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# An Abode for Therapy: Rediscovering the Lost Art of the Home Visit

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An Abode for Therapy: Rediscovering the Lost Art of the Home Visit

Submitted by Zachery A. LeCrone,  
B.S.W. May 16<sup>th</sup>, 2014

M.S.W. Clinical Research  
Paper

The Clinical research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

School of Social Work  
St. Catherine University & University of St. Thomas  
St. Paul, Minnesota

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## **Abstract**

The home visit is a service which began in early social work practice where the worker would visit the client in their home to ensure best practices. The literature and dominant beliefs of social workers highlight therapy in an individual's home environment as an avenue of practice filled with difficulties, justifying abandonment of this method of service. This study examined the experiences of in-home therapists who provide services to individuals and families in order to explore how their experiences either aligned or contradicted the current literature. Therapists were recruited through convenience and snowball sampling. Using a focus group qualitative design, four in-home therapists discussed their experiences of conducting therapy in a client's environment and how they were able to increase the effectiveness of therapeutic intervention through utilizing the client's surrounding atmosphere. Participants identified increased effectiveness in the home setting regarding assessment, empowerment, rapport building, and ethical services. Participants also identified strengths in this setting regarding confidentiality and boundary setting, two areas identified as difficulties in the literature. The implications created from this study articulate the enhanced ability of assessment when conducted through a home-visit and the importance of social work education to incorporate in-home therapy as a method of practice to class curriculum.

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## An Abode for Therapy: Rediscovering the Lost Art of the Home Visit

Although still underutilized, social workers or “friendly visitors” have been assisting people in their homes with concrete emotional and financial help for over a century (Beder, 1998; Richmond, 1917; Waisbrod, Buchbinder, & Possick, 2012). Use of the client’s home as the environment for intervention became more extensive through the implementation of the Adoption Assistance and Child Welfare Act of 1980 (AACWA), which encouraged the use of home-based family services in order to keep children in their homes while ensuring safety for the entire family (Christensen, 1995). Over the last two decades, the fields of mental health and rehabilitation have begun to explore home-based services more in-depth (Waisbrod et al., 2012). In-home therapy services are defined as a variety of psychotherapy methods offered in a nontraditional setting, including, but not limited to Cognitive Behavioral Therapy, Motivational Interviewing, Solution Focused Therapy, Narrative Therapy, Prolonged Exposure, and the use of system or strength based perspectives.

Some existing literature has found home-based therapy to be beneficial across a variety of situations, including working with individuals or families with a history of chronic substance abuse, mental illness, medication non-compliance, or instability in maintaining independence in living (Lima, 1995; Randolph, Eth, Glynn, & et al., 1994; Yorgason, McWey, & Felts, 2005). However, most in-home therapy research emphasizes its challenges rather than the advantages around assessment, rapport building, client empowerment, and increased opportunities for intervention. Several of the challenges identified in current literature, when effectively addressed, can become beneficial

therapeutic opportunities for intervention. Research also suggests that boundaries and confidentiality can become challenges when therapy is conducted in this environment (Beder, 1993; Thomas, McCollum, & Snyder, 1999). These challenges are important to address in the field of social work, as they align with the National Association of Social Work Code of Ethics' values of service, integrity, and competence (National Association of Social Workers, 2008).

Many therapists and therapeutic practices have been slow to incorporate in-home services or have abandoned such services altogether, due to possibly assumed effects that the change of environment may have on the therapeutic process. Abandonment of methods and procedures which provide a useful purpose, like the home visit, is often associated with rapid growth and development of a profession (Paterson & Cyr, 1960). This has been the case in the field of social work regarding use of the home visit and the delayed integration of in-home therapy practices (Paterson & Cyr, 1960; Waisbrod, Buchbinder, & Possick, 2012). Of the twenty-six published articles found and reviewed for this study, only three appeared in social work journals. The majority of current literature on this subject is derived from Marriage and Family Therapy, Psychology, Psychiatry, and Psychotherapy journals.

The focus of this study is to gain insight into the strengths of in-home therapy, including an exploration of ways that identified challenges of in-home therapy may actually enhance the therapeutic process. This study seeks to answer the question: How does therapy provided in the home environment enhance the effectiveness of that therapy? Data was collected through a focus group discussion conducted with a variety of licensed

therapists who have experience in conducting home-based therapy. This study can help improve and reclaim methods of the home visit as a useful function for the field of social work.

### **Literature Review**

The current literature on in-home therapy concentrates on challenges experienced within this environment for therapy. Little research has been completed that examines how the things that have been identified as challenges in the environment may actually benefit the therapy. This section of the paper reviews literature on how the client's home environment came into use for therapy, challenges experienced with in-home therapy, and the advantages of using the client's home environment in therapy.

The current literature uses the terms "in-home," "home-based," "home-intervention" and "friendly visitor" to describe a worker entering the environment of the client's home. These terms are used interchangeably in the literature review and throughout the paper.

### **History of Home Intervention**

The home as the environment in which services were offered began with "friendly visiting" through the Charity Organization Societies (COS) movement in the 1870's (Beder, 1998; Day & Schiele, 2013; Wenocur & Reisch, 2001). The intent of the COS was to help those in need by offering financial and emotional assistance through a friendly visit to the home in which the worker became the liaison between the COS and the client (Beder, 1998).

Mary Richmond, who had a strong presence in the COS movement, discovered



the benefit of home visits as a tool in family assessment and evaluation (Beder, 1998; Day & Schiele, 2013; Wenocur & Reisch, 2001). In Mary Richmond's *Social Diagnosis* (1917), she deliberately made clear the importance of collecting real life struggles of a client in a systematic way and putting the gathered data into a broader context known as the diagnosis. Richmond noted that the most accurate way of witnessing these real life struggles was through the client's home environment (1917). Richmond discussed how the uninterrupted environment of the office can bring privacy and value to both the worker and client, but that the home visit challenges the caseworker to establish human relations, creates the ability to answer many questions without having to ask those questions directly, and creates a direct exchange of experiences for both the client and caseworker (1917).

Richmond's discovery led to the practice of the home visit, which still continues in social work, child welfare, and case management (Waisbrod, Buchbinder, and Possick, 2012). The sustained rationale for this type of service is that it provides a way to reach difficult clients who have not responded to traditional clinic-based interventions and it allows the worker to see the client in their natural setting (Beder, 1998; Waisbrod et al., 2012).

In more recent years, as a result of the Adoption Assistance and Child Welfare Act of 1980, home-based intervention with families has become more widely used in an effort to keep children in their home while ensuring safety of the child and family (Christensen, 1995). Congress passed this act to transfer the use of federal funding from foster care to prevention in hopes of promoting family reunification and reducing out of home placements (Christensen, 1995; Nelson & Morris, 2003). Home-based intervention is

considered as an alternative to the placement of children outside of the home in foster care, hospitals or group homes (Christensen, 1995). Zarski, Pastore, Way, & Sheplar (1989) discuss the philosophy of home-based intervention in the family preservation model. This model advocates that in order for improvement to be made with a child, the child must be seen as a part of the family unit. Therefore, the importance of the family-at-risk is just as important as the individual-at-risk (Zarski et al., 1989). This theory promotes the use of assessing the client in relation to their surroundings and working with both in order to make change.

A prevalent concept in social work practice, which aligns with viewing the client in their social context of home or surrounding environment, is the person-in-environment perspective (PIE) (Zastrow & Kirst-Ashman, 2010). The PIE perspective focuses on seeing people in relation to their surrounding systems and on how interaction between people and their environment occurs. These surrounding systems involve, but are not limited to, family, friends, neighborhood, work, politics, and religion. Social work practice intends to improve the interaction between the client and their social context (Zastrow & Kirst-Ashman, 2010). Social work's distinct use of PIE ideally trains practitioners to be effective as in-home workers (Beder, 1998). The NASW standard for social work practice in the client's home, in keeping with PIE, is based upon improvement and preservation of the social, emotional, environmental, functional physical, and mental health status of the client and family (National Association of Social Workers, 2005).

### **Challenges of In-Home Therapy**

The existing literature on in-home therapy primarily emphasizes challenges that

exist in this setting, including boundaries, confidentiality, safety, and pacing (Christensen, 1995; Knapp & Slattery, 2004; Thomas et al., 1999; Waisbrod et al., 2012). This review focuses on boundaries and confidentiality, as the current literature identifies these areas as eliciting the most difficulties.

**Boundaries.** The importance of boundaries in therapy has been found in a number of studies which explore both the clinic and home environment (Beder, 1998; Knapp & Slattery, 2004; Smith & Fitzpatrick, 1995; Thomas et al., 1999; Waisbrod et al., 2012). Smith and Fitzpatrick (1995) note that when therapeutic boundaries are presented effectively, therapists refrain from exploitation of the worker-client relationship for personal benefit and strive to enhance the client's independence, while ineffective presentation of boundaries inhibits a client's ability to make independent choices. Literature finds that establishing boundaries is one of the more difficult tasks to do when entering a client's home (Beder, 1998; Thomas et al., 1999).

In a study on the transition of Marriage and Family Therapy interns from practicing in the clinic to practicing in the client's home, Thomas et al., (1999), discuss how boundaries in the environment challenge the therapeutic relationship and change the usual balance of power. Power may shift from the therapist to the client (Thomas et al., 1999). The client, not the therapist, may get up to answer the ringing phone or the knock at the door, and it is not unusual for a worker to feel the need to respect the client's autonomy and right to do so even though it interrupts the session (Thomas et al et al., 1999). The interns expressed these interactions as a distraction from therapy, but due to the power shift, the therapist did not feel confident in limiting such actions (Thomas et al et al., 1999).

Multiple studies stress that boundaries must be established from the start and revisited throughout future sessions in order to continue offering effective therapy in the home (Smith & Fitzpatrick, 1995; Thomas et al et al., 1999). However, existing research lacks analysis of how establishing boundaries in a nontraditional setting creates additional opportunities to integrate into real life scenarios. Many of the boundary related issues which occur in the presence of the therapist are common issues for the client in their daily life. When the therapist is present and available to analyze the situation, an opportunity to integrate teaching into a real life scenario arises.

**Confidentiality.** Typically, confidentiality is maintained between the therapist and client in a clinic-based setting without many problems due to identifiable information not being accessible to the outside world. Existing research portrays challenges in maintaining true confidentiality when therapy is home-based (Smith & Fitzpatrick, 1995; Thomas et al., 1999). For example, a neighbor present when the worker is arriving to the client's home becomes a challenge to the typical notion of confidentiality (Thomas et al., 1999). An especially challenging issue is when the client gives permission for an individual to be present during the session. This is a concern to workers when conducting sessions, especially in the case of children who are not old enough to understand the implications of confidentiality and how being present can be a possible breach of such ethical guidelines (Thomas et al., 1999).

Concerns with breaking confidentiality bring hesitation and fear into practice for a group of Marriage and Family Therapy interns in a study on moving therapy from the clinic to the home. One intern stated, "sometimes there are situations . . . which feel so strange, leaving me with an unsettled, 'Oops, did I do something wrong' feeling" (Thomas

et al., 1999, p. 183). This concern was seen to dwindle with the interns as familiarity with the setting increased, although it still sheds light on a challenge that is threatening to ethical in-home practice (Thomas et al., 1999).

### **Advantages of In-Home Therapy**

The few studies that emphasize advantages of in-home therapy highlight the therapist's enhanced capacity to provide services due to the ways in which the client's environment improves the therapeutic process (Beder, 1998; Nelson & Morris, 2003; Thomas et al., 1999; Yorgason, McWey, & Felts, 2005). The following section reviews the advantages identified within these studies.

**A Home for Therapy.** A small percentage of literature on in-home therapy identified advantages of therapy in the environment of the client's home, including gathering more data with less questions, empowering the client, and determining if the client's daily needs are met (Beder, 1998; Nelson & Morris, 2003; Thomas et al., 1999). Nelson & Morris (2003) discuss the home visit as providing the therapist with a lengthened opportunity to become acquainted with the family system. Getting acquainted to the family system allows for an improved ability to gather data and make a thorough assessment of the individual or family. Through observation, the therapist can identify what is important to the client and what may be challenging to the client (Thomas et al., 1999). The therapist is able to view the nuances of the home, including hygiene, symbols of meaning, housing accommodations, and sleeping arrangements, and the neighborhood in relation to the home (Beder, 1998; Nelson & Morris, 2003; Richmond, 1917).

The importance and benefits of witnessing the client in their own environment in order to make an accurate assessment were noted by Mary Richmond. In Social

Diagnosis (1917), Mary Richmond wrote;

...the photographs on the wall, the framed certificates of membership in fraternal orders, the pensioner's war relics, the Sunday school books, the household arrangements are all eloquent. And far more revealing than these material items are the apparent relations of the members of the household to one another – the whole atmosphere of the home (p. 107).

This atmosphere of the home cannot be witnessed from a clinic setting. At times, to the worker entering the home, gathering all of this information may be overwhelming and they may experience a feeling of not know where to start (Thomas et al., 1999). However, without the worker seeing the client in their natural setting, client issues that the client does not disclose on their own may never be addressed (Beder, 1998).

Meeting the client in their setting is a way of empowering the client (Beder, 1998; Nelson & Morris, 2003). Visiting the home may communicate that the therapist views the client or family as resourceful and deserving of enough respect to offer a friendly visit (Nelson & Morris, 2003; Richmond, 1917). It may also send a message of a therapist who is open and interested. Most importantly, the home visit permits the social worker to meet the client where they are at both literally and metaphorically. For many, the clinic can be perceived as unfamiliar, frightening, and unsettling (Nelson & Morris, 2003). These feelings regarding the environment can have an effect on accurate testing, assessments, and treatment (Nelson & Morris, 2003).

A study that examined the pre-post tests of client scores on the Global Assessment of Functioning (GAF) and Child and Adolescent Functional Assessment Scale (CAFAS) found a noticeable improvement in functioning of clients receiving therapy in the home

(Yorgason et al., 2005). Over a four month period, entailing a total of 54 hours of in-home therapy, the researchers found significant differences in pre-post CAFAS scores (an average decrease in impairment of 32.5 points) and GAF scores (an average increase in function of 11 points). These significant differences in pre-post testing suggest that therapy in the home environment contributes to positive treatment outcomes (Yorgason et al., 2005).

Another benefit of therapy being offered in the home is that additional in-home services can be introduced at any point along treatment (Nelson & Morris, 2003; Beder, 1998; Thomas et al., 1999). An example that has been seen much too often in the field of mental health is an individual with a severe mental illness who has frequent emergency room or crisis unit visits. In this example, the client may not comply with medication requirements, and therefore, transfers from treatment facility to treatment facility until inpatient hospitalization is required. Often times, treatment and goals are changed and altered when a client is transferred back and forth from treatment center to community, causing instability in care and recovery (Lima, 1995; Waisbrod et al., 2012). This example sheds light onto the frequent and reoccurring cases in mental health, in which the clients lack the necessary support of home-based intervention (Lima, 1995; Thomas et al., 1999). In this example, the therapist who is able to see the individual in a community setting now has the option of calling on additional in-home health care services to provide much needed additional support. The assurance that goals and interventions are consistent with the individual's ongoing treatment in the natural setting is the crucial benefit here. Waisbrod et al., (2012) discuss that home-based intervention was only used as a last resort strategy for difficult to reach clients. However, as workers realized the effectiveness of

home-based intervention, it became the preferred method of service for families who were referred to therapy.

### **Gaps**

Current literature lacks an analysis of how challenges in the home create enhanced opportunities for teaching that are beneficial for therapy. Another existing gap in the research is the few studies published in social work journals or examining licensed social workers who conduct therapy in the home. After reviewing twenty-six published articles on the topic of in-home therapy, only three articles derived from social work journals (Paterson & Cyr, 1960, Johnson, 1999; Waisbrod et al., 2012). This is especially surprising since one of the earliest social workers, Mary Richmond, made clear the importance of the home visit in conducting a diagnosis (Richmond, 1917). The framework of Generalist Practice in social work teaches social workers how to work within the client system, to look at the Person-In-Environment, and many other methods that would lend themselves to addressing challenges through therapy in the home.

This study seeks to gain insight to the strengths of in-home therapy by exploring how challenges found within the home may actually enhance the therapeutic process by addressing the primary research question: How does therapy provided in the home environment enhance the effectiveness of that therapy?



## Conceptual Framework

The conceptual framework which will be used for this study is the strengths perspective. Saleebey (2006) describes the strengths perspective as doing everything in practice in a positive manner. This includes helping to discover, embellish, explore, and exploit strengths in order to assist in achieving goals and dreams. This perspective creates a demand for seeing only the positive differences in practice at all levels, including individuals, environments and current situations (Saleebey, 2006). Rather than focusing on negatives, intentional focus on possibility is the key component of this perspective (Saleebey, 2006).

Saleebey (2006) discusses how many practice models and cultural viewpoints focus on negative perspectives, including psychopathology, victimization, and abnormality. These perceptions focus on the issues of the client and categorize them as deficits, problems, pathologies, and diseases. The labels placed upon the client perpetuate a notion that the individual is flawed or weak. When a person is transformed into a case, the individual is often viewed with the context removed and valuable elements of the client are missed. Wollins (1997) discusses how the "damage model" of development, which is prevalent in mental health's present day thinking, leads to discouragement and pessimism (as cited in Saleebey, 2006).

Working through the micro, macro and mezzo structures of society, it may be difficult at times to draw upon the assets, resources, knowledge, and wisdom of societal structures. When focus is placed upon the shortfalls of an environment rather than the advantages, opportunities to draw upon wisdom and strength are missed. The strengths perspective focuses on utilizing the potential of those resources that may otherwise be overlooked in order to build resiliency and achieve goals (Saleebey, 2006). "No matter

how harsh an environment, how it may test the mettle of its inhabitants, it can also be understood as a potentially lush topography of resources and possibilities" (Saleebey, 2006, p. 19).

This study is based upon a strength-based exploration of advantages to treatment when conducting therapy in the client's home environment. The strengths perspective was utilized through investigating the advantages within this environment and identifying how the perceived challenges within this environment may potentially enhance the therapy. Resources and assets which may have been overlooked in this environment were identified through using the strengths perspective for this study.

## **Methodology**

### **Research Design**

This qualitative study explored the advantages and challenges experienced by licensed therapists who have conducted therapeutic services in a client's home. The purpose was to explore therapists' perspectives on factors in home-based therapy which may be perceived as negatively affecting the process of therapy, but that may actually provide an opportunity for growth greater than what can be experienced in a clinic-setting. The experiences of participating therapists were used to draw out strengths of therapy within the home environment in order to highlight an effective method which has been overlooked. A focus group of four therapists was conducted using open ended questions in a semi-structured group discussion (see Appendix C). Dialogue was based on advantages and challenges experienced in the client's home and ways that challenges may open a door into the client's life otherwise missed in a clinic-based setting.

## **Sample**

The sample for this study included four licensed therapists who had at least one year of experience conducting in-home therapy and were willing to participate in a 90 minute focus group discussing advantages of conducting therapy in the client's home environment. A total of six therapists who qualified for the study expressed an interest in participating, however only four people were able to attend the focus group.

Participants were chosen through convenience sampling followed by snowball sampling, beginning with a flyer sent by email to therapists with experience conducting in-home therapy. The flyer asked therapists to forward information about the study to other therapists with experience conducting in-home therapy (see Appendix A). The participants included two Licensed Independent Clinical Social Workers (LICSW), one Licensed Graduate Social Worker (LGSW), and one combination Licensed Marriage and Family Therapist (LMFT)/Licensed Psychologist (LP). The participants had a range of one to thirty-two years of in-home therapy experience. Two participants only had in-home therapy experience and the other two had both in-home and clinic-based therapy experience.

## **Protection of Human Participants**

This study was reviewed and approved by a research committee and the St. Catherine University's Institutional Review Board. Engagement in this mandatory review served to ensure the protection of human research participants.

Before beginning the focus group, the consent form was reviewed with the participants. The consent form explained the structure of the study and the possible risks and benefits that may be involved with participating in the focus group. The participants

were assured by the researcher of confidentiality in handling the data at all phases of the study, but they were also informed that, due to the focus group format, other participants may choose to break confidentiality outside of the group beyond the researcher's control. It was also made clear to the participants that the findings would be presented in an oral presentation at University of St. Thomas and through a written report which would be published as a Master of Social Work Clinical Research paper. The respondents who participated in this study signed the consent form before beginning the focus group.

In order to maintain confidentiality of the participants and the data retrieved from the participants, all consent forms were kept in a locked file in the researcher's possession. The researcher is the only person who listened to the audio recording. A transcript was created from the audio-recording and did not include names or identifying information of the participants. Audio from the focus group and transcript of the audio were kept on the researcher's personal computer, which required a secure password for access. A researcher's assistant was in the room during the focus group to take notes, identify who was speaking in what order, and report a summary at the end. The researcher's assistant signed the confidentiality form as well. Published results of the data exclude identifying information in order to maintain participant confidentiality.

There were minimal risks involved in participating in this study. This study involved a minimal risk that an employee may feel pressured to participate if the flyer was passed on by a supervisor. This risk was minimized by informing all potential participants that their supervisor would not be told whether or not they had participated. Participants were informed verbally and through the consent form that if any discomfort was experienced at any time through the focus group, they could leave the group or

choose not to participate in a question without facing negative repercussions.

The consent form clearly explained there were no direct benefits to the participants or related agencies other than snacks and refreshments offered at the focus group. Participants may have gained a personal sense of satisfaction from knowing that their experiences and opinions were used to increase current knowledge on the subject of in-home therapy for the fields of social work and mental health.

### **Data Collection**

For this study, a focus group served as a discussion based atmosphere for identifying experienced strengths within the perceived challenges of in-home therapy. The focus group was semi-structured, guided by a set of questions, and was approximately 90 minutes long (see Appendix E).

The questions were developed as objectively and open-ended as possible to maintain authenticity of the research and encourage applicable feedback without bias of the researcher. The questions developed for the focus group sought to discover strengths of in-home therapy which may be absent in a clinic setting. Questions were developed using three major challenges noted in literature: confidentiality, boundaries, and safety. These challenges were reframed to explore the ways in which they could potentially enhance the therapeutic process. The questions were then reviewed by the research committee to ensure necessary factors were addressed.

A copy of the questions was sent to the participants ahead of time. This was done in order to enable the participants to prepare with examples and thoughts before the focus group so that time within the focus group could be used efficiently. A short written survey was also administered to the participants after the focus group to collect general

background information regarding education, licensure, experience as a therapist, opinion of effectiveness about in-home therapy, and opinion of how current literature represents in-home therapy (Appendix D).

The focus group questions and discussion began with a focus on the experiences of participants with conducting in-home therapy and the effect of environment on the therapeutic process. Following that, discussion focused on ways in which what the literature identifies as challenges of in-home therapy may really be strengths that are not present within a clinic-based setting. Discussion of challenges which may be strengths included addressing boundaries, confidentiality, empowerment of the client, and preventative measures (see Appendix E).

### **Data Analysis**

Data analysis was based on Data Management and Analysis by Deborah Padgett (1998). In accordance, data was initially drawn from the "raw data," which was the recording of the focus group through transcription. The "partially processed data" was then coded and recurring codes were put into categories of themes. In order to identify themes, the researcher listened to the interview multiple times in order to obtain a strong awareness of the data. The researcher then color coded quotes and made comments in the margins in order to categorize responses into related themes. After, the researcher compiled quotes from the transcription into a larger document for each identified theme.

The transcript was reviewed again using a partner with similar research education and background to ensure codes and themes were accurate in relation to the research question and to provide inter-coder reliability (Monette, Sullivan & Dejong, 2011). The majority of codes and themes discovered by the partner matched those of the researcher.

The codes and themes which differed between the researcher and partner were discussed and together the researcher and coding partner decided how to classify them.

The researcher was particularly interested in the participants' views of in-home therapy and how it may enhance the therapeutic relationship. The use of this qualitative method enhanced the ability to capture the participants' opinions on the subject, enabling information that is detailed and complex.

### **Findings**

This study explored the strengths of in-home therapy by analyzing identified challenges found within the home which enhance the therapeutic process. This section reviews seven themes identified from the focus group. Most of the themes were therapeutic benefits of in-home therapy identified by participants: information for assessment, enhanced relational building, opportunities to empower the client, reaching out to at-risk populations, addressing confidentiality, and addressing boundaries. One additional theme addresses safety in the field and a final theme which reviews the participant's attitudes toward in-home therapy.

### **Assessment**

All research participants discussed many aspects of how therapy conducted in a client's home increased their ability to make an accurate assessment through observation of the environment. One participant stated,

*You get to see what you wouldn't capture in an office...you get to see the environment, if it's organized or not, whether it's chaotic or not, whether it is pristine and sterile like no one lives there, so you can capture some of the nuances.*

All participants discussed ways that this enhanced ability to assess, which informed the treatment. One therapist said that,

*Understanding the client through their physical environment and assessing the client based on what you see, what you hear, what you smell... that's helpful to get a whole sense of them and what could potentially be supportive for them and what they may or may not be taking advantage of.*

Participants identified spiritual practices, affective perception, and symptom assessment as specific nuances they observed in the home which informed assessment for the client or family.

**Spiritual practices.** Participants reported that their ability to assess for spiritual practices as a supportive strength became easier when entering a client's or family's home. One participant expressed,

*There are things that we as therapists don't often ask clients that might be more noticeable in their home. I'm thinking about spiritual practices I have noticed in the home that I have been able to use as part of the healing sect for the family.*

Another therapist added,

*It helps to see the religious aspects in my Hmong clients. I could go there and it's this tiny one bedroom, and they have this huge...Shaman- stuff [altar] with papers and incense...and it helps to identify their spiritual belief and the families.*

Participants also discussed how symbols and pictures in the home helped initiate conversation around spirituality. One therapist stated this was helpful with,

*...folks who have crucifixes on the wall...with a signed picture from Pope Benedict, so I can more easily ask a question about their spirituality. Which we*



*try to do when people are in the office as well, but when it's right there in front of you, it's a less awkward thing to do.*

Enhanced assessment around the client's spirituality created an integrative opportunity for one therapist,

*I came in and saw that she had a little altar set up – she practices native spirituality and some form of Christianity, so I just asked her if she would be willing to guide us in an opening meditation each time we met and she did! But I don't know that I would have been able to do that, had I not been in her home and noticed the little altar.*

**Social environment's residual energy.** Participants (n=2) also discussed how their perception of the client or family amplified when entering their home as a result of attunement to the residual emotional energy of their environment.

One therapist stated,

*When in that environment, I rely on my gut feeling and kind of the energy in the room...it's like I kind of use that as a diagnostic tool. 'Mmmm – anxiety. There's anxiety in the air...the client's home helps with being more empathic... because you experience in one hour what they experience in 24 hours.*

Another participant added,

*Walking into a family's home you get a feeling...whatever that feeling is might say something about the environment...you can tell when you walk into a home where there's grief and loss, and where there's anger, you kind of soak that up in a different way.*

**Symptom evaluation.** Participants (n=3) also discussed how the client's

environment helped them evaluate the severity of their symptoms. One therapist stated, *I work with a young female whose apartment is very chaotic, and how it looks from week to week helps me to see how well regulated she is.* Another therapist added, *The window shades being down, maybe it's a beautiful sunny day and they're closed in, you can certainly get a sense of depression.*

Explained another therapist,

*Sometimes their environment helps me kind of identify how severe their illness is and if the client seems well put together, you see that, someone's very depressed... and they think they're at a 2 [1-10 scale] but the windows are all shut, and they haven't been able to get up, and they haven't been bathing, and seeing them in that environment, you can tell how severe their depression is.*

### **Enhanced Relationship Building**

All research participants discussed how in-home therapy helped increase the pace of rapport building with the client when compared to clinic-based therapy. One therapist expressed,

*I think one huge one [advantage of home-based therapy] for me is that it aids in rapport building, really quickly.* Another therapist added to this understanding by saying, *Instead of having to spend 2 or 3 sessions building that relationship [in an office], you get that right away by going to the home.*

Research participants described how in-home therapy enhanced rapport building through creating a reciprocal relationship. A participant stated,

*You go to someone's house and they feed you, because that's a cultural welcoming. I think to not take it is detrimental or would be offensive, and*

*completely negate the relationship building that you have been doing up until now.*

Another therapist added, *There is something that shifts boundaries about going into people's homes, where as to not take a piece of homemade cake on your way out the door would have been very detrimental to the relationship with the family.* Another therapist added,

*Sometimes they [the client] feel like you are coming into their home and you are offering them this support, this help... based on a relationship being reciprocal, they want to give you something. So by accepting that, you're helping them feel they're bringing something to the table.*

An additional participant concluded,

*They feel like there's a benefit for you coming into their home seeing that you are the expert. In a cultural standpoint [Hmong], after therapy they like to pack things with you to go. Either lunch or a little mango or whatever that they have in the home and even though you can't take gifts, it's one of those things that you take because it meant a lot to them...just to do that, is a great way to build the relationship.*

### **Opportunities to Empower**

All research participants identified how entering into the client's environment for therapy also empowers the clients. One participant stated, *You are in their element... you go into their world...and there isn't that, that power differential.* Different strategies identified by participants for empowering the client through use of their environment include addressing the power differential and displaying positive regard to the

environment.

All research participants expressed that conducting therapy in the client's home addressed the power differential between client and therapist. One therapist explained,

*In-home provides with a more, um, leveling the playing field if you will. You are a human being walking into another human being house and you are there to provide a service, but I think too often clients see us as experts in our office and going into their home levels that.*

An additional participant added,

*Just by virtue of us being there is empowering – It's like I'm valuable enough for you to come to me and come into my place and...that's pretty empowering – our presence. An additional therapist adds to how this also assists with building rapport: It allows that relationship to build; you are going in as a guest, so it makes you somewhat vulnerable.*

Another participant discussed an opportunity to model mutual accountability in order to empower the client and the therapeutic relationship. The therapists stated,

*I am not always on time, and so I think in that respect I am apologizing to clients for maybe not having respect with their time...that helps them to feel like I am accountable too, I am not asking them to be accountable when I am not expected to be also.*

Several of the therapists also discussed how portraying positive regard to the home and efforts made in decorating empowers the client as well. One therapist stated,

*I really bring in a lot of positive regard for clients and pointing out strengths and positives that I see... just kind of scanning the environment and what are some*

*genuine things that I'm noticing that I can point out .*

Another therapist affirmed this:

*Noticing something in someone's home that they have designed themselves or made themselves... 'Oh my gosh, did you make that afghan that you're wrapped up in?'" "Yes." "So I think that it helps kind of empower some of their sense of skills or how they've decorated their house.*

An additional participant added, *Providing affirmation when you see someone who is well organized. They have talked about depression, but they're able to keep things organized, and providing affirmation helps the client.*

One participant added,

*I have one client...he's an artist and his illness is so significant that you would not think of him being an artist. His whole home is an art studio and that's one of his strengths. But in therapy if he were to come to the office, I don't think you would get to see that side of him. Particularly when his mental health he sometimes can have delusions – so you don't know what's real, what's not. And so to see his art, it's not a delusion – he's actually really good at that.*

### **Reaching At-Risk Clients**

All of the research participants discussed how in-home therapy has been a way of reaching out to at-risk populations. Many participants discussed how this form of therapy addresses cultural stigma and increases the ability for connection to populations that would not otherwise attend therapy. One participant expressed, *There is some stigma when getting therapy and sometimes going into a mental health office can be difficult for some clients. So by us [therapists] coming to them, there isn't as much of that.* Another

therapist explained,

*When I talk with GLBT, gay and lesbian youth, they don't want to be going to a clinic being seen as an illness, they would rather see you in the community of their choice...some place they feel safe in is really important.*

The same therapist later expressed,

*In certain cultures, therapy is not accepted...if you see somebody in their home, um, especially if the person [therapist] doesn't have the rapport with the family, it's more likely they will continue to see you...so being in their environment can help them come back or accept therapy.*

Several of the participants identified how in-home therapy assisted in maneuvering around reality-based constraints which may cause clients to not participate in therapy. A participant expressed,

*Individuals I work with have a diagnosis that makes it really hard for them to go out and about... if you are diagnosed with depression and you just can't get out of bed or can't get moving for the day, you certainly can't leave, so you need someone to come to you.*

Another participant stated,

*In my experience, in-home therapy has really increased in attendance...it alleviates the client's anxiety of how to get to therapy. An additional therapist added, For clients that have transportation issues, to go to one appointment may take their whole day on the bus...so for a therapist to go there [client's home], they are not all tense and they're able to concentrate and focus. A participant added, Just seeing clients who are victims of the system – nobody's really taken the time to*

*help them facilitate so that they can meet those appointments...on top of that, arranging for childcare and everything else...in home therapy helps with that.*

### **Confidentiality**

Research participants discussed both the challenges of maintaining confidentiality during in-home therapy and the opportunities provided due to the presence of other people in the home environment during therapy. One participant described this as, *Walking into a morass of ethical issues.* Another participant explained, *Some of the places where we serve clients there's little privacy, you're sitting there and the phone is ringing off the hook and people are coming to the windows and you hear noise outside.*

At the same time, the participant also expressed

*We have gone to kids' homes and they want their best friend to stay and participate in therapy with them...so on occasion we have been able to get a signed release from that kid's family that says it's alright that they participate because it might be useful for the client to work on relational skills and developing safety plans.*

Many of the participants discussed how the presence of other people in the environment created additional therapeutic and assessment opportunities. One participant stated, *The rule of thumb in family therapy is if you get stuck broaden the picture.* A participant added, *You can use the presence of other people to really help, especially when you are stuck – it provides a contextual kind of reference to the work we do, which we don't always have.* Another therapist expressed, *Sometimes having a mom and dad there—collateral information is very helpful to kind of give you that whole picture and the whole picture could be from an assessment of how they interact with each other.*

Another therapist discussed,

*I had an opportunity to see how the client interacted with this child and did so in a very nurturing way. Which was helpful...[F]rom an assessment standpoint, I think every little interaction that you see between the client and the significant people in their lives helps to inform your treatment.*

One participant proclaimed,

*An assessment in an office with just you and a client is going to give you this much information [low hand gesture], compared to when you are in their environment and you're seeing interactions with the people who's in their life.*

Another participant articulated a personal experience,

*We're doing therapy for a person who has a severe TBI [Traumatic Brain Injury] and hears voices...no provider has been successful in working with this person, but through in-home therapy we find out that the family has no system – they're always in and out and they don't let him know...he's concerned about the family and he throws a tantrum...When the family comes back, he tries to tell them his concerns, but he can't intellectualize it...the family is just all over the place and I think that's where it really helps me to pull the family together.*

## **Boundaries**

All research participants discussed the increased need and opportunity to set and model therapeutic boundaries with clients when entering their home environment. One therapist stated,

*A lot of times what I'm talking to the client about is pretty personal, and in my*



*opinion doesn't need to be talked about in front of children. So that's just an opportunity for me to set and model that boundary.*

One participant stated,

*Earlier in my career there would be five or six people smoking at a time...when I was pregnant I would ask for them to not smoke while I was there. It was like something they hadn't thought of; they were very respectful and sort of got a clue of how they needed to pay attention to other's needs.*

Another participant said,

*A particular client of mine at one point asked me if I would help her clean...I set a boundary there and it helped establish the boundary to understand what a therapeutic relationship is. One therapist added, You have to keep your boundaries – you're not their friend, you're not their next door neighbor, you're their therapist – but sometimes they want to invite you for a dinner and you can turn that dinner into a therapeutic lesson.*

Another participant expressed,

*I am not real comfortable with dogs so you can imagine that that doesn't make in-home work easy all the time...I finally set a boundary and said 'I am not very comfortable with dogs'...there was a shift; I made myself vulnerable to her... I didn't know this before it had come up, but I seemed to her as this all powerful critic, like I was there telling her what she is doing wrong. In that way I was not only setting boundaries, but I was letting myself be vulnerable to her, and it shifted, and then she became a little bit more open to me to make progress because I didn't seem like this scary thing in person because I asked her to call*

*her dogs off.*

### **Safety in the Field**

All research participants discussed measures they take to protect their safety, including contracting with the client to mitigate risk, deescalating situations, bringing a co-therapist to the sessions, and listening to their judgment about whether to enter the home environment and when to exit that environment. However, the same participants also talked about feeling safe in the home environment and attributed this to the lack of threat they carry as being a part of a helping profession.

Participants (n=4) conversed about how many preventative measures for safety can be accomplished through contracting with the client in the beginning phase of in-home treatment to mitigate risks. One participant stated, *We have really been clear over the years about when we would call 911 if there's a child who's disrupting and getting aggressive.* Another therapist stated, *To work in this environment you do have to be careful about never putting a client between you and the door...I feel like I had to make those kinds of rules ahead of time.* A third participant stated,

*We try to figure out a head of time whether or not they have weapons in the home.*

*We ask them to secure them and make sure that the bullets are separated from the guns.* The same therapist later stated, *We also ask for dogs to be secured ahead of time...we have been really clear about that...these early measures set a standard for safety.*

One participant stated,

*There's certainly things I think you can do to mitigate some of the risk – I mean there's a risk in everything we do [in society], so all we can do is lessen the*

*risk, we can't be safe 100% of the time anywhere we are at. So things that you can do is where you position yourself in the environment and making sure you have a charged phone with you.*

Two of the research participants also discussed how skill development in deescalating crises is very important when doing in-home work. A therapist expressed, *Paying attention, to somehow bringing in the piece about deescalating crisis...[It is] much more beneficial than any other types of preventative measures...skill in deescalating is huge!* An additional participant added, *As in-home therapists, we are responsible for the safety for the people in that house, so if things start to get escalated we have to put a stop to it.*

One participant stated,

*I think in-home therapists, especially the ones with some experience, have amazing de-escalation skills...we're gonna push sometimes when we need to, but we're also gonna assess constantly when we can't push... so we have to go back a little bit and kind of do that dance.*

A few of the therapists also discussed how bringing in a co-therapist can be a beneficial option. One participant stated, *we've made decisions about whether to bring a co-therapist or not...but I do think just having an emotional witness makes it feel safer.* A female participant stated,

*Having another person [therapist] there is helpful when you work with gender specific, someone who could have a lot of trauma or be highly sexualized. To kind of get that sense, you have to see that in the home. So to have another person there adds safety.*

An additional therapist added, *I have worked with a team for 32 years so I kind of always see it as a 'we' We have done most of our years conducting family therapy with co-therapist, which has been an incredible advantage.*

A few participants also discussed how using one's best judgment on whether or not to enter the client's home when concerns may arise is always an option. One participant stated, *There certainly have been times when we have forgone in-home and asked people to come in the office when it's been way too chaotic and we thought there might be domestic violence.* Another participant expressed the importance of, *Knowing when not to engage or call the session off – if they're drinking to a certain point, or if there's suspected drug use...make that assessment and just trust your gut.*

Despite the group's extensive conversation on preventative measures, none of the participants identified an experience where they felt in physical danger when conducting in-home therapy. One tall, male participant stated, *"I haven't really had much concern...I feel the issue of safety and our clients are dangerous is sometimes overstated...I just don't see the papers lined with stories about home-based therapists getting chopped up.* A short female therapist added insight,

*I've done this for a long time and for the most part I don't feel unsafe, sometimes which I think is funny because that I am a short woman, that I don't pose any risk so and I mean I am not often scared...I have not found it over the years being all that unsafe, we're not stupid about going in. I don't think – oh, someone's gonna shoot me!*

An additional short participant added, *I've dealt with a couple MI and D*

*[Mentally Ill and Dangerous clients], and I haven't felt threatened in my home visits, so and maybe it's because me being small too, but I've had a really positive experience in the home.*

The research participants discussed how the role of an in-home therapist is not perceived as threatening. One participant stated,

*I would think there would be more risk involved if you were entering someone's home in an adversarial way like child protection worker, a housing inspector... I think of all the number of professions other than in-home therapy that are entering people's homes... I would see the therapist as probably our risk down here [hand gesture to the ground].*

Another participant agreed, *Our role is a good point. We're there not to take away... [A]s a therapist, it's really about unconditional positive regard and building of rapport – they want you there, for the most part.* One therapist proclaimed this idea of not feeling threatened by stating, *In-home workers rush in where angels fear to tread.*

### **Participants' Attitudes Toward In-Home Therapy**

All research participants completed a survey (see Appendix D) which ended with two likert scale questions (#4 and #5) that collected their attitudes toward in-home therapy and the relevancy of literature on the subject. Question Four asked: On a scale of 1 to 5 (1 much less effective, 5 much more effective), how effective do you feel in-home therapy is compared to clinic-based therapy? Four participants responded to this question by rating the effectiveness of in-home therapy at a 4 and one participant responded by rating the effectiveness at a 5. This suggests the overall attitude of the participants toward home-based therapy as more effective than clinic-based therapy.

Question Five asked: On a scale of 1 to 5 (1 being not at all relevant, 5 being very relevant), how relevant to you are professional literature and education in identifying strategies for conducting in-home therapy? All participants responded to this question by rating the relevance of literature to in-home therapy strategies at a 4. This suggests the overall attitude of the participants toward in-home literature strategies as being relevant.

### **Discussion**

The purpose of this study was to explore therapists' perspectives on home-based factors which may affect the process of therapy, but when addressed become an opportunity to enhance the therapeutic process. This section will review how this study's findings compared to literature regarding use of the client's environment to enhance therapy, confidentiality in the presence of others, integrating therapeutic boundaries into the environment, and the participant's attitudes toward therapy. Implications for practice, policy, and future research will also be discussed.

#### **Using the Client's Environment to Enhance Therapy**

All participants in this study expressed how utilizing the client's environment when conducting therapy had enhanced their capability to provide accurate treatment through enhanced assessment, empowerment, and rapport.

**Enhanced assessment.** This study found that providing therapy in the client's environment provided additional nuances which improved the therapist's ability to make initial and continuous assessment. These individuals expressed how in-home provision of therapy captured elements of the individual that a therapist would not be able to see in a clinic. These findings are congruent with Nelson and Morris' (2003) research, which showed that a therapist is able to view the distinctiveness of the home, including hygiene,

symbols of meaning, housing accommodations, and sleeping arrangements, and the neighborhood in relation to the home. These findings are also consistent with findings from Thomas, McCollum, and Snyder's (1999) research as well as Richmond's (1907) book, *Social Diagnosis*, which noted that, through observation, the therapist can identify what is important to the client and also what can be challenging to the client. This knowledge in assessment can be extremely important considering that assessment informs treatment. Several of the participants spoke to how assessment in the client's home increased their capacity to notice change in severity of symptoms over time. The participants discussed how witnessing small distinctions, like whether or not the shades are open on a sunny day, provided insight to the client's symptoms. Thomas et al.'s (1999) research suggests that, without the worker seeing the client in their natural setting, many of the client's issues may only be addressed if the client discloses them. Many clients may be apprehensive or intellectually incapable of disclosing information to a therapist, but in-home assessment addresses that apprehension or incapacity.

**Enhanced empowerment.** Participants in this study unanimously agreed how visiting the client's home addressed the power differential between therapist and client and made the client feel important. This is consistent with the research of Nelson and Morris (2003), suggesting that meeting the client in their setting is a way of empowering the client. This idea is also consistent with Richmond's (1907) *Social Diagnosis*, stating that visiting the home may communicate that the therapist views the client or family as resourceful and deserving of enough respect to offer a friendly visit. Participants (n=3) in the current study also noted that displaying positive regard toward details of the home which recognize the client's skill and ability makes use of this environment to enhance empowerment; this finding is consistent with the strengths perspective. These

understandings are significant for consideration with clients who struggle with self-esteem or who become anxious when in a therapist's office. Nelson and Morris (2003) note that the clinic can be perceived as unfamiliar, frightening, and unsettling for many clients. These feelings regarding the setting can have an effect on accurate testing, assessments, and treatment.

**Enhanced rapport building.** All participants discussed how visiting the client's home enhances their ability to build rapport with both the individual and the family and attributed this to both the environment and the sharing of food. This strength was not identified in the reviewed literature.

Participants (n=3) in this study expressed how rapport building began at the first session in the home, but might take a few sessions in an office before rapport building occurs. This quicker avenue to rapport can be an important consideration regarding agency feasibility and insurance billing for the method of in-home therapy. This consideration becomes important because when rapport is being built faster, the therapeutic process is expedited, resulting in possibly less sessions. This benefit may then be passed to insurance companies and agency feasibility for services.

Several of the research participants also described how clients often offer a beverage or food item and how talking over the sharing of food can be a great way of improving the therapeutic relationship and also an opportunity to model healthy meal eating behavior for families. The participants also recognized that refusing to accept an offer of food or drink may be detrimental to the therapeutic relationship, as an aim of therapy is to assist in developing the client's interpersonal relationships, and to deny this reasonable form of reciprocation can be quite invalidating.



## **Confidentiality in the Presence of Others**

Participants discussed both challenges and strengths of working in the client's home when other people are present. Several of the participants expressed that other people in the environment can create some ethical issues around confidentiality, but can also provide an opportunity for therapeutic intervention. This benefit of utilizing other people in the client's environment has not been identified in the literature and challenges research literature that defines this as solely a threat to confidentiality (e.g. Smith & Fitzpatrick, 1995; Thomas et al., 1999). This finding is also consistent with the strengths perspective's emphasis on identifying and using available resources in the environment to improve intervention, and is discussed more below.

All therapists in this study identified how other people being present in the home create an opportunity to model, assess, and teach in the session. A few participants discussed how opportunities for intervention may arise within the tension of the environment and can then be integrated into the client's conscious experience through applying observations of the client's interaction with other individuals from the environment to the therapy discussion.

Many of the participants (n=3) felt that having other people present or around the home of the client broadened and informed the therapeutic focus. Participants discussed how the client's environment lends itself well to integrate family members into the therapy, which assists in adding context and broadening the picture of the therapy. The participants also expressed that seeing the client interact with neighbors or family members informed the worker of the client's environment and their strengths and weaknesses in that environment.

## **Integrating Therapeutic Boundaries into the Environment**

All research participants expressed the importance of setting therapeutic boundaries in the client's home environment. This is consistent with current literature (Beder, 1998; Knapp & Slattery, 2004; Smith & Fitzpatrick, 1995; Thomas et al., 1999; Waisbrod et al., 2012). Literature also states that establishing boundaries is one of the more difficult aspects to do when entering a client's home (Beder, 1998; Thomas et al., 1999), but this study's participants did not identify boundary setting as being only a difficulty.

Participants (n=4) viewed the need for setting boundaries in the home environment as an aspect of the therapy that can enhance the process; this was not seen in the literature reviewed for this project. Participants (n=2) additionally discussed how consistent boundary setting in a client's home can easily be integrated into real life scenarios that create a more enriching experience for the client. One participant portrayed this through an example of a conversation around the client's children that was not age appropriate. This created an opportunity for the therapist to model boundaries using a real life scenario by establishing what conversations may not be appropriate for children to hear. The common boundary conflicting scenarios which may arise in session are also likely to be present in other parts of the client's personal life; during in-home therapy, the two scenarios can be connected easily and integrated into a therapeutic lesson. One participant elicited this through an example of a family smoking around her when she was pregnant. The family was not conscious of how smoking cigarettes in the home may affect visitors until the boundary was discussed in session and integrated into other similar scenarios.

Findings from this study suggest that when boundary setting is addressed restoratively in the home environment, it potentially enhances the therapy through utilizing scenarios which result from daily living interactions. This insight to boundary setting in a client's home is not expressed in the reviewed literature.

### **Participant's Attitudes Toward In-Home Therapy**

The survey administered to the participant's reflected their attitudes toward in-home therapy as being optimistic toward this method of service delivery. Each participant rated their feelings toward in-home therapy as being more effective than clinic-based therapy. Two of the participants have experience in both clinic-based and home-based therapy, and two of the participant's have only home-based experience. The two participants who have experience in both areas of therapy reported having over ten years of experience conducting therapy. This is an important consideration for the notion that these professionals prefer the effectiveness of home-based therapy over clinic-based therapy for their clients. Literature reviewed for this study that interviewed therapists and their attitudes toward in-home therapy reported having participants with experience in both environments and preferred clinic-based therapy over in-home therapy (Thomas et al., 1999). However, experience of these participants was less than a year total conducting therapy (Thomas et al., 1999). Therapists with less than a year practice may experience difficulties no matter the environment the therapy would be conducted in.

The second question reflected the participants' attitudes toward literature and education on identifying relevant strategies to in-home therapy. All participants felt that literature and education are relevant to finding strategies for in-home therapy. This suggests that the participants in this study have found educational materiel which assisted

in conducting in-home therapy. This reflects the educational practice the participants have experienced in order to be effective in conducting therapy in a client's home. When comparing the differences of findings between this study and Thomas et al. (1999), where intern therapists were interviewed, the notion of experience plays a big part of being effective in home-based therapy.

### **Implications for Practice**

This section will discuss the implications this research creates for social work practice, addressing how social workers can affect change in order to increase effective application of in-home therapy. Particularly, this section will address the need for social work to better incorporate in-home therapy skill building in educational programs and professional practice.

The implication this study creates for mental health practice is the ability to enhance assessment when conducted through a home-visit. Assessments that are completed in a client's home enhance the assessor's ability to view the client in relation to their environment and in turn better inform treatment. This method for assessment is an important consideration for clients that struggle with conceptualizing difficulties within their environment or family.

This study also suggests that in home therapy may be more effective with at-risk populations with a severe mental illness which interferes with regular attendance or cognitive functioning while in a clinic-setting. It also may be more effective with populations that may not show up for therapy in a clinic due to viewing therapy as a stigmatized service, a weakness or a threat to their culture's honor.

Clinical social workers, as well as other mental health workers and helping

professionals, can use this study's findings to better understand how to conduct in-home therapy and create an effective home visit. Through this, mental health professionals may be better suited to identify resources and opportunities within the client's home to use to enhance the treatment.

This study also highlights the effectiveness of in-home therapy as a means of empowering the client. Social workers can use the information within this study to effectively reclaim home-based therapy.

Social work education should incorporate in-home therapy as a method of practice in courses on therapy. Through educating social work students on the opportunities that arise in the home environment and the skills needed to succeed in that environment, the profession as a whole will better equip young social workers to be effective with client populations that would greatly benefit from home-based services. Through this education, the field can regain an abandoned art of therapeutic intervention which can be beneficial for many populations.

### **Implications for Policy**

This section features implications for policy derived from this study, including the importance of advocating on behalf of the continued need for public grants to provide assistance to agencies which provide in-home therapy. This section also discusses the need for legislators to hear the voices of clients and professionals who have experienced the effectiveness of in-home therapy.

The 2003 Children and Community Services Act (CCSA) created a fund for counties to address social service needs of children, adolescents, and adults that are not already provided for by public assistance or public health care programs (Mental Health Policy Manual, 2012). CCSA funds can be used for community-based care related to

child protection, crisis, keeping a person in their home, assessments, guardianship, case management, and licensing (Minnesota Department of Human Services, 2012).

Therefore, funds are allotted for many home-based services to keep an individual in their home. However, this does not include therapy. In-home therapy needs to be added to this community-based care list in order to make the service more accessible to individuals in need.

With funding for mental health care often sporadic, clinic-based therapy may likely be perceived as the most feasible option even though this study highlights the effectiveness to this method of service and its alignment with the NASW Code of Ethics. Public funding should be dedicated to address the mental health needs of our society in order to ensure everyone an equal opportunity to access mental health services for recovery.

Facilitation between clients, in-home therapists, and legislators is a necessary process in order to advocate for this change. The voices of in-home therapists and their clients should be considered as changes to the mental health system are being made. Social workers can help in this process through advocating for in-home service, as well as by providing education and resources to help build connections between clients, in-home therapists, and their legislative representatives.

### **Implications for Research**

Further research is necessary to confirm and further explore the findings within this research report of how challenges experienced when conducting in-home therapy may create additional opportunities for intervention. In addition, research which explores the differences in attitudes between experienced and inexperienced therapists regarding

in-home versus home-based therapy is another important area for future research.

Program evaluations which comparatively assess the client's experience in a clinic-setting and their home setting would further develop the field's understanding. Research which also investigates the client's attitude toward in-home therapy compared to clinic-based therapy would be valuable in exploring the effectiveness of in-home therapy to client populations. This research should include exploration of a client's level of anxiety and ability to process when entering a clinic compared to their own home. Research which measures effectiveness of in-home therapy across rural, suburb, and inner-city populations would offer beneficial insight to possible changes to the dynamics of home-based therapy. Research which explores commute time as a deterrent to seeking therapy services would be beneficial.

Current literature reviewed for this study did not explore the notion of a residual energy from the client's social environment. Research which explores this concept of an emotional energy being displaced into the surrounding environment bears a need for investigation to explore the potential utility and challenges of in-home therapy and social work practice.

### **Strengths and Limitations**

This research had both strengths and limitations. Qualitative methods yielded data that was more comprehensive and complex than what was possible through a quantitative method. This data collected the personal subjective experiences of the participants in order to gain a more in-depth view (Monette, Sullivan & Dejong, 2011). Unlike quantitative research that uses random sampling, the data from this sample cannot be generalized to the larger population.

Due to the time constraint of this project, a disadvantage to this study was that only one focus group could be conducted. Conducting only one focus group did not allow the data to not achieve saturation, or the point at which the range of ideas on the subject has been heard and new ideas are no longer emerging (Kruger & Casey, 2009). Another limitation to this study was the difficulty finding individuals who were willing to participate in the study despite extensive recruitment efforts. Several individuals who displayed interest in participating in this study were unable to attend the focus group due to conflicts around availability.

Focus groups offer strength not available in individual interviews based on a more effective technique for idea generation (Morgan, 1996). Other methods of data retrieval may explore what people have to say, but do not provide insight into the complex behaviors and motivation of the participants that are possible in a focus groups (Morgan, 1996). The focus group provided an opportunity to gain more in-depth understanding and clarity of answers (Kruger & Casey, 2009).

The interactions between the participants of the focus group, including the impact of the attitudes of group members, may have impacted the data, and the group itself, in positive or negative ways (Morgan, 1996).



## Conclusion

Therapists who have the opportunity to provide in-home service for a client can empower the individual or family, enhance the therapeutic relationship, and integrate lessons into current issues the client is struggling around. This can be done through working directly with the client in their surrounding environment and witnessing first hand their daily struggles. In order for this to become fully effective, social work and other mental health professions need to incorporate in-home practice into their education and their metaphoric tool boxes.

This study intentionally used Saleebey's strength perspective (2006) by focusing on what's effective about in-home therapy in order to draw out the strengths of this therapy and reframe commonly experienced difficulties as an opportunity to enhance treatment for the client or family. This study challenges previous literature which underemphasizes the effectiveness of this means to therapy (Christensen, 1995; Knapp & Slattery, 2004; Thomas et al., 1999; Waisbrod et al., 2012). When the focus is on pathologies and short falls of a service, what is highlighted is their ineffectiveness. However, when professions tweak their lens to find and incorporate the strengths, it is possible to achieve goals not otherwise met. This study underscores the value of viewing difficulties not as a threat to service, but as a challenge to find a new avenue of success.

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## Appendix A: Flyer

### **Are you a licensed therapist?**

Do you have one year or more of experience  
providing in-home therapy?

Are you interested in being part of a focus group  
study that explores advantages of  
in-home therapy?

**If so, you are invited to participate in a study!**

**The purpose of this study is to explore the strengths of this  
underutilized method of therapy in order to supplement  
current literature and education on the subject.**

**Interested in participating?  
Contact Zach LeCrone for more details.**

**[Lecr7088@stthomas.edu](mailto:Lecr7088@stthomas.edu)**

**952-393-8368**

**Snacks and refreshments will be provided!  
Please forward this flyer to anyone who may be willing to  
participate.**

**This study will be conducted by Zach LeCrone, BSW – a student in the St.  
Catherine University/St. Thomas University Master of Social Work Program.**

## **Appendix B: Consent Form**

# **An Abode for Therapy: Rediscovering the Lost Art of the Home Visit**

I am conducting a study about the advantages of in-home therapy. I invite you to participate in this research. You were selected as a possible participant because of your experience in offering in-home therapy services. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Zach LeCrone, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and supervised by Able Knochel, PhD.

### **Background Information:**

The purpose of this study is to discover licensed therapists' opinions of in-home therapy and understand advantages of the home setting which may not be available in a clinic-setting.

### **Procedures:**

If you agree to be in this study, the researcher will ask you to do the following things: complete a 90 minute focus group which will be recorded and transcribed. The focus group questions will address boundaries, confidentiality, empowerment of the client, and preventative measures regarding in-home therapy. After the focus group, a short written survey will collect demographics including education, licensure, experience as a therapist, opinion of effectiveness about in-home therapy, and opinion of how current literature represents in-home therapy which will take roughly 10 minutes. The total time will be approximately 100 minutes. The focus group will be held in a private room at University of St. Thomas. You will be given a copy of the consent form before the focus group begins.

### **Risks and Benefits of Being in the Study:**

There are minimal risks involved in participating in this study. You are assured of confidentiality by the researcher in handling the data at all phases of the study, but due to the format of the study being in a focus group, other participants may choose to break confidentiality outside of the group beyond the researcher's control. Possible pressure to participate may occur if a person receives notice of this study by a supervisor, in order to address this risk, supervisors will not be informed by the researcher whether or not employees are participating in this study. Findings in this study will be presented in an oral presentation at University of St. Thomas and through a written report which will be published as a Master of Social Work Clinical Research paper. No identifying information will be made available in either the oral presentation or in the published report. If any discomfort is experienced at any time through the focus group, you may leave the group or choose not to participate in a question through no penalty.

The study has no direct benefits. There will be snacks and refreshments provided at the focus group for your comfort.

### **Confidentiality:**

The records of this study will be kept confidential. When transcribed, the text will not include any names and in any published report, no identifying information will be included. All forms will be kept in a locked file in the researcher's home that only the researcher has access to. All audio-recorded interviews and interview transcriptions will be kept on the researcher's personal computer, which requires secure password access. An assistant to the researcher will be in the room during the focus group to assist the researcher in taking notes, handling logistics, identifying who is speaking and in what order, and report a summary at the end in order to allow

the researcher to focus on group discussion. The researcher's assistant will agree and sign the confidentiality form. The researcher's assistant will not have access to the data or be involved in any other aspects of the research beyond assisting in the focus group. Only the researcher will have access to the original records. The audio-tapes and transcriptions will be used for educational and research purposes only and destroyed after all data is collected and analyzed on or before June 1, 2014.

**Voluntary Nature of the Study:**

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the focus group at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected of your statements will not be used if you so wish.

**Contacts and Questions**

My name is Zach LeCrone. You may ask any questions you have now. If you have questions later, you may contact me at 952-393-8368. Instructor: Abel Knochel, PhD. 612-876-2125. If you have any other questions or concerns regarding the study and would like to talk to someone other than the researcher or instructor, you may also contact John Schmitt, PhD, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

**You will be given a copy of this form to keep for your records.**

**Statement of Consent:** You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Also, by signing this consent form you are agreeing to be audio-recorded for the use of this research. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

\_\_\_\_\_  
**Signature of Study Participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Study Participant**

\_\_\_\_\_  
**Signature of Researcher**

\_\_\_\_\_  
**Date**

## Appendix C: Focus Group Questions

1. What is your name and briefly tell us your title and responsibilities?
2. What practice theory, if any, do you align yourself most with when conducting therapy?
3. Through your experiences, what are some advantages of conducting therapy in a client's home? If possible, give an example from your practice
4. Talk about a time when boundaries helped build the therapeutic relationship when practicing in a client's home.
5. In what ways do the presence of other people while providing in-home therapy enhance that therapy?
6. How have you used the client's environment to empower the client?
7. How does experiencing the client's environment help you understand and serve the client?
8. What are important preventative measures you may address with the client when conducting in-home therapy.
  - How do you tailor therapy in order to achieve this?



## Appendix D: Individual Survey Questions

1. What is your current clinical licensure?

LICSW      LMFT      LPCC      LP      Other: \_\_\_\_\_

2. For how many years have you been conducting in-home therapy?

3. In what environments do you have experience in conducting therapy: clinic-based, in-home, or both?

4. On a scale of 1 to 5 (1 much less effective, 5 much more effective), how effective do you feel in-home therapy is compared to clinic-based therapy?

Much less effective					Much more effective
1	2	3	4	5	

5. On a scale of 1 to 5 (1 being not at all relevant, 5 being very relevant), how relevant to you are professional literature and education in identifying strategies for conducting in-home therapy?

Not at all relevant					Very relevant
1	2	3	4	5	