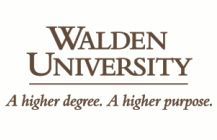

2018

Therapists' Comfort Level in Providing Psychotherapy in Home-Based Therapy Settings

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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2018

Abstract

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by

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MS, Walden University, 2015

MA, Richard Stockton University, 2009

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Dissertation Submitted in Partial Fulfillment

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Abstract

Home-based psychotherapy has expanded in the mental health community; however, little was known about the therapists' comfort level in a home-based venue. The purpose of this quantitative study was to assess therapists' comfort level (TCL) in providing psychotherapy in a home-based setting and how therapeutic competency (TC), therapeutic relationship (TR), and advanced therapeutic training (ATT) related to the comfort level. The social-ecological systems theory and the theory of comfort served as the theoretical frameworks. The present study used the Therapist Comfort Scale, Counseling Competencies Scale-Revised, the Scale to Assess Therapeutic Relationship in Community Mental Health Care-Clinician, and a demographic questionnaire. A multiple linear regression and correlational analysis were conducted to assess the predictive relationships among the variables. The participants were 76 therapists who provided psychotherapy in a home-based setting. The results revealed a statistically significant positive relationship between TCL and TR. This finding indicated that as the TR score increased, TCL also increased. There was a statistically significant positive relationship between TCL and TC, which indicated that as the TC score increased, TCL also increased. There was a statistically significant positive relationship between TCL and ATT, which indicated that as the ATT score increased, TCL also increased. It was hoped that this study's findings can serve to inform and guide the home-based psychotherapists to improve their therapeutic relationship. Once the therapeutic relationship is formed, the therapists will obtain a high level of comfort in discussing concerns openly with the patients, and parents/caregivers. In addition, when therapists reach a high level of comfort, it could make a positive difference in the patients' treatment outcomes. Thus, the findings of this study initiated positive social change at the level of the individual home-based therapist as well as to the vulnerable population that they serve.

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Dedication

This study is dedicated to my family, whose love and care give me the self-reliance to persevere to pursue higher education. This study is dedicated to my husband, Cesar, and my son Bryan for their unconditional love, continuous support, and admiration. This study is dedicated in loving memory to my son Jefrey, for whom I could have never done this without his faith, support, and constant encouragement. My son, you are forever in my heart until we meet again. This study is dedicated to my daughter-in-law Stephanie for her love and continuous support. This study is also dedicated to my two grandchildren, Jax and Izmerelda, for their daily love and happiness. With love and appreciation to my mother and in loving memory to my father. Thank you all for the inspiration and encouragement to believe in me, my spirituality, and my thoughts.

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First, I would like to acknowledge my spiritual faith that allows me to follow my goals and dreams. I would like to acknowledge my beloved father for his blessing from heaven during my educational pathway and beyond. I also would like to acknowledge my family for encouraging me to move forward to accomplish this educational journey.

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Finally, I would like to take this opportunity to especially thank my sons Bryan and Jefrey (who prematurely went to heaven) for their support and encouragement that inspirited me to continue moving onward to complete this long but rewarding educational journey.

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Chapter 1: Introduction to the Study

Introduction

Since the 1980s, home-based psychotherapy has become progressively convenient and a common service in the mental health community (Cortes, 2004; Glebova, Foster, Cunningham, Brennan, & Whitmore, 2012; Zarski, Sand-Pringl, Greenbank, & Cibik, 1991). Home-based psychotherapy service was designed as a preventive strategy for families at risk (Cortes, 2004; Glebova et al., 2012). The home-based setting is beneficial for families and children who have difficulty either economically or with insurance issues when seeking psychotherapy services (Cortes, 2004; Glebova et al., 2012; Thompson, Bender, Lantry, & Flynn, 2007; Zarski et al., 1991). Mosier et al. (2001) indicated that home-based psychotherapy could significantly and successfully maintain the youth at home regardless of their initial higher levels of difficulties.

Home-based psychotherapy is usually delivered by master's level therapists who are providing services in the patient's home, school, or neighborhood settings. Many of the families seeking this convenient alternative come from highly disadvantaged backgrounds and live in poor communities, (Glebova et al., 2012). The home-based services provide extensive psychotherapeutic interventions at home or in a community setting as long as the patient needs. However, the interventions might also occur on a moderately short period of time such as an 8-week timeframe (Cortes, 2004; Glebova et al., 2012; Slone & Owen, 2015; Woodford, 1999). This psychotherapeutic alternative is intended to benefit patients who for numerous reasons have not responded to the traditional method of mental health services (Glebova et al., 2012). For instance, families that may not be able to access office-based services because of a lack of transportation or because of a family member with a chronic illness (Glebova et al., 2012; Slone & Own,

2015) as well as families who do not want treatment because a prior involvement with social services has led to a lack of trust, may benefit from home-based psychotherapy service (Woodford, 1999). It is clear that a home-based setting provides many benefits to youths and parents/caregivers. If there is an unsuccessful therapeutic relationship, the therapists might feel discomfort while providing psychotherapy in home-based.

Moreover, expectations regarding treatment and the psychotherapeutic relationship between the therapist and the patient can be attributed to the therapist's skills to employ and retain the youth in treatment (Glebova et al., 2012; Thompson et al., 2007). Scholars have suggested that the psychotherapeutic relationship is essential for successful outcomes in psychotherapy (Carey, Kelly, Mansell, & Tai, 2012), in delivering psychological treatment, and in achieving positive outcomes (Horvath & Symonds, 1991; Thompson et al., 2007). Scholars have also indicated that the therapist and the patient therapeutic relationship has traditionally been considered one of the most important factors in the psychotherapy role (Carey et al., 2012; Thompson et al., 2007). Hence, therapists' self-comfort may contribute to or influence the patients' treatment as well as the ability to obtain a successful therapeutic relationship.

Scholars have continued surveying the therapist's comfort level by examining the nature of the therapeutic relationship between the therapist and patient (Glebova et al., 2012). The findings suggested that regardless of the benefits that home-based services provide, there were times where the therapists experienced varying degrees of discomfort in providing psychotherapy in the patient's home environment (Glebova et al., 2012; Slone & Owen, 2015). The authors recognized that the therapist delivering the service was required to be tranquil and comfortable while providing psychotherapy in that particular setting (Thompson et al., 2007; Slone & Owe, 2015).

In summary, home-based psychotherapy has expanded in the mental health community (Glebova et al., 2012; Thompson et al., 2007; Woodford, 1999). Home-based psychotherapy has been used in some cases to prevent children from out-of-home placement (Woodford, 1999). It has also been employed as a way to shift children or youths securely back into the home after an inevitable out-of-home placement (Thompson et al., 2007; Woodford, 1999). Scholars have examined the nature of the therapists' comfort level displayed in a home-based psychotherapy session; however, this comfort level has been specifically rated by the patients and parents/caregivers (Glebova et al., 2012; Slone & Owen, 2015; Thompson et al., 2007). Further, Slone and Own (2015), and Levy, Hilsenroth, and Owen (2015) found that therapists who are more comfortable in their working environment are likely to promote better therapeutic processes that enable working collaboratively with the patient. However, limited research was available focusing specifically on therapists' comfort level self-evaluation (see Dunkle & Friedlander, 1996; Glebova et al., 2012; Levy et al., 2015; Slone & Owen, 2015). Discovering the therapists' perceptions of their self-comfort in providing psychotherapy in a home-based setting enhanced the understanding of the most important aspects that can be used to promote patients' treatment and may be an important facilitative element to the therapist-patient therapeutic relationship. A positive social change resulted by improving the therapist-patient psychotherapeutic relationship through greater awareness and understanding of the importance of the comfort level in providing psychotherapy in that particular setting.

In this study, I examined the therapists' comfort level self-evaluation in providing psychotherapy in a home-based setting. In this chapter, I presented a background of the home-based psychotherapy setting and the problem statement of the importance of the

therapists' comfort level in providing psychotherapy in the patient's environment. I also addressed the purpose of the study, research questions, and hypotheses. The theoretical frameworks that guided the study and the nature of the study are included. Additionally, I described key terms, followed by assumptions, scope, delimitations, and social significance.

Background

In the early 20th century, the social work practice started in the United States that embraced the process used by members of charitable organizations named Friendly Visitors aided individuals in need (Adams & Maynard, 2000; Cortes, 2004; Woodford, 1999). The initial professionals involved with the family were the social workers; they were focused on the family as a unit and on the communications between the members at home (Cortes, 2004). In 1980, the Federal Adoption Assistance and Child Welfare Act (Public Law 96-272) in the United States promoted family preservation services (FPS), a structured, skills-building program that provided services on a short-term basis in a family's home and in the community, such as schools and public libraries (Woodford, 1999). The program was established with the intention of teaching parents new tools to manage family members' conflicts and constant worry in their environment. The FPS's intention was to preserve the family as a functioning social unit (Cortes, 2004). Adams and Maynard (2000) found that the program offered a whole new understanding of family dynamics by incorporating systemic principles that assisted and continuing assisting them to no longer receive full blame for their child's maladaptive behaviors and helped parents to move away from self-blame, reproaching, or just looking for simple causes of their child's misbehavior (Cortes, 2004; Glebova et al., 2012). The FPS is today known as

Home-Based Services and/or Intensive In-Home Therapy and Family-Based Programs (Adams & Maynard, 2000; Cortes, 2004).

Historically, home-based psychotherapy focused on individuals and family therapy to prevent out-of-home placement of children and youths who were otherwise placed in foster care, group homes, residential treatment centers, psychiatric hospitals, and correctional institutions (Adams & Maynard, 2000; Cortes, 2004; Woodford, 1999). Today, home-based services continue advocating for the children to remain in their environment while receiving psychotherapy. Scholars have indicated that parents/caregivers often seek home-based psychotherapy for youths who present frequent and persistent pattern of anger, irritability, arguing, defiance toward authority figures and friends, anxiety, and depression (Adams & Maynard, 2000; Cortes, 2004; Glebova et al., 2012, Slone & Owen, 2015; Thompson et al., 2007). According to scholars, families who benefited from home-based psychotherapy were often characterized by complex situations that involve generational boundaries and unclear rules that govern family dynamics (Boyd-Franklin & Hafer, 2000; Cortes, 2004). The home-based setting also serves as a psychotherapeutic alternative where the therapists provide family and individual psychotherapies to those who otherwise might not be able to access mental health services. In addition, scholars have acknowledged that home-based psychotherapy eliminates barriers for families who do not have adequate child care options, health insurance, or who have trouble securing transportation to outpatient facilities (Glebova et al., 2012).

On the other hand, the home-based psychotherapy setting might cause therapists a high level of discomfort. Brown (2008) defined an individual's comfort based on different ways to respond when an individual is placed in a stressful or challenging

situation. Thus far, depending on the situation that a person is placed in, different factors could influence the individual's comfort level (Brown, 2008). Researchers who examined a home-based psychotherapy setting have defined therapists' comfort level as trusting others and feeling safe and secure going into a patient's environment (Dunkle & Friendlander, 1996; Glebova et al., 2012; Slone & Own, 2015). Additionally, Urdang (2010) acknowledged that working with mentally ill individuals is a sensitive and demanding task for therapists, especially if the service is at a home-based setting where the therapists have direct involvement in the patient's environment. Urdang (2010) discussed that there are situations when therapists might appear to be crossing strict boundary issues, such as visiting the patients' rooms or accepting food during psychotherapeutic sessions. This type of situation may impose a higher risk of discomfort (Glebova et al., 2012; Slone & Owen, 2015; Urdang, 2010). For this study, the therapist's level of comfort was viewable as psychotherapeutic engagement in the home-based context and a therapist's responsiveness to the psychotherapeutic relationship.

Previous researchers have focused on therapists' comfort level factors rated by patients, and parents/caregivers generally received significant consideration in treatment outcomes. For instance, Glebova et al. (2012) measured therapists' comfort level in the home-based treatment context and the relationship between therapist comfort and therapist characteristics rated by the patients and parents/caregivers. Further, Slone and Owen (2015) evaluated therapists' alliance activity and therapist comfort as related to an individual psychotherapy outcome and measured therapists' comfort rated by patients and parents/caregivers. When examining the therapists' comfort level, I built upon the idea to examine therapists' comfort level self-evaluation associated with the following variables: therapeutic relationships, advance therapeutic training, and therapeutic competency. No

researchers have examined therapists' self-evaluation of comfort level in home-based psychotherapy; thus, a knowledge gap existed in the literature concerning therapists' self-evaluation of comfort in providing psychotherapeutic services in nontraditional settings (Blow, Sprenkle, & Davis, 2007; Herman, 1998; Slone & Owen, 2015). In Chapter 2, I presented an in-depth literature review concerning those variables and the importance of therapists' comfort level in providing psychotherapy to youth in a home-based setting.

Problem Statement

One of the advantages of using home-based psychotherapy is that patients are more engaged in treatment since they are in their home environment (Glebova et al., 2012). Therefore, building successful rapport and developing a healthy therapist and patient therapeutic relationship in a home-based setting is essential for successful psychotherapy (Glebova et al., 2012; Herman, 1998; Slone & Owen, 2015). Glebova et al. (2012) suggested that for a successful therapeutic relationship, therapists' comfort level when providing mental health services in nontraditional settings (e.g., hospitals or outpatient facilities) is imperative. However, to date, no empirical evidence addressed self-evaluation of therapists' comfort level in providing psychotherapy to youths in a home-based setting. Instead, the therapists' comfort level displayed in home-based setting has been rated mostly by the patients and parents/caregivers (see Dunkle & Friedlander, 1996; Glebova et al., 2012; Levy et al., 2015; Slone & Owen, 2015); thus, scholarly literature was limited in providing data mostly focused on therapists' comfort level self-evaluation (see Dunkle & Friedlander, 1996; Glebova et al., 2012; Levy et al., 2015; Slone & Owen, 2015).

To address this knowledge gap, I focused on therapists' self-evaluation of their comfort level in providing psychotherapeutic services in nontraditional settings, including

factors such as the therapeutic relationship, advanced therapeutic training, and therapeutic competency that may contribute to differences in comfort levels (Blow et al., 2007; Slone & Owen, 2015). The therapeutic relationship is one of the common factors across a psychotherapeutic venue that contributes to the psychotherapy outcome (Blow et al., 2007; Gelso & Carter, 1994; Herman, 1998; Slone & Owen, 2015). Thus, I examined the association between the therapeutic relationship and the therapists' comfort level with home-based psychotherapy. Additionally, I examined the advanced therapeutic training and therapeutic competency which are factors across the psychotherapeutic venue (see Hill, Sullivan, Knox, & Schlosser, 2007) in providing psychotherapy in a home-based setting. The common goals in home-based psychotherapy setting are to get and keep the family wellbeing. However, the process requires therapeutic competency and advanced therapeutic training in initiation and cooperation as well as an effective therapeutic relationship (Glebova et al., 2012; Thompson et al., 2009). Hence, in this study, I examined the association between the therapists' comfort level, advance therapeutic training, and therapeutic competency in providing psychotherapy in the home-based setting.

Purpose of the Study

The purpose of this quantitative study was to assess therapists' comfort level in providing psychotherapy in a home-based setting by examining the associations among therapists' comfort level, therapeutic relationship, advanced therapeutic training, and therapeutic competency. No empirical evidence has addressed the self-evaluation of therapists' comfort level in providing psychotherapy to youths in a home-based setting. Instead, the therapists' comfort level displayed in the home-based setting has been rated

mostly by the patients and parents/caregivers (see Dunkle & Friedlander, 1996; Glebova et al., 2012; Levy, Hilsenroth & Owen, 2015; Slone & Owen, 2015).

Research Questions and Hypotheses

The following central research questions and hypotheses were addressed in this study:

Research Question (RQ)1: What is the relationship between therapists' comfort level and therapeutic competency in providing home-based psychotherapy to youths?

$H1_0$: There is not a relationship between the therapists' comfort level and therapeutic competency in providing home-based psychotherapy to youths.

$H1_a$: There is a relationship between the therapists' comfort level and therapeutic competency in providing home-based psychotherapy to youths.

RQ2: What is the relationship between the therapists' comfort level and advanced therapeutic training in providing home-based psychotherapy to youths?

$H2_0$: There is not a relationship between the therapists' comfort level and advanced therapeutic training in providing home-based psychotherapy to youths.

$H2_a$: There is a relationship between the therapists' comfort level and advanced therapeutic training in providing home-based psychotherapy to youths.

RQ3: What is the relationship between the therapists' comfort level and the therapeutic relationship in providing home-based psychotherapy?

$H3_0$: There is not a relationship between the therapists' comfort level and the therapeutic relationship in providing home-based psychotherapy.

$H3_a$: There is a relationship between the therapists' comfort level and the therapeutic relationship in providing home-based psychotherapy.

Theoretical Frameworks

Bronfenbrenner's (1979) social-ecological systems theory (SES) and Kolcaba's (1992) theory of comfort (TOC) served as the theoretical frameworks for this study. In this section, I provide a brief overview of both theories; however, a more detail explanation is provided in Chapter 2. This section is organized into the following subsections: Social-ecological system and theory of comfort.

Social-Ecological Systems Theory

The SES looks at the individual's development within the context of the system of relationships that form his/her environment (Bronfenbrenner, 1979). The theory contributed to understanding the relevant risk and protective factors across individuals toward psychosocial stress systems and the environment (see Glebova et al., 2012). Furthermore, the theory showed that individuals can be best understood in the context of their environment (e.g., patient's home). Bronfenbrenner (1979) further explained that the environment could be classified into multiple systems and the individual. He presented the ecological environment as a set of nested structures, each inside the other, moving from the personal level to the outside, called the microsystems, mesosystems, exosystems, macrosystems, and chronosystems (Bronfenbrenner, 1994).

The Bronfenbrenner's system that was detailed in the present study was the microsystem, which is the most influential system in regards to the environment (Bronfenbrenner, 1994). The microsystem consists of the individual's frequent and direct environmental contact. It is a pattern of activities, social roles, and interpersonal relations experienced by the developing person in a given face-to-face setting, with particular social and inhibit engagement sustained in more complex interaction progressively with the immediate environment (Bronfenbrenner, 1994; Berk, 2000). Furthermore, at the

microsystem level, the relationships have an impact in two directions, both away from an individual and toward the individual (Berk, 2000). At this level, the bidirectional influences are strongest and have the greatest impact on the individual (Berk, 2000).

The microsystem aspects fit with the perspectives of many practicing home-based psychotherapy (Glebova et al., 2012; Sheidow & Woodford, 2003; Slone & Owen, 2015). The Bronfenbrenner's system emphasized that family preservation outlines most home-based psychotherapy programs (Glebova et al., 2012; Macchi & O'Conner, 2010). It provides a focus on the environmental and contextual mechanisms impacting the family and therapeutic process (Glebova et al., 2012; Macchi & O'Conner, 2010). Therefore, the theory was appropriate for the current study because it allowed me to enhance my understanding of the multiple environmental and relationship factors influencing the therapists' comfort level in providing psychotherapy in the patient's environment. Bronfenbrenner's microsystem is discussed in detail in Chapter 2.

Theory of Comfort

The TOC was used in this study to understand the importance of the therapist's comfort level. Kolcaba (2003) defined *comfort* as the immediate state of being strengthened through having the human needs for relief, ease, and transcendence, which are addressed in four essential contexts of experience (physically, psycho-spiritually, environmentally, and socially). TOC was originally developed between 1900 and 1926 for medicine and nursing because it was thought that a patient's comfort led to their recovery (March & McCornack, 2009). Later, in 1992, Kolcaba developed her TOC after conducting a concept analysis of an individual's comfort that examined literature from medicine, nursing, psychiatry, psychology, English, and ergonomics. According to Kolcaba (1992) analysis (as cited in March & McCornack, 2009) "comfort is a positive

concept and is associated with activities that nurture and strengthen individuals and patients" (p. 76). Although the theory was at first unique to nursing, it has the potential to place comfort level in the forefront of the mental healthcare setting (Kolcaba, 2007). Therefore, the TOC was appropriate for this study because it enriched the understanding of the therapist's comfort level in providing psychotherapy in home-based settings. Kolcaba's TOC is discussed in detail in Chapter 2.

Nature of the Study

In this quantitative study, I used the therapists' self-evaluation data to examine the associations between therapists' comfort level in providing home-based psychotherapy to youths and advanced therapeutic training, therapeutic relationship, and therapeutic competency. By focusing on the importance of the therapists' comfort level with home-based psychotherapy and an effective therapist-patient therapeutic relationship, I offer an enhanced understating of how home-based mental health care agencies can use the information gathered to improve the delivery of in home-based psychotherapy.

Participants were assessed throughout surveying therapists who provide services in home-based settings. I obtained the permission needed to use the Therapist Comfort Scale (TCS; see Slone & Owen, 2015) to measure the therapists' comfort level in providing psychotherapy in a home-based setting. I also obtained the permission needed to use the Scale to Assess Therapeutic Relationship in Community Mental Health Care (STAR) developed by McGuire-Snieckus (2007) to measure the therapeutic relationship. Additionally, I obtained the permission needed to use the Counseling Competencies Scale-Revised (CCS-R; see Lambie, et al., 2014) to measure the advanced therapeutic training and therapeutic competency. To analyze the data gathered, I considered multiple linear regression analysis and Pearson correlation analysis, as they were statistical tools

that can identify how different variables in a process are related. The multiple linear regression tool communicates what factors are the best starting point for a process improvement project (Mishra & Min, 2010). The Pearson correlation was conducted using Cohen's standard to evaluate the strength of the relationship. The nature of the study is discussed in detail in Chapter 3.

Definitions of Terms

Advanced therapeutic training: Refers to a program designed to help front-line mental health professionals apply the knowledge and clinical techniques from psychotherapy to their work with patients (Fairburn & Cooper, 2011).

Home-based psychotherapy: Refers to situations where psychotherapists, social workers, or counselors travel to conduct therapy or assessment at the site where a client resides. The practice comes with many advantages for patients and therapists because the therapist has the benefit of seeing how and where the patient lives, and the patients enjoy the convenience of therapy/assessment that comes to them (Thompson, 2009; Slone & Owen, 2015).

Individual comfort: Individual comfort refers to a situation or a place where a person feels safe and with no stress. Kolcaba (2007) defined comfort as the state of an individual's immediate experience of comfort. The three needs that must be met for an individual's comfort include relief, ease, and transcendence addressing in four contexts of experience (physically, psycho-spiritually, socially, and environmentally).

Mental health therapist: A mental health therapist uses a variety of psychotherapeutic methods to treat patients with emotional, behavioral, and mental disorders. The aim of the psychotherapy is to resolve the underlying issues that fuel ongoing complaints.

Social-ecological system (SES): Bronfenbrenner's (1979) SES places the individual and an individual's behavior patterns as being part of and shaped by larger systems of influence (see Sheidow & Woodford, 2003). The systems extend out from family, school systems, and the neighborhoods.

Therapeutic competency: Refers to psychotherapists delivering appropriate psychological treatments in a competent manner that requires training (Fairburn & Cooper, 2011).

Therapeutic relationship: Refers to the relationship between the patient and the therapist engaged in the psychotherapy process. The process can be described as collaborative conversation and involves a consensus about therapeutic goals and the means of achieving the established goals (Glebova et al., 2012; Khoshnavay, Rahimababi, & Rafii, 2012; Rogers & Truax, 1967; Thompson et al., 2009).

Theory of comfort (TOC): Kolcaba's TOC was defined theoretically as "the state of having met basic human needs for ease, relief, and transcendence that are addressed in four essential contexts of experience (physically, psycho-spiritually, environmentally, and socially)" (Kalcoba, 2001, p. 90).

Assumptions

The major assumption in this study was that every therapist in a home-based setting was more likely to be comfortable providing psychotherapy services and constructs experiences and responding within his or her surroundings. The above-mentioned assumption was used to formulate the independent variable (therapist's comfort level) and the dependent variables (therapeutic relationships, therapeutic competency, and advance therapeutic training). In addition, I assumed that the participants in the study responded truthfully to questions posed on the TCS (use as self-

evaluation) instrument (see Slone & Owen, 2015), the CCS-R (used as self-evaluation) instrument edited by Lambie et al. (2014), and the STAR (used as self-evaluation) developed by McGuire-Snieckus (2007) because they were chosen to take part in the study voluntarily and I informed the participants that the responses to the instruments were confidential (see Fassinger & Morrow, 2013; Wiles, Crow, Heath, & Vikkri, 2008).

In this study, the sample consisted of bachelor-, master- and doctoral-level therapists who provide psychotherapy in a home-based setting. The study excluded therapists who worked in a home-based agency who provide psychotherapy using the agency facility. The participants were both male and female of all levels of experience and training (counselors, social workers, psychologists, and therapist assistants). The study only included therapists in the southern New Jersey area where home-based agencies are located.

Limitations

This study had some limitations, including self-evaluation data, home-based agencies selection bias, and survey research design. The self-evaluation data were considered as a limitation to the study because in completing the instruments, the participants may not have truthfully answered the questions. The TCS was used as self-evaluation rather than the therapist's evaluation rated by patients and families/caregivers. The CCS-R was used for self-evaluation rather than being rated by supervisors. The selection of the participant home-based agency was another limitation because the agency had the freedom of stop the participantion due to any psychotherapist's personal issue or other factors pertaining the agency. However, I contacted few home-based agencies to diminish such limitation. In addition, the survey design research was another type of

limitation regarding of participants' responses, which generated some differences between those who did not respond compared to those who did respond.

Social Change Significance

Therapists who specialize in home-based psychotherapy work with patients and parents/caregivers in their homes, giving them much-needed assistance. By providing home-based psychotherapy services in the patient's environment, the therapist is more likely to acquire an accurate representation of how the patient interacts with the family members and the community (Thompson et al., 2007). However, it is imperative that the therapist appears tranquil and comfortable in providing that type of service in order to be able to break common barriers (Thompson et al., 2007), such as in unsuccessful therapeutic relationships (LaRowe, 2004).

Thus, self-evaluation of therapists' comfort level was assessed for the purpose of ensuring healthy therapist-patient therapeutic relationships that can facilitate successful treatment. By assessing therapists' comfort level in these settings, this study contributed to the psychotherapy literature by providing an understanding of how therapists' comfort level enhanced the therapeutic relationship (Glebova et al., 2012; Herman, 1998; Slone & Owen, 2015; Thompson et al., 2007). Subsequently, home-based mental health care agencies and therapists have a greater understanding of the importance of the therapists' comfort level in providing psychotherapy in home-based setting to youths. Through a greater understanding of therapist's comfort level when providing home-based services, positive social change resulted through more effective home-based psychotherapy services. By focusing on the importance of the therapist's comfort level in the home-based psychotherapy and an effective therapist-patient therapeutic relationship, the study offered an enhanced understating of how the home-based mental health care agencies can

use the information gathered to improve the delivery of the in home-based psychotherapy.

Summary

Home-based psychotherapy is intended to benefit patients who for various reasons do not respond to traditional forms of mental health services (Glebova et al., 2012; Woodford, 1999). Home-based services depend on a wide-range of psychotherapy interventions at the patient's home or any other community settings (Glebova et al., 2012; Thompson et al., 2007). The purpose of this quantitative study was to assess the therapists' comfort level in providing psychotherapy to youths in a home-based setting. In this chapter, I discussed the overall topic of home-based setting and the comfort level. In addition, I examined the associations between therapists' comfort level, therapeutic relationship, advanced therapeutic training, and therapeutic competency.

This study was noteworthy because the therapeutic relationship was viewed as a significant factor to build and maintain the therapists' comfort level (Glebova et al., 2012; Khoshnavay et al., 2012; Thompson et al., 2007). However, no empirical evidence has addressed the self-evaluation of therapists' comfort level in providing psychotherapy to youths in a home-based setting. Instead, the therapists' comfort level displayed was rated mostly by the patients and parents/caregivers (Dunkle & Friedlander, 1996; Glebova et al., 2012; Levy et al., 2015; Slone & Owen, 2015). Limited research was available in providing data primarily focused on therapists' comfort level self-evaluation (Dunkle & Friedlander, 1996; Glebova et al., 2012; Levy et al., 2015; Slone & Owen, 2015). Throughout a greater appreciation of therapists' comfort level when providing home-based services, a positive social change resulted through greater awareness and

understanding of the importance of the comfort level in providing psychotherapy in that particular setting.

Chapter 1 included the introduction, background, problem statement, purpose of the study, hypotheses and research questions, theoretical frameworks, nature of the study, definition of terms, assumptions, scope and delimitations, social change significance and summary. Subsequently, Chapter 2 includes the introduction, literature research strategy, theoretical framework foundation, review of research, home-based psychotherapy as a mental health alternative, home-based versus office-based psychotherapy, mental health therapy role, understanding individual comfort, advanced therapeutic training, therapeutic competency, therapeutic relationship, and chapter summary.

Chapter 2: Literature Review

Introduction

The home-based therapy setting provides a convenient psychotherapy service for family and individuals who otherwise might not be able to access mental health services. Historically, this particular setting has been moderately accepted, as the greater emphasis is on office-based setting training (Adams & Maynard, 2000; Brosman, 1990). Home-based psychotherapeutic services have the following characteristics: (a) psychotherapeutic sessions are provided in the patient's home as contrary to office-based setting, (b) the family system is the focus of treatment and outcome, and (c) is psychotherapy delivered by mental health professionals (Glebova et al., 2012).

As mentioned above, this psychotherapeutic alternative is intended to benefit patients who for numerous reasons have not responded to the traditional method of mental health services (Cortes, 2004; Glebova et al., 2012). The psychotherapeutic session can give the therapists an opportunity to observe the patients and families in their environment and have the opportunity to engage and build a therapeutic relationship with the whole family who often do not come in for office-based sessions (Cortes, 2004; Glebova et al., 2012; Thompson et al., 2009). It is imperative for the therapists to feel comfortable delivering therapy in this type of setting for a succeful patient and therapist home-based therapeutic relationship (Thomson et al., 2009). Nevertheless, Glebova et al. (2012), and Slone and Owen (2015) noted that therapists might experience discomfort while delivering services due to the challenges of working in a home-based setting. Not only do therapists often have to involve the entire family and the community but there are also distractions in the home, which can make it difficult to manage the therapy sessions

(Slone & Owen, 2015). Thus, such obstacles may present potential difficulties for mental health professionals (Slone & Owen, 2015).

The purpose of this quantitative study was to assess therapists' comfort level in providing psychotherapy in a home-based setting by examining the associations among therapists' comfort level, the therapeutic relationship, advanced therapeutic training, and therapeutic competency. No empirical evidence had addressed the self-evaluation of therapists' comfort level in providing psychotherapy in a home-based setting. Instead, the therapists' comfort level displayed in the home-based setting has been rated mostly by the patients and parents/caregivers (see Dunkle & Friedlander, 1996; Glebova et al., 2012; Levy et al., 2015; Slone & Owen, 2015). Hence, the scholarly literature was limited in providing data regarding therapists' self-evaluation of comfort level with providing home-based therapeutic services (see Dunkle & Friedlander, 1996; Glebova et al., 2012; Levy et al., 2015; Slone & Owen, 2015). Due to the limited research specifically on therapists' comfort level self-evaluation, additional investigation was needed in this area.

Chapter 2 includes the chapter introduction, literature research strategy, theoretical framework foundation, review of research, home-based psychotherapy as a mental health alternative, home-based versus office-based psychotherapy, mental health therapy role, understanding individual comfort, advanced therapeutic training, therapeutic competency, therapeutic relationship, and chapter summary.

Literature Research Strategy

The Walden University research databases and search engines used to support the literature review are as follows: *EBSCOhost, ProQuest Central, Academic Search Complete Premier, Google Scholar, PsycINFO, PsycARTICLES, ERIC database,* and

more. The key search terms used to find the relevant articles are as follows: *home-based psychotherapy, therapist and patient psychotherapeutic relationship, psychotherapeutic training, and psychotherapeutic competency, therapy's comfort, mental health therapy, the theory of comfort, social-ecological systems theory,* and *home-based quantitative studies*. I included peer-reviewed and journal articles to research the home-based psychotherapy and therapist's comfort level up to 2016 in the review of the literature.

Theoretical Framework Foundation

The theoretical frameworks in this quantitative study were Bronfenbrenner's (1979) SES and the TOC (Kalcoba, 1992). The SES is a system model outlining three important structures: microsystems, mesosystems, and exosystems (Bronfenbrenner, 1979). The TOC is organized into three classifications: (a) It is based the effort on human necessities, (b) the individuals are seen in terms of appreciation that involve their development, and (c) there is individual adaptation to their surroundings (Kolcaba, 1992). I organized this section in two subsections: SES and TOC.

SES

The SES was developed by Bronfenbrenner (1979) to explain human development from the perspective of the system that forms the individual's environments (McLaren & Hawe, 2005; Woodford, 1999). The theory was grounded in a systematic ecological perspective that focuses on the interdependence between the individual and their environment (Bronfenbrenner, 1979; McLaren & Hawe, 2005). In addition, the SES theory offers an emphasis on the social-ecological and background mechanisms impacting the therapy process (Macchi & O'Conner, 2010). The intergenerational relationship experiences within the context may influence the therapy expectations, process, and outcomes (Macchi & O'Conner, 2010).

Bronfenbrenner comprised the environment in five structures of systems (microsystems, mesosystems, exosystems, macrosystems, and chronosystems) that interrelate in complex ways and can affect and be affected by the person's progress (Bronfenbrenner, 1994). One of the most important systems in regards to the environment is the microsystems (family or neighborhood, activity, role, and interpersonal relationships; Bronfenbrenner, 1979), which is the relevant system to understanding the therapists' comfort level while providing psychotherapy in a home-based setting.

The definition of the microsystem includes the pattern of individual's immediate surroundings and social relations experienced, which is best understood by examining the context of the individual's environmental effect (Bronfenbrenner, 1994). The microsystem formulates a conventional structure through which an individual has a direct contact that influences the developing individual (Bronfenbrenner, 1994). It refers to (a) an immediate individual situation (the patient), and another individual who he/she relates to a face-to-face routine (parents/caregivers), (b) the influence of another individual within the scenery (the therapist), and (c) the natural surroundings of these relationships impacting all of the individual's direct or indirect influences (the home; McLaren & Hawe, 2005). With this stipulation, the home-based setting is the unit of awareness, and the microsystem of the home-based setting includes therapists, the youths, and parents/caregivers and the natural surroundings.

The SES is relevant in examining the therapists' comfort level as they interact with their personal and professional environment. The therapists can be understood in terms of the emotional and social relationships with physical and social components that comprise his/her environment (Heller & Gitterman, 2011). Perhaps the most important factor is the opportunity to interact with the youths and their family in their natural

setting as it provides a wealth of evidence regarding the relations of the patient, the therapist, and the family interaction, and how all parties prioritize their therapeutic relationship (Cottrell, 1994; Lawson & Foster, 2005). However, previous researchers have acknowledged that an individual's interpersonal interaction may be perceived as negative (Williams & Irurita, 2006) and perhaps result in a feeling of discomfort.

TOC

TOC was originally developed between 1900 and 1926 for medicine and nursing, assuming that a patient's comfort directed to their recovery (March & McCornack, 2009). Later, in 1990, Kolcaba established her TOC when investigating an individual's comfort using literature from various fields: medical, nursing, psychiatry, psychology, and English. Kalcoba (2001) organized the TOC into three classifications: (a) It is based the effort on human necessities, (b) the individuals are seen in terms of appreciation that involve their development, and (c) the individuals adapt to their surroundings.

As the TOC is about human necessities, it is relevant to individuals who experience various stimuli in distressing health care circumstances (Kalcoba, 2001). Although the TOC was originally developed for nursing, it meets the criteria to be applied to many situations and to be used for outcomes research (Kalcoba, 2001; March & McCornack, 2009). Furthermore, Kolcaba (2003) acknowledged that the TOC is relevant to all cultures in which the accomplishment of optimum comfort is an appropriate worldwide focus for the healthcare needs of individuals. March and McCornack (2009) acknowledged,

> If all health care practitioners within an institution deliver care are guided by the comfort theory, the institutional integrity would be enhanced even more greatly. By increasing institutional integrity in such manner could potentially aid in

> strategies for recruitment and retention of healthcare staff; and improve societal acceptance and appreciation of the institution, as well as increase satisfaction, due to the aforementioned positive connotations of the concept (p. 78).

March and McCornack (2009) concluded that because Kolcaba's TOC could be adapted to include all health care providers and employed as an established framework, this interdisciplinary method of theory implementation may perhaps permit for greater understanding and alliance between healthcare group members. Thus, the TOC is relevant for this study to understand therapists' comfort level while providing a home-based psychotherapy.

Review of Research

Research in Home-Based Mental Health Therapy

Existing research in the field of home-based psychotherapy practice encompasses quantitative and qualitative information detailing the therapist's comfort while providing psychotherapy in the patient's environment. Recent studies measured and explored hypotheses corroborating much of the data on home-based setting and revealed the importance of therapists' comfort level.

A qualitative study by Glebova et al., (2012) examined therapists' comfort in delivering family therapy at home and community settings. The participants included 37 female therapists and 14 male therapists. 84% reported having a Master's degree in the field of Social Work, 19% in Counseling, 15% in Psychology, 12% in Marital and Family Therapy and 4% in other fields. The participants completed a questionnaire designed to gather therapist demographic information and therapists' experience. Also, the therapists rated their attitudes toward Multisystemic Therapy (MST). The therapists' comfort was measured at four time points using the Therapist Comfort Scale (TCS) by the patients and

caregivers (Glebova et al., 2012). The scholars found that therapists' comfort was associated with the therapeutic alliance, a factor believed to be related to clinical outcomes across studies and treatment models. The finding suggested that psychotherapists should regularly examine their own level of comfort while providing services in a home-based setting (Glebova et al., 2012).

In 2015, Slone and Owen conducted a quantitative study of therapist alliance activity, therapist comfort, and systemic alliance on individual psychotherapy outcome. The participants included 49 therapists treated 247 families (Slone & Owen, 2015). The purpose of the study was to evaluate the association between therapist's alliance activity and therapist comfort with the patient's outcome in individual therapy. The therapists were rated by the patients and parents/caregivers with the TCS to assess how the patients and parents/caregivers viewed the degree of comfort the therapist appeared to exhibit in therapy (Slone & Owen, 2015). The scholars wanted to gather an overall impression, across sessions from the client's point of view. The results revealed that the therapists' alliance activity and being comfortable while providing psychotherapy were positively related to psychotherapy outcomes (Slone & Owen, 2015).

In sum, the literature has established that home-based setting make unique demands on the therapists working with youths and the families, resulting in advantages and disadvantage for both the therapists and the patients (Cortes, 2004; Glebova et al., 2012; Thompson et al., 2009; Lawson & Foster 2005; Slone & Owen, 2015). One of the disadvantages for the therapists is their level of discomfort while providing the psychotherapy (Glebova et al., 2012; Slone & Owen, 2015). To date, no studies have examined therapists' self-evaluation of their comfort level, resulting in a gap in the literature. This study specifically examined the therapists' comfort level self-evaluation

in providing home-based psychotherapy to youths. Participants consisted of Bachelors', Masters' and Doctoral levels therapists. The design of this study is discussed in further detail in Chapter 3.

Home-Based Psychotherapy –Mental Health Alternative

In the 1950's, a Family Service Association of America (FSAA) was one of the central organizing forces in the country that started the development of skilled, professional community services that provided services to families with multiple mental health problems in their environment. These families were referred to as "Multi-Stressed Families" (Reiter, 2000). The Multi-Stressed Families area a family unit, which views the importance of not automatically put the youths in a mental health facility (Reiter, 2000; van-Wasik & Bryant, 2001). Hence, in the mid-seventies, the Public Law 96-27 passed the Adoption Assistance and Child Welfare Act of 1980 aimed to keep at-risk youths in their home setting while also maintaining their well-being (Christensen, 1995; Reiter, 2000; Macchi & O'Conner, 2010). According to scholars, the programs that provided home-based psychotherapy intended to avoid formal placement of at-risk youths (Cortes, 2004; Glebova et al., 2012; Maluccio, Fein, & Olmstead, 1986; Thompson et al., 2009; Zarski, Greenbank, Sand-Pringle, & Cibik, 1991). The scholars described that home-based setting psychotherapy was offered to the families and youths who experienced high levels of chaos, with the expectation of increasing their level of attendance and participation in the treatment (Cortes, 2004; Thompson, et al., 2009; Walter & Petr, 2006).

Home-Based Versus Office-Based Psychotherapy

Psychotherapy sessions based in the home are generally arranged to meet the individual's mental health necessities directly related to maladaptive family dynamics

(Cortes, 2004). Further, the home-based setting is an alternative psychotherapy service projected as a precautionary approach for the at-risk family who is facing multiple mental health issues (Cortes, 2004). The setting is convenient to the family and youths because they are receiving the treatments in their everyday environment, and it is convenient to the therapists because they are more likely to obtain a precise picture of the youths' and the family's interactions (Cortes, 2004; Wood, 1988). Standard features of in home-based therapy setting are as follows: a) The services most frequently target families facing severe problems that put a youth in jeopardy for out-of-home placement; and b) The home-based psychotherapy model typically applies an ecological and/or family systems approach (Walter & Petr, 2006).

In addition, Bowen and Caron (2016) asserted that a home-based alternative is one of the fastest developing sections of mental health services. One of the benefits mentioned is that therapists have been able to involve with the family who may not have come to the office-based setting for different reasons (Cortes, 2004; Hicken & Plowhead, 2010; Woodford, 1999; Woods, 1988). Another benefit of home-based setting mentioned is that the service lies in the higher engagement of therapy sessions (Walter & Petr, 2006). However, compared with the office-based setting, home-based psychotherapy setting is vitally different. A traditional office-based psychotherapy is arranged to treat the individual's mental health needs in an office setting that is predetermined by the therapists (Bowen & Caron 2016; Cortes, 2004). Therefore, the office-based setting is controlled in the sense that potential distractions, discomfort, and safety concerns are predictable, which allows the therapists to identify safety risks proactively and create effective contingency plans that help eliminate any concerns and maintain the psychotherapy session focus (Bowen & Caron, 2016; Macchi & O'Conner, 2010). In

contrast, bringing the therapists into the youths' environment puts the whole family more at ease, allowing them to feel more comfortable with the therapists (Reiter, 2000).

Additionally, Thompson et al., (2009) specified that families that receive home-based instead of office-based psychotherapy services benefit more by having a great attending rate and are more involved in treatment. However, the therapists entering the patients' homes to do treatment may feel unsafe going into the patient's neighborhoods (Thompson et al., 2009) which may present potential obstacles for the therapy (Woodford, 1999). In addition, there are interruptions in the home that can make the psychotherapy sessions more demanding to manage (Snyder & McCollum, 1999; Thompson et al., 2009). Challenges that the therapists face at home-based setting can make the setting less-than-desirable environment to work; for instance, the therapists may become over-involved with the whole family members and sometimes the community as well (e.g., the school and the neighborhood's issues), generating possible boundary matters and discomfort with the therapist's role (Thompson et al., 2009; Stinchfield, 2004).

Mental Health Therapist Role

In general, the mental health therapists' role is to focus on prevention, to address health disparities, to help diminish psychological distress, and to enhance and promote psychological well-being in all populations in both office-based and home-based psychotherapy. Therapists who provide psychotherapy play a significant role in understanding how the patients' biological, behavioral and social factors influence their well-being (Wahass, 2005). Bowen and Caron (2016) found that the therapists who serve at home-based setting have identified numerous elements that make the approach a high-

intensity experience, for instance, the duration of time spent in rural locations, participants, treatment, settings, and ethical issues (McWey, 2007).

According to Reiter (2000), home-based therapists interact with the youths and families two or three times weekly and have to cope with the patients' daily routines. Cottrell (1994) and Macchi and O'Conner (2010) described varying degrees of discomfort that the therapists might experience when visiting the patient's home, such as security issues impeding them to have a lack of control over the surroundings. Also, the distances they have to travel to get to the assigned home may yield a degree of tension and unease (Macchi & O'Connor, 2010). Furthermore, the therapists perceive the daily events in their patient's environment as distractions that might cause interferences with a productive psychotherapeutic process that might enhance psychotherapeutic effectiveness, particularly during the beginning phase of the joining process with the patients (Reiter, 2000). Since the therapists are in the patients' territory during the psychotherapy sessions, they have to use every available means to connect and strengthen the therapeutic relationship which might be difficult if they experience discomfort while providing the psychotherapy in the patient's environment.

Understanding Individual Comfort

Generally, comfort is sought in response to threatening experiences and an area that places the individual outside their comfort leading to experience a stressful situation (Brown, 2008). Psychological comfort links psychosocial aspects of the individual with the environment through territoriality, privacy, and environmental control (Vischer, 2008). Moreover, there is growing evidence demonstrating that comfort in the workplace environment has a positive impact on productivity (Vischer, 2008). The scholar emphasized that the concept of comfort links the psychological aspects of an individual's

environmental likes and dislikes with the concrete outcomes, such as improved performance and effectiveness (Vischer, 2008).

Being comfortable in the workplace includes meeting the basic individual needs such as safety and accessibility without feeling stressed when providing the service. The stress does not come with a single dose of proximal anxiety. The negative experiences activate the anxiety's producing behavioral inhibition, heightened arousal and increased vigilance (Sleegers & Proulx, 2015). The scholars far reviewed the evidence for the proposition that meaning violations induce a state of anxiety and inhibition (Sleegers & Proulx, 2015). Furthermore, stress in the workplace environment may affect an individual's performance adversely when he/she is high intensity or prolonged in a stressful situation slowing down his/her ability to process and understand the number and predictability of signals that may increase discomfort (Vischer, 2008). Thus, satisfaction, comfort, and the environmental psychology of workspace established concepts such as motivation that may influence service quality (Vischer, 2008).

Additional evidence in individual comfort found that if the individual is in a comfortable state of contentment, he or she experiences comfort and a sense of ease (March & McCormack, 2009). However, the individual feels discomfort after having issues that are causing stress (March & McCormack, 2009). Thus, a calm and comforting environment allows the individual's stress or anxiety level to decrease (Kalcoba, 2003). In addition, scholars emphasized that after stress or anxiety are addressed, the therapists are able to provide needed care (Kalcoba, 2003; March & McCormack, 2009), and hopefully build and maintain an effective therapeutic relationship. Nonetheless, inconveniently, there are cases in which the therapists assigned to work at home-based setting do not have proper training in providing psychotherapy in home-based systems

(Zarski et al., 1991), which might contribute to an uncomfortable state. Further, providing the services in the patient's environment may give therapists unique opportunities; however, appropriate training is required when encountering potential challenges (Reiter, 2000).

Advanced Therapeutic Training

In general, the psychotherapy curriculum's training emphasis on preparing the mental health therapists to provide psychotherapeutic services in an office-based setting (Macchi & O'Conner, 2010). In addition to the traditional clinician setting, therapists may also receive supervision and training experiences through unconventional settings such as home-based psychotherapy. In which, therapists have to deal with poverty stricken, multi-problem families' characteristics that may present particular challenges to them, (Adams & Maynard, 2000), which may cause a high level of discomfort (Geneva et al., 2012; Slone & Owen, 2015). However, developing a statewide training curriculum to be applied across mental health modalities, settings, and diverse patient populations is challenging as it would require an all-encompassing context embedded in the evidence-based practice (Macchi & O'Conner, 2010).

Adams and Maynard (2000) emphasized the importance of tailoring the home-based training curriculum. Specific training and support are needed to be effective in the particular work the therapists performed. Other scholars examining the training prerequisites in home-based psychotherapy by identifying concerns among therapists, including issues of security with youths and families, work in their environment, and help alleviate multiple problems (Lawson & Foster, 2005). Walter and Petr (2006) asserted that providing home-based service requires skills in crisis, including the capability to evaluate and address the well-being of self and the family. Other skills required are to

build concurrent therapeutic relationships with the patient and the parents/caregivers (Woodford, 1999).

Also, the literature addressed specific types of training required to prepare therapists for an effective, deliverance a home-based therapy. The scholars acknowledged that advanced therapeutic training program to service home-based settings should provide an approach to training therapists, including focused on understanding and proficiency development, highlighting the use of observation, enabling self-care strategies for therapists, offering multiple chances for ongoing assistance and interconnected interactions, partnerships, and consultations (Macchi & O'Conner, 2010). In addition, it is particularly essential to continue training and supervision in the home-based setting because home visiting is a difficult, uneasy and at times uncomfortable position. Another significant training that the scholars emphasized is a module on diversity issues that may benefit the therapists to outline and distinguish the various scopes of racial and multicultural background (Sheu & Lent, 2007).

Moreover, the relational intensity of being in the patient's environment and being wide-open to their social context can challenge conventional notions of what is a proficient behavior in the area of the psychotherapeutic process (Walter & Petr, 2006). An instance that may result in heightened concern about what is appropriate and how competent the therapists are to join the family environment successfully and to assist the patients, parents or caregivers. Thus, it is significant that the mental health discipline highlights the significance of obtaining a set of core competencies required while providing clinical treatment (Cortes, 2004; Macchi & O'Connor, 2010; Thompson et al., 2009). Pre-graduate training in office-based setting is a traditional vehicle for providing supervised hands-on experiences and a level of competency in the mental health field

(Bradley & Fiorini, 1999; Thompson et al., 2009). The training is designed to refine the trainees' skills in listening, reflecting patient's feelings, implementing established diagnostic, assessment and treatment practices, clinical writing, identifying and correcting professional weakness and working with diverse groups (Bradley & Fiorini, 1999). According to Dobmeyer, Rowan, Etherage, and Wilson (2003), a mental health pre-graduate training provides the interns with the knowledge and skills necessary to function effectively as primary care therapists. The clinical training is effective as it builds competence in assessment, intervention, consultation and practice management skills and skills in working with patients across the life span, and with variety of problems in different mental health settings (Dobmeyer et al., 2003).

Therapeutic Competency

The therapist has to be able to demonstrate his/her efficacy while providing services to the patients either in the office-based and/or home-based settings. The mental health profession must be able to demonstrate its effectiveness to increase the confidence of its public and the members to practice ethically (Eriksen & McAuliffe, 2003). Fairburn and Cooper (2011) highlighted the importance of therapists' competency affirming that there are at least three reasons why therapists' competency while delivering psychotherapy is vital to provide the best possible care and treatments. The first reason is that therapy quality needs to be distinguished from therapist competence; second, the latter notion refers to an attribute of the therapist, not the treatment (Fairburn & Cooper, 2011). Third, the therapists have to possess a range of other psychotherapeutic abilities such as the skill to assess patients, capacity to select treatment appropriately, and cultural competence (Fairburn & Cooper, 2011).

One of the greatest challenges for the therapist providing psychotherapy in the home-based setting is to include support strategies in the conversation with the patients, regardless of their race or cultural background as stipulated in the Standard A.2.c., American Counseling Association (ACA, 2005) ethical codes. The ACA-Standard B.1.a., indicates that it is essential that the therapists communicate in a culturally thoughtful way to make sure he/she does not disclose and/or break the patient's confidentiality. Additionally, therapists should know that the patient's age, ethnicity, racial background, and socioeconomic issues contribute to their worldview and intervene with the psychotherapeutic process (Sue & Sue, 2008). Sheu and Lent (2007) examined multicultural psychotherapeutic competence and found that the real challenge for therapists rests on the finding of applicable methods to help the therapists understand how they think and feel about psychotherapeutic behaviors that could facilitate a healthy therapeutic relationship.

In addition, the scholars stated that therapists are required to deliver the psychotherapy in a competent manner utilizing evidence-based treatments (Fairburn & Cooper, 2011; McHugh & Barlow, 2010). However, Fairburn and Cooper (2011) specified that a large number of therapists required training in order to become competent, such as the knowledge and skills needed to deliver a psychotherapy to the standard necessary to attain the expected effects; also the ability to assess the patients well, to select the appropriate treatments, and to develop and maintain an effective therapeutic relationship (Sharpless & Barber, 2009; Palisano, Chiarello, King, Novak, Stoner, & Fiss, 2011). The scholars asserted that during the initial interview, the therapists begin to establish rapport and engagements with the family and the youths and should be an ongoing process throughout the intervention (Palisano et al., 2011).

Previous studies have recognized that establishing a strong therapeutic relationship is an important skill across different psychotherapies (Blow, Sprenkle, & Davis, 2007; Herman, 1998; Thompson et al., 2009). However, to maintain a collaborative therapeutic relationship in a home-based setting can be a challenge for the therapists.

Therapeutic Relationship

The therapeutic relationship is a fragile entity that takes care in cultivating; it is also a foundation of the psychotherapeutic process that can be mightily beneficial (Herman 1998; Glebova et al., 2012; Thompson et al., 2009). Reiter (2000) and Woods (1988) established that the patients' environment sends a message to the family of respect and facilitates the potential for developing a resilient therapeutic relationship between the patient and the therapist. In addition, researchers recommended a five step process for a healthy therapeutic relationship: (a) determine mutually arranged psychotherapeutic goals and activities for the home; (b) accurately assess the youths, parents/caregivers and the environment strengths (Glebova et al., 2012; Palisano et al., 2011); (c) develop and implement an intervention plan together; d) evaluate the process and outcomes (Glebova et al., 2012; Palisano et al., 2011); and e) establish a resilient and stable therapeutic relationship, that is accepting, empathic, supportive, and genuine (Palisano et al., 2011).

Other scholars emphasized that a collaborative therapeutic relationship is where the youths and their family openly participate in the psychotherapy and are able to express their interest, asking for their input and involving them in the decision-making (Glebova et al., 2012; Thompson et al., 2009). However, from an ecological perspective, an individual has a particular uniqueness to access their surroundings; he/she also depends on other individuals for an open interaction (McLaren & Hawe, 2005). Based on the importance of the therapeutic relationship, this study hypothesizes that the therapists'

level of comfort while delivering home-based psychotherapy could be an essential factor in establishing a healthy therapeutic relationship with the youths and their family. A quantitative study (Glebova et al., 2012), examined the therapist comfort rated by the youths and the parents/caregivers in delivering family therapy in the home and community settings and development, which reported the significant of the therapist level of comfort when providing psychotherapy in a home-based setting.

Summary

Each article in this literature review has revealed that the youths and their family involved in the home-based setting experienced greater benefits than those involved in customary office-based setting, resulting in symptom reliefs, improved family collaborations, the family improved responsiveness and community assets (Cortes, 2004; Glebova et al., 2012; Macchi & O'Connor, 2010; Slone & Owen, 2015; Thompson et al., 2009). Home-based services are centered on an ecological approach to the whole family and the community system, in which, the family environment is hypothesized as the focus of the therapy. In addition, the environment where the family lives provide evidence that can be beneficial in the therapy process, for example, patients sleeping arrangement, indicators of substance or physical abused or even the presence of family members' photos on the walls (Lawson & Foster, 2005). However, home-based services make unique strains on the therapists working with the youths and the parents/caregivers, with remarkable needs and highly unstructured settings, and managing multiple complex systems (Cottrell, 1994; Reiter, 2000; Lawson & Foster 2005). Furthermore, scholars examined the significance of the therapist and patient therapeutic relationship, suggesting the importance of the training in the mental health profession and exploring the insights of multicultural therapeutic competence (Sheu & Lent, 2007).

In conclusion, the foci of the home-based setting interventions are to promote behavioral change in the patients' environment by teaching parents/caregivers strategies and providing resources to adequately address the youth's difficulties (Glebova et al., 2012). However, the process may increase therapists' discomfort, and ineffective therapeutic relationship. In addition, the literature revealed that therapists' comfort while providing psychotherapy in the home-based setting is also associated with the therapeutic training and competency (Glebova et al., 2012; Slone & Owen, 2015). Thus, a better understanding of the therapists' comfort level through self-evaluation is an essential aspect that can be utilized to promote the patient's treatment and may be a significant element of an effective therapist and patient therapeutic relationship in a home-based setting.

Chapter 3 presented the research design and rationale, site, participant selection, methodology, instrumentation, data analysis plan, threats to validity, ethical procedures and issues of trustworthiness, and chapter summary.

Chapter 3: Research Method

Introduction

The purpose of this quantitative study was to assess therapists' comfort level in providing psychotherapy in a home-based setting by examining the associations among therapists' comfort level, the therapeutic relationship, advanced therapeutic training, and therapeutic competency. No empirical evidence has addressed self-evaluation of therapists' comfort level in providing psychotherapy to youths in a home-based setting. Instead, the therapists' comfort level displayed in the home-based setting has been rated mostly by the patients and parents/caregivers (Dunkle & Friedlander, 1996; Glebova et al., 2012; Levy et al., 2015; Slone & Owen, 2015).

The study site to conduct the survey was located in Southern New Jersey. The agency is composed of 170 staff including psychologists, counselors, social workers, and other related staff. The therapists' comfort level in providing psychotherapy in a home-based setting was measured using TCS developed by Owen (2015). The advanced therapeutic training and therapeutic competency were measured using the CCS-R (Lambie et al., 2014). The STAR developed by McGuire-Snieckus (2007) was used to measure the therapeutic relationship. In addition, a researcher-constructed demographic questionnaire (DQ) was administered.

This study was conducted in accordance with Walden University's Institutional Review Board (IRB) guidelines to ensure the study's ethical protection. The data were collected throughout the SurveyMonkey. I used a selective sampling approach, multiple linear regression analysis, and Pearson correlation analysis. The data were analyzed using the Statistical Package for the Social Science (SPSS). Chapter 3 includes the introduction, the research design and rationale, site and participant selection procedures, methodology,

instrumentation and operational instrumentation, data analysis plan, threats to validity, ethical procedures and issues of trustworthiness, and the chapter summary.

Research Design and Rationale

The goal of this study was to examine the association among the following variables: TCL, TR, ATT and TC. I used a quantitative research design. The quantitative method was appropriate as it can use statistics to generalize a finding and often reduces and restructures a complex problem to a limited number of variables (Delice, 2010; Yilmaz, 2013). In addition, the quantitative method allows the examination of relationships between the variables and can establish cause and effect in highly controlled circumstances; it is also more objective than qualitative methods (Creswell, 2009; Yilmaz, 2013). In this study, I used a descriptive, correlational study, which was appropriate because my primary goal was to assess a sample at one specific point in time without trying to make inferences or casual statements and identify areas for further research (see Creswell, 2009; Delice, 2010; Yilmaz, 2013). The descriptive study was appropriate to apply the relationship obtained among the variables to the population and to test the hypotheses (see Creswell, 2009; Delice, 2010; Yilmaz, 2013).

The quantitative descriptive research design allowed me to address the research questions (see Creswell, 2009) regarding a relationship among TCL, TR, ATT and TC. The variables' relationships were assessed using an online survey containing the TCS, CCS-R, STAR-C, and the DQ presented to the participants via the agency's website. The online survey was beneficial for this study, as the Internet is ideal for surveying a number of participants. The online survey was also a shorter, timelier way for collecting the data with less cost (see McGuire-Snieckus et al., 2007; Wright & Schwager, 2008). After completing data collection, I used statistical analyses to examine the relationship among

TCL, TR, ATT, and TC. Finally, after the data were collected, the descriptive characteristics of the participants was reported and benchmarked against the population of therapists who provided psychotherapy in a home-based setting.

Site and Participation Selection Procedures

A website contact link from the nonprofit home-based psychotherapy agency located in the Southern New Jersey area was used to communicate with the appropriate personnel and recruit the participants. A letter of the petition was sent via e-mail to the owner and director of the agency to ask for permission to participate and to specify the purpose of the study and the number of participants required. The director was encouraged to contact me via cell phone to obtain more information about the study and to assure the number of participants. The director and owner of the agency agreed via email to take part of this study. In addition I did not have any conflict of interest because there was not affiliation with the nonprofit home-based psychotherapy agency.

Methodology

In this section, I discuss the methodology in sufficient depth for replication by other researchers. The section is organized in the following subsections: the population, the sample size, the sampling and sampling procedures, the data collection procedures, the multiple regression analysis, the research questions and hypotheses, and the variables.

Population

The affiliated nonprofit home-based psychotherapy agency is composed of approximately 170 staff. The target population of this study consisted of bachelor-, master-, and doctoral-level psychotherapists, including social workers, psychologists, counselors, and other related staff who provide psychotherapy in a home-based setting. The participants were both men and women of all levels of experience and

psychotherapeutic training (counselors, social workers, psychologists, and therapists assistants). According to the nonprofit home-based agency's website, the staff included professional licensed and master's therapists, doctoral therapists, board certified behavior analysts and assistants, and behavior assistants. In accordance with the information obtained from its website, the staff has a broad range of specialties and are ethnically representative of Southern New Jersey.

Sample Size

When using multiple regression for prediction purposes, the issue of minimum required sample size often needs to be addressed (Knofczynski & Mundfrom, 2008). Power analysis was used to determine the sample size of the study. A-priori sample size calculator for multiple linear regression sample size calculator to assess the required sample size (Mishra & Min, 2010) was used. Using an anticipated effect size ($f^2 = 0.15$), desired statistical power level = 0.8, number of predictors = 3, and probability level = 0.05, the required sample size was $n = 76$. The sample was appropriate based on the guideline of the multiple linear regression models that allow researchers to investigate proposed relationships (see Mishra & Min, 2010). Thus, the sample size consisted of $N = 76$ participants of Bachelors, Masters, and Doctoral levels, including social workers, psychologists, counselors, and related staff who work in home-based psychotherapy settings. The criterion for each participant to participate in the study was that the therapists provide psychotherapy services in the patient's home.

Sampling and Sampling Procedures

The population sample in this study consisted of $N = 76$ participants purposively selected therapists from the Southern New Jersey area. In order to be included in this study, the participants were therapists who provide psychotherapy in a home-based

setting, including psychologists, counselors, social workers, and therapist assistants. The therapists who provide psychotherapy solely in the agency facility were excluded. Thus, in the present study, I included quantitative therapists of all levels of training and experience in the home-based setting. Therefore, the sampling procedure of this study was purposive sampling, which allows the use of cases that have the required information with respect to the subject of the study (see Creswell, 2009). The motivation behind using purposive sampling in this study was to generate a sample that was representative of the population (see Creswell, 2009).

Data Collection Procedures

An email addresses from the nonprofit home-based agency located in Southern New Jersey was used to recruit the participants. Hence, I contacted the potential participants via the agency's website email and informed them that I was a PhD student from Walden University, and I was in the process of conducting a research and collecting data for a study on a Therapists' Comfort Level in Providing Psychotherapy in a Home-Based Setting. I encouraged the participants to participate in the study by going to the SurveyMonkey link, where an electronic consent form was provided. By completing the proposed instruments, the participants gave me the consent to participate, as a signed consent were not available. Thus, the target participants' identities were completely anonymous, and further contact with the participants after completening the research is not necessary.

Operationalization of Constructs and Instrumentation

The study used purposive sampling, which was based on characteristics of the population and the objective of the study. The research instruments consisted of a researcher-created demographic questionnaire (DQ) (see, Appendix A). The second

instrument was CCS-R (see, Appendix B) with the author's permission to be used (see, Appendix C). The CCS-R consists of 23-items designed to measure counseling competencies within three domains Counseling Skills, Professional Dispositions, and Professional Behaviors, using a 5-point Likert scale response categories. The third instrument used is the STAR composed of two different scales, STAR-Patient and STAR-Clinician, however, for this study, only the STAR-C (see, Appendix D) was utilized with the authors' permission. The STAR-C is composed of 12 items, compromising three subscales: Positive Collaboration, Emotional Difficulties and Positive Clinician Input (McGuire-Snieckus et al., 2007). The STAR-C rates each item on the following scale (e.g., 0 = *Never*, 1= "*Rarely,*" 2 = "*Sometimes*," 3 = "*Often*," 4 = "*Always*." The fourth instrument used was the TCS (Slone & Owen, 2015), with the proper modification used as self-evaluation (see, Appendix E), with the author's permission. The TCS has 10 items rated on a 5-point Likert scale format, which is useful as self-assessment (Slone & Owen, 2015). Likert (1932) developed the principle of measuring attitudes by asking individuals to respond to a series of statements on a topic, in terms of the extent to which they agree with each item. The 5-point Likert-type scales are used to fix choice response formats (Likert, 1932). The scale format assumption is that the strength/intensity of the experience is a linear continuum scaled (from 1 = "*Strongly Disagree*" to 5 = "*Strongly Agree*") making the assumption that attitudes can be measured (Likert, 1932).

Demographic questionnaire. A researcher-created demographic questionnaire was utilized. The purpose of the demographic questionnaire was for the participant to provide some basic background information about themselves and their educational background. The participants self-reported each demographic variable. The researcher

collected the data of each participant's gender, degree program and major (e.g., Gender: "Female, Male," "Degree program: Bachelors, Master's, Doctoral Level.," "Major: Psychologist, Social Worker, Counselor, Related Staff (therapist assistants") (see, Appendix A).

CCS-R. The CCS-R (Lambie et al., 2014) instrument was suitable to be utilized to compare therapists' therapeutic competencies and advanced training skills. The CCS-R is theoretically grounded composed in the two-part model (Part 1: Primary Counseling Skills – (PCS); Part 2: Primary Counseling Dispositions and Behaviors (PCDB) both encompassing a total of 23 items. Part 1- PCS includes 11 items focusing on primary counseling skills, (e.g., "*Encourages, Questions, Reflecting/Paraphrasing,* and *Reflecting/Reflection of Feelings*") (Lambie et al., 2014). Part 2- PCDB includes 11 sub-items each focus on qualities and behaviors in counseling in training that are crucial for psychotherapeutic competency (e.g., "*Professional Ethics, Professional Behavior, Professional* and *Personal Boundaries*,") Score by add-up total items using a 5-point Likert scale ranging (5= *Exceeds Expectations/Demonstrates Competencies*; 4= *Expectations/Demonstrates Competencies*; 3= *Near Expectations/Developing towards Competencies*; 2= *Below Expectations*; 1= *Harmful*) (Lambie et al., 2014) (see, Appendix B).

The internal consistency reliability analysis results for the CCS-R were strong. Part 1-PCS was (a = .94); Part 2- PCDB was (a = .94); the total CCS-R Score was (a = .96) (Lambie et al., 2014; Leech, Onwuegbuzie, & O'Connor, 2011). According to the authors, the CCS-R was empirically tested to evaluate and facilitate formative and summative feedback on the therapists' training and competency through manner and

support the development of ethical and effective psychotherapy professionals (Lambie et al., 2014).

Scale to Assess Therapeutic Relationship in Community Mental Health Care (STAR) **(**Priebe, 2007). The STAR was a short and easy to administer scale, in which completing it usually takes five minutes or less (Priebe, 2007). It was specifically designed to assess the therapeutic relationship in community mental health care consisting of 12 items and 3-factor models using a 5-point Likert scale (0 = "*Never*," 1 = "*Rarely*," 2 = "*Sometimes,*" 3 = "*Often*," 4 = "*Always.*" The STAR has a version for patients (STAR-P) and clinician (STAR-C), has good psychometric properties, and if possible, it captures distinct factors (Priebe, 2007). For this study only the STAR-C was used, consisting of 12 items (e.g., "*I get along well with my patient*," "*My patient and I share a good rapport,*" "*I listen to my patient,*" "*I feel that my patient rejects me as a clinician*") (Priebe, 2007) (see, Appendix C).

The STAR-C compromises three-factor model (Positive Collaboration; Positive Clinician Input and Emotional Difficulties) (McGuire-Snieckus et al., 2007). The STAR's items for the subscales were selected on the basis of internal consistency and predictive validity for the subscale score regression analysis. The Positive Collaboration was (a = .95), Emotional Difficulty was (a = .71), and Positive Clinician Factor was (a = .75) (McGuire-Snieckus et al., 2007). The STAR-C test-retest reliability ranged .44 to .73. The reliability of the STAR-C's items retained in the scale ranged .46 to .73 in which, the factorial structure of the scale was confirmed with a good fit (McGuire-Snieckus et al., 2007).

Therapist Comfort Scale (TCS). The TCS (Slone & Owen, 2015) instrument was designed to assess therapists' level of comfort and feelings of safety when providing

psychotherapy in the family and youths' home and their community (e.g., school). The purpose of this particular measure was to assess how clients viewed the degree of comfort the therapists appeared to exhibit in a psychotherapy session when providing psychotherapy in a home-based setting. The instrument was composed of three parts: 1. The therapist's comfort level; 2. Cultural background; and 3. Cultural identity. However, this study was interested in using only Part 1 "The Therapist's Comfort in the Therapy Session" with the author's permission to be used only part one as self-evaluation.

Part 1 of the TCS consists of 10 items using a 5-point Likert scale ranging (from 1= "*Strongly Disagree*" to 5 ="*Strongly Agree*") previously used for the purpose of assessing how clients viewed the degree of comfort the therapists exhibited during psychotherapy sessions (Slone & Owen, 2015). The statement and the questions of the instrument were modified to be used as self-evaluation in this study. The instruction of the session was as follows: "We are in interested in how you (therapist) were in your psychotherapy sessions. It is important to know that there are no right or wrong answers here. Therapists are human and have a range of emotions and reactions. We are trying to get a sense of how relaxed you were in the patients' environment". "*Overall, how comfortable did you generally feel in the psychotherapy sessions?*" The possible responses were: (e.g., "*Comfortable," "Awkward," "Nervous," "Calm," "Tense," "Confident," "Uneasy," "Relax," "Edgy, "Genuine"*) (Slone & Owen, 2015) (see, Appendix D). This study used this part of the instrument to measure the dependent variable, therapists' comfort level. The intention of the assessment of the therapist's comfort was to gather an overall psychotherapy impression, across sessions from the therapists' point of view.

The TCS was developed and previously used by the patients and family to assess the therapists' comfort when working in their home. Glebova et al., (2012) conducted a study to evaluate the therapist's feelings of safety and comfort when working with a family in its home. For that particular study, the TCS items were developed based on semi-structured interviews where the therapists (n = 7) and supervisors (n = 3) were asked to identify specific instances when they or a supervised experienced discomfort while treating families referred with severe and chronic juvenile delinquents or substance-abusing offenders (Glebova et al., 2012). The study revealed that psychometrically the TCS showed adequate validity and reliability, the internal consistency of the rating was (a = .86), test-retest reliability ranged from .66 to .74, (ps <.01) showing considerable stability in therapist ratings during the course of treatment (Glebova et al., 2012).

Data Analysis Plan

Descriptive statistics were used to assess the demographic data of home-based therapist' professional levels are as follows: (e.g., Degree: "Bachelors, Masters, and Doctoral." Degree: "Psychologists, Counselors, Social Worker and Related Staff (Therapists' assistants), and Gender"). To examine the dependent variable (therapists' comfort level), and the independent variables (therapeutic relationship, advanced therapeutic training, and therapeutic competency), the hypotheses were tested with inferential statistics. The dependent and independent variables, research questions and hypotheses and the data analysis were discussed in detail in this section. The section is organized as follows: dependent and independent variables, research questions and hypotheses, and data analysis.

Dependent and independent variables. The dependent variable (Therapists' comfort level) of this study was the variable in question. The therapeutic relationship, advanced therapeutic training, and therapeutic competency were the independent variables, which allow the evaluation of alternative hypotheses. Thus, measuring the comfort level of the therapists in providing psychotherapy in a home-based setting may provide an alternative explanation resulting in an inadequate therapeutic relationship, therapeutic advanced training, and/or therapeutic competency.

Research Questions and Hypotheses

The following central research questions and hypotheses will be addressed in this study:

Research Question (RQ)1: What is the relationship between therapists' comfort level and therapeutic competency in providing home-based psychotherapy to youths?

$H1_0$: There is not a relationship between the therapists' comfort level and therapeutic competency in providing home-based psychotherapy to youths.

$H1_a$: There is a relationship between the therapists' comfort level and therapeutic competency in providing home-based psychotherapy to youths.

RQ2: What is the relationship between the therapists' comfort level and advanced therapeutic training in providing home-based psychotherapy to youths?

$H2_0$: There is not a relationship between the therapists' comfort level and advanced therapeutic training in providing home-based psychotherapy to youths.

$H2_a$: There is a relationship between the therapists' comfort level and advanced therapeutic training in providing home-based psychotherapy to youths.

RQ3: What is the relationship between the therapists' comfort level and the therapeutic relationship in providing home-based psychotherapy?

$H3_0$: There is not a relationship between the therapists' comfort level and the therapeutic relationship in providing home-based psychotherapy.

$H3_a$: There is a relationship between the therapists' comfort level and the therapeutic relationship in providing home-based psychotherapy.

Data Analysis

In this section, the research questions and hypotheses were analyzed using descriptive statistical analysis, including the mean, standard deviation, maximum and minimum range, variance and standard error (George & Mallery, 2011). Upon receipt the surveys, the data were entered into the SPSS Statistics software to analyze it. The findings were presented in a narrative format supplemented by tables and/or figures. In addition, the findings were presented objectively and without speculating, free from the researcher's bias (George & Mallery, 2011).

Multiple linear regression analysis was suitable for this study for understanding the relationship between more than two variables (Mishra & Min, 2010). In this study, the linear regression model was appropriate to analyze the relationship between the independent variables (therapeutic relationship, advance therapeutic training, and therapeutic competency) and the dependent variable (therapists' comfort level) (Knofczynski & Mundfrom, 2008). The multiple linear regression was the best straight line through a set data that measured how well the dependent and the independent variables interrelate (Mishra & Min, 2010). The multiple linear regression analysis models was applicable because this study includes more than one independent variable (Mishra & Min, 2010). In addition, the multiple linear regression analysis models assumed that the independent variables measured without error variance (Mishra & Min, 2010). Yet, a number of studies have shown that such general assumption of low levels of

measurement error is exceedingly questionable in practice (Mishra & Min, 2010). Another assumption was that the multiple linear regression needed the relationship between the independent and dependent variables to be linear (Knofczynski & Mundfrom, 2008). In addition, the linear regression analysis required that the error between observed and predicted values (e.g., the residuals of the regression) should normally be distributed (Mishra & Min, 2010).

In addition, a Pearson correlation analysis was conducted using Cohen's standard to evaluate the strength of the relationship between the variables. The correlation expressed the strength of linkage or co-occurrence between the variables in a single value; this value measured the strength of linkage which is called correlation coefficient (Cohen, 1988). The Pearson correlation was suitable for this study as it was useful to establish the possible influences among the variables. The Pearson correlation assumed that the relationship between each pair of variables was linear (Conover & Iman, 1981).

Threats to Validity

Since collecting data via the Internet become easier and faster (Wright, 2005), this study used this research tool to collect the data. However, the used of the Internet implied limitations as online surveys bring problems, especially in terms of validity, which refers to the accuracy of a measurement (Lameck, 2013; McGuire-Snieckus et al., 2007; Wright & Schwager, 2008). When inviting participants and administering the actual surveys, the researcher categorized and assessed threats to validity such as low response rates. This study used a purposive sampling approach and a volunteer sample of participants from a home-based agency in Southern New Jersey. A further threat to this study was that the participants completed all the instruments surveys and the demographic questionnaire on the Internet without the researcher to be present to clarify and review, which may

possibly lead to less reliable data (Lamarck, 2013; McGuire-Snieckus et al., 2007; Wright & Schwager, 2008). The bias may stem from sources, like questions format, data collection mode, and participants' characteristics and behavior (Coutts & Jann, 2008). Furthermore, when filling out the instrument surveys and the demographic questionnaire, the participants may find some of the questions ambiguous. However, the participants were given my contact information and Walden University information to reply to any inquiries or concerns.

Social desirability was a concern due to the tendency of survey respondents to response questions in a fashion that will be viewed favorably by others (Lameck, 2013). To mitigate this concern, the participants were informed that their responses were completely anonymous with no threat of tracking the respondents of each of the instruments surveys and the demographic questionnaire. In addition, the researcher used only one part of the STAR instrument (STAR-C). However, researchers agreed that a single-item in both instruments could be more effective and more favorable in some respects than by both-item measures (Dolbier, Webster, McCalister, Mallon & Steinhardt, 2004). Additionally, the researcher used only the top part of the TCS instrument with the author's permission to evaluate the therapist's feelings of safety and comfort when working with the patients in their environment (Slone & Owen, 2015).

Ethical Procedures and Issues of Trustworthiness

This study was conducted in accordance with Walden University's IRB approval to ensure the ethical protection of research participants. In accordance with the research process, the data collection began after the IRB application to Walden University was received and approved to conduct the study. As required, prior to collecting the data, the researcher completed the National Institutes of Health (NIH) of Extramural Research

Web-based training course "Protecting Human Research Participants." Additionally, I complied with the United States federal and state regulations, which was to include the information for the participants about the level of anonymity in the study through a consent form document.

The participants received a consent form before completing the survey instruments. The consent form included my contact information in case they have inquiries at any time during the study. Furthermore, the selection criteria of the study, the anticipated benefits, and risks of the study, the lack of compensation, the privacy information, disclosure of any potential conflicts of interest, were included in the consent form. In addition, the consent form included the contact information of the Walden University representative for further discussion about their rights as research participants. Thus, it was proposed that the participants in this study read and accepted the consent form by taking the surveys using SurveyMonkey. Participation in the study was completely anonymous. All data files, both hard copy, and computer based, are kept in a locked file cabinet and with secure passwords. In accordance with Walden University guidelines, the study's record data will be destroyed after 5 years. After that time period, the electronic data will be kept in a password-protected laptop. Additionally, the hard copy record data will be appropriately destroyed using the shredding method.

Summary

This study examined the associations among therapists' comfort level, therapeutic relationship, advanced therapeutic training, and therapeutic competency when providing psychotherapy in a home-based setting. The researcher used the TCS to measure the therapists' comfort level in providing psychotherapy in a home-based setting (Slone & Owen, 2015). The researcher asked for the author's permission to modify and utilized the

instrument and only used part one as self-evaluation. A demographic questionnaire was developed by the researcher to obtain the participants information about themselves and their educational background. In addition, with the author's permission, the STAR-C was used to examine the relationship among therapists' comfort level and therapeutic relationship (McGuire-Snieckus et al., 2007); and the CCRS-R was used to examine the relationship among therapists' comfort level, therapeutic competencies and advanced therapeutic training (Lambie et al., 2014).

The study used purposive sampling approach. The proposed data collected was *n*=76 participants from Bachelors, Masters, and Ph.D., degrees, including social workers, psychologists, counselors and the related staff of a home-based agency located in Southern New Jersey. The participants were invited via the agency's website email. The study utilized a require consent form that was in effected when the participants, clicked to begin the surveys on SurveyMonkey; hence, the participants' identity was anonymous. The data was analyzed using the SPSS, which include descriptive statistics, Pearson correlation analysis and multiple linear regression analysis. The data will be secured for at least 5 years as stipulated by Walden University; the 5 years the hard-copy data will be destroyed, and the electronic copy will be filed with a secure password.

Chapter 3 included the introduction, the research design and rationale, the site and participant selection procedures, the methodology, instrumentation, data analysis plan, threats to validity, ethical procedures and issues of trustworthiness, and the chapter summary. Chapter 4 included the introduction, data collection, methodological and statistical assumption, results, the chapter summary and transition to Chapter 5.

Chapter 4: Results

Introduction

The purpose of this quantitative study was to assess therapists' comfort level in providing psychotherapy in a home-based setting by examining the associations between TCL, TC, ATT, and TR. Descriptive statistics were used to describe the DQ data, including gender, degree (Bachelors, Masters, and Doctorate) and majors (Psychology, Counselor, Social Work and Related Staff, e.g., Mental Health Assistants). The first two research questions were developed to assess the relationship between TCL, TC, and ATT measured by the CCS-R and TCL. The third research question was developed to assess the relationship between the TCL and TR measured by the TCL and the STAR-C. A multiple linear regression analysis was conducted to assess the predictive relationships among the variables. In addition, a Pearson correlation was conducted using Cohen's standard to evaluate the strength of the relationship.

Research Questions and Hypotheses

I examined the following research questions and hypotheses:

Research Question (RQ)1: What is the relationship between therapists' comfort level and therapeutic competency in providing home-based psychotherapy to youths?

$H1_0$: There is not a relationship between the therapists' comfort level and therapeutic competency in providing home-based psychotherapy to youths.

$H1_a$: There is a relationship between the therapists' comfort level and therapeutic competency in providing home-based psychotherapy to youths.

RQ2: What is the relationship between the therapists' comfort level and advanced therapeutic training in providing home-based psychotherapy to youths?

$H2_0$: There is not a relationship between the therapists' comfort level and advanced therapeutic training in providing home-based psychotherapy to youths.

$H2_a$: There is a relationship between the therapists' comfort level and advanced therapeutic training in providing home-based psychotherapy to youths.

RQ3: What is the relationship between the therapists' comfort level and the therapeutic relationship in providing home-based psychotherapy to youths?

$H3_0$: There is not a relationship between the therapists' comfort level and the therapeutic relationship in providing home-based psychotherapy to youths.

$H3_a$: There is a relationship between the therapists' comfort level and the therapeutic relationship in providing home-based psychotherapy to youths.

In Chapter 4, I provide an outline of the data collection, including the recruitment, and the response rates. The descriptive statistics and demographic characteristics of the sample's representation are also discussed. I present the results of the statistical analysis of the research questions, result tables, and hypotheses's conclusions. I also include the summary and a Chapter 5 transition.

Data Collection

In July 2017, a director of a home-based agency was informed about the nature of the study and the need for recruitment of participants. The participant's criteria were explained. A letter of cooperation was received indicating the approval for participation. The home-based agency received a survey link along with the procedures and instructions for conducting the research study. The therapists accessed the survey link posted on the agency's website. All scales were administered and collected through SurveyMonkey.

Social desirability bias regarding the validity of data collection was a concern because in self-reports, participants often report inaccurately on sensitive topics in order

to present themselves in the best possible light (Lameck, 2013). Social desirability can also be due to self-deception (Fisher, 1993) and can affect the validity of survey research findings (Fisher, 1993; Lameck, 2013). To diminish this concern, forced-choice items were included to reduce social desirability bias effectively. The use of the online survey method, regarding the validity of data collection, was also a concern (see Lameck, 2013; McGuire-Snieckus et al., 2007; Wright & Schwager, 2008). To diminish this concern, the data collection was conducted from a single location to be relatively certain that the data were authentic (see McGuire-Snieckus et al., 2007).

Timeline

The data collection took place from December 9, 2017 through January 18, 2018. Over a 30-day period, 106 therapists of Bachelors, Masters, and Doctoral levels, including psychologists, counselors, social workers, and related staff (therapists' assistants) participated in the study. However, 30 (27.73%) participants did not complete all the required scales. Thus, the data collection continued until the 76 participants completed the three scales listed in the survey (DQ, TCS, CCS-R, and STAR-C), which was the required sample size ($N = 76$) in accordance with the multiple regression sample size calculator.

Results

Descriptive Statistics

Descriptive statistics were reported to describe the demographic characteristics of participants. Before administering the survey, the concern was to minimize potential sample bias and achieve a representative sample. Purposive sampling was used, in which the controls were placed on the types of respondents chosen for the survey by looking for different therapists to make sure the sample was correctly balanced (see Creswell, 2009).

The population of the agency was *n* = 170 participants and a total of N= 106(80%) participants responses were recorded. However, 30 (23.73%) responses were incomplete. Of these returned surveys, 76 (80.5%) were fully completed. Hence, the data collection was stopped once the desired sample size (*N* = 76) was reached.

The sample included (*N* = 76*)* therapists of a not-for-profit home-based agency who voluntarily completed the online survey. The most frequently observed category of "What is your gender?" was female (*n* = 55, 46%). The most frequently observed category of "What is your Degree Program?" was MA (*n* = 60, 50%). The most frequently observed category of "What is your Major?" was counselor (*n* = 26, 22%). Frequencies and percentages are presented in Table 1.

In the current study, the majority who responded and were assessed in a home-based setting were female (46%) and had a master's degree (50%). A study conducted in 2005 by Lawson and Foster on profile ego development, conceptual complexity, and supervision satisfaction for home-based counselors reported the following demographics of the sample drawn from therapists in home-based setting; the majority were females (73.3%), and most had a master's degree (62.5%). Thus, my study had similar demographics to the study conducted by Lawson and Foster. These demographic characteristics are consistent with the general therapist's population.

Table 1

Demographic Characteristics for Gender, Degree, and Majors

Variable	*n*	*%*
What is your gender?		
Female	55	46.22
Male	31	26.05
Missing	33	27.73
What is your degree program?		
BA	21	17.65
Doctoral	4	3.36
MA	60	50.42
Missing	34	28.57
What is your major?		
Counselor	26	21.85
Other	13	10.92
Psychology	14	11.76
Related staff (e.g., therapist assistants)	14	11.76
Social worker	19	15.97
Missing	33	27.73

Results of the TCL/TC and ATT. In the current study, I examined the relationship between TCL, TC, and ATT while providing psychotherapy to youths in a home-based setting. The TCS and CCS-R were used to assess the relationship between

TCL, TC, and ATT. The TCS presented a single question: "Overall, how comfortable did you generally feel in the psychotherapy sessions?" The CCS-R is theoretically grounded composed in the two-part model (Part 1: Primary Counseling Skills – measured TC. Part 2: Primary Counseling Dispositions and Behaviors measured ATT).

Seventy-six therapists ($N = 76$) responded completely to the TCS and the CCS-R. The observations for TCL had an average of 28.23 ($SD = 18.50$, $SE_M = 1.76$, Min = 0.00, Max = 50.00). The observations for TC had an average of 51.20 ($SD = 9.30$, $SE_M = 1.07$, Min = 28.00, Max = 64.00). The observations for ATT had an average of 26.54 ($SD = 4.35$, $SE_M = 0.51$, Min = 15.00, Max = 32.00). The summary statistics for the TCL, TC, and ATT are found in Table 2.

Results of the TCL/TR. The STAR-C is specifically designed to assess TR in community mental health care consisting of 12 items (e.g., "I get along well with my patient," "My patient and I share a good rapport," "I listen to my patient," "I feel that my patient rejects me as a clinician"; McGuire-Snieckus et al., 2007). Three-factor models (positive collaboration, positive clinician input, and emotional difficulties) were included. The study followed the STAR Scale scoring protocol.

Home-based therapists ($N = 76$) participated to examine the relationship between TCL and TR. The observations for TCL had an average of 28.23 ($SD = 18.50$, $SE_M = 1.76$, Min = 0.00, Max = 50.00). The observations for TR had an average of 39.09 ($SD = 5.84$, $SE_M = 0.67$, Min = 18.00, Max = 48.00). The summary statistics for the TCL and TR is found in Table 2.

Table 2

Summary Statistics for Therapists' Comfort Level, Therapeutic Relationship, Therapeutic Competency, and Advance Therapeutic Training

Variable	*M*	*SD*	*n*	SE_M	Skewness	Kurtosis
TCL	28.23	18.50	111	1.76	-0.71	-1.18
TR	39.09	5.84	76	0.67	-1.19	2.68
TC	51.20	9.30	76	1.07	-0.48	-0.48
ATT	26.54	4.35	76	0.51	-0.71	0.02

Skewness and kurtosis. Prior to conducting the linear regression, the assumptions of normality of residuals, homoscedasticity of residuals, the absence of multicollinearity, and the lack of outliers were examined. Both skewness and kurtosis of the distributions were calculated to measure normality. When the skewness is greater than 2 in absolute value, the variable is considered to be asymmetrical about its mean. When the kurtosis is greater than or equal to 3, then the variable's distribution is markedly different than a normal distribution in its tendency to produce outliers (Westfall & Henning, 2013). The results of this study indicated that none of the Skewness and Kurtosis values exceeded the cut off values.

Assumptions. Prior to conducting the linear regression, the assumptions of normality of residuals, homoscedasticity of residuals, the absence of multicollinearity, and the lack of outliers were examined.

Normality. Normality was evaluated using a Q-Q scatterplot (Bates, Mächler, Bolker, & Walker, 2014; DeCarlo, 1997; Field, 2009). The Q-Q scatterplot compares the distribution of the residuals with a normal distribution (a theoretical distribution which follows a bell curve). In the Q-Q scatterplot, the solid line represents the theoretical quantiles of a normal distribution. Normality can be assumed if the points form a relatively straight line. The results of this study indicated that the points form deviates away from being a straight line. The Q-Q scatterplot for normality is presented in Figure 1.

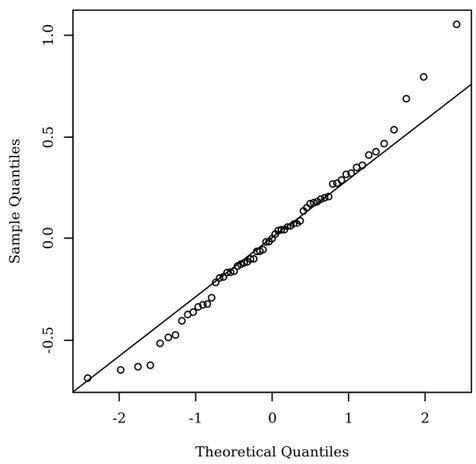

Figure 1. Q-Q scatterplot testing normality.

Homoscedasticity. Homoscedasticity was evaluated by plotting the residuals against the predicted values (Field, 2009; Bates et al., 2014; Osborne & Walters, 2002). The assumption is met if the points appear randomly distributed with a mean of zero and no apparent curvature. The results of this study indicated that the points do not appear to be randomly distributed around the line and no apparent curvature. Therefore, the assumption is not met. Figure 2 presents a scatter plot of predicted values and model residuals.

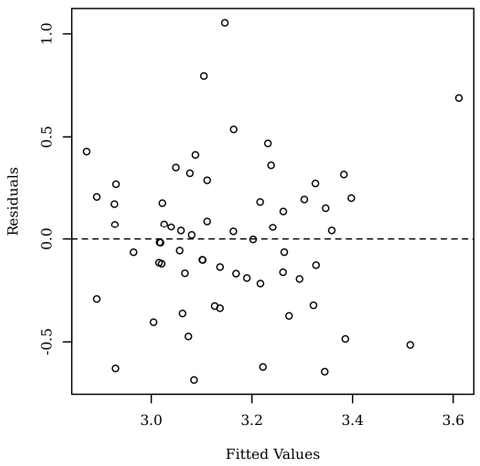

Figure 2. Residuals scatter plot testing homoscedasticity.

Variance inflation factors (VIFs). The VIFs were calculated to detect the presence of multicollinearity between TR, TC, and ATT. High VIFs indicate increased effects of multicollinearity in the model. VIFs greater than 5 are cause for concern, whereas VIFs of 10 should be considered the maximum upper limit (Menard, 2009). The results of this study indicated that all predictors in the regression model have VIFs less than 10. Table 3 presents the VIF for each predictor in the model.

Table 3

Variance Inflation Factors for Therapeutic Relationship, Therapeutic Competency, and Advance Therapeutic Training

Variable	VIF
TR	1.20
TC	4.07
ATT	4.21

Studentized residuals were calculated, and the absolute values were plotted against the observation numbers to identify influential points (Field, 2009; Stevens, 2009). Studentized residuals are calculated by dividing the model residuals by the estimated residual standard deviation. An observation with a Studentized residual greater than 3.23 in absolute value, the .999 quartile of a *t* distribution with 62 degrees of freedom, was considered to have a significant influence on the results of the model. Observation numbers are specified next to each point with a Studentized residual greater than three. Figure 3 presents the Studentized residuals plot of the observations

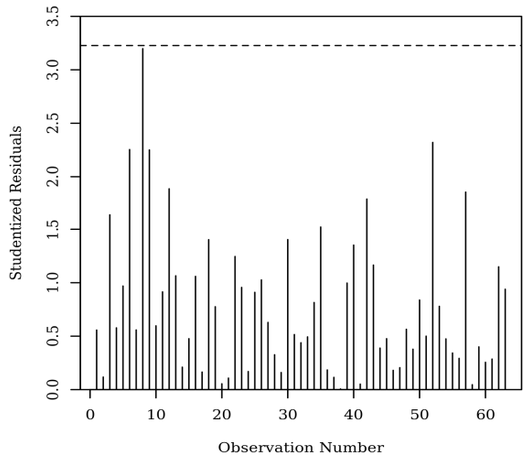

Figure 3. Studentized residuals plot for outlier detection.

Linear regression results. Linear regression was used to assess the predictive relationships among the TCL, TC, ATT, and TR. The results revealed F (3,59) = 6.53, p < .001, R^2 = .26, indicating that approximately 26% of the variance in TCL are explainable by TC, ATT, and TR. TC did not significantly predict TCL, B = 0.25, t(59) = 1.62, p = .111. Based on this result, a one-unit increase in TC did not correspond with any change in TCL. ATT did not significantly predict TCL, B = -0.33, t(59) = -0.98, p =.332. Based on this result, a one-unit increase in ATT did not correspond with any change in TCL. TR was an individually significant predictor TCL, B = 0.34, t(59) = 2.67, p =.010. This indicates that a one-unit increase of TR corresponds with an increase in the value of TCL by 0.34 units. This linear combination can be represented by the equation (TCL = 0.34*TR + 34.01). The results of the regression can be found in Table 4. The results of the analysis of the individual predictors are presented in Table 5.

Table 4

Results for Linear Regression With Therapeutic Relationship, Therapeutic Competency, and Advance Therapeutic Training Predicting Therapy Comfort Level

	SS	*df*	MS	F	*p*
Regression	759.74	4	189.94	6.53	.001
Residual	1687.68	58	29.10		
Total	2447.43	62			

Note. a. Dependent Variable: TCL

b. Predictors: (Constant), TCL, ATT, TR, TC

Table 5

Results of the Analysis of the Individual Predictors

	B	SE	*β*	*t*	*p*
(Intercept)	34.007	9.557	-	3.552	.001
TR	.337	.126	.332	2.673	.010
TC	.251	.155	.366	1.618	.111
ATT	-.325	.332	-.221	-.979	.332
TCL	-3.688	1.957	-.225	-1.884	.065

Note. Dependent variable is Therapists Comfort Level (TCL)
TCL = .337X + 34.007

Assumption. A Pearson correlation requires that the relationship between each pair of variables is linear (Conover & Iman, 1981). This assumption is violated if there is curvature among the points on the scatter plot between any pair of variables. No curvature is present. Therefore, the assumption is not violated. Figure 4 presents the scatter plot matrix of the correlations.

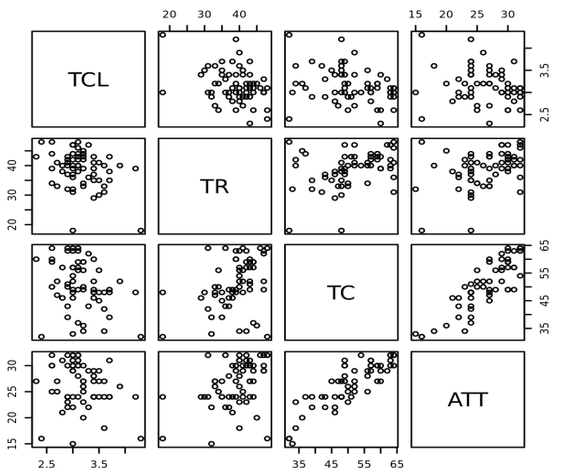

Figure 4. Scatterplot matrix among TCL, TR, TC, and ATT.

Pearson correlation results. A correlation analysis was conducted to assess statistically significant relationships between TCL and TR, TC, and ATT. There was statistically significant positive relationship between TCL and TR, r (74) = .421 and $p <$ .001. This finding indicated that as TR score increased, TCL also increased. There was a statistically significant positive relationship between TCL and TC, r (74) = .353 and $p =$ .002. This finding indicated that as TC score increased, TCL also increased. Thus, there was a statistically significant positive relationship between TCL and ATT, r *(*74*)* = .289 and p = .014. This finding indicated that as ATT score increased, TCL also increased.

Statistically significant positive relationships also existed between TR and TC, r *(74)* = .353 and p = .003; TR and ATT r *(74)* = .407 and p = .001; and TC and ATT r *(74)* = .843 and $p <$ .001. Of those relationships, the strongest association was assessed between TC and ATT. The direction of these relationships indicated that all the associations were positive, and as one variable increased the other decreased. Table 6

presents the Pearson correlation matrix for Therapists' Comfort Level, Therapeutic Relationship, Therapeutic Competency, and Advance Therapeutic Training.

Table 6

Pearson Correlation Matrix Between Therapists' Comfort Level, Therapeutic Relationship, Therapeutic Competency, and Advance Therapeutic Training

	TR	TC	ATT	TCL
Therapeutic relationship (TR)	-	.353**	.407**	.421**
Therapeutic competency (TC)	.353**	-	.843**	.353**
Advance therapeutic training (ATT)	.407**	.843**	-	.289*
Therapists' comfort level (TCL)	.421**	.353**	.289*	-

Note. **. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Spearman Rho correlation results. The researcher also conducted a confirmatory Spearman rho correlation analysis to assess statistically significant relationships between TCL and TR, TC, and ATT. There was statistically significant positive relationship between TCL and TR, $r\ (74) = .370$ and $p = .001$. This finding indicated that as TR score increased, TCL also increased. There was a statistically significant positive relationship between TCL and TC, $r\ (74) = .380$ and $p = .001$. This finding indicated that as TC score increased, TCL also increased. Finally, there was a statistically significant positive relationship between TCL and ATT, $r\ (74) = .306$ and $p = .009$. This finding indicated that as ATT score increased, TCL also increased.

Statistically significant positive relationships also existed between TR and TC $r\ (74) = .390$ and $p = .001$; TR and ATT $r\ (74) = .397$ and $p = .001$; and TC and ATT $r\ (74) = .820$ and $p < .001$. Of those relationships, the strongest association was assessed between TC and ATT. The direction of these relationships indicated that all the associations were positive, and as one variable increased the other decreased. Table 7

presents the Spearman rho correlation matrix for Therapists' Comfort Level, Therapeutic Relationship, Therapeutic Competency, and Advance Therapeutic Training.

Table 7

Spearman Rho Correlation Matrix Between Therapists' Comfort Level, Therapeutic Relationship, Therapeutic Competency, and Advance Therapeutic Training

	TR	TC	ATT	TCL
Therapeutic relationship (TR)	-	.390**	.397**	.370**
Therapeutic competency (TC)	.390**	-	.820**	.380**
Advance therapeutic training (ATT)	.397**	.820**	-	.306**
Therapists' comfort level (TCL)	.370**	.380**	.306**	-

Note. **. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Hypotheses Analysis

Hypothesis 1

$H1_0$: There is not be a relationship between the therapists' comfort level and therapeutic competency in providing home-based psychotherapy to youths.

$H1_a$: There is a relationship between the therapists' comfort level and therapeutic competency in providing home-based psychotherapy to youths.

There was a significant positive correlation between TCL and TC. The correlation coefficient between TCL and TC was .35 indicating a moderate effect size. TC did significantly predict TCL r (74) = .353 and p = .002. Therefore, the null hypothesis was rejected.

Hypothesis 2

$H2_0$: There is not a relationship between the therapists' comfort level and advanced therapeutic training in providing home-based psychotherapy to youths.

$H2_a$: There is a relationship between the therapists' comfort level and advanced therapeutic training in providing home-based psychotherapy to youths.

There was a significant positive correlation between TCL and ATT. The correlation coefficient between TCL and ATT was .29 indicating a small effect size. ATT did significantly predict TCL $r\ (74) = .289$ and $p = .014$. Therefore, the null hypothesis was rejected.

Hypothesis 3

$H3_0$: There will not be a relationship between the therapists' comfort level and the therapeutic relationship in providing home-based psychotherapy to youths.

$H3_a$**:** There will be a relationship between the therapists' comfort level and the therapeutic relationship in providing home-based psychotherapy to youths.

There was a significant positive correlation between TCL and TR. The correlation coefficient between TCL and TR was .42 indicating a moderate effect size. TR significantly predicted TCL, $r\ (74) = .421$ and $p < .001$. Therefore the null hypothesis was not supported.

Summary

Chapter 4 included descriptive statistics to describe the sample collected for the study. A multiple linear regression was used to predict the relationship between TCL, TC, ATT, and TR. The results revealed that approximately 26% of the variance in TCL are explainable by TC, ATT, and TR. TR was an individually significant predictor of TCL.

A correlation analysis was conducted to assess statistically significant relationships between TCL and TR, TC, and ATT. There was statistically significant positive relationship between TCL and TR. This finding indicated that as TR score increased, TCL also increased. There was a statistically significant positive relationship between TCL and TC which indicated that as TC score increased, TCL also increased. There was a statistically significant positive relationship between TCL and ATT which

indicated that as ATT score increased, TCL also increased. Statistically significant positive relationships also existed between TR and TC, TR and ATT, and TC and ATT. Of those relationships, the strongest association was identified between TC and ATT. The direction of these relationships indicated that all the associations were positive.

Chapter 5 will present a discussion of the study's results presented in Chapter 4 and will include the implications of the findings as they relate to the literature. It will include social change implications and limitations of the study. Chapter 5 will also include recommendations for further research, and conclusions.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of the quantitative study was to assess the therapists' comfort level in providing psychotherapy in a home-based setting by examining the relationship between TCL, ATT, TC, and TR. Participants in the study consisted of therapists of Bachelors, Masters, and Doctoral levels, including social workers, psychologists, counselors, and related staff (therapists' assistants) who work in a home-based psychotherapy setting. The criterion to participate in the study was that the therapists provide psychotherapy services in the patient's home.

Overview of the Study

The literature indicated that the home-based setting is beneficial for family and children who have difficulty either economically or with insurance issues when seeking psychotherapy services (Cortes, 2004; Glebova et al., 2012; Thompson et al., 2007; Zarski, 1991). Scholars have indicated that home-based psychotherapy could significantly and successfully maintain the youths in their home regardless of their initial higher levels of difficulties (Mosier et al., 2001). Nevertheless, two studies conducted 20 years apart, one by Hill et al. (2007) and another by Williams et al. (1997) agreed that the therapist may experience a high level of discomfort when providing psychotherapy in a home-based setting.

In the current study, I considered the home-based setting as a psychotherapeutic alternative intended to benefit the patients. Families who benefit from home-based psychotherapy are often characterized by complex situations that involve generational boundaries and unclear rules that govern family dynamics (Boyd-Franklin & Hafer, 2000; Cortes, 2004). The home-based setting also serves as a psychotherapeutic alternative

where the therapists provide family and individual psychotherapies for those who otherwise might not be able to access mental health services. In addition, home-based psychotherapy eliminates barriers for families who do not have adequate child care options, health insurance, or have trouble securing transportation to outpatient facilities (Glebova et al., 2012).

The current study included two theories, the SES developed by Bronfenbrenner (1979) that suggests that the individual's development within the context of the system of relationships from his/her environment. The theory focuses on the environmental and contextual mechanisms impacting the therapists and therapeutic process (Glebova et al., 2012; Macchi & O'Conner, 2010). The second theory was the TOC developed by Kolcaba in 1992 that suggests that an individual's comfort is a positive perception associated with events that nurture and strengthen individuals. TOC delivered an understanding regarding the therapists' comfort level when providing home-based psychotherapy, proposing that the therapists' comfort levels should be significant in the therapeutic process.

Interpretation of the Findings

The SPSS software was used to calculate descriptive statistics, frequencies, and analysis results. A descriptive research design was included, and I conducted a linear regression and correlation analysis. The linear regression revealed that approximately 26% of the variances in TCL are explainable by TC, ATT, and TR. The result revealed that TC did not significantly predict TCL. Based on this result, a one-unit increase in TC did not correspond with any change in TCL. ATT did not significantly predict TCL. Based on this result, a one-unit increase in ATT did not correspond with any change in TCL. TR was an individually significant predictor of TCL. This indicated that a one-unit

increase of TR corresponded with an increase in the value of TCL. In other words, TR can be used to predict TCL.

A correlation analysis was also conducted to assess statistically significant relationships between TCL and TR, TC, and ATT. There was a statistically significant positive relationship between TCL and TC. This finding indicated that as the TC score increased, TCL also increased. There was a statistically significant positive relationship between TCL and ATT. This finding indicated that as the ATT score increased, TCL also increased. There was a statistically significant positive relationship between TCL and TR. This finding indicated that as the TR score increased, TCL also increased. Statistically significant positive relationships also existed between TR and TC. Of those relationships, the strongest association was assessed between TC and ATT. The direction of these relationships indicated that all the associations were positive, and as one variable increased the other increased as well.

The scales TCS, CCS-R, and the START-C have been widely used in the literature (see Lambie, et al., 2014; McGuire-Snieckus; 2007; Owen, 2015). In the current study, the TCS was used as a self-evaluation to measure TCL. The CCS-R was used to examine the relationship between TCL, TC, and ATT. Additionally, the STAR-C was used to examine the relationship between TCL and TR indicating that approximately 26% of the variance in TCL are explainable by TC, TR, and ATT.

RQ1: What is the relationship between TCL and TC in providing home-based psychotherapy to youths?

$H1_0$: There is not a relationship between TCL and TC in providing home-based psychotherapy to youths.

$H1_a$: There is a relationship between TCL and TC in providing home-based psychotherapy to youths.

The results revealed that approximately 26% of the variance in TCL is explainable by TC. There was a statistically significant positive relationship between TCL and TC. This finding indicated that as the TC score increased, TCL also increased.

RQ2: What is the relationship between TCL and ATT in providing home-based psychotherapy to youths?

$H2_0$: There is not a relationship between TCL and ATT while providing home-based psychotherapy to youths.

$H2_a$: There is a relationship between TCL and ATT while providing home-based psychotherapy to youths.

The results revealed that approximately 26% of the variance in TCL is explainable by ATT. There was a statistically significant positive relationship between TCL and ATT. This finding indicated that as the ATT score increased, TCL also increased.

RQ3: What is the relationship between TCL and the TR in providing home-based psychotherapy?

$H3_0$: There is not a relationship between TCL and TR while providing home-based psychotherapy.

$H3_a$: There is a relationship between TCL and TR while providing home-based psychotherapy.

The results revealed that approximately 26% of the variance in TCL is explainable by TR. There was a statistically significant positive relationship between TCL and TR. This finding indicated that as the TR score increased, TCL also increased.

In the current study, I used a theoretical approach in examining the relationship between TCL, TC, ATT, and TR while providing psychotherapy to youths in a home-based setting. Previous researchers have focused on the factors associated with the therapists' comfort level as rated by patients and parents/caregivers and which generally focused on treatment outcomes. Other researchers evaluated therapists' alliance activity and the therapist comfort level rated specifically by patients and parents/caregivers. In the current study, the results derived from TCS and CCS-R indicated a significant relationship between TCL, TC, and ATT. The results derived from the TCS and START-C also indicated a significant relationship between TCL and TR.

The results of this study are supported by the findings of Glebova et al. (2012) and Slone and Owen (2015), which indicated that the therapists' comfort level when providing mental health services in a nontraditional setting is imperative. Glebova; Slone and Owen's finding suggested that economically disadvantaged families treated in a home-based setting may be at risk for erosions in the therapeutic relationship as a function of a lower therapist's comfort level and alliance activities (Glebova et al., 2012; Slone & Owen, 2015). The authors also agree with other studies suggesting that advanced therapeutic training and therapeutic competency are factors that contribute positively to therapists' comfort level (Hill et al., 2007; Williams et al., 1997).

Although the results are supported by past research, this research study is unique compared to the studies by Glebova et al. (2012) and Slone and Owen (2015) because I examined therapists' self-evaluation of their comfort level, while the previous researchers examined the therapists' comfort level rated by the patients and parents/caregivers. Regarding the importance of self-evaluation, researchers indicated that self-evaluation is a major component of effective reflective practice (Messina et al., 2017). Therefore,

therapists need not only be aware of their skills, knowledge, and performance as professionals but also be mindful of any personal factors that may interfere or impede their ability to provide an effective and objective service (Messina et al., 2017). Thus, an effective therapeutic relationship should be considered for a high level of therapists' comfort.

Limitations

There were limitations in this study such as self-evaluation data, home-based agency's selection bias, and survey research design. The self-evaluation data was considered a limitation to the study because in completing the instruments, participants may not truthfully answer the questions or do not answer all the questions. In this study, the participants were self-selected to complete the survey. However, some individuals were more likely than others to complete the entire survey (DQ, TCS, CCS-R, and STAR-C). In order to diminish this limitation, the survey was open until the desired participants were reached. Another limitation was the selection of the home-based agencies due to the agency decision of non-participation in the study due to any therapists' personal or professional issues. In this study, the selection of the home-based agency was not a limitation as the first contacted agency agreed to participate. In addition, the survey design research was another type of limitation regarding the differences between the participants who did not respond compared to those who did respond to the complete survey. The limitation was diminished by continuing to collect data until the proposed participants (76) completed the instruments (DQ, TCS, CCS-R, and STAR-C).

Future Research Recommendations

The findings of this study indicated that there were a statistically significant positive relationship between TCL, TC and ATT. However, future research should examine the relationship between TCL, ATT, and TC using a qualitative exploration of how advanced therapeutic training and therapeutic competency can affect perceptions of therapist's comfort level.

Continuing quantitative research should be done using larger samples in other therapeutic settings to better comprehend the relationship between TCL, TC, ATT, and TR. It should be emphasized that there is a lack of studies involving therapists' comfort level self-evaluation used in this study, as the number of studies reviewed rated the therapists' comfort level by the patients and parents/caregivers evaluations. Future research could be conducted to compare the environments where the therapists rate their comfort levels to describe factors other than competency and training that might impact their perceptions and also their comfort level and services.

Social Change Significance

Scholars recognized that it is imperative that the therapists appear comfortable while providing psychotherapy in home-based setting (Thompson et al., 2007). This study offers an enhanced understating of how the home-based mental health care agencies can use the information gathered, to improve the delivery of the in home-based psychotherapy. The information and recommendations would be beneficial for the agencies providing the services, the therapists, as well as the clients who are receiving the services. The current study provides the home-based mental health care agencies and therapists a greater understanding of the importance of an effective therapeutic relationship for a high level of therapists' comfort while providing psychotherapy in a

home-based setting. Positive social change may result through more effective home-based psychotherapy services.

Conclusion and Recommendations

Historically, home-based psychotherapy focuses on avoiding out-of-home placement of youths who would otherwise end up being placed in foster care, group homes, residential treatment centers, psychiatric hospitals and correctional institutions (Adams & Maynard, 2000; Cortes, 2004; Woodford, 1999). Today, home-based services continue advocating for the youths to remain in their environment while receiving psychotherapy. One of the advantages of using home-based psychotherapy is that patients are more engaged in treatment since they are in their home environment; however, therapists' comfort level is also an important consideration for delivering the treatment (Glebova et al., 2012). Preview research examined the therapists' comfort level displayed in a home-based setting rated mostly by the patients and parents/caregivers (Dunkle & Friedlander, 1996; Glebova et al., 2012; Levy et al., 2015; Slone & Owen, 2015). Therefore, this study focused on self-evaluation, primarily attentive to therapists' comfort level self-evaluation, by examining the relationship between TCL, TC, ATT, and TR.

The population data included in this study consisted of therapists of Bachelors, Masters, and Doctoral levels, including Social Workers, Psychologists, Counselors and related staff (Therapists' assistants) that deliver psychotherapy in a home-based setting. The participants were obtained from a Southern New Jersey Home-Based Agency. Three research questions were examined to find the relationship between TCL, TC, ATT, and TR. The study showed that TR was the best predictor of TCL, and that there were significant positive relationships between TCL, TC, TR, and ATT.

Previous research indicated that ATT and TC might be factors that could contribute to TCL while providing psychotherapy in a home-based setting (Hill et al., 2007; Williams et al., 1997). The linear regression analysis revealed that TC and ATT did not significantly predict TCL. Based on this result, a one-unit increase in TC and ATT did not correspond with any change in TCL. The correlation analysis findings showed statistically positive relationship between TCL, TC, ATT and TR participants who completed the DQ, TCS, CCS-R and STAR-C. Thus, this study recommended establishing a therapeutic relationship as a vital step in the process of therapists' comfort level while providing psychotherapy in a home-based setting. It is hoped that this study's findings serve to inform and guide the home-based psychotherapists to improve their therapeutic relationship. a) Once the therapeutic relationship is formed the therapists will obtain a high level of comfort to discussing concerns openly with the patients, and parents/caregivers. b) The therapists would be more effective while delivering the service. c) When therapists reach a high level of comfort could make a positive difference in the patients' treatment outcomes. Thus, the findings of this study initiated positive social change at the level of the individual home-based therapist, as well as to the vulnerable population that they serve.

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Appendix A: Demographic Questionnaire

The purpose of this questionnaire is for you to provide some basic contextual about yourself and our educational background. Please indicate your role below with a check mark.

Duration 1 minute.

What is your gender?	What is your Degree Program?	What is your Major?
□ Female □ Male	□ BA □ MA □ Doctoral	□ Psychology □ Social Work □ Counselor □ Related Staff (Mental Health Assistant) □ Other

Appendix B – CCS-R Instrument

Home-Based Therapist Survey					
Counselor Competencies Scale-Revised (CCS-R) © (Lambie, 2016)					
The purpose of the CCS-R is to assess counselors' and trainees' skills development and professional competencies. **Duration 4 Minutes**					
Part 1 - Primary Counseling Skills (PCS)					
Score	(5) Exceeds Expections Demonstrate Competencies	(4) Meets Expectations Demonstrate Competencies	(3) Near Expectations Developing Competencies	(2) Below Expectations	(1) Harmful
Nonverbal Skills (Includes Body Position, Eye Contact, Posture, Distance from Client, Voice Tone, Rate of Speech, Use of silence, etc.).	☐	☐	☐	☐	☐
Encouragers (Includes Minimal Encouragers & Door Openers such as "Tell me more about...", "Hmm"	☐	☐	☐	☐	☐
Questions (Use of Appropriate Open & Closed Questioning (*e.g., avoidance of double questions*) **.**	☐	☐	☐	☐	☐
Reflecting - *Paraphrasing* Basic Reflection of Content – Paraphrasing (*With couples and families, paraphrasing the different clients' multiple perspectives*)	☐	☐	☐	☐	☐
Reflecting *Reflection of Feelings* (*With couples and families, reflection of each clients' feelings*)	☐	☐	☐	☐	☐
Reflecting *Summarizing* (Summarizing content, feelings, behaviors, & future plans)	☐	☐	☐	☐	☐
Primary Counseling Skill(s) (Specific Counseling Skills and Therapeutic Conditions Descriptors).	☐	☐	☐	☐	☐

Advanced Reflection (*Meaning*) (Advanced Reflection of Meaning, including Values and Core Beliefs).	☐	☐	☐	☐	☐
Confrontation (Counselor challenges clients to recognize & evaluate inconsistencies).	☐	☐	☐	☐	☐
Goal Setting (Counselor collaborates with clients to establish realistic, appropriate, & attainable therapeutic goals).	☐	☐	☐	☐	☐
Focus of Counseling (Counselor focuses or refocuses) clients on their therapeutic goals).	☐	☐	☐	☐	☐
Facilitate Therapeutic Environment: *Empathy & Caring* (Counselor focuses (or refocuses) clients on their therapeutic goals	☐	☐	☐	☐	☐
Facilitate Therapeutic Environment: *Empathy & Caring* (Expresses accurate empathy & care. Counselor is "present" and open to clients.)	☐	☐	☐	☐	☐
Facilitate Therapeutic Environment: *Respect & Compassion* (Counselor expresses appropriate respect & compassion for clients	☐	☐	☐	☐	☐
Part 2 - Primary Counseling Dispositions & Behavior (PCDB)					
Score	(5) Exceeds Expections Demonstrate Competencies	(4) Meets Expectations Demonstrate Competencies	(3) Near Expectations Developing Competencies	(2) Below Expectations	(1) Harmful
Professional Ethics (Adheres to the ethical guidelines of the ACA, ASCA, IAMFC, APA, & NBCC; including	☐	☐	☐	☐	☐

practices within competencies).					
Professional Behavior (Behaves in a professional manner towards supervisors, peers, & clients (e.g., emotional regulation). Is respectful and appreciative to the culture of colleagues and is able to effectively collaborate with others).	☐	☐	☐	☐	☐
Professional & Personal Boundaries (Maintains appropriate boundaries with supervisors, peers, & clients).	☐	☐	☐	☐	☐
Knowledge & Adherence to Site and Course Policies (Demonstrates an understanding & appreciation for *all* counseling site and course policies & procedures).	☐	☐	☐	☐	☐
Record Keeping & Task Completion (Completes *all* weekly record keeping & tasks correctly & promptly (e.g., case notes, psychosocial reports, treatment plans, supervisory report).	☐	☐	☐	☐	☐
Multicultural Competence in Counseling Relationship (Demonstrates respect for culture (e.g., race, ethnicity, gender, spirituality, religion, sexual orientation, disability, social class, etc.) and awareness of and responsiveness to ways in which culture interacts with the counseling relationship).	☐	☐	☐	☐	☐
Emotional Stability & Self-control					

(Demonstrates self-awareness and emotional stability (i.e., congruence between mood & affect) & self-control (i.e., impulse control) in relationships with clients).	☐	☐	☐	☐	☐
Motivated to Learn & Grow / Initiative (Demonstrates engagement in learning & development of his or her counseling competencies).	☐	☐	☐	☐	☐
Openness to Feedback (Responds non-defensively & alters behavior in accordance with supervisory &/or instructor feedback).	☐	☐	☐	☐	☐
Flexibility & Adaptability (Demonstrates ability to adapt to changing circumstance, unexpected events, & new situations).	☐	☐	☐	☐	☐
Congruence & Genuineness (Demonstrates ability to be present and "be true to oneself").	☐	☐	☐	☐	☐

Appendix C: STAR-C - Instrument

Duration: 2 Minutes

Scale To *Assess* Therapeutic Relationships in Community Mental Health Care (STAR-C)

(Priebe, 2007)

STAR-C: Clinician Version"

1. I get along well with my patient.
2. My patient and 1share a good rapport.
3. I listen to my patient.
4. I feel that my patient reject s me as a clinician.
5. I believe my patient and I share a good relationship.
6. I feel inferior to my patient.
7. My patient and I share similar expectations regarding his/her progress in treatment.
8. I feel that I am supportive of my patient.
9. It is difficult for me to empathize with or relate to my patient's problems.
10. My patient and I are open with one another.
11. I am able to take my patient's perspective when working with him/her.
12. My patient and l share a trusting relationship.

- Rate each item on the following scale:

Never	Rarely	Sometimes	Often	Always
0	1	2	3	4

Scoring protocol
A total STAR-C score and three subscale scores can be obtained. Before scoring, scores for the Emotional Difficulties subscale are reversed. Subtract each of the item ratings in this subscale from 4 rating of O becomes 4 (4-0); a rating of I becomes 3 (4- 1); a rating of 2 remains 2 (4-2); a rating of 3 becomes l (4 -3); and a rating of 4 becomes 0 (4-4). After reversing items for this subscale, the total STAR-C score is obtained by adding the scores for each of the 12 items (range 0-48). The three subscale scores are each obtained by summing the relevant subscale items as follows:

Positive Collaboration: I, 2, 5, 7, 10, 12
Emotional Difficulties: 4, 6, 9
Positive Clinician Input: 3, 8, 11

A total STAR-P score and three subscale scores can be obtained. Before scoring, scores for the Non-Supportive Clinician Input subscale are reversed. Subtract each of the item ratings in this subscale from 4: therefore, a rating of O becomes 4 (4-0); a rating of I becomes 3 (4-1); a rating of 2 remains 2 (4-2); a rating of 3 becomes I (4-3); and a rating of 4 becomes 0 (4-4). After reversing, the total STAR-P score is obtained by adding the scores for each of the 12 items (range 0-48). The three subscale scores are obtained by summing the relevant subscale items as follows:

Positive Collaboration: 2, 3, *5,* 6, 8, 11
Positive Clinician Input: I, 10, 12
Non-Supportive

Appendix D: TCS Instrument

Duration: 2 minutes

Therapist Comfort Scale - Part I

(Slone, & Owen, 2015)

We are in interested in how you were in your psychotherapy sessions. It is important to know that there are no right or wrong answers here. Therapists are human and they have a range of emotions and reactions. We are trying to get a sense of how relaxed you were when providing services in the patients' environment.

Part I. Overall, how did you feel in the home-based psychotherapy sessions?

	Strongly Disagree (1)	**Mildly Disagree (2)**	**Neutral (3)**	**Mildly Agree (4)**	**Strongly Agree (5)**
1. Comfortable	1	2	3	4	5
2. Awkward	1	2	3	4	5
3. Tense	1	2	3	4	5
4. Nervous	1	2	3	4	5
5. Confident	1	2	3	4	5
6. Uneasy	1	2	3	4	5
7. Relaxed	1	2	3	4	5
8. Calm	1	2	3	4	5
9. Edgy	1	2	3	4	5
10. Genuine	1	2	3	4	5