in this context.

Declaration of Conflicting Interests
The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding
The author(s) received no financial support for the research, authorship, and/or publication of this article.

References:

Adams, J., Maynard, P. (2000). Evaluating training needs for home-based family therapy: A focus group approach. The American Journal of Family Therapy, 28, 41–52. Google Scholar, Crossref

American Psychological Association. (2003). Addressing missed opportunities for early childhood mental health intervention: Current knowledge and policy implications—Report of the task force on early mental health intervention. Washington, DC: Author. Google Scholar

Braun, S. A., Cox, J. A. (2005). Managed mental health care: Intentional misdiagnosis of mental disorders. Journal of Counseling & Development, 83, 425–433. Google Scholar, Crossref

Canino, I. A., Spurlock, J. (2000). Culturally diverse children and adolescents: Assessment, diagnosis, and treatment. New York, NY: The Guilford Press. Google Scholar

Carassco, J. M., Fox, R. A. (2012). Varying treatment intensity in a home-based parent and child therapy program for families living in poverty: A randomized clinic trial. Journal of Community Psychology, 40, 621–630. Google Scholar, Crossref

Charmaz, K. (2006). Constructing grounded theory. Thousand Oaks, CA: Sage. Google Scholar

Christensen, L. (1995). Therapists' perspectives on home-based family therapy. The American Journal of Family Therapy, 23, 306–314. Google Scholar, Crossref

Cortes, L. (2004). Home-based family therapy: A misunderstanding of the role and a new challenge for therapists. The Family Journal, 12, 184–188. Google Scholar, Link

Creswell, J. W. (2012). Qualitative inquiry and research design: Choosing among five approaches. Thousand Oaks, CA: Sage. Google Scholar

Denzin, N. K. (2012). Traingulation 2.0. Journal of Mixed Methods Research, 6, 80–88. Google Scholar, Link

Department of Health and Family Services. (2007). Wisconsin medicaid and badgercare update. Retrieved from https://www.forwardhealth.wi.gov/kw/pdf/2007-10.pdf Google Scholar

Fox, R. A., Holtz, C. A. (2009). Treatment outcomes for toddlers with behavior problems from families in poverty. Child and Adolescent Mental Health, 14, 183–189. doi: 10.1111/j.1475-3588.2009.00527 Google Scholar, Crossref

Fox, R., Keller, K., Grede, P., Bartosz, A. (2007). A mental health clinic for toddlers with developmental delays and behavior problems. Research in Developmental Disabilities, 28, 119–129. Google Scholar, Crossref, Medline

Fox, R. A., Mattek, R., Gresl, B. L. (2013). Evaluation of a university-community partnership to provide home-based, mental health services for children from families living in poverty. Community Mental Health Journal, 49, 599–610. Google Scholar, Crossref, Medline

Fox, R. A., Nicholson, B. C. (2003). Parenting young children: A facilitator's guide. Longmont, CO: Sopris West. Google Scholar

Gresl, B. L., Fox, R. A., Fleischmann, A. (in press). Home-based parent-child therapy in low-income African American, Caucasian, and Latino families: A comparative examination of treatment outcomes. Child & Family Behavior Therapy. Google Scholar

Hays, D., Wood, C. (2011). Infusing qualitative traditions in counseling research designs. Journal of Counseling and Development, 89, 288–295. Google Scholar, Crossref

Lawson, G., Foster, V. (2005). Developmental characteristics of home-based counselors: A key to serving at-risk families. The Family Journal, 13, 153–161. Google Scholar, Link

Lewis, J. A., Arnold, M. S., House, R., Toporek, R. L. (2002). ACA advocacy competencies. Retrieved February 3, 2013, from http://www.counseling.org Google Scholar

Martín-Baró, I., Aron, A., Corne, S. (1994). Writings for a liberation psychology. Boston, MA: Harvard University Press. Google Scholar

Mattek, R. J., Jorgenson, E. T., Fox, R. A. (2010). Home-based therapy for young children in low-income families: A student training program. The Family Journal: Counseling and Therapy for Couples and Families, 18, 189–194. Google Scholar, Abstract

Mellin, E. A., Pertuit, T. L. (2009). Research priorities for mental health counseling with youth: Implications for counselor preparation, professional development, and research. Counselor Education and Supervision, 49, 137–155. Google Scholar, Crossref

Mulhall, A. (2002). In the field: Notes on observation in qualitative research. Methodological Issues is Nursing Research, 41, 306–313. Google Scholar

Roysircar, G., Arredondo, P., Fuertes, J., Ponterotto, J., Toporek, R. (2003). Multicultural counseling competencies 2003: Association for multicultural counseling and development. Alexandria, VA: Association for Multicultural Counseling and Development. Google Scholar

Rubin, H. J., Rubin, I. S. (2012). Qualitative interviewing: The art of hearing data. Thousand Oaks, CA: Sage. Google Scholar

Snyder, W., McCollum, E. (1999). Their home is their castle: Learning to do in-home family therapy. Family Process, 38, 229–242. Google Scholar, Crossref, Medline

Stinchfield, N. (2004). Clinical competencies specific to family-based therapy. Counselor Education and Supervision, 43, 286–300. Google Scholar, Crossref

Strauss, A., Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques (2 ed.). Thousand Oaks, CA: Sage. Google Scholar

Thomas, V., McCollum, E., Snyder, W. (1999). Beyond the clinic: In-home therapy with head start families. Journal of Marital and Family Therapy, 25, 177–189. Google Scholar, Crossref, Medline

Worth, J., Blow, A. (2010). A survey of the attitudes and practice experiences of home-based practitioners. Contemporary Family Therapy, 32, 459–474. Google Scholar, Crossref