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An Exploration of the Experience of In-Home Counseling Services

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An Exploration of the Experience of In-Home Counseling Services

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JAMES MADISON UNIVERSITY

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Abstract

This qualitative study explores the lived experience of in-home counseling services by using a phenomenological method. In-home counseling services are used in situations where families experience extreme emotional distress, in part owing to the problematic behavior of a child. A semi-structured interview was used to elicit parents' experience of in-home services in a geographical area that included a large portion of Virginia. The study found that the whole of parents' experience of in-home services was dynamically influenced by constituent parts including the parent's experience of the child, their experience of parenting, their experience of systems of care, and their experience of the intervention itself. The analysis resulted in three primary findings that describe the essence of participants' experience.

Chapter I

Introduction

Children and adolescents have few treatment options available to them should mental health counseling become necessary. In the United States, the need for services far outpaces the ability of various systems of care to meet them; indeed, 1 in 5 children suffer from a mental health disorder, and many do not receive the necessary care (Perou et al., 2013). In general, assistance for children can be understood as occurring on a continuum with one end being outpatient counseling and the other being residential care. Along this continuum of options, one in particular is reserved for children whose level of distress is so acute that placement out of the home is a possibility. Called variously *family preservation* (Biegel & Wells, 1991) or *intensive in-home* (Virginia Department of Medical Assistance Services, 2014, p. 7), this type of intervention is seen as means to stabilize a child in the home in order to prevent dissolution of the family.

In-home services are part of a broader array of social, mental health, and educational services that attempt to support children and families in coping with various challenges and problems. However, owing mainly to its primary existence within the Medicaid system (where it is called intensive in-home), in-home has become a common, even standard, intervention favored by the child welfare system in the United States (Children's Welfare Information Gateway, 2014). This service is recommended and provided as a last resort: the family circumstance must be such that a child is at-risk for being removed from the home ostensibly because of how the child is behaving. However, most often these scenarios emerge from a family context bathed in both new and enduring stress. Families for whom in-home is recommended are often dealing with

immediate stressors, including the behavior of the child, physical illness, mental illness, court involvement, and substance abuse, while at the same time coping with the legacy of past stressors including physical and sexual abuse, neglect, domestic violence, racism, and poverty. Families who experience such circumstances are often referred to as *multistressed families* (Madsen, 2007). Currently, however, most in-home services only peripherally involve the family, and most often it is a child who, surrounded by a network of deeply unsatisfying and exceedingly poor interpersonal relationships, becomes the *IP* or *identified patient*.

The development of in-home stretches back to the beginnings of the field of family therapy and to changes in treatment philosophies for children with behavioral and emotional difficulties. While the notion of home has long been associated with healing and comfort, the development of the home as a place of mental health treatment has followed a broad trajectory over the course of the twentieth century paralleling societal trends. Indeed, the manner in which individuals in the United States experience and conceive of mental health, community, and the place of trained professionals has shifted significantly. As I will show, it was not until the latter half of the twentieth century that in-home came to be seen as a useful and promising treatment option for children and, to a lesser degree, their families.

The exact nature of in-home services has been unclear: they have developed in a social and economic context that has shaped the regulatory landscape in specific ways and obscured the purpose of the intervention leaving deep questions that have persisted throughout their history: does in-home exist solely as a means to stabilize a crisis? Is it therefore time-limited? What are the goals of the service? Should it be focused on the

child solely or the family as a whole? Is it psychotherapeutic? Who is best-suited to provide it? Does it work? If so, how? How will it be paid for, and who pays for it? These and other questions have dogged the practice of in-home and, as I will show, remain largely unresolved to the present day.

Perhaps the most significant question, and one that I explore in this study, is the simplest: what is it? What is the nature of this phenomenon as participants experience it? Put another way: what is in-home like for people? In particular, what is it like for the parents, those who are responsible for managing the household? Owing to the incredible variability in the practice of in-home, exploration of this question is not practical from a traditional quantitative standpoint: agencies have wide latitude to adopt whatever practices they deem appropriate as long as they are in keeping with regulations. Regulations, however, do not require a theoretical basis for the practice of in-home, leaving open for interpretation the exact nature of the services provided. Unfortunately, what was perhaps intended as a means to spur innovation has resulted in in-home differing depending upon the agency administering it. Therefore, a qualitative approach that seeks to capture and describe the lived experience of participants is likely to be most useful in contributing to the literature in this area.

A means to illuminate the lived experience of in-home as well as the voices of participants is that of phenomenology. As I will show, this method has at its core a deeply humanistic purpose of describing the essence of phenomena in a way that honors and dignifies the diversity of human experience. In this way, the research is congruent with my desire to provide both a contribution to the field as well as an amplification of the

voices of those whose voices might otherwise go unheard and unheeded. To begin, I review the literature on intensive in-home services.

Chapter II

Review of the Literature

A Brief History of In-Home Services in the United States

The historical thread I will follow is the development of in-home as a therapeutic modality addressing the needs of families experiencing emotional and behavioral crises of one family member, usually a child. To be sure, other social and health services occur in the home. Here, I am specifically narrating the development of in-home as it is constellated as a psychosocial intervention. It is important to note that something of a distinction exists between *family preservation* services and *in-home counseling* services. To an extent, this distinction reflects two different ways of meeting child and family need: family preservation is based in child welfare and the social services system in the United States, and in-home counseling is based in clinical mental health and family systems theory. Of course these two perspectives share many goals, but differences also exist. A significant difference pertinent to this study is that some in-home services are not considered to be *therapy* and some in-home services are. I will discuss this issue in depth in my discussion section.

I will outline the evolution of in-home services in general and indicate when such services were understood as therapeutic or not. Further, in the interest of greater organization, I will break down this growth into three distinct periods: the Exploratory Period from the early 20th century up to 1977; the Developmental-Experimental Period from 1977 to 2000; and the Contemporary Period from 2000 to the present day. In order to provide the context in which the exploration of parents' lived experience of in-home

counseling services will occur, I will highlight developments specific to Virginia and note deviation from national trends.

Exploratory Period: to 1977. The Exploratory Period of in-home counseling services was marked both by the emergence of family systems theory as well as by the scattered manner in which in-home work took place owing to the response of a nascent child welfare system to troubled children and families. In this period, little coherent and cohesive effort was made to formalize work specific to the home context as such; therapy in the home was seen as an outgrowth of psychotherapy in general.

What is presently considered intensive in-home developed over the last four decades as a result of national and state-wide attempts at family preservation (Kinney, Madsen, Fleming, & Haapala, 1977). However, the roots of family preservation stretched back to at least the turn of the century when individuals saw opportunities to assist in the amelioration of suffering (Richmond, 1917). Individuals first known as “friendly visitors” went to the homes of those in need (Glicken, 2011, p. 29). Beginning with Jane Addams and Hull House in Chicago, the notion of community-based services embedded in the family context slowly became professionalized with the advent of the field of social work (Glicken, 2011). While psychoanalytic psychotherapists had long held that the earliest years were formative for the adult personality, it was the clinical insight of family systems theory that provided the strongest evidence supporting the child’s healthy relational surround as an important aspect of adult well-being (Lappin, 2014).

Indeed, early efforts at working in the home considered the therapeutic potential for working in the home flowing from the “advent of a new family therapy” (Friedman, 1962, p. 132). Referring to by-gone days of medical practice, Friedman (1962), a

psychiatrist working with people who were schizophrenic, wrote that for many patients in the late 1950s and early 1960s, “it has become a frequent complaint in recent years that it is difficult to get a doctor to come to the home” (p. 132). At the same time, it was recognized that substantial family dynamics were present in the home in a way that they were not in clinics and hospitals: “the direct observation of the family in the natural background of their home can bring into quicker focus the significant dynamics in the life of the family. . . . it sometimes serves dramatically to remove the façade of adjustment which the family has been presenting to the therapist (Friedman, 1962, p. 134). The “heightened reality context” of the home environment was seen as an important factor in treatment because it led to a “greater on-the-spot opportunity to examine interactions” as well as giving “tacit recognition to the fact that the entire family has problems and is in need of help rather than allowing certain family members to escort the trouble-maker of the family to an office” (Speck, 1964, p. 72). To be sure, these were beginning moves toward conceptualizing of the child and family in terms of family systems theory.

With President Lyndon Johnson’s War on Poverty (1964) as a backdrop, community-based services, in their infancy, began to address dynamics in families and communities that threatened family cohesion. At the time, the problematic behavior of a child, if severe enough, might merit placement in a psychiatric facility. In this context, Salvador Minuchin, Jay Haley, and colleagues began to question the notion of the sick individual as they developed their ideas that focused on the individual in the context of a dynamic family system and wider social systems. Indeed, Minuchin wrote, “the importance of the individual’s context is recognized, but there has been a curious dearth of therapeutic attempts to modify that context” (Minuchin et al., 1975, p. 1032). They

experimented with what social scientists today might call different service delivery models at the Philadelphia Child and Family Guidance Center: here, using Minuchin's structural model of family therapy based largely on family systems theory, individuals in neighborhoods were trained as peer therapists. While the home was, in theory, one more location where therapy could be provided based on the idea that what went on in therapy should be as "open and transparent" as possible, when individuals went to the home, the process was "mostly about joining" (entering in such a way as to understand the family's implicit rules); the neighborhoods in which the families lived were better known to the therapists (Lappin, 2014, p. 43; S. Greenstein, personal communication, July 31, 2014). The interventions that took place were indeed seen as therapeutic in nature.

The first program specifically designed to provide services in the home for the purpose of preventing an out-of-home placement of the child was called Homebuilders (Kinney et al., 1977). Beginning in 1977 in Tacoma, Washington, and motivated by a recognition of both the financial and psychological costs of out-of-home placement, Homebuilders pioneered on a wider scale the experiment of Minuchin and colleagues: going to the homes of families to provide services. Funded through a grant from the National Institutes of Mental Health, Homebuilders piloted an in-home intervention designed to address crisis: families for whom, "the referring agency staff, potential clients, and Homebuilder staff member all agree that if the referral is not accepted, at least one family member will be placed in an alternative living situation" (Kinney et al., 1977, p. 668). After treatment, focused on crisis intervention and teaching communication skills, over 90% of the family members initially considered at-risk for removal in fact avoided placement outside of the home.

Homebuilders recognized the benefits of in-home in a similar manner that others had in the past: “when therapy occurs in the home, staff are able to see the problem situations as they are happening. Clients seem to feel that the therapist really does understand just how complicated and painful a situation it is” (Kinney et al., 1977, pp. 672-673). Additionally, the intensity of the experience was significant. Staff members, over a six week period, spent countless hours with families, “the equivalent of 2 years of therapy in most traditional outpatient clinics” (Kinney et.al, 1977, p. 672).

The Homebuilders study was important for several reasons. To begin, it was funded in part by the National Institute of Mental Health, which provided a degree of legitimacy to the modality in that it was seen as worthy of study. Secondly, the researchers had some clarity with regard to the modalities they were using in the provision of in-home. Third, the staffing patterns were specific to the work, and clinicians were well-supported. Lastly, the study demonstrated significant cost savings when compared to likely outcomes for children had in-home not been in place (Kinney et al., 1977).

In the Exploratory Period, in-home counseling began as a way to serve children and families. The pioneering spirit drawn from the field of family therapy led to more organized attempts to provide services in the home. These attempts culminated in the first study of in-home services and the beginning of efforts to generalize the practice of in-home. Still, the exact nature of the experience was unknown, and the metric used to indicate success, avoidance of out-of-home placement, was narrowly focused and did not identify qualities of the experience that led to the outcome.

Developmental-Experimental Period: 1977-2000. The Developmental-Experimental period that began with the Homebuilders program was marked by greater use of in-home services in many parts of the country. Even though the Homebuilders pilot was not a randomized, controlled study that would today meet standards of experimental rigor, it showed that there was a relationship between the in-home intervention and the goal of preserving the family.

An increase in the use of in-home during this period was spurred on by the increasing recognition, first achieved in 1974 with the passage of P.L. 94-142, the Education of All Handicapped Children Act, that Federal legislation was necessary to protect and meet the needs of children. Shortly after the passage of the aforementioned act, 1980 saw the passage of the Adoption Assistance and Child Welfare Act which had as a requirement the expectation that states would make “‘reasonable efforts’ to prevent removal of the child from the home” (“Adoption Assistance and Child Welfare Act of 1980 P.L. 96-272,” n.d., para. 4). Largely credited with increasing the use and reliance on in-home as a treatment option, this law called for a new set of capacities to emerge within communities. With the Homebuilders project having demonstrated efficacy, the home became something of a focus for policymakers and service providers, particularly as the emphasis on service provision for children was moving away from residential hospitalization and toward community-based services.

To this end, the Federal government passed the Child and Adolescent Service System Program (CASSP) in 1984, a law intended to help states re-design systems of care to reflect a growing emphasis on community-based services (Newton & Sprengle, 2000). Many states began the process of reorganization with the recognition that

community-based services often suffered from fragmentation amongst providers and a general lack of coordination of care; the organizing principle for community-based service provision came to be known as *wraparound* (Newton & Sprengle, 2000).

In Virginia, in-home was first conceived of as a specialized service administered by Community Service Boards attempting to create community-based systems of care mandated by CASSP. Beginning in the late 1980s and using grant funding, these services followed the Homebuilders model with small caseloads, intensive supervision, a time-limited period of treatment lasting no longer than three months, and ongoing training for staff members. In fact, it was possible for individuals who were paraprofessionals to gain employment to work in the home owing to the manner in which they were carefully trained and supervised.

Shortly after the beginning of in-home in Virginia, two changes would ensue that would have profound implications for the service: 1) private companies began to move into the state to provide in-home services, and, 2) with funding and budget crises continually at issue, a decision was made for the services to become Medicaid-dependent. With Medicaid, the state would be responsible for only half of the cost while the Federal government would pick up the other half. However, since the publicly funded Medicaid system was used to pay for in-home services, private, for-profit agencies made the case that they had to be allowed to compete for the use of such funds. In Virginia, a system of agency licensure was put in place, and, once licensed, private, for-profit providers could bill Medicaid for in-home services.¹

¹ This information was taken from a personal interview conducted on March 1, 2011 with Dr. Les Saltzberg, Director of the Office of Licensing, Virginia Department of Behavioral Health and Developmental Services.

Other states were also affected by increasing costs and the need to keep children in local communities. In Connecticut, a model of services specific to the home was developed. Called Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS), this model arose from the work of psychiatrists at Yale University and came into usage in 1996. According to the developers of the model, IICAPS was “conceptualized as an intervention that was able to combine the benefits of intensive, psychiatric in-patient treatment with the holistic, ecological, family-centered, child-welfare oriented approach of clinically informed in-home family preservation” (Woolston, Adnopoz, & Berkowitz, 2007, p. 20). IICAPS provides treatment in three phases, utilizing a treatment team consisting of a “Master’s level clinician” and a “bachelor’s level mental health counselor” to work with the child and family in a manner informed by systems theory, developmental psychopathology, and the medical model (“Intensive In-home Child & Adolescent Psychiatric Services [IICAPS],” n.d., para. 6). IICAPS has proven to be effective at keeping children in the home and out of in-patient facilities.

Further re-organizing systems of care, states began to develop ways to meet perceived gaps in service with funding from state and local levels. In Virginia, lawmakers passed the Comprehensive Services Act (CSA) in 1993 which mandated a pool of state funds to be used “to purchase services for at-risk youth and their families” (“What is CSA?” n.d., para. 1). Intended to help coordinate care across multiple systems, state funds would be combined with local funds and be managed by a local team comprised of representatives of stakeholder agencies including the school system, the Community Services Board, the Department of Social Services, and the Department of Juvenile

Justice. These individuals were called the Family Assessment and Planning Team (FAPT) and were overseen by a Community Planning and Management Team (CPMT). A particular mandate in Virginia has been the development of a system of services that is “child-centered, family-focused, and community-based” (“What is CSA?” n.d., para. 2). In some cases, in-home services were funded solely by the local FAPT team or its equivalent; however, states shifted the cost of in-home services into the Medicaid system when possible. Such a cost shift became possible owing to Medicaid’s inclusion of in-home as a treatment option for children as well as the expansion of Medicaid to include more children. By the end of the 1990s the use of in-home as a treatment was only beginning to gain traction within Medicaid, and providers were slowly coming to realize the potential of the home as a treatment option.

A new treatment approach arose at this time owing largely to the realization that the home could be a treatment setting: Multisystemic Therapy (MST) began as an attempt to treat children who struggled with anti-social behaviors and were involved in the juvenile justice system (“Our History,” n.d., para. 2). Utilizing concepts from ecological systems theory and structural family therapy, MST sought to meet children, especially adolescents, in their home environment in order to elicit change. MST focused on both the parents and the child, supporting parents in learning more effective strategies of discipline and supporting the adolescent in developing pro-social peer groups and vocational aspirations (“MST Treatment Model,” n.d., para. 5).

More research into in-home was also conducted during this period. Focusing on the characteristics and qualifications of the in-home workers who they called *home visitors*, Wasik and Roberts (1994) conducted a national study in which they surveyed

individuals who were going into the home to work with children in a variety of contexts. Two key points were raised that are important to highlight: 1) “in employing paraprofessionals, project directors need to seek a close match between the demands of the position and the home visitor’s qualifications,” and 2) “the data on training and supervision suggest that many home visitors are not experiencing adequate ongoing training, are rarely provided with written materials, and in general receive very little supervision” (Wasik & Roberts, 1994, p. 340).

Continuing the focus on the contribution of the in-home worker, Christensen (1994) conducted a qualitative study with individuals who had provided both home-based therapy and outpatient therapy. Using a semi-structured interview, the researcher sought to gather information from providers regarding “factors that may not have been discovered or considered important in previous studies” (Christensen, 1995, p. 308). Interviewing ten people, four of them did not have any formal training in family therapy. Recommendations from the study included the provision of ongoing process evaluations “in order to determine how the clinicians and clients are experiencing home-based and clinic-based family therapy” (Christensen, 1995, p. 313) in response to the finding that it was difficult for therapists to tell if the client’s needs were being met by the service. The second recommendation, flowing from the finding that therapists who had training in a clinical field did not have training specific to in-home, called for training specific to in-home for both supervisors and therapists. A third recommendation focused on meeting the therapists’ perceived need for safety in the home (Christensen, 1995).

Another qualitative study explored the voices of parents who participated in in-home. A forerunner of the current study, Coleman and Collins (1997) conducted

interviews with parents who had experienced in-home services from one agency, asking three questions centered on the helpfulness of in-home, what was not helpful, and what occurred as a result of the services (Coleman & Collins, 1997). This study was broadly qualitative and did not focus its method on the phenomenology of the experience but sought to explicate themes common across interviews. The interviewees included a group of parents whose child was demonstrating behavior problems and a group of parents referred to in-home because of abuse of the child. They found that the families most remembered not “fancy techniques” but instead the “dignity and respect received in treatment, and the validation and support” (Coleman & Collins, 1997, p. 275).

Highlighting the importance of the relationship with the in-home worker, parents reported having great difficulty when they had to switch workers in the treatment process. Indeed, “switching workers seems to nullify the feelings of validation that families received from their previous worker, leaving parents less motivated to work with the next” (Coleman & Collins, 1997, p. 276). Power dynamics within the home were also included as an area of concern for parents; the authors stressed the importance of workers being able to partner with parents in the context of the intervention and being aware of alliances that develop in the therapeutic process (Coleman & Collins, 1997).

A significant contribution to the field of in-home counseling was a book entitled *Creating Competence from Chaos: A Comprehensive Guide to Home-Based Services* by Lindblad-Goldberg, Dore, and Stern (1998). The authors apply an ecosystemic structural family therapy model to the provision of in-home and also provide substantial guidance with regard to best practices in all aspects of in-home service provision. Drawn from the

experience of the authors and colleagues in Pennsylvania, the authors offer a detailed map of the service down to how to structure supervision and how to bill for service.

The Developmental-Experimental Period was marked by Federal mandates regarding children's well-being which had the effect of increasing the demand for in-home services. Owing to such mandates, a regulatory apparatus developed that dictated the manner in which services would be provided. Two theoretically-grounded interventions were developed: MST and IICAPS. Remaining unknown, however, was the manner in which individuals experienced the service and what it was like for individuals participating.

Contemporary Period: 2000 to Present. The Contemporary Period is marked both by a proliferation of the number of private, for-profit in-home providers (some of them local, some of them regional, and some of them even national) and by a continuation of the inchoate nature of these services with most providers developing their own practices. To a large extent, in-home has continued to inhabit two worlds, that of clinical mental health and that of family preservation. This is reflected in the services available, the funding for services, and the manner in which these services are carried out.

Research on in-home continued in this period and became more focused on demonstrating efficacy in order to meet the criteria of an evidence-based practice. Studies found benefits associated with in-home services in general. For example, Slesnick & Prestopnik (2004) found that the home as a treatment setting provides greater access to clinical services thus increases participation in those. Yorgason, McWey, & Felts (2005) found that in-home reduces hospitalization and other placements out of the home. It is a modality that increases treatment engagement (Thompson, Bender, Lantry, & Flynn,

2007) and provides the opportunity for clients to practice new skills, attitudes, and behaviors in the environment where generalization of those is desired. Additionally, it provides substantially more information about a client for the observant clinician and often affords greater salience for intervention given the inherent nature of home for many clients.

Existing models of treatment were specifically applied to in-home in a somewhat more deliberate fashion throughout the Contemporary Period. Multisystemic therapy (MST) was tested extensively. A meta-analysis of studies involving MST was completed by Curtis, Ronan, and Borduin (2004). Stretching back to 1986 and continuing to 2003, Curtis identified 91 articles that had studied MST in some manner. Articles selected for meta-analysis included those in which randomized samples were present with control groups. These articles were then compared using Cohen's d to measure effect sizes. Curtis found that across the selected studies, MST had an average effect of $d = .55$ when compared to the control groups, a moderate effect size. Curtis went on to indicate that the findings revealed that "families treated with MST were functioning better and offending less than 70% of their counterparts who received alternative treatment or services" (Curtis et al., 2004, p. 416). Curtis also found "larger effects on measures of family relations than on measures of individual adjustment or peer relations . . . indeed, two of the studies included in this review showed that, in contrast to MST, the individually focused comparison conditions led to a deterioration in family relations over the course of treatment" (Curtis et al., 2004, p. 416). As an in-home treatment, then, MST has demonstrated utility; however, its cost with regard to certification has limited its accessibility for local agencies and providers.

Barth and colleagues (2007) sought to assess the manner in which intensive in-home therapy works or fails to work and whether or not typical assessment measures had predictive value regarding outcomes as compared to the predictive value of certain risk factors. A quantitative study which looked at MST and used 3 instruments to assess family functioning, family structure, and child behavior, the authors include a lengthy and comprehensive literature review indicating the manner in which studies of MST in the past have met statistical rigor for using certain variables as covariates in their research design. The study methodology utilized 862 participants in in-home services who had been administered the three measures alluded to above – the Child Behavior Checklist (CBCL), the Family Assessment Measure – General Scale (Fam III-Gen), and the Family Adaptability and Cohesion Scale (FACES-III). Demographic information was collected including several “risk factor domains:” the “youth’s criminal charges, presenting problems, past treatment, past runaway behavior, gang involvement, commission of a sex offense, and the presence of siblings in out-of-home care” (Barth et al., 2007, p. 997). The authors then created probability models to ascertain which variables had more explanatory power with regard to predicting youth outcomes. They found that the assessment measures given at intake did not explain as much of the variance as did the demographic risk factors.

This study serves to confirm and highlight the importance of using at least a mixed methods approach when studying in-home counseling. It is possible that, had a mixed methods or qualitative approach been employed from the start of services with the sample of 862, themes could have been identified which would have pointed to the importance of the various risk factors in each child’s life. At the same time, while the

specific assessments noted above may not have had as much predictive value according to this study, it is likely that they were quite useful to gain some insight into treatment directions for each client.

Perhaps responding to the increasing prevalence of in-home services, several studies sought to explore the training and supervision needs of in-home providers. As a result of the proliferation of providers, more and more individuals were needed to provide in-home services. Individuals in pre-professional programs were often hired while still in graduate school (mostly those studying clinical social work and clinical mental health counseling) and often remained in agencies after graduation in order to meet residency requirements for licensure. Significant gaps continued to be identified in studies of the training and preparation of in-home providers (Adams & Maynard, 2000). Challenges were identified in supervision practices as well; Lawson (2005) shone a light on supervision practices in the in-home milieu and made recommendations that are consistent with the Homebuilders model. Indeed, findings regarding supervision have echoed earlier studies regarding a general lack of guidance for workers in the home. Building on increasing concerns about the complexity of in-home work and the relative lack of training and experience on the part of many providing the service, a recent article explored significant ethical concerns in in-home with regard to boundaries (Lauka, Remley, & Ward 2013).

Researchers at this time continued to inquire about the lived experience of clients who participated in in-home services. McWey, Humphreys, & Pazdera (2007) collected data from an agency in Florida. In this study, the researcher worked with this agency to implement *action-oriented research*, “a method that attempts to produce knowledge to

address the ‘practical concerns’ of specific groups” (McWey, Humphreys, & Pazdera, 2011, p. 141). The researchers first found it difficult to contact families, and their initial goal of a randomized sample drawn from 162 parents yielded only 24 non-randomly assigned participants. Interviews were then undertaken with both clients and therapists. The researchers used open coding and then went through a team process of identifying concepts, organizing concepts into categories, and creating themes. Several themes emerged which seemed to question elements of past research: where researchers have emphasized one strength of in-home as viewing “naturalistic behaviors” of clients, some clients experienced someone coming into their home as a significant vulnerability leading to fear (McWey et al., 2011, p.143). Another finding was that of client’s expressions of being overwhelmed by the therapist’s need to follow a time-limited plan of intervention (McWey et al., p. 147).

The Contemporary Period of in-home services included ongoing expansion of the practice of in-home across the country as well as research into several aspects of the practice. Researchers attempted to establish an evidence base for the practice of particular ways of providing in-home, including MST and IICAPS. Responding to the increase in providers, other researchers investigated staffing issues including supervision. In much of the country, however, in-home remained largely defined by parameters developed by third party payers in terms of service provision. Researchers began to inquire more deeply into the lived experience of in-home services (McWey et al., 2011).

The Current State of In-Home: Ongoing Issues and Challenges

With the notable exceptions of scenarios in which IICAPS or MST are used, much of what is currently considered in-home is more a set of procedural requirements

instituted by funding sources than a theoretically-grounded, cohesive activity. By contrast, the field of clinical mental health holds, for example, substance-abuse counseling as a distinct, bounded kind of counseling for which one must have specialized training and supervision — not so with in-home counseling. In the Contemporary Period, in-home has functioned in a largely *ad hoc* manner with each agency providing what the agency considers to be therapeutic services in ways that are untested, unknown, idiosyncratic, and highly variable with regard to outcome.

The United States Department of Health and Human Services currently considers the intervention called “intensive family preservation services (IFPS)” to be:

family-focused, community-based crisis intervention services designed to maintain children safely in their homes and prevent the unnecessary separation of families. IFPS are characterized by small caseloads for workers, short duration of services, 24-hour availability of staff, and the provision of services primarily in the family's home or in another environment familiar to the family. They are often offered to families as an alternative to their children's out-of-home placement (Intensive Family Preservation Services, n.d., para. 1).

These criteria for in-home harken back to the Homebuilders model and provide a broad framework for in-home as a practice. However, many agencies continue to provide in-home services in a manner that is not theoretically grounded. In Virginia, recent study has indicated that the practice of in-home counseling is varied and uneven; a document looking at children’s mental health in Virginia had as its subtitle, “system deficiencies and unknown outcomes” (Nimmo-Crowe, 2011, p.1). Another more recent publication in August of 2012 indicated that it was “time to focus on quality” in intensive in-home

treatment across the Commonwealth (Hovey, 2012, p.1). To be sure, several challenges remain with regard to providing services in the home.

A question that reaches back into the history of in-home services remains unanswered in the Contemporary Period: how best should communities meet the needs of children and families experiencing acute levels of distress? Regarding the children, in many if not most cases, these are the most vulnerable: those who suffer the consequences of broken relationships and fractured families owing to substance abuse, poverty, mental illness, disability, violence, and fear. Regarding the families, these are individuals, dyads, and extended kinship networks who are attempting to maintain some manner of coherence amidst ongoing crises of circumstance made more difficult by the sense that a child, *their* child, is slowly being lost.

A significant challenge to the practice of in-home is the changing cultural constellation of American society coupled with the fact that scant attention has been paid to the multicultural issues present in the in-home setting. To date, only two studies have explored cross-cultural dynamics (Allen-Portsche, 2008; Damashek, Bard, & Hecht, 2012). Damashek et al., (2012) looked at clients' perceptions of in-home providers' cultural competency using post-treatment survey methods when comparing a sample of individuals receiving a manualized treatment intended to address cultural difference to those receiving "services as usual" (Damashek et al., 2012, p. 57). Quantitative data were analyzed using structural equation modeling, and researchers looked at whether or not cultural competence had a mediating influence on treatment in the control and experimental groups. Overall, families who participated in the manualized treatment program achieved more of their treatment goals than those who did not. Allen-Portsche

(2008) conducted a qualitative study of participants' experiences of in-home with regard to their own cultural heritage finding that the therapeutic relationship and trust experienced therein was an important element of the treatment process (Allen-Portsche, 2008). Participants who experienced a sense of safety with the therapist were more able to approach cultural differences in treatment when it was important to do so, suggesting that individuals providing the service need a nuanced and well-considered understanding of their own approach to cultural difference in a therapeutic setting (Allen-Portsche, 2008). The provision of safe, protected environments for such engagement is most likely to occur with individuals trained to facilitate these environments.

Given the changing demographics in the United States and the stark inequalities created and perpetuated by neoliberal economics (Piketty, 2014; Block & Somers, 2014), more and more families are finding themselves in scenarios in which the oft-cited moniker *multistressed* applies to their lived experience. Families of color, be they African-American, Hispanic, or Asian, are more likely to interact with the juvenile justice system and the child welfare system in the United States (Fagan, 2008; Piquero, 2008). An understanding of the cultural roots of family and what it means to different peoples to exist in one is crucial to providing effective assistance for children and families. Additionally, scholars have begun to identify other aspects of the changing nature of the idea and experience of family in the United States. Recently, the notion of *family complexity* has developed in an attempt to capture the variety of ways in which the traditional, nuclear family has changed and is changing (Carlson & Meyer, 2014).

The increasing complexity of familial relationships has a direct bearing on the provision of in-home counseling services given the instability often found in family

arrangements that do not conform to the tradition, nuclear model. From the standpoint of assessment and evaluation, traditional quantitative methods may be of limited use. In order to support a better understanding of family needs given cultural differences and increasing family complexity, methods of inquiry that attempt to capture the quality and nature of experience are necessary; given that the very nature of the home is embedded in communities and is therefore local, an inquiry based in the local nexus of relationships that comprise the community is necessary. Emerging notions of family complexity point to the need for inquiry into the parent's lived experience, particularly as parents' roles and responsibilities are evolving in uncertain ways.

Context for This Study

As I have shown, the experiences of those who have been participants in clinical mental health services in the home have been left largely unexamined, and research into in-home suffers from a lack of focus on the lives of the participants themselves. The bulk of the research that has been done on in-home has a certain distance to it, the kind of distance that comes from a focus on policy as applied to people "out there." With so many needs present for the field of in-home counseling, one of the most crucial is for professionals and policymakers involved at all levels to be consistently and continuously connected to the lives and suffering of the real, live human beings who find themselves working with an in-home counselor.

It is well known that a connection exists between mental illness and poverty (Pols, 2007), and many writers have attempted to bring awareness to the lives of those struggling beginning with Michael Harrington and his classic *The Other America* (1962) Jacob Riis' *How the Other Half Lives* (1972) and continuing to the present day with

books like *Nickel and Dimed: On (Not) Getting By in America* (Ehrenreich, 2001).

However, a pervasive and stubborn tendency to blame those suffering for their suffering persists; “the other” is often thought to be at fault. Part of the problem, then, is that of dehumanization as deep human need comes to be seen and represented more by budgetary considerations than by human connection and compassion in service of helping to relieve suffering.

With the exception of one published study and a dissertation that each sought to hear participants’ voices, little is known about the lived experience of in-home services. The purpose of this study is to contribute to the literature on in-home services in a manner congruent with the practice of *joining* and *being with* in order to illuminate the lived experience of in-home counseling, fostering connection to the lives and experiences of the people who participate. Since in-home is a last resort for the most vulnerable children and families in the United States, it is hoped that knowing the phenomenon in this manner will lead to a deeper understanding of the needs of children and families, delineating the qualities of the phenomenon in such a manner that elements which contribute to its effectiveness (or lack thereof) can be identified. Such elements are most likely to emerge through a process of listening to and hearing the voices of participants in a manner that allows for the creation of an intersubjective space in which participants’ fullness of experience is welcomed and joined (Stolorow & Atwood, 1992). While one study has been done that has a similar purpose, that study used a general qualitative approach and was specific to only one agency (Coleman & Collins, 1997). The current study will adopt a phenomenological method that attempts to bring forward the experiences of parents and children in a way that leads to understanding of the challenges

inherent to in-home as well as the resilience of the families who participate.

Additionally, this study is an invitation to the fields of clinical mental health counseling, social work, and child development: what is critically needed in order to serve this population is a consistent, coherent voice regarding the complex needs of children and families who find themselves participating in intensive in-home.

Considering the Research Design

To answer the primary research question, “what is the lived experience of in-home counseling services for parents,” a design that would support a phenomenological methodology was developed. As a method, phenomenology requires that the researcher follow the data in order to discover the nature of the phenomenon being investigated, intentionally bracketing *a priori* assumptions about the nature of the phenomenon that might unduly influence the analysis (van Manen, 1990). Merriam (2009), however, argues that regardless of qualitative approach, a theoretical framework is impossible to avoid in doing research. It is the “underlying structure . . . of your study” (Merriam, 2009, p. 66). Still, the *a priori* assumptions that I had were consistent with the method itself, particularly with regard to the intersubjective nature of human encounter.

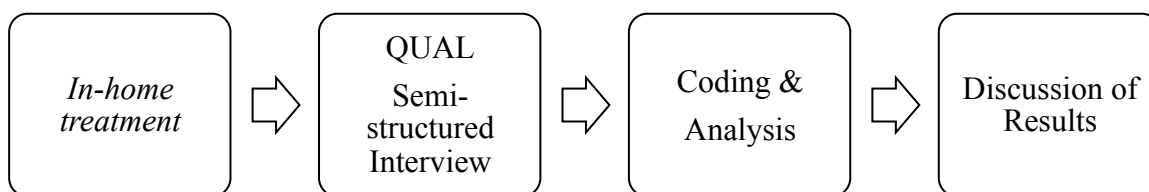
The primary assumptions which undergird this study and directly inform the research design are: 1) in clinical mental health counseling, client improvement is predicated on variables associated with a client’s lived experience of the therapeutic relationship (Wampold, 2012); 2) parents and children participating in in-home services have undeveloped and/or underutilized capacities for interpersonal relationships generally; 3) this lack of capacity is experienced in interactions throughout the various

systems of care; and 4) in-home is a real phenomenon that is bounded, can be defined, and is distinct from other therapeutic experiences.

Through an exploration of the lived experience of in-home in the areas noted above, we can begin to identify the qualities that make it unique as well as those that contribute to its potential as a specific healing modality for children and families.

Therefore, the design was intended to capture parents' post-treatment reflections on the experience of in-home counseling. Situated in the broad context of a qualitative methodology, this design can be graphically represented as follows:

Figure 2.1
Research Process



Phenomenology

As a qualitative method, phenomenology invites the researcher to investigate the lived experience of phenomena. van Manen (1990) outlines the assumptions of this way of knowing; perhaps the most significant aspect of phenomenology is its seeking the essence of a phenomenon: van Manen writes that,

the essence of a phenomenon is a universal which can be described through a study of the structure that governs the instances or particular manifestations of the essence of that phenomenon. In other words, phenomenology is the systematic attempt to uncover and describe the structures, the internal meaning structures, of lived experience” (van Manen, 1990, p. 10).

Moreover, phenomenology has a fundamentally humanizing quality to it, touching as it does aspects of being that invite the researcher into a deeper relationship with the phenomena. Indeed, the very nature of developing a question is to “interrogate something from the heart of our existence, from the center of our being. Even minor phenomenological research projects require that we not simply raise a question and possibly soon drop it again, but rather that we ‘live’ this question, that we ‘become’ this question” (van Manen, 1990, p. 43). Phenomenology is therefore congruent with my desire to capture the essence of the lived experience and to represent that essence faithfully in order to give voice to those whose voices are rarely heard in the literature.

Moustakas (1994) provides additional guidance regarding the phenomenological method, a method which can also be understood both as a process of research and as a philosophical orientation toward that process. In gathering data and as will be clear in the results, I have attempted to integrate Moustakas’ “Transcendental Phenomenology,” building, as he does, from a foundation of Husserl’s phenomenology. Moustakas points out that in Husserl’s conception, *transcendental* can be understood as an “opposition to dogmatism of any kind” (Moustakas, 1994, p. 49). In this way, the method points to a cognitive orientation that does not presuppose the nature of another’s lived experience or even categories for such. On the contrary, the invitation offered is to explicate the essence of the experience, to tell of “the phenomenon in terms of its constituents and possible meanings . . . arriving at an understanding of the essences of the experience” (Moustakas 1994, p. 49).

In order to approach such essences, Moustakas identifies an important “core process” that undergirds and make possible this epistemological stance (Moustakas 1994,

p. 33), that of the *Epoche*. As Moustakas explains, the meaning of the word *Epoche* has to do with suspending ordinary, even natural ways of perceiving the world. Instead, “phenomena are revisited, freshly, naively, in a wide open sense” (Moustakas 1994, p. 33). As an element of the phenomenological method, the *Epoche* further supports a careful regard for the place of one’s own lived experience in the interpretation of the data, ensuring that the phenomenon itself is the focus. The specific manner in which I used the *Epoche* in this study to investigate the lived experience of in-home counseling services will be discussed in the following chapter.

Chapter III

Methods

Procedures

In this chapter, I describe the procedures I used to conduct this study including the intersubjective aspects of the process: my positioning as a researcher, instrumentation, sampling methods, participants and their characteristics, inclusion and exclusion criteria for participants, and the analytical process.

Intersubjectivity and Researcher Positioning. In my approach to the research process and the data, I am cognizant of how I am situated within the contextual world of both the interview processes and the in-home process. To be sure, the ongoing relationship I have with the various systems of care involved in in-home processes have influenced all aspects of this study. My professional experience over eight years informs my interest in this topic: I have gleaned substantial, first-hand knowledge of in-home counseling from the perspectives of a provider, supervisor, community member, and, for a time, a member of a Local Human Rights Committee associated with the Commonwealth of Virginia. My professional identity is that of a Licensed Professional Counselor (LPC).

Additionally, I am aware of the intersubjective experience of each interview process as it occurred and the implicit communicative features of each as I experienced those. It is, then, in such a context that I enter into the analysis of the data as a process that still holds intersubjective copresence: the intersubjective nature of my encounter with each participant led to certain feelings, thoughts, and experiences that will manifest throughout the analysis as I re-engage in the felt sense of the interpersonal encounter.

However, only vestiges of those experiences will present themselves to consciousness as I remain conscious of the *Epoche*, the suspension of judgment.

Such an attitude is highly consistent with the fundamental clinical stance of both contemporary psychoanalysis and, arguably, one of Carl Rogers' core conditions, that of *unconditional positive regard* (Rogers, 1980). In other words, I am approaching the data with the recognition of the intersubjective nature of human encounter accompanied by an attitude of non-judging curiosity that seeks to understand the experience of the other.

Instrumentation. A semi-structured interview was developed to guide the interview process with parents. In the development of the questions, attention was given to the variety of experiences individuals have of in-home. Included in the interview were demographic questions as well as questions designed to elicit all aspects of the experience including parents' experience of the broader system of care, their experience of their child, their experience of themselves as parents, and their experience of the in-home intervention (see Appendix A). Such questions have either been absent or the data minimally interrogated in prior qualitative studies of parent experience. Specific questions included:

1. Describe the events that led to your family's participation in in-home counseling services.
2. What (if anything) did you know about in-home counseling services prior to participating?
3. Describe a typical session with your in-home counselor.
4. Tell me five words that describe your child. You said [words 1, 3, 5]. Tell me about a time that your child was [word 1]; [word 3]; [word 5].

5. Tell me about your strengths you discovered or developed because of in-home counseling.

Sampling and participants. Identifying participants posed a particular problem given that anyone who participates in an in-home service is a behavioral health client and is therefore protected by the ethics and legalities of confidentiality. Given the research design and method, a large, representative sample was not necessary. A purposeful sample that achieved maximum variation in all dimensions was desired in order to capture as many perspectives on the phenomenon as possible; given the obstacles to sampling, however, the method used was convenience sampling.

In order to gain access to participants, the researcher sought the assistance of two different providers of in-home services and one local governmental agency: a private, for-profit community counseling agency; a private, for-profit agency providing attachment-based services using the Circle of Security[®] Individual and Family Protocol (Marvin & Whelan, 2006), and the Community Policy & Management Team (CPMT) of Harrisonburg and Rockingham County, Virginia. These three entities were chosen in order, again, to attain maximum variation. As has been the case since the inception of in-home, funding is a determining factor in how the service is provided, and these participants represented all funding sources currently available: some families were funded through Medicaid, and some were funded through the Family Assessment and Planning Team (FAPT), the interprofessional team overseen by the CPMT.

In addition to maximizing the variation in funding, these three entities were selected in order to maximize variation in the nature of the treatment provided. Indeed, Medicaid-funded in-home services are rather prescriptive, particularly in defining the

client: the IP (“identified patient”) is always a child. In the Circle of Security[®] (Marvin & Whelan, 2006), however, intervention was specific to working with parents and was guided by a protocol. Other in-home services funded through FAPT varied in terms of the focus of the treatment.

Inclusion and exclusion criteria. Since invitations were sent to anyone who had experienced and completed in-home services over the span of one year, any respondent families met inclusion criteria. Parents were interviewed, but children were excluded from the research. While the most prevalent applications of in-home service focus on the child as the identified patient, it is widely acknowledged in the fields of family therapy and attachment that parents have a fundamental role as leaders in a nuclear family (Minuchin, Colapinto & Minuchin, 1998; Powell, Cooper, Hoffman & Marvin, 2014). Indeed, John Bowlby said, “if a community values its children, it must cherish their parents” (as cited in Bretherton, 1992). Additionally, for many families involved in in-home, the child may or may not still be present in the home. Lastly, children have less ability to engage reflectively in the interview process; adults have a comparatively greater capacity to reflect on their experience.

Data collection. The Comprehensive Services Act (CSA) Office of Harrisonburg and Rockingham County, Virginia mailed 25 letters to parents whose cases closed on or before May 2013. The private provider mailed 20 letters to parents whose cases closed on or before December 2013, and the attachment agency mailed 30 letters to parents whose cases closed on or before December 2013. The geographic area covered by these mailings included the Western part of Virginia, Central Virginia, and the Richmond, Virginia metro area.

Interested individuals were asked to phone the researcher at a number provided in the mailing. Five parents set up interviews and completed the same. The researcher offered to visit with participants in their homes, and two sets of parents participated in this manner. In two other cases, participants met the researcher in a public place, and in one case, the participant came to the researcher's office.

The researcher explained the rationale for the interview, and each participant provided a signature indicated that they were informed of the risks and potential benefits and consented to the interview process. Each was told that they could elect not to answer any question and that they could stop at any time and cease participating in the process. Each was also told that the interview would be audio recorded for later transcription and analysis. Each interview took between one hour and one and one half hours. At the end of the interview, the researcher provided a gift card to each participant as a token of gratitude for participating. After transcription, interviews were printed out and analyzed.

Participants

Of the three single parents and two couples who responded to the invitation, one had had in-home through Medicaid; one had had four different in-home experiences including Circle of Security[®] In-Home (Marvin & Whelan, 2006); one had had Circle of Security[®] In-Home only (Marvin & Whelan, 2006); and two had had a FAPT-funded in-home service from a local agency. Demographically, participants represented reported incomes ranging from \$0/month to \$12,000/month. Racially, two were Caucasian, two were African-American, and one was Aniyunwiya (Native American); ages ranged from the early twenties to the late fifties. Educational attainment ranged from completion of high school to some post-Bachelor's graduate school. The nature of the IP varied as well:

in one case, the child had been removed from the home and parental rights terminated; in two others, the child was in the home. In one case, the child was in a residential treatment facility at the time of the interview, and in the last, the child was in foster care in the process of being returned to the home. Three of the five participants were not the biological parent(s) of the child. For one family, the identified child was adopted just after birth and was, at the time of the interview, 16 years of age; in another, the child was adopted by a family member, and the remaining child was adopted through a local agency. The other two participants were speaking of their biological children during the interview.

To provide further understanding of the participants, I include my intersubjective experience of each during the interview. I experienced my first interviewee as someone who was clearly struggling with all aspects of life at that point. I felt from the interviewee sense of regret and sadness as we moved through the interview, and I noticed an inherent uncertainty in many responses. The uncertainty appeared as confusion with the interviewee's feelings and impressions. The second interviewee was someone I experienced as having done substantial therapeutic work in order to be a better parent to her child — a sense of commitment to the child was evident. I found the interviewee to be coherent and clear with responses and definitive regarding feelings and impressions. The third interviewee was actually a couple who I experienced as highly articulate, thoughtful, and insightful. I found my experience of them as one of intrigue regarding their story. I experienced the fourth interviewee as someone who had a strong sense of pride and determination and was going to allow nothing to get in the way of success. Again, it was evident that substantial therapeutic work had taken place, and I experienced

a clarity from this individual throughout the interview process. The final interviewee was one individual from a couple; my experience of this parent was one of astonishment at the insight into the overall process. This parent appeared to have been able to intuit clinical aspects of the in-home experience in compelling ways that suggesting a long experience with the processes under investigation.

Table 3.1

Demographics of Participants

Race of Parents		Education of Parents	
African-American	2	High School	2
Caucasian	2	Some College	2
Other	1	Bachelor's Degree	1
Age of IP		Monthly Family Income	
Infant-2.11	1	0-\$1,000	2
3.0-5.11	0	\$1,000-\$3,000	1
6.0-8.11	1	\$3,000-\$5,000	0
9.0-11.11	2	\$5,000-\$7,000	1
12.0-14.11	0	\$7,000 and above	1
15.0-17.11	1		
Status of IP		Age of Parents	
		18-24	1
Living in home	2	25-34	0
In residential	1	35-44	3
In foster care	1	45-54	0
Removed	1	55-64	1

Analysis

Data analysis proceeded in four stages. First, using Nvivo, a software program designed for qualitative analysis, I coded the data using an initial or open coding method (Charmaz, 2006) and supplemented that with an in vivo coding method (Saldaña, 2009). My rationale in combining these two coding methods was to capture and preserve the participants' voice; Saldaña (2009) indicates that in vivo coding, in which the researcher

uses the words of the participants as the code, is particularly appropriate for methods that seek to amplify and honor the voice of participants (Saldaña, 2009, p. 74). By using a combination of these methods, I was able to preserve as much of the voice of the participants as possible while also ensuring fidelity to the *Epoche*: indeed, at this point in the process, one should “remain open to all possible theoretical directions indicated by your readings of the data” (Charmaz, 2006, p. 46). Throughout the process of this first cycle coding, the primary research question, ‘what is the lived experience of in-home counseling services?’ was the focus of my inquiry.

Initial coding of the interview responses resulted in 934 nodes, or meaningful phrases. As I became more deeply sensitized to the data, thematic categories emerged from the individual nodes. Nodes that included parents’ description of the child, their relationship with the child, and their descriptions of the child’s behavior led to a category I called *parents’ experience of the child*. Illustrative statements included: “she’s curious about how things work, and it seems to be almost magical to her sometimes. It’s kind of cute,” and “she has a high need to be in control,” and “she wants to know, you know, about just about everything. It seems to almost feed her.” Nodes that illustrated parents’ perceptions of discipline, thoughts about knowing or not knowing how to be a parent, and reflective moments in which the parent considered what it meant to be a parent led to a category I called *parents’ experience of parenting*. Some statements parents shared were: “obedience is very important to me,” and “it’s like I don’t reward you for being bad. I don’t reward you for not listening,” and “when I had my baby, while I was pregnant I read, like, all these Sigmund Freud books and every parenting, how-to-raise-a-baby book ever because I wanted to do it right.” Nodes that expressed thoughts on how parents

became involved with in-home services, their feelings about the process, and their perception of a variety of agencies and organizations with whom they were involved led to the category *parents' experience of systems of care*. Sample nodes included: “that was part of the process of why he ended up in the system. He had issues with school,” and “I guess my biggest thing, my only gripe about it is the way the system is designed. You can't always get the service that's for the child,” and “my daughter's guardian ad litem. . . I just feel like, you know, like they can smile in your face but they can also hurt you. You have to be very careful what you say and what you do around them.” Finally, nodes that included descriptions of specific in-home sessions, the relationship with the in-home worker, and discussions about change that took place as a result of in-home were placed in a category called *parents' experience of the intervention*. For example, parents indicated: “I would have to do things I normally wouldn't and that caused a problem in, you know, she and I's little relationship because when the worker leaves it's back to mom's way,” and “it [in-home] never made sense to me because in-home to me is about the child living in the home, so to me it should be the whole [family], not just [child's name],” and “I mean anybody's welcome in my home but at the same time six hours a week someone's coming in your home, they're evaluating you.”

These categories appeared to be parts of a whole: distinct but intimately related elements that constituted the lived experience of in-home counseling services. I began to conjecture that the essence of the lived experience of in-home counseling might best be understood and communicated through an investigation of the parts in relation to the whole, consistent with the idea of the hermeneutic circle in which “parts of the work are thus assessed in relation to an understanding of the totality while knowledge of the whole

is constituted by study of the parts” (Stolorow & Atwood, 2014, p. 4). Such an approach is consistent with my positioning as a researcher (see above) in that “the investigator can, indeed *must*, draw upon his or her own experience and self-knowledge to guide interpretations of the lives of those being studied;” this approach also invokes a construct (the hermeneutic circle) that bridges psychoanalytic phenomenology and hermeneutic phenomenology (Stolorow & Atwood, 2014, p. 4). In this manner, my method of understanding lived experience has support from both a clinical and a research perspective.

Given the analytical possibility suggested by the data, I sought to confirm the validity of the four categories in the second stage of analysis. In this stage, I began to code analytically, moving “beyond descriptive coding” (Merriam, 2009, p.180) in order to begin to assign meaning to the data. Richards (2009) refers to analytical coding as coding that “comes from interpretation and reflection on meaning” (Richards, 2009, p. 102). In order to confirm the validity of these categories, I used a process of *horizontalization* (Moustakas, 1994): each of the 934 distinct comments was reviewed individually to determine if it could fit into the broad themes. I was able to confirm that these four broad categories could in fact be used to organize and conceptualize of the lived experience of in-home counseling as a whole that was comprised of these four parts. I transferred the placement of these nodes into the NVivo software.

In the third stage of the process, I continued to employ an analytical coding method to generate meaning within each constituent category, more deeply interrogating each of the four parts of the in-home experience. Taking each one in turn, I used NVivo to cluster related nodes into themes. In the main category of the parent’s experience of

the child, eight themes were saturated across at least three interviews. These included describing the child, describing the relationship with the child, noticing a change in the child, behaving in challenging ways, the child demonstrating compulsive compliance, hoping for the child, sensing the child's inner world, and realizing the limitations the child has. I consolidated these eight themes into three broader themes: 1) knowing the person of the child, 2) relating through difficult behaviors, and 3) identifying hopes for the child. The main category of the parent's experience of parenting also included eight themes that achieved saturation across at least three interviews: self as parent, advocacy, identifying child's need, obstacles to parenting, perception of discipline, changes in parenting resulting from in-home, not knowing how to do it, and reflective capacity.

These were consolidated into three broader themes which were: 1) identifying obstacles to parenting, 2) growing in capacity for parenting, and 3) owning the parenting process.

The main category of the parent's experience of the system of care included three themes that achieved saturation across at least three interviews: 1) experiencing the system as 'they,' 2) negative feelings, and 3) perception of the intervention within the system.

Lastly, the main category of the parent's experience of the intervention contained several themes across at least three interviews which included: describing the child and the in-home worker together, describing a session with the worker, feeling uncomfortable bringing someone into the home, describing the relationship with the worker, going through scrutiny, describing how the in-home worker helped, describing the worker as really good, defining the helping relationship, reflecting on regulations, naming family systems dynamics, reflecting on in-home, and learning about "miscues," or behaviors that mask the child's underlying need (for example, a child might behave in ways that appear

angry in order to hide an underlying fear and associated need for protection). These were consolidated into broader themes which were 1) identifying helpfulness, 2) learning to relate, 3) feeling vulnerable, and 4) critiquing the process.

Finally, the fourth stage of the analytic process involved developing theoretical categories that would communicate the totality of the lived experience of in-home counseling. I used each of the aforementioned categories and broad themes (knowing the person of the child, relating through difficult behaviors, identifying hopes for the child, identifying obstacles to parenting, growing in capacity for parenting, owning the parenting process, experiencing the system as ‘they,’ negative feelings, perception of the intervention within the system, identifying helpfulness, learning to relate, feeling vulnerable, and critiquing the process) to develop the following statements that represent the essence of the experience of in-home counseling services in this sample:

- 1) In-home counseling services are experienced as a complex and paradoxical nexus of relational closeness and distance;
- 2) In-home counseling services are experienced as containing elements of both helpfulness and frustration;
- 3) In-home counseling services are experienced as constantly imbued with a variety of internal and external pressures.

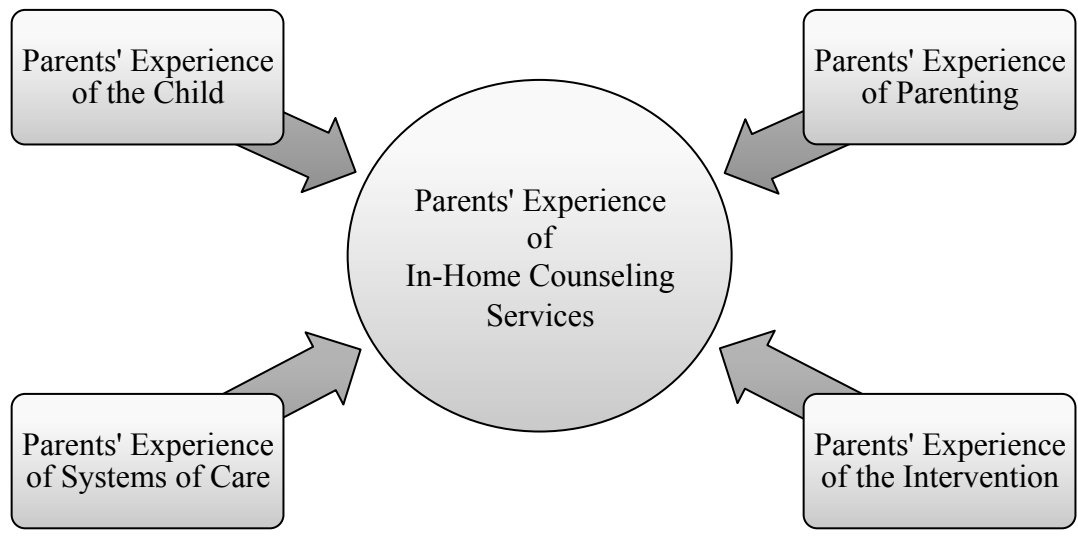
I will describe the essence of the experience of in-home counseling in greater depth in the next section.

Chapter IV

Results

To illuminate the primary research question, “what is the lived experience of in-home counseling services for parents?” the data were analyzed first with this question in mind. As seen in figure 4.1, the parents’ experiences of the identified child, of parenting, of the system of care, and of the intervention itself were found to constitute and influence the experience of in-home counseling services. These constitutive aspects of the lived experience of in-home counseling services were analyzed further; I will describe each constituent part in turn, using those descriptions as a foundation to communicate the essence of the in-home experience.

Figure 4.1
Constitutive Aspects of In-Home



Parents' Experience of the Child

As noted, in-home services as currently organized focus on one child, called the *identified client* or sometimes the *identified patient*. In the sample, three of the five participants were not the biological parent(s) of the child. In one case, the identified child was adopted just after birth and was, at the time of the interview, 16 years of age; in another, the child was adopted by a family member, and the remaining child was adopted through a local agency. The other two participants were speaking of their biological children during the interview. Three main themes emerged from the data: 1) knowing the person of the child; 2) relating through difficult behaviors, and 3) identifying hopes for the child.

Knowing the person of the child – outer qualities. Parents described both seeing the child from the outside in terms of qualities and characteristics as well as knowing the child at a deeper level which included recognizing the child's limitations. In spite of the innumerable difficulties parents had experienced, they were still able to see positive aspects of their child's personality. A descriptor that emerged across several interviews was "smart" or "very smart;" other descriptors that parents shared included seeing the child as bright, sparkly, happy, curious, innocent, sensitive, and sweet.

Parents also described their children in terms that represented negative aspects of their experience. Descriptors here included references to the child's intensity of behavior, overall activity level, and perceptions about motivations. Parents used words like "manipulative," "oppositional," "lonely," "sad," "intense," "defiant," "anxious," and "always on," describing children who "needed to be in control," "who did not trust

adults,” who “upped the ante” by running away, and who “sabotaged parents’ efforts to get close to the child.”

A consistent theme across interviews was that of the child’s anger. One parent described a foster child as coming into the home, “like a loaded bomb.” Another characterized her daughter, having been adopted out of her biological parents’ home at nine months of age, similarly: “she came just as wired as she is now, black or white, no gray, either really, really good or really, really awful.” Others spoke of the child “getting in students’ faces” at school, hitting other students, punching staff members at day care, tearing rooms apart, lunging at the parent, and having fits of anger that appeared to the parent to be seizures.

Knowing the person of the child – inner worlds. Parents also described being able to sense their child’s inner world in various ways. One parent described her child as, “having a pure heart:”

The number one thing that I describe in her is that she has this pure heart. Do you know how sad it is to see a child wanting to attach but not know how? And that’s [name redacted]. She wants it and that’s that pure heart. She wants it more than anything but everything in her body tells her to not do it. She’ll come for the comfort but once she gets it she doesn’t know what to do with it. And that, to me, how do you teach that? It’s not inherent, you know? I try to get as much information as I can but at the same time you’re only as good as the information.

And Google does not give you a lot of information about attachment.

Parents indicated their intuitive sense of their child, speaking of the child’s struggle to find comfort with adults and being able to sense the child’s inner conflict. Parents were

able to compare what they knew of their child's inner world with what they were seeing behaviorally in order to identify times that the child seemed to be seeking comfort on one level but behaving in a problematic manner.

Relating through difficult behaviors. Parents described their relationship with their child as well as the challenges they experienced on an ongoing basis. They used words like, "difficult," "strained," "not normal," and "confusing" to describe the way in which their relationship with their child was experienced. With regard to "confusing," one parent said, "I think confusing in comparison to raising your own children, you know, and confusing for her because the world she lived in...it's almost like we've done a flop, both of us. I know this normal world; she knows this chaotic world and we both have switched trying to understand the other world. So that's where I think it's confusing for both." They also used words like, "loving," and "caring" to describe the nature of the connection they experienced with the child. These relational aspects were particularly important given the challenging behaviors the parents described. Parents tended to rely on moments of really *knowing* the child in order to manage their own responses to the child's negative behavior. One parent spoke of being able to relate to the child's pain as a means of understanding and coping with the child's behavior:

Because when you have a child that's lunging at you or refusing to do what you say or tearing the room apart, you know, if you know that their intent is not necessarily within their control, you just help them through it and then work with them later. You know what I mean? I think that they give you those answers... 'cause like if your kid just takes a ball and throws it through the window because they want to break the window, then you're not gonna have as

much patience for that. But yet if they're having a flashback to their dad having sex with them, it's still wrong and you'll identify that but that's not the time. Does that make sense?

Another parent talked about being able to recognize in the child the manner in which her ability to stay present with the child in spite of the difficult behavior allowed for the naming of the emotion and the child soothing: "...you could see when it worked, when you had read her miscue and gone right for the meat, you know? And then you could just feel that she was..." Trailing off in her narrative, this parent appeared to be referencing being able to feel that the child was less emotionally aroused.

In part because of the capacity to relate through difficult behaviors, parents also identified changes they saw in their child as a result of in-home. Many of these changes were seen as useful and welcome while others led to further uncertainty about the child. In terms of changes that parents experienced as helpful, a major focus for parents of the younger children in the sample was "listening" and "doing what you are told." To the end, one parents experienced such changes:

Yeah, she had begun to really listen more, you know what I'm sayin'? Like, if I asked her to do something it wasn't about asking her 2 or 3 times to do it. She would do it and then sometimes she would do it on her own. So I mean she began to listen more 'cause she wanted to have somethin' to tell the in-home worker, you know what I'm sayin'?

Other parents spoke about the child "doing phenomenal" at one point in the treatment, "staying in the boundaries," "following the rules," "being honest," and "trying hard."

With regard to the child's self-experience, one parent remarked, "I think she probably has

more understanding, head understanding of emotions and understanding [of] herself...[she is] learning to verbalize...that angst or whatever. She has words to describe that.”

With regard to aspects of their experience of the child that led to greater uncertainty, parents recognized when the child was overwhelmed by the changes also noted when it appeared that the child was unable to maintain those: “Like she just couldn’t do it anymore and you could just see her have this, like, buildup to doing good, and then all of a sudden it’s like she realized it and that scared her and she fought it.” Parents spoke of degrees of compulsive compliance that they noticed in their children, putting this in terms of the child’s ‘presentation.’ For the younger children in the study, this took the form of their overt behavior, and for the adolescent, it took the form of becoming “therapeutically savvy,” “picking up buzzwords...to the point where it’s comical.” One parent, speaking of a child, said that her daughter, “presents very well. I mean, you can tell there’s issues, there’s trauma, whatever, but she will present herself well.” Continuing, she said that the child “presented herself almost well enough that the therapist was kind of scratching her head like, why am I here? which is a common thing a get with [child’s name]. The school is the same way. They’re like, there’s nothing wrong with this kid. What are you all talking about?” A more explicit example came from another parent who said, “I think she was more or less trying to show them that she was on her good behavior ‘cause in her mind she was taken because she was being bad...at the time she would not listen. So it’s like, okay, I’m gonna show them that I can be good so I can stay with my mommy.” The parent continued, describing ways in which the presence of an in-home worker led to compulsively compliant behavior:

The case worker bought it [a small broom] for her because [the child] said, ‘I want to help my mommy sweep but that broom is just too big.’ So she went and bought her that broom and she’s been sweeping. She’ll sweep in there, lift the carpet, and sweep in here. You know it’s just somethin’ to tell the case worker that she’s done.

In these ways, the parent’s experience of the child is one of the child “being good,” but the child’s experience is one of suppression and fear. As I will discuss in the section on the parent’s experience of the intervention, some parents were able to recognize these patterns while others were not.

Identifying hopes for the child. Amidst all of the challenges that parents experienced with the child, the enduring hopes they had for their child’s future emerged as a powerful exemplar of care. In one case, hope persisted even with recognition that the child would never again come to live with her biological mother:

if someone is going to take on the responsibility of shaping my child into the person she’s going to be for the rest of her life I would just hope that that person would instill the same values and everything in her that I would and they would make her an individual that gonna be prosperous in life... I don’t want her to make the same mistakes that everyone before her has made. I want her to be completely different. I want her to have opportunities that we didn’t have.

Other parents who were currently raising the child in the home had more practical and immediate hopes; one parent indicated that “we hope to get her through high school and get her disability set up when she’s 18” in order to facilitate an ongoing familial relationship. Another parent spoke of the hope that the child would become a part of the

foster family in preparation for adoption; another indicated that she just “wanted her son to be OK.”

Parents’ Experience of Parenting

The manner in which individuals experienced themselves as parents was another constitutive aspect of the experience of in-home counseling services. Parents’ sense of themselves was greatly challenged in the face of the difficulties noted above, including parents who had raised older children. In the sample, the experience of parents varied greatly, including first-time, biological parents, parents of multiple children including the identified child, therapeutic foster parents in the process of adopting the identified child, and adoptive parents. Emergent themes across interviews coalesced into 1) identifying obstacles to parenting, 2) growing in capacity for parenting, and 3) owning the parenting process.

Identifying obstacles to parenting. Parents identified several different kinds of obstacles in the raising of children. Related to the physical world of the parent were issues such as injury, job loss, incarceration, a child having cancer, and substance abuse. Other issues included children being in foster care and biological parents attempting to negotiate the visitation process with the child. One parent spoke about the feeling of sadness in seeing the child return to the foster family, not knowing whether or not the child would ever return home. Additional obstacles included not knowing what to do in a variety of situations, being “new to parenting” and not knowing what is normal for children.

Parents cited the challenging behaviors of the child, seen above, as significant obstacles to their parenting. Descriptors that emerged included words like “chaos” and

“being in a war.” In discussing recommendations for parents who hadn’t yet participated in in-home, one parent encouraged those parents

to not give up. I know that that sounds so contradictory to most everything I’ve said but it is a fight. It’s a battle. The system’s a battle; the in-[home] is a battle; everything’s a battle: your internal battle, the child’s battle. A lot of people don’t realize that. If the in-[home] is coming in the home, there’s a battle going on. So you’ve got to keep going.

Citing a high degree of stress owing to other life issues, one parent said that it was not desirable for the child’s behavior to add to that stress. This affected the manner in which the parent typically disciplined the child:

I would much rather let you know what it is and let you know that there is no room for you to try to negotiate your own terms in this than for you to try that and then I just allow you, and then you continue to do it and then you further add to the stress I already have going on. I don’t need that. Why would I reason with you or barter with you to get you to act a certain way when you literally have no choice?

Others talked about being frustrated with the child’s behavior and being additionally frustrated that they were unable to figure out how best to help the child. One parent told of her daughter’s “clinginess” to the point that the parent experienced

not being able to go to the bathroom by myself. So we worked on that in counseling and she stopped. ‘Cause she wouldn’t knock or nothin’ and it was just coming in, shut the door and just stand at the door like this. And I’m just like, “I

can't use the bathroom if you're standing there." She's like, "Yeah you can. I'll turn my back." That's just the type of stuff she did and that frustrated me.

This frustration continued as the parent and in-home worker attempted to understand the meaning of the child's behavior, eventually resulting in the child being seen by an outpatient counselor:

Yeah, I mean I told her everything and she would ask her and she would try to talk to her too and she'd sit there and be like, "I know, I know, but I just want my mommy." At first we were like, okay, she ain't been home. She's been gone for 3 weeks, whatever, and she'll get out of it. So I just took it to her counselor 'cause, you know, her counselor is trained to connect with children so I took her to her counselor.

Parents spoke of "being exhausted" and just being "tired," particularly foster parents. Even when parents were trauma-informed in their outlook and approach, they still alluded to the significant energy required to continue to meet the needs of the child in question, talking about the numerous appointments with in-home providers, psychiatrists, counselors, social workers, and schools.

Growing in capacity for parenting. Parents identified changes in their capacity for parenting as a result of in-home counseling. In particular, they noted different strategies that they could now use, a greater degree of focus on their child's needs, and being able to reflect on their own attitudinal and behavioral tendencies in addition to those of their child.

Parents were able to identify different behavioral strategies they could now use to parent. One indicated that she had had difficulty setting limits prior to in-home: "you

know, it was a little hard for me to transition myself into the disciplinary and mean it and make it stick. Because I know I can say 'no' and, like, get over my conscience, you know what I'm sayin', not let my conscience beat me up because I said 'no.'" She noted the change after in-home in her ability to set limits, saying, "so it's like, you know, like 'no' means 'no', L. That's what she [the in-home worker] installed. No means no. Not 'no' and then 'yes.' 'No' means 'no.'" The parent saw a corresponding change in the child: "I got more respect from her, you know what I'm sayin'? It's like I don't reward you for being bad. I don't reward you for not listening. You only get rewards for good deeds, good things. She [the child] started appreciating that more."

Another parent referred back to the kind of discipline she practiced prior to her in-home counseling service. She told of times with her son before in-home counseling:

It was harder. I can't say that I wouldn't've done, you know, some of the things but it would have been a big fight and a big argument between him and I.

Basically, like, I would be saying 'no' and he would be arguing with me or he'd be fighting with me. I'm not one to smack my child; I'm one to tell my child to go stand on that wall over there. There's a line right there on the wall where their heads had to be if they were that height and that's the last height he was a year in this house. Then my other kids have other lines on the wall, even the teenage daughter.

After the experience of in-home, she found herself able to discipline her son by "sitting down and talking to him and finding out what was going on...now I know how to do that, and I say I know now because of the work that [in-home worker's name] put in.

With [the specific intervention], I've seen where I have made errors, you know? It's more or less needing to know what is it that he needs from me instead of what does he want from me." Reflecting on how she came to see her child's behavior differently, she continued, "I just wasn't picking up on what he wanted or what he needed, I mean all he needed was that extra time to talk. But I've noticed a change in him and I both is that he now can feel like he can come to me. I've seen it." Behavior once interpreted in one manner began to be seen in another. In speaking of behavioral tantrums, one parent remarked, "like I said earlier, I've learned that they're miscues; they're not just him acting out being all ornery or you know having these meltdowns that look like seizures and stuff like that." The parent encouraged other parents who might have in-home in the future to "make sure it's not you're putting them first because they want something but because they need something." Another parent talked about being better able to meet her child's need for nurture after in-home:

So the nurturing is different and I think I do a pretty good job of meeting the needs of what that child is. Like, sometimes you have to ask the foster kids a lot of times, 'Is it okay if I give you a hug.' You know, because touch sometimes freaks them out, stuff like that. So nurturing to their needs is probably a better way to describe that.

Reflective functioning with regard to the child and the parent differed across interventions. One parent was thoughtful owing to the outcome of the process which resulted in the child being permanently removed from the home. The parent reflected, "now that she's not here I think back on a lot of the things that I could have done differently." In thinking about the child, the parent continued, "I always wanted to know

what was going on with her because I think that that's a big reason why the things I've done in my life were done because I had no one that understood me." Others came to recognize changes that they made themselves were leading to changes with the child. One remarked, "It's not always the child. I think this is the biggest battle that you have sometimes, even with your own kids. Okay, what am I doing to contribute to this?" Another, on being asked why she thought changes happened in her child, responded immediately, "because of the things that have changed in me." Two parents reflected:

[Mother] So one difference for us though, with [the specific intervention] especially, is being able to kind of take that step back, that subjective step back and look at the behaviors that she could perceive to be personal attacks and to say 'Hmm, what does this mean?' I think that's another change that's not in her but I think more in us. [Father]: Yeah, I agree.

Parents described additional aspects of reflecting on their own and the child's behavior, continuing to note growth in their parenting. Growth occurred for one parent because of insight into her own patterns of relating to her child. She said, "there was a particular video where this woman was kind of clingy to her child and I could see that was me. I was clinging to [child's name] on everything that he said. Anything he said, anything that he did, I was always hovering over him. I was able to see where I was too clingy or too whatever." Another parent noted a difference in the way that she handles her child's feelings. She said,

So you've got to be willing when the child comes and says, 'I don't like it when you scream at me' or 'I don't like it whenever you look at me like that,' you have to just understand that child's entitled to their feelings. It doesn't mean they're

right, but you just have to be willing to accept that. I don't think that was necessarily hard for me, it was just more interesting that that kind of occurred. One parent talked about being able to observe the behavior of their child in a different way: "But I think with [the specific intervention] I just feel like we're a lot better at reading her and a lot of that is those videos. Looking at the videos of other children, but then the videos of her and recognizing when she's like kind of in that pre-dissociative state and what that looks like." Continuing to speak of her experience as a parent, she noted being able to read what was going on in the child's inner world, saying, "I'm getting ready to lose her here. She's shutting down inside. I never would've been able to read that without that understanding that we gained in [the specific intervention]... I think it's probably made me a more compassionate parent. This understanding had a direct effect on the parent approaching the child, "when she's having a really difficult time at school or some place and I'm able to comfort her."

Owning the parenting process. While parents' identity as parents was palpably strong throughout the data, parents' sense of ownership was tinged with an ongoing uncertainty as to whether or not they were doing it right. Ownership of the parenting process was experienced in both a negative and a positive manner; parents described aspects of themselves as parents, and some found themselves more able to be advocates than others.

Descriptors that parents used for themselves included, "dedicated," "being a hard worker," "cautious," "disciplinary," "kind," "loving," "nurturing," "open-minded," "organized," "talkative," "unconditional," "caring," "loving," "playful," "ready to listen," "savvy," "studied," and "tenacious." In spite of these words, other sentiments including,

“obviously not very good parents,” “crappy mother,” and “old and tired” were used. One parent remarked that, “I think there are times when we question our parenting skill because you feel like it must be something you’ve done wrong, or that you can’t get right. And then at times when you don’t and you say ‘we’re doing a great job.’ This is just the hand we’ve been dealt. It’s a tough hand.” Another echoed this idea in a slightly different manner, speaking of the perception of others regarding her foster child: “It just felt like sometimes people were saying, ‘Why can’t you manage this?’ Well, I’m like I didn’t do the trauma to her. But at the same time that doesn’t matter.” One parent added, “for the last 10 years or so, I think our expectations as parents has become quite a bit diminished based on the results that we see [with the adoptive child].” Such questions persisted in spite of the Herculean efforts these parents were making with their child.

Parents were able to demonstrate advocacy in several ways throughout their experience of in-home, taking charge and leading the way for their children. These scenarios extended from acting in ways that most parents would consider typical to developing skills in the context of the intervention and concomitant involvement with other service providers. In some cases, parents were able to take responsibility for situations that caused pain for their children. One parent remarked, “It was the mistakes I made that even allowed her to get into the system.” In other cases, parents were clear on their intra-familial leadership:

I’m kind of the ‘Mom’s not happy; nobody’s happy.’ The one that says, okay, this is what we’re doing. This is how it’s going. This is the routine, you know, that everything kind of goes, boom, boom, boom, boom, boom. And it’s real important for the foster kids, but I have to find the balance between the normal (I shouldn’t

say 'normal', that's a bad word)...my biological children who've had this normalized, you know, family. Then the kids that need, they latch onto that routine so I have to find that balance. So to me it's more I have to organize the house and every individual's needs. And then referee it.

One parent described forging a leadership role within the treatment team, recognizing her relative lack of power and gradually taking more and more ownership through self-advocacy. She related that, "in the past couple weeks I've actually asked for more control with [child's name]. Instead of [the social worker] putting her two cents in and not letting me be the parent that I'm supposed to be." Going on to describe supervised visits with her son, this parent said, "how am I supposed to do anything with him or learn or, you know, use what I've learned if [the social worker is] always constantly 'eeh, eeh, eeh' at [child's name] and I have to sit back and then it seems like she's taking control." With the support of the in-home worker and her outpatient therapist, this parent was able to advocate for in order to

set up a monthly meeting...We do it every month now to see how [the social worker] thinks things are going and how I think things are going, they think things are going. And now we're also going to include doctors, [the GAL], if they can come. You know, we're opening an invitation to them on how they think things are going and stuff like that.

This parent continued to advocate for herself, demonstrating her leadership as a parent by meeting with the social worker to discuss her feelings and desires about her son:

we had a meeting basically with [the social worker], and I said, 'look, I don't know how to say this to you myself.' Like, I didn't know how stepping on her

toes would be but ‘I’ve been discussing this with [in-home worker] and [outpatient therapist] that I don’t have enough power. It seems that you’re taking it from me. And he doesn’t understand who to talk to. And, obviously, who is he going to go to? He’s not going to always come to me. He’s gonna come running off to you. Is there any way that you can just step back and just let me? And then if I need you, I will get you. If there’s something I don’t know, you know, him and I walk together or if he’s at the playground and you’re right there and I can walk over to you to talk to you, you know, and keep it low so he don’t have to hear.’”

This sense of efficacy was demonstrative of a shift in perspective to own the parenting process in ways that had not previously been possible.

Parents’ Experience of Systems of Care

Throughout analysis, it was clear that experiences of the various systems of care in which parents and children were involved impacted the experience of in-home. These systems included the Department of Social Services, particularly Child Protective Services, the court system and the guardian *ad litem*, school systems, funding streams including FAPT and Medicaid, as well as the various treatment providers of in-home in different localities. In this constituent part of the in-home experience, themes that achieved saturation were 1) experiencing the system as ‘they,’ 2) negative feelings, and 3) perception of the intervention within the system.

Experiencing the system as ‘they.’ Parents had a number of different thoughts regarding what was consistently called “the system,” referring broadly to the mental health, child welfare, special education, juvenile justice, and juvenile and domestic

relations court systems and the ways in which those manifested in the lives of parents and their children. Talking about how the child began a process that continued with foster care, one parent said, “that was part of the process of why he ended up in the system. He had issues with school.” Another said, “you get stuck in that a lot in the system.” Referring to reading her child’s behavior, another said, “I’ve learned to pick up on what they [tantrums] are and he’s actually not ever had one since he’s been in the system.” Describing her own culpability in the process, another parent said, “it was the mistakes I made that even allowed her to get into the system. But I just think sometimes it’s just a little overbearing.”

In order to assign agency to whatever action was being taken, references to “the system” were most frequently accompanied by the pronoun “they.” For example, one parent remarked, “I had a thing where I let her do what she wanted to do and they didn’t want me to do that.” Talking about her child’s various services, a parent had been told that, “there’s other services that he could go in. We did all the other services they suggested.” Describing a degree of resignation about her situation, a parent said that, “as far as having your kid, I don’t think they’re really concerned about all that. It just seems as though once your child gets all caught up in the system it’s not really something that they pay attention to.” In describing her understanding of the rationale for her child’s removal from the home, a parent surmised that, “my kid was taken because they feel as though my mental capacity isn’t where it should be as far as having patience and knowing how to react to certain situations positively.” One parent, referring to an ancestral ritual, remarked, “that’s a thing that’s changed now because I can’t do that with [her kids] because we would speak a lot in [native tongue]. In the system we’re not

allowed to, while he's in the system, speak a language they don't speak." Finally, a parent talking about the in-home intervention *vis a vis* her perception that the social worker was "calling the shots" said, "that's the downfall of it, you gotta listen, you gotta do what they want you to do."

Speaking of her experience as a foster parent, one parent's reflection on the system of care warrants inclusion in its entirety:

I guess my biggest thing, my only gripe about it is the way the system is designed. You can't always get the service that's for the child. That was the biggest thing with [child's name] was everyone, and this is pretty common, everyone is saying that she needs attachment but because she doesn't have that RAD [reactive attachment disorder] diagnosis and she's under Medicaid, she couldn't get the attachment because it's so expensive. So sometimes I was a little frustrated in that and that's still very confusing to me. I don't understand. I have a pretty sneaky feeling when she comes out of [residential treatment facility] we're going to have the same thing happen. They're going to want her to have in-[home], and she's not going to be able to get attachment because even [residential treatment facility] is saying she doesn't meet all of the requirements for RAD. We're going to ride this pony again. I guess that's kind of back to when you were asking about what would I tell another parent: accept that, take what you can get, compromise, and just make the best you can. That's where my fight comes on. Keep asking questions. Why? I guess that's kind of my curiosity. Why is it that you've got a child's life and it's this budgeting? It doesn't make sense to me. And we're going to do it again, probably.

She continued, saying:

Let me explain something to you. This makes no sense. [Residential treatment facility] costs \$156,000 a year. I mean I worked in corporate so I did a little bit of the budgeting: \$156,000 a year for [child's name] to be at [residential treatment facility]. I don't know what the attachment therapy costs in comparison to the behavioral therapy. Had she had that attachment therapy, I don't think she would have gone to [residential treatment facility].

Negative feelings. Parents described negative feelings associated with their experience of systems of care at various levels. A common experience was that of feeling blamed within systems of care for the difficulties the child was having and/or unheard. One parent, speaking about a move to Virginia and the behavior in the school of her adoptive daughter, shared, "I guess the first time I ever felt that was when we had to go meet with the school psychologist when we first moved here and they basically told us this is all our fault. [Child's name] was banging her head on the floor at school and that's when they said, "this kid needs help," and they looked at us and said, "what have you done to do this?" After participating in a screening process, this parent got the message that she was "your typical older mother, neurotic, overprotective, adoptive mother. It was like, I don't think so, and, of course, that proved not to be true, but I do think that that idea that we have had to kind of go through that being judged." Of the overall assessment process within the system of care, another parent said that, "a good portion of it seemed to be focused on what's wrong with you to end up needing us, and that was kind of weird I thought." Others spoke of a sense of being critiqued, watched, and feeling "under the microscope" alluding to those outside of the intervention: "[I] try to be extremely sincere

when it comes to my child because I don't want anyone trying to critique anything else.”

This sense of critique extended to relationships with professionals within the system of care with two parents expressing similar thoughts:

I felt like I learned that you have to be careful what you say around certain people irregardless of how willing to help they may seem to be. They can have the best intentions but it may not work out that way. So I learned to kind of bite my tongue sometimes around people. That definitely taught me that.

In continuing to describe perceptions of the possible systemic reverberations of the in-home work, the other parent said:

and I think they should be very careful with what they say and do around that person [the in-home worker] 'cause they're being critiqued and, you know, the slightest mistake or negative reaction could be the difference in keeping their children and not. They should be on their Ps and Qs, definitely.

This parent continued to describe her perception of the relationship with the *guardian ad litem*, an attorney appointed to represent the interests of a child in foster care:

that was my daughter's guardian ad litem and I just feel like, you know, like they can smile in your face but they can also hurt you. You have to be very careful what you say and what you do around them...once your child has got a GAL their word is basically the nail in the coffin. If they say 'I don't feel like this child needs to be at home,' that child is as good as gone.

Another parent, describing her exasperating journey to be allowed to participate in the attachment-based intervention, spoke movingly about her own family's process within the system of care and wondered about that of other families:

I went back six years ago so I spent her whole life being, like, the advocate and the person trying to get the kind of services that she needs. And even here, too, trying to get her the level of care she needs. Parents should not have to be that tenacious. And most parents aren't, or can't be, and we say that every step of the way. What about the parent who doesn't know or is intimidated by someone educated or who doesn't know how to navigate the system, or just advocate ... until someone actually try this, try this, try this? So for other families I would want them to know about this sooner and be available sooner.

Perception of the intervention within the system. Indeed, parents spoke of additional issues in terms of the nature of the intervention within the broader system of child mental health care and child welfare including how they became involved with in-home and what they knew about it prior to participating. Some of these issues were specifically focused on the regulatory environment and the manner in which parents perceived that impinging upon the work; others were focused on interactions amongst different aspects of the system of care.

Parents generally knew nothing about in-home prior to participating. At most, one parent indicated that she had had a friend who had in-home and hence knew that it existed but did not know anything particular about it. Families became involved with in-home in different ways including the school having concerns about the child and recommending additional services, the child being hospitalized and in-home being recommended by a social worker, the parents advocating and asking for assistance, and parents who were involved with Child Protective Services and participated in in-home as an attempt to ameliorate issues that led to the removal of the child. The number of in-

home providers each family had experienced varied, the least being one and the most being four.

In learning about the intervention for the first time, parents indicated that they generally did not know what to expect. One parent remarked with uncertainty that she thought that the in-home worker was “supposed to be like a, um, a go-to person as far as, like, when I needed assistance with something pertaining to my child or with my household or, you know, how to do this right or how to do that right.” Another said that she “knew that, you know, there was people that came out to your house, you know what I’m saying, to help you, like, if you had any concerns or whatever about your child, that maybe they could help with or get you help with.” Still another indicated that she “kinda thought it would be a Big Brother/Big Sister program.” Others spoke about their perception of the lack of training and capacity of the in-home worker. Responding to her perception that the in-home worker was a “quack” who was not helping her son, one parent told the worker to “get the eff out” of her house,” and another parent indicated that she “didn’t understand the wide range of skills and experience of the different providers” when her family began the in-home process. Elaborating, she said, “well they had sent me people who are not qualified to do the job. This wasn’t easy-peasy, you know, teach us how to be parents or to train you on behavior modification. That’s not what we were dealing with.”

Some parents, particularly foster and adoptive parents, indicated that they became well-acquainted with the various regulations that informed in-home as well as other treatment providers. In speaking of the manner in which she first came to participate in

in-home services, one parent said that it was, “after the first Commonwealth [Center]² stay because we dropped the ball in the sense that we didn’t do it within the 30 days of their recommendation and we had to redo a VICAP [Virginia Independent Clinical Assessment Program]. So, yeah, it was after the Commonwealth stay.” Referring to the children’s hospital, she said, “the Commonwealth Center, I’ve learned, is just a place for them to calm down, not a real treatment center.” She continued, echoing other sentiments of parents noted above, alluding to both the regulatory environment as well as to the nature of most in-home services, saying, “because one of her stays at the Commonwealth Center, they said that you can’t get into a bartering with [child’s name] and that behavior modification probably wouldn’t work the best for her. But we were, like, that’s all we qualify for.” She continued:

I think that...it’s kind of complicated because the Commonwealth Center will say that behavior therapy...and this is the most mystery to me that I don’t understand...[child’s name] very much needed attachment therapy but because of the system and how it works and what you need and it’s expensive, you don’t get it.

The impact of, in this case, Medicaid regulations was ever-present. Describing her perception of what happened in the session, a parent noticed that

I would ask for things and stuff like that and you could just tell that she was in a struggle because she would do her best to try to do it but you could always tell she’d gravitate and pull back towards [child’s name] and working with [child’s name] ‘cause you would have to have specific things for it to be working with

² The Commonwealth Center for Children and Adolescents, located in Staunton, Virginia, is an acute care, psychiatric facility.

other. It had to be, like, okay [child's name] having a problem with her brother, that sort of thing. It can't be, you know, the brother's having a problem with [child's name]. Does that make sense?

Commenting on the in-home worker focusing on the child and the child as the identified client, she went on to say, "it never made sense to me that in-home because in-home to me is about the child living in the home so to me it should be the whole home, not just [child's name]." The environment created by regulations and the resultant practices that typified in-home services were experienced as limitations that often were unable to meet the needs of children and families. Still, parents found utility and helpfulness in various aspects of the intervention itself, to which we will now turn.

Parents' Experience of the Intervention

The intervention itself is at the heart of in-home counseling services. As noted elsewhere, the intervention which the parents in this sample experienced differed in substantial ways. Nonetheless, common themes emerged in the data. These were: 1) learning to relate, 2) identifying helpfulness, 3) feeling vulnerable, and 4) critiquing the process.

Learning to relate. An aspect of the experience of the intervention, learning to relate was experienced with both a positive and negative valence depending on the manner in which the parent experienced the relationship with the in-home worker and, when the child was in the home, how the parent observed the in-home worker with his/her child. To describe positive aspects relationship with the in-home worker, parents used words and phrases like, "caring," "organized," "coming from the same background," "honest," "intense," "enlightening," "knowing us," "respectful," "helpful,"

and “supportive.” Further describing their relationship with their in-home worker, parents expressed being able to trust, to express any feeling, to be able to talk about anything, and that they felt validated by the in-home worker. One parent talked about “getting tight” with the worker; another spoke of being able to be “tearfully upset” and experience comfort from the in-home worker. One parent described, her worker, say he was,

one of the best workers that I’ve ever seen. To be able to work with someone like [worker’s name], the way that he showed me things and he would ask questions. I would be able to answer them or I would get them right and even if I didn’t quite get them right, it was never “No, you’re wrong!” He never makes me feel like I’m dumb or stupid or anything like that. He actually has a very big positive. And he’s always positive.

Another parent said that, “I had a good counselor, I must say. Like if my daughter done something and she felt like I didn’t, you know, approach it appropriately, like, she would tell me, you know. I mean she wouldn’t say it in front of my daughter but she would be like, you know, ‘this is the way I would have handled it.’” Others sought out a specific worker to provide their in-home experience after that individual went to work for a different service provider. One parent was able to apply a concept from the intervention itself to the therapeutic relationship, describing her in-home worker as a trustworthy support, “I know with [name of intervention] that it’s a plus having somebody to fall back on.” She further elaborated on an intervention she experienced, saying, “like, if I would’ve been crying like I was before, you know, tearing up or whatever he’d be like, ‘Okay now, come on with that. Tell me about that. What are you thinking?’ And that

would be the same thing to use even with your child.” One parent spoke of qualities of the individual worker that she found helpful, saying,

His persona about him. He’s also like caring, you know. On Mondays we talk about what’s happened on Friday. Like today I have a visit with [child’s name]. So I have a visit with [child’s name] and after that, you know, I’ll wait until Monday and then I tell him how the visit went and if I felt there was anything I could do better that maybe I thought about later that afternoon, if there was anything.

Parents expressed moving into relationship with their in-home worker in a deliberate fashion and the usefulness of that process for them, in some cases over several years. One said, “her and I both had those equally strong personalities, so at first it was this indifference in the similarities, which is the best way to describe it. But it evolved because it turned into a respectful relationship.” Another attempted to describe the relationship:

Close isn’t the right word but I feel like we have a very knowledgeable relationship with each other. She knows us and we know her...there’s a depth of understanding of each other’s personalities and, you know, when you have someone working that closely with you for that many years...And we kind of come from the same type of background and stuff so we can relate on that level.

One parent talked about the availability of her in-home worker, indicating the manner in which she contacted her when in doubt: “and if I had issues with my little girl, and I’ve done everything I felt like I could do, I would call her. I think I got a little tight with her ‘cause I would say she was my friend, you know what I’m sayin’?” She

continued, describing the confidence and trustworthiness she felt in the relationship: “even though we’re not allowed, I didn’t know that but we’re not supposed to, you know, consider them as friends but to me she was a friend that I could talk to and I knew it wouldn’t go nowhere.” In-home workers provided encouraging statements to parents, saying, “you can do this:” “it’s like just sitting there and talking to, you know, the in-home worker it was like, ‘okay, I can do this.’ She was like, ‘yeah, you can do it.’ I’m like, ‘yeah, I can do this.’” Such encouraging moments led one parent to say she now knew that, “I can damn right do it! It ain’t down right doing it; damn right doing it. I know I can do it!”.

Conversely, parents noted times when they felt the relationship was, “contradicting,” “a mistake,” “irritating,” and angering: they “buted heads” with the worker, became “pissed off,” “getting into it” with the worker to the point of throwing the worker out of the home. For one parent, this resulted in, “a couple of ladies com[ing] out, you know, but I ended up refusing the ladies; the one lady to never come out again. And then I asked [in-home worker] not to come back no more.”

Understandably, parents were sensitive to the manner in which the in-home worker related to the child and were able to note elements that worked and those that did not. Parents described in-home workers entering the home and getting to know the child in various ways. Sometimes, this process went well. One parent said, “[in-home worker] would spend time with [child’s name], might take her for a drive, or run an errand. Developed a relationship with her. Then we’d try to spend time together as a family. Sometimes [just the parents] would meet with [in-home worker] So she kind of did the whole thing.” Another talked about how the in-home worker spent the first month

meeting just with the child and then slowly integrated the parent into those sessions. Often, this resulted in close relationships between the child and the in-home worker as this parent noted: “[the child has] developed a very close relationship with [in-home worker] and still sees [in-home worker] in outpatient once a week...She wants to go talk to [in-home worker]. She relies on her.”

Other times, the relationship between the child and the in-home worker did not go well. Identifying vestiges of the child’s past experiences, one parent shared that, “it took [the child] a long time to even open up to [the in-home worker] because she thought that [the in-home worker] was coming to get her to take her away. So it took her a while to get that feeling that okay, maybe she’s not here to take me.” Another parent described an in-home worker’s initial meetings with the child:

[the in-home worker] would come and kind of follow [the child] around. I think it was the second time she came in and she said, ‘This girl needs help! She said this and this and this and this.’ And I said, ‘I know. That’s why you’re here.’ So she came in and put in time but didn’t really do much except for just follow someone who is very agitated around.

Another parent described attempting to protect her child from what she perceived to be problematic aspects of the in-home worker’s relationship with her child. The in-home worker would tell the child, “he would take him different places, and not follow through with it. [The child] would get upset. [The in-home worker] would say ‘because you were bad in school today.’ That was not his call. That pissed me off.” One parent talked about the intervention itself becoming overwhelming for the child, saying,

it just became to the point that the therapist, you know, really kept coming in and working on her with things and holding her accountable and stuff that it almost just became too much. She ran on the therapist because the therapist was having expectations of her, you know, because that's the way it progresses. It progresses from getting to know you to, okay, I'm going to work with you and I'm gonna have expectations. You know, I'm another adult figure in your life and I'm asking you to sit down at the table. That was it. She wasn't doing it.

Identifying helpfulness. Parents were able to identify several aspects of the intervention that they experienced as helpful. For some, the direct message of the worker to the child were perceived as most helpful. For example, a parent shared that “[the in-home worker] would tell [the child], look, you can't do that when your mommy says this or whatever.” Feedback in the form of discussing incidents that arose in the home was also helpful: “you handled it good but this is the way I would've handled it.” Another spoke about the practical helpfulness of taking the parent to doctor's appointments and “help[ing] me with so many different things, like she helped me get in school, all types of stuff.” Other parents indicated that in-home, “helped us be present as parents when without that support we probably, what would you do?”

Other parents pointed to the understanding of their child that they gained as a result of in-home, in many cases being able to identify needs that were underneath the child's overt behavior. One remarked, “understanding why people are reacting the way that they are in certain situations, I think [in-home] is very helpful with that. Reflecting on the experience, a parent indicated that in-home workers “help us understand [child's name] and our relationships better.” Another added, “I think that I understand her better,

like, because you really have to kind of...you know you have a therapist that's kind of explaining to you the whole trauma story, the things that are going on in her, the therapist kind of adds that up for you so you get that explanation." Understanding the child was aided by the acquisition of specific language and frames of reference including the idea of a *miscue* and the idea of *emotional dysregulation*. One parent, referring to idea of a *miscue*, said about her son's talking about the foster parent that "he had expressed to me [that] 'I don't like her. I hate her.' And he would tell me that, like, kind of under his breath either while she was in the room or if she went to go get something and somebody else was in the room. He would tell me and I'd be like, that's not nice. Why don't you like her? And that wasn't what he was really saying. That was a *miscue*." Describing the effect of this shift in her perspective on her parenting, she said, "I don't say to him 'No, you can't feel that way' or 'No, that's not appropriate.' I'll say something to the effect of 'I see you're upset. I see you're sad.' I name it; I tame it, and that's it. And then go from there." The parent was able to reinterpret earlier perceptions of the child's behavior, saying, "I've learned that they're *miscues*; they're not just him acting out being all ornery or you know having these meltdowns that look like seizures and stuff like that." Other parents noted that "we love the idea of cue and *miscue*. It's kind of like learning a language that fits, like words that we needed to talk about what was going on. And the concept of regulation or dysregulation. It's one of our favorite words." These parents were "really drawn to that idea that we were talking about the neurology instead of behavior because if it was behavioral it would've already been done, so that appealed to us. Also the fact that it was centered on us instead of [the child] because she's oppositional and defiant and she's also very smart." Citing the specific intervention, the

parent indicated that it “it helped us understand her...we had a better understanding of where she was coming from.” This understanding came, in part, from being able to read the child’s behavior more effectively:

And I think learning to read [child’s name], I think we’re much more expert than we were, although we’ve always been...when you have a kid like that who can go and you’re putting her in these social or community activities and trying to read when’s the moment that for everybody’s best interest we get her out of there.

When is she getting ready to knock down and not be able to be in control of all of her behavior?

The post-treatment reflections of parents in one case merit inclusion in detail given the degree of depth and insight into the process they expressed:

[Interviewer]: Do you think that there were changes in your parenting? You’ve alluded to that, I think, in many ways.

[Parent]: I would say definitely as a result of [specific intervention]. I wouldn’t say so much as a result of in-home.

[Parent]: No, the traditional in-home. We were well-versed in those kinds of skill sets a traditional in-home person would bring. Yeah, I think [specific intervention]...

[Parent]: I think [name of in-home worker] said it gave us a new lens with which to look through to see these situations.

[Parent]: Yes, definitely.

[Interviewer]: Why do you think that change occurred with [specific intervention]?

[Parent]: That new lens, new pair of glasses.

[Interviewer]: Having a new lens, being exposed to that?

[Parent]: And the experience of seeing some of the results that it can make a difference, especially with someone who's not always on board.

[Parent]: And to understand the dynamic of miscues and the results of miscues and how to deal with miscues. That was huge.

[Parent]: But how has it changed us? I think it's changed me, it's more up here than in parenting we do. But that's not true either.

[Parent]: Yes, it's kind of hard to put into words. I think it's given me maybe more of an acceptance when [child's name] is off the circle and it's understanding that where it's coming from for her.

[Parent]: Supportive, and I would say enlightening on both. They help us understand [child's name] and our relationships better.

[Parent]: And then for [specific intervention] I would recommend anybody. All parents should be able to do it. I don't care if you have a child with attachment issues. I think understanding children and understanding what that circle looks like can make anybody a better parent, or just better at people relationships.

[Parent]: Like when we were going through this and we had gone to the park. My brother was coming and he has little ones and they were coming to stay with us for the weekend and they got here before I got off work so they went to the park. I met them at the park and seeing [name of child], my nephew who was 3 at the time, look at me and light up and run into my arms. It's like, 'Oh, he's on the

circle!” And then to watch him do his ‘come watch me,’ and then running off and then coming back and going.

[Parent]: It’s like having that kind of deeper knowledge. I think it’d be good for anybody.

Feeling vulnerable. Parents experienced being vulnerable in different ways through the course of the intervention. Some talked of the whole experience as one of “scrutiny” and “bearing our souls.” Said one parent, “I don’t think a lot of people realize when you do in-home you’re bringing someone into your privacy. I’m an open person and it still is a little uncomfortable for me. I mean anybody’s welcome in my home but at the same time six hours a week someone’s coming in your home, they’re evaluating you.” One parent said of a male in-home worker, “He made me very uncomfortable as a woman and as a person.” Others felt a sense of being called out: “like I said, my [in-home worker] made me feel like I was doing things wrong a lot so it made me rethink the way that I wanted to raise my child because she said it wasn’t okay.” Another parent felt a sense of imposition through the process, saying,

I liked the fact I had the in-home worker but they set hours for them, you know? So it’s like they say, like right now, she said it’s 15 hours a month. I said, “You’re not gonna be in my house for half the month.” And she was like, “It’s 15 hours a month.” So she said that next month they’ll go to 10, and then in September it’ll go down to 5. I like her, I just feel like that’s a lot of time. You know what I’m sayin’? You’re taking 15 hours of my whatever out of a month. I could be doing somethin’ else with that 15 hours, like sleeping, going to the gym, or something else. You know?

Critiquing the process. Parents had a number of reflections about the process of the intervention, describing their experience in ways that identified areas they found difficult. Parents were able to recognize the impact the child as identified client had on the child and the intervention as a whole:

I kind of got the feeling, I mean I never know for sure, but I kind of got the feeling that the therapist's hands are tied because [child's name] is her client. And my understanding is that they have to be over with the client and it's a tricky slope to be working with, you know, us or the other kids. You know what I mean? So it almost to a degree made it a little bit worse because it empowered [child's name] to control the home for the time that the therapist was there because the rest of us were kind of either I had to sit there in the session with her and just watch it and interact accordingly.

Another parent spoke of the effect of the in-home worker meeting only with the parents when the identified child was in the home. She told of going to the office of the in-home worker in order to "diffuse [the child's] agitation over us having these meetings at home where we seemed to go behind closed doors and talk about her. So for her to see a little bit that we were working on our stuff and that's how we phrased it, we were working so that we could be better parents so that we could be a better family."

One parent shared that she would change her behavior with her child only when the in-home worker was present, saying, "I would have to do things I normally wouldn't and that caused a problem in, you know, she and I's little relationship because when the [in-home worker] leaves it's back to mom's way." She continued to share her experience of the process, saying

But I know my [in-home worker] would sit down a lot and she would write notes and it would seem as though she would just, like, watch me and my child interact. I felt like she would sit there and instead of her addressing the issue with me it seemed like she wrote whatever she wrote and then it would be brought to my attention by someone, like, you're not allowed to do this or you're not allowed to do that.

The parent wanted the in-home worker to

you know, see what I was doing, address it and say, 'hey, look, maybe you should do this differently.' Instead of her doing that it would just be, 'no, you're doing this wrong. You can't do that. You're not allowed to talk to the child like that' or 'you can't do this to a child.' It was never, 'you can't do this but let's find something that'll work for you that you can do.' I just felt like it was just a spy mission or something for a while and I really didn't like that.

Another parent described how she and the in-home worker managed the process in the context of the limitations of the intervention. In talking about the services the child qualified for, the parent said,

so the thing that she did qualify for was behavior modification so that was that therapist's good thing. Trial and error and we did all these things and figured out we balanced my agency's empathetic base and the therapist's behavior modification and we found this great balance to work with her. This might not be the best but we're going to make the best of it. So we balanced it and that's how we got to a point where we were able to tag team her.

In considering recommendations for other parents, parents advised others:

well, for traditional if they were local I would say get [name of in-home worker]. Make sure the person...and I think some of this is based on information that [name of in-home worker] shared because they've changed or in-home now is more widely what it's supposed to be instead of what it could be...but I would say make sure the people that you're working with have the credentials and the skill to do the job. You don't want to mess around with people that don't...that can't help you...if you're not helping you're hurting. It's what we've seen a lot.

Other parents cautioned against “having too many people involved all at the same time” which “can be confusing to a child.”

Parents' Experience of In-Home Counseling Services

This investigation has found that the whole of the lived experience of in-home counseling services includes and is informed by the parts or constituent elements of the whole: the experience of in-home is one that moves between and among the parent's experience of the child, of parenting, of the system of care, and of the intervention itself. These parts continuously feedback to the whole in an ongoing, dynamic, and recursive manner giving rise to the experience of in-home counseling.

The experience is characterized by the broad themes which emerged from the data: knowing the person of the child, relating through difficult behaviors, identifying hopes for the child, identifying obstacles to parenting, growing in capacity for parenting, owning the parenting process, experiencing the system as ‘they,’ negative feelings, perception of the intervention within the system, identifying helpfulness, learning to relate, feeling vulnerable, and critiquing the process. The essence of the experience is

further understood by the consolidation of these themes into three statements that are the primary findings of this study:

- 1) In-home counseling services are experienced as a complex and paradoxical nexus of relational closeness and distance;
- 2) In-home counseling services are experienced as containing elements of both helpfulness and frustration;
- 3) In-home counseling services are experienced as constantly imbued with a variety of internal and external pressures.

In the final section, I discuss these in detail, tying them to the literature regarding the development of in-home as well as the current constellation of in-home services.

Chapter V

Discussion

In this chapter, I elaborate on the primary findings of this study in the context of the relevant literature where appropriate. I include reference to the history of in-home as a family preservation and clinical mental health service within wider systems of care that have attempted to meet the needs of children and families in acute and deep distress. I consider the various issues raised by the findings of this study and discuss implications for the provision of in-home services. I discuss limitations of this study, suggest areas of future study, and, lastly, recommend paths forward with regard to the provision of in-home counseling services.

It can be stated that *in-home counseling services are experienced as a complex and paradoxical nexus of relational closeness and distance containing elements of both helpfulness and frustration and are constantly imbued with a variety of internal and external pressures*. Each of these elements speaks to the essence of the lived experience of in-home counseling services. However, before exploring each of these, it is important to note the challenge that exists with regard to naming the service. Part of what has existed since the beginning of in-home has been in the conceptualization of in-home: is it a therapeutic or non-therapeutic service? This tension has been reflected throughout this study in the naming of the individual doing the work and in the naming of the intervention itself: following the lead of the parents in the study, I have used both “in-home worker,” and “worker,” to refer to the individual in the home, and I have used “in-home,” and “in-home counseling” to refer to the intervention itself. To a large extent, this usage reflects the tension and confusion inherent in one of the initial questions under

investigation, “what is it?” An implication of the findings of this study is that *what it is* largely depends on how it is experienced, and how it is experienced is mediated by the goals of those providing the service and whether or not they are equipped to achieve those goals. In some cases, in-home was intended to be and was experienced as therapeutic. In other cases, where the goals were unclear at best, parents indicated unsatisfactory and unhelpful experiences.

The finding that in-home is experienced as a *complex and paradoxical nexus of relational closeness and distance* indicates, in part, that a family’s relational experience within systems of care has a constant and ongoing influence on what occurs (or does not occur) in the home: a continuous isomorphism exists, suggesting that in-home relationships have the most likelihood of leading to positive outcomes if relationships in general are experienced as helpful and supportive across all aspects of care. In other words, “everything counts” (J. Presbury, personal communication, April 12, 2007). Parents are struggling with how to feel supported and supportive, how to be close to a child and be in charge, and how to negotiate all of the new relationships to which they have been introduced by virtue of having an in-home intervention; children are struggling with emotions and behavior and that they are unable to regulate on their own.

As we have heard from one parent, “if you’ve got in-home, you’ve got some stuff going on in your home. It ain’t a happy time.” Relationships are embedded in contexts in which the stakes are high, and sensitivity to subtle messages regarding one’s abilities or competency is intense: indeed, parents who participate in in-home are already feeling powerless and incompetent with their child, and, if any relationship within the system of care recapitulates this dynamic, the parent is likely to feel even more alienated from self

and family. If such dynamics occur, the consistent message is “you are a bad parent” likely followed closely by “you are a bad person.” We saw in the data parents expressing feelings of being judged, blamed, and scrutinized; indeed, parents tended to question themselves and their parenting as a result of these feelings. Such a sense of vulnerability is consistent with the finding of an earlier study (McWey, Humphreys, & Pazdera, 2011). Needless to say, these kinds of relational dynamics make a successful outcome less likely; in fact, it was in the narratives that included words like “trust” and “support” that parents also expressed having been helped by the intervention. This presents a challenge to every helping professional involved in any aspect of a child and family’s care: we have the best chance of success with a child and family when we interact in ways that are supportive and kind, even (and especially) when firmness is needed. A ongoing question suggested by this finding involves bridging the gap between parents and their experience of “the system” as a “they.”

Another important element of this finding is that of the importance of the parent’s relationship with the child. The level of commitment that the parents in the sample had to their children was moving and profound. The scenario that resulted in the child being removed permanently from the home was particularly poignant given the mother’s reflection on her childhood and her realization that she had never had the kind of relationship she was attempting to provide for her daughter. Her love for her child was deep and enduring but also obscured in her self-experience and affected how she was able to relate to her child.

This highlights the experience of closeness and distance, for, at the same time, this parent felt both a sense of longing for her daughter coupled with a sense of not

knowing how to connect in fulfilling ways. Such an experience was common to all parents in the sample, albeit for different reasons. For those experiencing a particular intervention, however, this yearning approached resolution when parents were able to see the person of the child underneath the manifest behavior, identifying the behavior as a *miscue*. When parents were able to connect with the child through the miscue, the behavior changed and the parent experienced a sense of efficacy. Even so, the needs of children with histories of abuse and neglect for repeated, ongoing attunement in this manner led to exhaustion on the part of parents, increasing a sense of distance.

The finding that in-home is experienced as *containing elements of both helpfulness and frustration* points substantially to the nature of the in-home intervention. As we have seen, the degree of helpfulness was mediated by a variety of factors including the idiosyncratic nature of each in-home worker and his or her level of training and experience. As some parents indicated, their lack of knowledge about in-home services included a sense of surprise when they learned of the varying degree of training of those providing the service. Sadly, such a circumstance is all too common (Cortes, 2004). While even the most experienced counselor would likely consider an individual client with a complex, lifelong history of traumatic stress and substance abuse to present substantial treatment challenges, it is the least experienced trainee who is most often asked to help *families* with these same (and more) concerns to change (Cortes, 2004). Given that in-home counseling provides such a unique and powerful opportunity for relational healing and is fraught with such challenges, it is instead those who are most trained, seasoned, and competent that are needed in the in-home environment. To this end, Tate, Lopez, Fox, Love, and McKinney (2014) have identified necessary

competencies for in-home counselors, and Hammond & Czyszczon (2013) have argued for the professionalization of in-home (what they call Home-Based Family Counseling or HBFC) as an issue of social justice in both the counseling profession and in considerations of child welfare.

It is entirely possible for parents build on and/or to develop significant capacities for ownership of the parenting process as a result of in-home counseling. Those interventions described by parents as most helpful did just that. Parents who described their relationship with their in-home worker in a positive light were most likely to benefit from the intervention itself. Nonetheless, these parents still described challenging relationships between themselves and individuals that comprise what many referred to as “the system.” A curious mix of the need for closeness coupled with the experience of wanting distance was typical of parents’ experience. At times, the manner in which services were provided seemed almost backward — parents who wanted treatment expressed not being able to get it, and parents who did not want treatment were required to have it. Parents were often caught between seemingly competing agendas and attempted to manage these throughout the process. As we saw, some parents were able to make use of the in-home worker as a sounding board and confidant, a role that was experienced as helpful and important in the parents’ life.

Some parents identified areas of helpfulness for them that were likely experienced as problematic for the child. A theme that emerged from the data was compulsively compliant behavior of the child in certain circumstances. One clear example was one mother’s description of her daughter being on her best behavior because the child thought the in-home worker was here to take her away for her “bad” behavior. From a clinical

standpoint, the parent is describing a child exhibiting a pattern of coping developed to survive her past trauma: working hard to appear to adults as though she is OK and doesn't have needs. Parents who did not participate in one specific kind of intervention had no knowledge or ability to name this pattern, while other parents who did were able to see it as indicative of the child's emotional arousal and had language to describe the pattern. The fact that such a series of events occurred highlights the difficulty facing child welfare workers but also sheds light on the need for in-home services to be the most informed as possible in areas of child development.

The finding that in-home is experienced as *constantly imbued with a variety of internal and external pressures* indicates, in part, its place in the wider system of care. As mentioned earlier, the stakes are high in situations where in-home occurs with the ultimate failure of in-home being the child's placement outside of the home. In some situations, in-home is used to support parents in regaining custody of their child, but in most, the focus is on the individual child as identified patient as alluded to earlier. In either case, the pressure for change is significant. Internal pressures include the parent's desire for the child's behavior to change, the parent's desire to be finished with services, and, as mentioned, the sense of yearning to know the child that the parent has. External pressures include demands placed on the family by courts, social services, and sometimes by the intervention itself. In-home was most likely to be useful for a parent when the counselor was able to create a container for the relationship that protected it from the influence of these forces.

While the workers who provide the service were not a focus of this study, such pressures influence them as well. As we saw from parents' description of some of their

in-home experiences, qualifications of staff who provide in-home services is an issue. Indeed, the tested practice models (MST and IICAPS) employ individuals who have training in clinical mental health, and these programs provide substantial, ongoing training and supervision for staff members. To manage the complex challenges inherent in most in-home scenarios, these programs also use a team approach with two individuals working in the home. Such practices are likely to lead to more favorable outcomes.

Limitations of the Study

Sample size. A small sample limits the trustworthiness of the data. However, the high degree of variation of the sample across all demographic and treatment domains is a strength of the sample and was not expected given the manner in which participants were identified.

Treatment providers. Another limitation of the sample was the inclusion of a disproportionate number of participants who experienced attachment-based in-home services and/or who had had substantial training as therapeutic foster parents. This also affects the trustworthiness of the data given a likely skew toward capturing outcomes consistent with those particular programs. At the same time, the results may point to important elements of the lived experience that are desired program outcomes and may therefore still be of use to stakeholders.

Lack of Spanish-speaking families. Owing to the demographics of the geographical area in which the study took place and my professional experience which suggested a high level of utilization of in-home in the Hispanic community, an initial desire was to include Spanish-speaking families in the sample. However, the demands of the method would have required a level of fluency in Spanish that I do not possess.

Additionally, the challenges of translating and back-translating that would have been necessary to establish a suitable degree of rigor exceeded the capacities of the research agenda.

In spite of these limitations, this study contributes to the literature in several ways. First, it is attendant to local, state, and national trends in the provision of in-home services. A second contribution is in its finding that in-home is a deeply systemic experience comprised of distinct elements that feed back upon one another in a mutually reciprocal, dynamic, and recursive manner. Another contribution is in the diversity of the participant pool across intervention types, socio-economic status, race, and status of the child in the home. A fourth and final contribution is the study's exploration and amplification of the voices of participants, capturing the manner in which they experienced in-home services.

Into the Future: Changing Paradigms and Areas of Study

Currently, in-home counseling services operate within the prevailing paradigm of the medical model that categorizes mental distress in terms of individual illness and disease. Applied to multistressed families, the child is identified as the source of the problem and is seen as sick: the child has a mental illness and must be treated for it; any attempt to deviate from this practice results in a lack of reimbursement for services. The paradigm applied in this manner, however, does a disservice to the child and family and to the healing process. Not only does the child as identified patient carry profound weight for the child, it also delegitimizes the role of the family overall, particularly as a crucial factor in need of healing. Indeed, one tenet of family systems theory asserts that it is often the child who "carries" family distress by acting out, a phenomenon well-known to

family therapists. Practice within the current paradigm also neglects the role of early developmental trauma in the lives of children, the effects of which are now well-documented (Van der Kolk, 2014; Levine & Kline, 2006; Hughes & Baylin, 2012; Siegel & Bryson, 2014). Indeed, a shift in perspective is badly needed.

The field of in-home counseling is poised for just such a shift. In his classic work, Kuhn (1962) describes the manner in which paradigm shifts occur; it could be that in-home is at a point consistent with its place in the development of science. Indeed, leaders in the field who have been helping practitioners and policymakers rethink how we have been addressing the needs of children point to relational approaches that rely on the parent's own perceptions and experience as foundational for supporting the child's capacity for self-regulation. In particular, the work of Powell, Cooper, Hoffman, and Marvin (2014) invites the parent to develop ways of being with a child that are focused on seeing through overt behavior and deeply into the child in order to understand and meet the child's developmental needs for safety and security. Dan Siegel and Tina Bryson (2014) have also contributed to this effort, grounding their approach in neurobiological insights that have emerged in the last fifteen years. The current study provides a powerful tool in pursuit of these goals, illuminating the lived experience of parents in the in-home milieu. Could it be that an in-home intervention can influence or change a parent's lived experience of the child in such a way that it leads to a more attuned, developmentally-appropriate, and competent parenting experience? If such a change were a goal and a consistent outcome of in-home counseling services, they are likely to become of substantial use not only for parents but also in the creation of a more just and compassionate world.

Areas for future study. In spite of research which points to continuing questions regarding training of those providing the service, supervision of those individuals, and questions regarding the clarity of purpose of in-home services, in most localities in-home as a treatment modality remains as fractured and as fragmented as it has always been. It is still largely undefined. Given that in-home has the potential to contribute to the healing and well-being of generations of children, the pursuit of social justice compels us to focus unambiguously on the development and refinement of in-home.

Abundant opportunities therefore exist for future research into in-home services. First and foremost, the inclusion of non-English speaking voices into the phenomenal world of in-home is crucial to having a more complete picture of the experience. Other questions arising from this study may include: 1) an exploration of family boundaries with regard to in-home. Could it be that families and parents who have healthier boundaries experience in-home in more invasive ways versus families and parents that do not? 2) an exploration of the parent's experience of the child and the impact of in-home on that experience. Does in-home change the parents' experience of the child? If so, how? On what elements of the treatment does that change depend? 3) a comparison of the outcomes from traditional, Medicaid-funded in-home and the Circle of Security[®] model. What are the major differences in outcomes? In service to these questions, program evaluation that is standard operating procedure for agencies and public funding streams will solve problems of access to participants and lead to a collection of data that can be analyzed for both outcome effectiveness as well as phenomenological components. In this regard, a mixed-methods program evaluation design would likely be most helpful in ferreting out the many variables that contribute to changes that when in-home is utilized.

Another area for future inquiry is associated with the methodology used to investigate the in-home experience. It could be fruitful to utilize other means to interrogate this data set or addition data sets from participants in in-home services. For example, a case study methodology would likely illuminate aspects of specific interventions (like the Circle of Security[®]) that could be useful in continuing to understand the experience. The utilization of a grounded theory method could reveal additional aspects of the in-home experience that are currently left out of accepted treatment models such as MST and IICAPS. Finally, critical theory as applied to the experience of in-home would likely continue to amplify marginalized voices and contribute to the competent provision of in-home services as a social justice imperative.

Recommendations

Given my professional and clinical identity, that of a Licensed Professional Counselor (LPC) and my commitment to the field of clinical mental health counseling, I will offer recommendations specific to that field. First, however, I will make recommendations for systems of care on two levels: one, the more local level system involving community-based providers and administrators in departments of social services, community service boards, departments of juvenile justice, and local educational agencies, and two, the more regulatory, state and Federal system of legislators and policymakers.

Recommendations for state and Federal systems. The regulatory environment that largely creates the practice of in-home services/in-home counseling is an important one; regulations regarding in-home practice should be strengthened and changed in specific ways to require that in-home to be practiced specifically and only as a clinical mental

health intervention staffed by individuals licensed or pursuing licensure in a clinical mental health field. Significant changes are necessary to bring this about: 1) create a tiered system of service and service reimbursement that differentiates between two in-home modalities: a shorter, non-therapeutic service of Intensive Crisis Intervention (ICI) and a longer, therapeutic service of Home-Based Family Counseling (HBFC), incentivizing the provision of HBFC by licensed practitioners; 2) appoint a task force to develop clinical standards of practice for both of these services with a focus, for the former, on strengths-based, theoretically-driven models of crisis intervention, and, for the latter, on integrative, theoretically-driven models of family therapy that are trauma-informed, culturally attuned, attachment focused, and rooted in both family systems and child development; 3) require that any agency providing in-home services adopt these clinical standards of practice or, if they wish to adopt other standards, require that they submit a comprehensive, theoretically-grounded rationale for the treatment they provide; 4) limit the ability to provide these services to licensed practitioners or post-graduate residents under supervision and pursuing licensure in counseling, clinical social work, or clinical psychology; 5) shift the focus of treatment from the child to the family, allowing for a team approach of two in-home counselors.

Recommendations for local-level systems of care. Regarding the local-level systems of care of which in-home is a part, several topics merit consideration. Recommendations for these systems are: 1) ensure that parents understand the purpose and goals of in-home; 2) create relational contexts in which in-home providers are provided clinical supervision and empowered to create a safe spaces for clinical work

within the context of the family; 3) ensure that the approach to children and families is clinically informed and therapeutically driven.

Recommendations for the field of clinical mental health counseling. Home-based services have long been the purview of the social work field primarily. However, individuals from other fields, particularly Master's level counselors and counseling residents, have provided "in-home." This trend has led to an even wider degree of variability in services than already existed given the differing training and assumptions held by new graduates and recent graduates of different Master's level programs including counseling. The presence of counselors and residents in counseling in the in-home setting creates an opportunity for the field of counseling and counselor education to make a substantive contribution to this unique modality by focusing on training and ethics for individuals who plan to become or who may become in-home counselors. Additionally, an opportunity exists to deepen both multicultural and social justice considerations in the counseling field. Therefore, the following recommendations are offered for the field of clinical mental health counseling: 1) develop in-home counseling as a separate and distinct specialty within the field of clinical mental health counseling similar to that of substance-abuse counseling; 2) develop a concentration within training programs that lead to a specialty in in-home counseling; 3) support students in connecting the practice of in-home counseling to social justice imperatives; 4) develop and promulgate supervision competencies specific to in-home counseling.

A final recommendation is for localities to conduct careful assessment and evaluation of the in-home services taking place in the area. This can be done through existing agencies and organizations in partnership with nearby universities or using

internal protocols. An ongoing program evaluation could be instituted that would utilize methods similar to those used in this study as well as other methods to continue to explore the lived experience of participants while also establishing a wider evidence base for in-home practices as they currently occur. In this manner, we can work toward assuring that children and families already struggling with enormous stresses are afforded the dignity of the most competent, state-the-art care possible. In the interest of kindness and compassion, it is imperative that we find a way to elevate to the highest priority the needs of the most vulnerable.

Appendix A Interview Questions

Demographic Data

How many people live in your home?

How many children are in your home? Biological ____ Adopted ____ Foster ____

Children's ages? Length of time in the home? Any out of home placements?

Do any of the children living in your home have a disability?

Do any of the children living in your home have an IEP (Individualized Education Plan)?

Do you own your home or rent your home?

Caregiver #1 M/F

Caregiver #2 M/F

What is your age?

What is your race?

What is the highest level of education you have completed?

What is your approximate monthly household income?

Do you receive any public assistance (TANF, SNAP, SSI)?

What is your occupation?

What is your employment status?

Country of origin: _____
(if not US) How long have you lived in the United States?

Primary language spoken in the home?

Approximately when did you participate in in-home counseling services?

Have you participated in other mental health counseling services?

When/duration/perceived success?

For how long did you participate in in-home counseling services?

Who was in the household when the services took place?

Which of your children was the “identified client/identified patient”?

Interview Questions

1. Describe the events that led to your family’s participation in in-home counseling services.

2. What (if anything) did you know about in-home counseling services prior to participating?

3. Describe a typical session with your in-home counselor.

4. Tell me five words that describe your child. You said [words 1, 3, 5]. Tell me about a time that your child was [word 1]; [word 3]; [word 5].

5. Have you noticed any changes in your child as a result of in-home counseling? (If so), How would you describe those? Why do you think change occurred? (If not), why do you think change did not occur?

6. Tell me five words that describe your relationship with your child. You said [words 1, 3, 5]. Tell me about a time that your relationship was [word 1]; [word 3]; [word 5].

7. Have you noticed any changes in your relationship with your child as a result of in-home counseling? (If so), How would you describe those? Why do you think change occurred? (If not), why do you think change did not occur?

8. Tell me five words that describe you as a parent. You said [words 1, 3, 5]. Tell me about a time that you were [word 1]; [word 3]; [word 5] as a parent.

9. Have you noticed any changes in your parenting as a result of in-home counseling? (If so), how would you describe those? Why do you think change occurred? (If not), why do you think change did not occur?

10. Tell me five words that describe your relationship with your in-home worker. You said [words 1, 3, 5]. Tell me about a time that your relationship was [word 1]; [word 3]; [word 5].

11. Tell me about your strengths you discovered or developed because of in-home counseling.

12. What were the most important lessons you learned as a result of in-home counseling?

13. What are your highest hopes for your family? To what extent has in-home counseling contributed to realizing those hopes?

14. What advice would you give another parent who has not yet participated in in-home counseling but is shortly to begin?

15. Is there anything else you think I should know in order to understand your experience of in-home counseling?

16. Is there anything you would like to ask me?

Appendix B
Invitation to Parents

You Are Invited!!

To talk about your experience of In-Home Services

Hello! My name is Greg Czyszczonek (siz-ZON), and I've worked in the Harrisonburg area providing counseling and in-home services for a number of years. I am currently earning a doctoral degree in counseling.

I am writing to invite you to share your story with me as part of a research study exploring how families experience "in-home," which may also be called: in-home services, intensive in-home, in-home family counseling, or in-home educational services. This study will help to determine how well our local programs work or do not work and will allow the community to develop better services.

You are receiving this letter because you have completed an in-home service sometime in the last year (May 2012-May 2013). You may have seen this as helpful, not helpful, somewhere in between – whatever your story, I am interested in hearing from you.

The agency where you received in-home sent this to you on my behalf; your name was not released to me. When you tell your story, I will not tell that agency anything you say or even that you chose to participate.

I would welcome the opportunity to talk with you for about an hour; in the spirit of in-home, I can come to you! If you would prefer that I not visit you at home, we can meet in Harrisonburg. Your participation is strictly voluntary, and participants will receive a \$10 Walmart gift card.

If you would like to talk about your experience of in-home or to learn more about the study, please contact me. I can be reached at:

540-246-2284 or inhomestudy@gmail.com

This study has been approved by the Institutional Review Board at James Madison University (IRB#13-0265) and by the Community Policy and Management Team of Harrisonburg-Rockingham. Your participation in the study will not affect in any way your access to services provided through the Harrisonburg-Rockingham County Family Assessment and Planning Team (FAPT); all responses are confidential.

Greg Czyszczonek, Ed.S., LPC
Doctoral Candidate in Counseling & Supervision
James Madison University

Appendix C IRB Approval

from: Tillman, Carrie Elizabeth - tillmace <tillmace@jmu.edu>
 to: "Czyszczonek, Gregory John - czyszczonek" <czyszczonek@jmu.edu>
 cc: "Stewart, Anne - stewaral" <stewaral@jmu.edu>
 date: Tue, Feb 19, 2013 at 2:08 PM
 subject: IRB- Protocol Approval

Dear Gregory,

I want to let you know that your IRB protocol entitled, "*An Exploration of the Experience of In-Home Counseling Services*" has been approved for you to begin your study. The signed action of the board form, approval memo, and close-out form will be sent to your advisor via campus mail. Your protocol has been assigned No. 13-0265. Thank you again for working with us to get your protocol approved.

As a condition of the IRB approval, your protocol is subject to annual review. Therefore, you are required to complete a Close-Out form before your project end date. You *must* complete the close-out form unless you intend to continue the project for another year. An electronic copy of the close-out form can be found on the Sponsored Programs Administration web site at the following URL: <http://www.jmu.edu/sponsprog/allforms.html#IRBform>.

If you wish to continue your study past the approved project end date, you must submit an Extension Request Form indicating an extension request, along with supporting information. Although the IRB office sends reminders, it is ultimately *your responsibility* to submit the continuing review report in a timely fashion to ensure there is no lapse in IRB approval.

If you have any questions, please do not hesitate to contact me.

Best Wishes,

Carrie

Carrie Tillman
Office of Sponsored Programs
 JMAC Bldg 6, Suite 26 MSC 5728
 1031 Harrison Street
 Harrisonburg, VA 22807
 (540) 568-6872

Appendix D IRB Approval

from: Tillman, Carrie Elizabeth - tillmace <tillmace@jmu.edu>
 to: "Czyszczonek, Gregory John - czyszczonek" <czyszczonek@jmu.edu>
 cc: "Stewart, Anne L - stewaral" <stewaral@jmu.edu>
 date: Fri, Feb 21, 2014 at 2:36 PM
 subject: IRB- Protocol Approval

Dear Greg,

I want to let you know that your IRB protocol entitled, "*An Exploration of the Experience of In-Home Counseling Services*" has been approved for you to begin your study. The signed action of the board form, approval memo, and close-out form will be sent to your advisor via campus mail. Your protocol has been assigned No. 14-0306. Thank you again for working with us to get your protocol approved.

As a condition of the IRB approval, your protocol is subject to annual review. Therefore, you are required to complete a Close-Out form before your project end date. You *must* complete the close-out form unless you intend to continue the project for another year. An electronic copy of the close-out form can be found on the Office of Research Integrity web site at the following URL: <http://www.jmu.edu/researchintegrity/irb/forms/index.shtml>.

If you wish to continue your study past the approved project end date, you must submit an Extension Request Form indicating an extension request, along with supporting information. Although the IRB office sends reminders, it is ultimately *your responsibility* to submit the continuing review report in a timely fashion to ensure there is no lapse in IRB approval.

If you have any questions, please do not hesitate to contact me.

Best Wishes,

Carrie

Carrie Tillman
Administrative Assistant
 Office of Research Integrity
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 Blue Ridge Hall
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 Harrisonburg, VA 22807
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Appendix E
Consent to Participate in Research

Project Title: An Exploration of the Experience of In-Home Counseling Services
Consent to Participate in Research

Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by Greg Czyszczon, Ed.S., LPC (principal investigator) and Anne Stewart, Ph.D. (advisor) from James Madison University. The purpose of this study is to explore families' lived experience of in-home counseling services. This study will contribute to the researcher's completion of his dissertation.

Research Procedures

Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. This study consists of an interview that will be administered to individual participants. You will be asked to provide answers to a series of questions related to your experience of in-home counseling. Your interview will be audio-recorded for later analysis.

Time Required

Participation in this study will require one hour of your time.

Risks

The investigator does not perceive more than minimal risks from your involvement in this study (that is, no risks beyond the risks associated with everyday life).

Benefits

Potential benefits from participation in this study include your opportunity to have a voice in the ongoing provision of in-home services in this geographic area. The research will be used to generate a grounded theory of in-home counseling in the interest of establishing both a model of in-home counseling and outcome measures.

Confidentiality

The results of this research will be presented at a Community Policy and Management Team meeting at the conclusion of the project. The results of this project will be coded in such a way that the respondent's identity will not be attached to the final form of this study. The researcher retains the right to use and publish non-identifiable data. While individual responses are confidential, aggregate data will be presented representing averages or generalizations about the responses as a whole. All data will be stored in a secure location accessible only to the researcher. Upon completion of the study, all information that matches up individual respondents with their answers, including audio tapes/files, will be destroyed.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the final aggregate results of this study, please contact:

Greg Czyszczon, Ed.S., LPC
Graduate Psychology
James Madison University
czyszcgj@jmu.edu

Anne Stewart, Ph.D.
Graduate Psychology
James Madison University
Telephone: (540) 568-6601
stewaral@jmu.edu

Questions about Your Rights as a Research Subject

Dr. David Cockley
Chair, Institutional Review Board
James Madison University
(540) 568-2834
cocklede@jmu.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

I give consent to be (*video/audio*) taped during my interview. _____ (initials)

Name of Participant (Printed)

Name of Participant (Signed)

Date

Name of Researcher (Signed)

Date

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