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In-Home Counseling Clinical Supervision: A Multiple-Case Study Analysis

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In-Home Counseling Clinical Supervision: A Multiple-Case Study Analysis

Abstract

An understanding of the knowledge and skills necessary for clinical supervision of in-home counselors is scarce in counseling. To address this gap, the authors conducted a multiple-case study with three clinical supervisors from two in-home counseling agencies in the Mid-Atlantic Region. Data was collected through multiple sources: individual interviews, clinical supervisors contracts, and philosophies. Within-case and cross-case analysis resulted in four themes: clinical supervision practices, training and evaluation, ethical dilemmas, and boundary setting. Implications of these findings suggest clinical supervisors at in-home agencies are not receiving formal training and rely heavily on previous experience to guide their clinical supervision practice, conflicting with best practices. The challenges faced by in-home clinical supervisors, and recommendations for clinical supervisors and counselor educators are discussed.

Keywords

clinical supervision, in-home counseling, counselor education, multiple-case study

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Clinical supervision is the cornerstone of a counselor's training, providing foundational knowledge and skills needed for competent practice within the profession (Johnson et al., 2014; Milne & Watkins, 2014). With distinct methods, strategies, encompassing theories, models, techniques, and ethical and legal obligations, clinical supervision has also come to be known as a distinct specialty within the profession of counseling as evidenced by the *American Counseling Association (ACA) Code of Ethics* (ACA, 2014), *Best Practices in Clinical Supervision* (Borders et al., 2011), and the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2015). Best practice of clinical supervision includes cultural, ethical, and legal considerations (Borders et al., 2011). These practices (Borders et al., 2011) aid supervisors in understanding their scope of practice and effectively train competent and culturally sound counselors. Also, state licensing boards require documented hours of clinical supervision prior to obtaining an independent counseling license, further demonstrating the significance of clinical supervision (Falender et al., 2013; Rodriguez-Keyes et al., 2012). Because clinical supervision aids in the development and scope of practice for all counselors, including in-home counselors it is vital to explore clinical supervision as it pertains to in-home counseling.

In-Home Counseling

Beginning in the 1970s, the provision of counseling services in clients' homes served to reduce accessibility barriers. Access issues include a lack of reliable transportation, affordable child and/or dependent care, employment, and/or school obligations (Lauka et al., 2013; Tate et al., 2014). In the field of counselor education, in-home counseling is not well defined and has various definitions. With theoretical roots in systems theory, behavioral and structural family therapy, in-home counseling is best defined as counseling and case management services focused on multiple needs conducted in the client's home by a masters-level licensed clinician and has

theoretical roots in systems theory, and behavioral and structural family therapy (Boyd-Franklin and Bry, 2012; Lawson and Foster, 2005).

Historically, in-home counseling focused on at risk children and adolescents with limited access to mental health services (Mattek et al., 2010; Macchi et al., 2008). In the 21st century, in-home counseling has expanded, with in-home counselors serving a more diverse composition of clients across the lifespan, such as young children (Tate et al., 2014), adults (Burns et al., 2001), and older adults (Maxfield & Segal, 2008; Bettis et al., 2020). Despite the expansion of in-home counseling services, there remains a dearth of research within the literature to support best practices supporting counselors working in home-based settings, and for the clinical supervisors who support them (Cortes, 2004; Hammond & Czyszczon, 2014; Lauka et al., 2013). Moreover, research on clinical supervision and counselor preparation for in-home counselors is lacking (Bowen & Caron, 2016; Hammond & Czyszczon, 2014).

In-Home Clinical Supervision

The lack of standards for clinical supervision of in-home counselors (Hammond & Czyszczon, 2014) spawns the need for further understanding about current clinical supervision practices and identifying the needs of clinical supervisors. Based on research that has been conducted there are several identifiable distinctions between clinical supervision of in-home counselors and office-based counselors (Bowen & Caron, 2016; Cortes, 2004; Christensen, 1995; Hammond & Czyszczon, 2014; Lawson 2005; Walter, 2006). The first major distinction is that in-home counselors need a greater focus on clinical responsibilities than administrative responsibilities (Bowen & Caron, 2016). As in-home counselors provide clinical services to culturally diverse individuals in various, diverse communities, the second distinction clinical supervision is needed to support the supervisee in identifying culturally sensitive treatment

approaches. In-home counselors practice within the context of a client's home, with direct access to the client's family and community. The third distinction is that in-home counseling is a high-intensity job as in-home counselors typically work alone with limited access to other mental health professionals, and support is continually needed to mediate feelings of isolation (Hammond & Czyszczon, 2014). Lastly, research illustrates that the majority of counselors who conduct counseling within the home have less than five years of experience, and may need additional clinical support (Culbreth et al., 2004; Hammond & Czyszczon, 2014; Lawson 2005).

Although there are noted distinctions between in-home and office-based counseling, utilizing a developmental clinical supervision approach with structure has been recommended within the research to best support in-home counselors (Culbreth et al., 2004; Hammond & Czyszczon, 2014). There are several benefits in providing clinical supervision to in-home counselors. For example, Macchi et al. (2014) found that in-home counselors' quality of life could be mediated with the frequency of clinical supervision, and that in-home counselors who had less clinical experience needed more frequent clinical supervision. Also, clinical supervision has been attributed to successful client outcomes and preservation of client welfare within the counseling relationship (Falender et al., 2013; Johnson et al., 2014). As stated earlier, there are distinctions that exist for clinical supervision with in-home counselors. Due to these distinctions, it is important to understand the needs of in-home counselors and challenges of the clinical supervisors who provide clinical supervision to these counselors. The supervision process is beneficial to the development of in-home counselors and clinical supervision models are helpful guides for supervisors to utilize ensuring client welfare and supervisee growth and development (Bernard & Goodyear, 2019). Next, Zarski and Zygmond's clinical supervision model will be discussed.

Clinical Supervision Models for In-home Counselors

Zarski and Zygmond's (1989) clinical supervision model, originally developed for clinical supervisors working with novice-level in-home counselors (Stoltenberg, 1981), has gained little attention in counselor education programs. Grounded in isomorphism, this model takes a developmental approach to negotiating transitions within three stages: (a) stressor (s) that impact the family system, (b) accommodation of family and supervisee to each other, and (c) supervisee and clinical supervisor's interaction. A transition is defined as a stressor that impacts the family system and requires a response from an outside system (Zarski & Zygmond, 1989).

Under Zarski and Zygmond's (1989) model the clinical supervisor is tasked with creating an environment during clinical supervision in which the supervisee works through transition issues such as trust, compliance, or autonomy and gains the skills needed to translate those skills in working with the family. For example, an in-home counselor may need help learning to clarify their role in the counseling relationship to a family who is mandated to attend counseling due to the risk of losing their child. The clinical supervisor would work through negotiating this transition with the supervisee through their interactions in clinical supervision to help model the skills needed in the counseling relationship with the family.

Clinical supervision is beneficial in assisting in-home counselors to clarify boundaries and responsibilities, especially at the beginning of the treatment process (Cortes, 2004; Knapp & Slattery, 2004). Several clinical supervision techniques have been identified as appropriate for the clinical supervision of in-home counselors such as live supervision, reflecting process, and case consultation (Gorman et al., 1995; Lawson, 2005; Zarski & Zygmond, 1989; Zarski et al., 1991). Despite the benefits of clinical supervision for in-home counselors, it is unclear, given the

limited research on the topic, if traditional supervision models are appropriate for supervision of in-home counselors.

Zarski and Zygmond's model (1989), although a credible one, is likely not utilized in clinical supervision, as counselor education programs rarely focus on skills, knowledge, and dispositions related to in-home counseling (Hammond & Czyszczon, 2014; Tate et al., 2014). The model is also outdated, and further research is needed to ensure it reflects current clinical needs within the profession. Zarski and Zygmond's (1989) model demonstrates an example of integrating a traditional Developmental clinical supervision approach by matching the needs of the supervisee in the supervisory relationship and negotiating stages/transitions to obtain the skills needed for family counseling. In contrast, key distinctions exist between the two models (Stoltenberg, 1981). One, the structure and format of the Zarski and Zygmond's model encompasses many individuals such as the supervisee, supervisor, and other team members. The supervisor and team members not only observe live supervision within the office but also travel to the home to observe the family. This is a huge difference in office-based clinical supervision, most times a clinical supervisor and a team will not travel to the home of a family to conduct live supervision. In addition, the focus of the Zarski and Zygmond's model is a systematic perspective to assist multifaceted problems within in-home families. Lastly, in-home counseling clinical supervisors have not historically been required to complete training in clinical supervision specific to the in-home setting (Hammond & Czyszczon, 2014; Lauka et al., 2013).

A dearth of literature exists that explores the methods and strategies clinical supervisors use at in-home agencies within clinical supervision (Hammond & Czyszczon, 2014). In fact, a call to action has been issued to the counseling profession by Hammond and Czyszczon (2014) to develop guidelines for clinical supervision of in-home counselors. The authors ask for

guidelines with articulate and clear standards, particularly because in-home counselors provide mental health services to vulnerable client populations (Boyd-Franklin & Bry, 2012). To date, there has been no research study conducted that explored the clinical supervision practices of supervising in-home counselors. Presently, counseling mental health agencies develop their own standards for clinical supervision, leaving room for error and variability (Hammond & Czyszczon, 2014).

Purpose of Study

As demonstrated through the review of the literature limited research outlines the unique techniques and models used by clinical supervisors at in-home counseling agencies. Given the significance of clinical supervision in ensuring client welfare and counselor development (Johnson et al., 2014), an understanding of the phenomenon of clinical supervision within in-home agencies is critical. The closest study to explore this phenomenon has been Culbreth et al. (2004), looking at in-home counselors' preference for clinical supervision but the study did not explore clinical supervisors' perspectives of providing clinical supervision. Thus, the purpose of this multiple-case study was to understand the clinical supervision practices of clinical supervisors at in-home counseling agencies. The researchers sought to answer the following question: What methods and strategies do clinical supervisors implement in supervising in-home counselors?

Method

The current study utilized a qualitative descriptive multiple-case study design to focus on the context and experiences of the participants (Baxter & Jack, 2008; Yin, 2014). Observing multiple cases allowed for exploration of a single phenomenon (clinical supervision) at two in-home agencies. This design also allowed for comprehensive observation of the bounded systems

(in-home counseling agencies) through in-depth data collection with multiple sources of data, providing a rich case description within the context of the case (Creswell, 2012; Merriam & Tisdell, 2016; Yin 2014). The literature on clinical supervision for in-home settings is limited, and, thus, the present research addresses a gap and provides an understanding of the practices of clinical supervisors at in-home counseling agencies.

Constructivist Framework

The study was conceptualized within a social constructivist paradigm whereas multiple realities exist that situate a phenomenon of interest (Hays & Singh, 2012). Two prepositions were assumed based on experiential knowledge: (a) clinical supervisors would provide accurate descriptions of their position at their in-home counseling agency and (b) there would be variations among each clinical supervisor's practice, likely due to the lack of literature to guide in-home agencies. Construction of the themes were developed based on co-construction between researchers and participants.

Participants

Purposeful sampling was used to capture the unique characteristics of clinical supervisors in-home counseling agencies (Hennink et al., 2011; Merriam & Tisdell, 2016). The researchers chose two in-home counseling agencies (Agency A and B) due to available access to participants from key informants at the counseling agencies. Three clinical supervisors were identified from the two in-home counseling agencies, one from Agency A and two from Agency B. Table 1 provides the characteristics of the in-home counseling agencies.

Table 1

Characteristics of in-home counseling agencies

<table>
<tr>
<td>Agency A
● Established 2016
● Services include:
(a) crisis intervention, (b) 24-hour emergency response, (c) care coordination, (d) building of communication skills, (e) family counseling, (f) outpatient therapy
● Staff: social workers and professional counselors
● Client demographics are:
(a) ages 6–64, (b), 70% African American and 30% Caucasian, (c) services paid through Medicaid or private insurance
● Supervisor Criteria:
a. independently licensed
b. at least one year of supervisory experience to be a clinical supervisor</td>
<td>Agency B
● Established in 2005
● Services include:
● intensive in-home services, (b) skill building, (c) homeless prevention, (d) outpatient mental health, (e) crisis intervention
● Staff: social workers and professional counselors
● Client demographics are: (a) ages 5–20, (b) 100% African American, (c) services paid through Medicaid
● Supervisor Criteria:
a. independently licensed or license-eligible
b. at least one year of supervisory experience
c. previous experience, on the job as in-home counselor</td>
</tr>
</table>

The unit of analysis was clinical supervisors who (a) identified as a clinical supervisor as outlined in their in-home counseling agency job description and (b) currently provide and have provided clinical supervision to in-home counselors within the last five years. Demographic information was obtained from participants to gain data regarding the culture and environment, supervisee demographics, background, education, gender, and race/ethnicity. The contextual information gave the researchers knowledge about participant's perceptions within their environment. Participant demographics are presented in Table 2 with their pseudonyms.

Table 2

Demographics of clinical supervisors

Pseudonyms	Race/Ethnicity	Gender	Clinical Experience	License	Geographical Region	Site
Heather	WHITE	FEMALE	2	LPC	Mid-Atlantic	Intensive In-home
Jill	BLACK	FEMALE	3	LMFT	Mid-Atlantic	Intensive In-home
Sheila	BLACK	FEMALE	3	LPC	Mid-Atlantic	Intensive In-home

Researchers

The primary researcher is an African American female who is an independently licensed counselor in Maryland. At the time of the study, the primary researcher had previously served as an in-home counselor for three years. The second author is an African American female who is provisionally licensed in North Carolina and is familiar with in-home counseling. She has provided home-based mental health services, but not as an in-home counselor. The third author was also a researcher on the project and identifies as a White female who is an independently licensed counselor in Virginia with five years of experience at an in-home counseling agency. An awareness of the researchers' personal experience as in-home counselors was considered throughout the study.

Procedure

Following Institutional Review Board (IRB) approval, a letter that contained the study objectives and purpose was sent to key informants at in-home counseling agencies. An informed consent form and interview request was emailed to prospective participants. Following completion of informed consent and a demographic questionnaire, individual interviews were scheduled. Interviews and supplemental documents were conducted until data saturation was met

(Bernard, 2012; Fusch & Ness, 2015). Saturation was met once data began to repeat itself within the data sources.

In alignment with case study best practices, the researchers used multiple data sources to collect data (Yin, 2014). Individual semi-structured interviews served as the primary source of data collection, ranging from 30-to-60 minutes, to gain a full understanding of the clinical supervisors' methods and practices. The interview protocol consisted of a combination of questions guided by *Best Practices in Clinical Supervision* (Borders et al., 2011). Interviews occurred telephonically, were audio recorded, and were transcribed by a third-party service.

Secondary sources included documents that support the clinical supervision practices of supervisors at the in-home counseling agencies. This included the clinical supervisors contract and the clinical supervision philosophy of each clinical supervisor. The clinical supervision philosophy is a document/statement outlining a clinical supervisor's personal belief about the process of supervision based on experience and training. The clinical supervision contract is a document signed by the supervisor and supervisee that offers clear boundaries about the supervision process.

Data Analysis

The procedures for data analysis were guided by Merriam and Tisdell's (2016) suggestions for conducting qualitative research. Data analysis of the multiple cases was conducted in two stages: within and cross-case analysis. Each clinical supervisor's individual interview was analyzed to gain an in-depth understanding of each case individually, then the clinical supervision philosophy, and, finally, the clinical supervision contract was analyzed. Each transcript for each clinical supervisor was read to identify significant statements, sentences and quotes that supported answering the research question. Clusters of meanings from the significant

statements, sentences and quotes were identified from the interview. Next, the researchers used a document summary form to key words/concepts, significance of the document, and relationship to research questions (Bloomberg & Volpe, 2016). Then, participants received their transcript and summary to ensure accurate understanding of the participant's description and engage in member checking. None of the participants provided further details regarding their transcript and summary. The within-case analysis stage yielded significant statements and phrases from each clinical supervisor that guided the final cross-case analysis themes (Merriam & Tisdell, 2016; Yin, 2014).

A cross-case analysis was then conducted based on the analysis of the individual interviews and supplemental documents. The primary researcher analyzed each case (clinical supervisor) across each other to identify the final five emergent themes that related to clinical supervision practices. A second level of member checking occurred when participants received summaries of their in-home agency after the cross-case analysis occurred. The researchers ensured fairness in the interpretation of findings by confirming that methods to increase trustworthiness, such as triangulation of data, member checking, and stating position or reflexivity, were used.

Trustworthiness

Several steps were utilized to ensure the credibility and trustworthiness of the study (Merriam & Tisdell, 2016; Yin, 2014). The researchers used triangulation of data, stating the researchers' positionality, and member checking (Creswell, 2013). Triangulation of multiple data sources increases the rigor and trustworthiness of a research study (Merriam & Tisdell, 2016; Yin, 2014). Second, the researcher's positionality was stated through a declaration of prior

experience with the phenomenon in question (Merriam & Tisdell, 2016). Third, member checks were conducted at two different points during the study (Merriam & Tisdell, 2016).

Findings

Data analysis of the multiple cases was conducted in two stages: within and cross-case analysis (Merriam & Tisdell, 2016). The within-case analysis yielded significant statements and phrases from each clinical supervisor that guided the final cross-case analysis themes (Merriam & Tisdell, 2016; Yin, 2014). The descriptions are guided by the following interview questions: (a) What guides your practice of clinical supervision? (b) What models of clinical supervision do you use? and (c) How do you evaluate your supervisees at your site?

Within-Case Analysis

Heather

Heather, interviewed at Agency A, is a White female who holds a master's degree in counseling and has two years of experience as a clinical supervisor at an in-home agency. Supervisees are usually under the age of 40, African American, White, and Latinx. In addition, most supervisees work at the site on a full-time basis.

Heather described her clinical supervision practice as guided by listening to the needs of the supervisee. She does this by providing feedback that is open and honest, following up with supervisees to check if the feedback was helpful, using a "client-centered approach", providing training when necessary, identifying deficits in the supervisee's skills, and providing material relevant to the case. This guidance is further supported by her statement, "Um, so providing feedback, being open and honest. Um, you know, I-- my approach, I don't sugarcoat things, but I'm also very-- I listen to my clinicians and receive feedback on what they need."

Heather’s description of the clinical supervision model she uses is rooted in a strengths approach,

> Um, I try to go more on the strength stage. I try to always focus on, you know, starting off with their strengths. You know, I noticed that you did this really well, you know, last week, or, you know, You-- way to go on your productivity. Like you got 90% this week on meeting your hours and your clients. That's super hard.

In addition, she reported, “The supervision sessions that I hold are not super-structured because they are designed to aid the supervisee in the areas that they desire to work on”.

Evaluation of supervisees at Heather’s agency includes assessing for the skills in-home counselors have been taught through training materials, and field supervision visits as clinical supervision methods to evaluate and assess competence. To further support the evaluation and training of in-home counselors, Heather is responsible for conducting three in-home field supervision visits within the first 90 days. Field supervision visits include observations in the home and the provision of summative feedback. Heather is also responsible for conducting quality assurance (QA) calls on a bi-weekly basis to clients/families in mental health services to discuss supervisees’ performance. Formative feedback is elicited during these QA calls. Heather reports that the QA calls assist with supervisee professional development,

> Um, and that's a really good opportunity to get positive feedback to give back to the clinicians because a lot of the times they don't get to hear that positive feedback, uh, from the families and the clients. And it really helps to build that self-esteem and confidence -- especially the newer clinicians.

Heather’s supplemental documents provided insight related to her methods and strategies in clinical supervision. Her clinical supervision philosophy, supported by her interview, focused

on a strength-based approach to meet the individual needs of her supervisee's. Heather's philosophy described the significance she places on supporting and providing guidance for her supervisee's. In addition to her philosophy Heather follows her state's clinical supervision contract that outlines criteria such as supervisor and supervisee responsibilities, laws/regulations related to supervision, identification of proposed counseling and treatment interventions, and emergency contact information for the supervisor.

Jill

Jill, interviewed at Agency B, is an African American female, who holds a master's degree in professional counseling. Jill has three years of experience as an in-home agency clinical supervisor. She has been in the field for 12 years, doing intensive in-home counseling, providing skill building, running group homes, and serving as a family support specialist. Supervisees are usually under the age of 40 and racially/ethnically identify as Black or Latinx, and female. Supervisees are bilingual; typically speaking English and Spanish. In addition, most supervisees work at the site on a part-time basis.

Jill described two key words that guide her clinical supervision practice- "support and transparency". This statement further supports her practice, "like, if you are honest with me, I can provide a certain level of protection. Not just me, but the agency can provide a certain level of protection for you". In this particular situation, Jill was describing that there are "bottom lines" for the business, so she balances the needs of the agency with those of the supervisee- this can occur through the supervisee being transparent so that she can best support them. Jill was not able to identify the clinical supervision model she uses. She reported,

> But as far as, like, a template, a guideline, a modality, or a theoretical approach for supervision, no. It's kind of just-- you can do what you do. Like, however you want to approach it. Like, there's no-- there's no real guidelines for that.

Evaluation of supervisees at Jill’s agency occurs with the use of a team approach to present different viewpoints in regard to the supervisee’s development. Evaluations are conducted at Agency B once a year, using a summative evaluation form. The summative process also includes feedback from the clinical team and the field supervisor. Several areas are considered in the evaluation, including HR reports, file audits, and input from a team of managers who meet twice a year to assess development.

Jill’s supplemental documents provided insight related to her methods and strategies in clinical supervision. Her clinical supervision philosophy focused on being supportive of Jill’s supervisee’s as well as being honest regarding feedback and administrative tasks that have to be completed. In addition, Jill follows her state's clinical supervision contract that outlines criteria such as formalizing the relationship between supervisor and supervisee, supervisor and supervisee responsibilities, laws/regulations related to supervision, and emergency contact information for the supervisor.

Sheila

Sheila, an African American female, has a master’s degree in marriage and family therapy. She has three years of experience as an in-home clinical supervisor. She described her clinical supervision practice guided by “the same way I guide my therapy. It’s case by case. It depends on what that supervisee needs”. Sheila does this by identifying supervisee needs in supervision, being flexible, and she reported “I typically ask for an update on the client and then we discuss areas that they may need assistance with regarding the client.”

Sheila was not able to identify the clinical supervision model she uses. She reported, “Not for supervision. I just kind of go in. Find out what they need and we kind of take it from there”. She further discussed her focus during supervision was to keep it flexible as to cater to the needs of the supervisee so they can choose what they need out of the process.

As discussed in Jill’s description, evaluation of supervisees at Sheila’s agency occurs with the use of a team approach to present different viewpoints in regard to the supervisee’s development. She specifically uses an evaluation form to document supervisees’ process and areas that need improvement.

Sheila supplemental documents provided insight related to her methods and strategies in clinical supervision. Her clinical supervision philosophy focused on enhancing the knowledge of a supervisee by addressing their individual needs in supervision. In addition to Sheila’s philosophy she, like Jill, follows her state's clinical supervision contract that outlines criteria such as formalizing the relationship between supervisor and supervisee, supervisor and supervisee responsibilities, laws/regulations related to supervision, and emergency contact information for the supervisor.

Cross-Case Analysis

The cross-case analysis yielded four themes: (a) clinical supervision practices, (b) training and evaluation, (c) ethical dilemmas, and (d) boundary setting. The first two themes illustrate clinical supervision practices. The last two themes discuss recurring topics in clinical supervision at in-home counseling.

Clinical Supervision Practices

Clinical supervisors described their clinical supervision practices in similar ways, particularly focusing on the individual and developmental needs of the supervisee. Sheila

discussed her supervision practices guided by the way she does counseling. She focuses on tailoring the sessions to the individual needs of the supervisee to determine their needs from clinical supervision. Jill described her supervision practices as:

> Nope [laughter]. But we literally are the...you know, guiders as far as what supervision should look like. I know that I have schemes I-I've chosen that I tend to reflect back on before supervision. So, I'll have a list of, like, topics that I'm-- I mean, ...change a view, boundaries, legal issues, like, mandated reporting-- --uh, maybe treatment planning, um, and self-care is a big thing. I'll talk about it in the field too as far as what I-- what I approach in supervision. But as far as, like, a template, a guideline, a modality, or a theoretical approach for supervision, no [laughter]. It's kind of just-- you can do what you do. Like, however you want to approach it. Like, there's no-- there's no real guidelines for that.

Similarly, Heather described her supervision practices as:

> Um, I try to go more on the strength stage. I try to always focus on, you know, starting off with their strengths. You know, "I noticed that you did this really well, you know, last week," or, you know, "You-- way to go on your productivity. Like you got 90% this week on meeting your hours and your clients. That's super hard." And so, I really try to focus on a more strength-based approach. And that client-centered approach you had talked about earlier-Right.

Across the cases, the clinical supervision contracts provided similarities. The contracts discussed supervisor and supervisee responsibilities in terms assuming responsibility of supervisee clinical practices, "Be responsible for the clinical professional practices of the supervisee;" or "The supervisor will assume full responsibility for the clinical activities of that

resident specified within the supervisory contract for the duration of the residency or until terminated.". Another similarity related to the supervisor providing evaluation of the supervisee, "The supervisor will complete evaluation forms to be given to the resident at the end of each three-month period." or "Provide a written evaluation of the supervisee's progress to the supervisee every 3 months.". Supervisee's also had responsibilities outlined across clinical supervision contracts related to verifying the status of a clinical supervision, "Verify that the supervisor has been approved by the Board" or "the resident will verify that the supervisor has been approved as a supervisor by the XXX Board of Counseling.".

Training and Evaluation

Heather reported that professional experience as an in-home counselor was the only prerequisite to supervise at her agency. She also reported a desire for training that could support her work as an in-home clinical supervisor. Sheila further reported her experience for training to supervise in-home counselors:

> Oh, my goodness, really no, no. I didn't get any. Really, I mean honestly um, that's the truth. I wish I could say that somebody like took me to some conference or something like that. They didn't. The only training that I had to be able to supervise in-home counselors was the fact that I was an in-home counselor. Um, that was my training. That was my on-the-job training.

Clinical supervisors at the in-home counseling agencies aimed to utilize a strength-based approach through being open and honest. They reported using this approach helped them to meet the needs of each supervisee. Evaluation of supervisees varied between agencies, from a yearly basis with additional input from the clinical team to the clinical supervisor as the sole individual. Heather explained, "And I always try to ask if the feedback that I'm giving them is helpful. Um,

so kind of that client-centered approach that I do with my clinicians,…”. Sheila described her evaluation style as, “Supervisees are evaluated utilizing an evaluation form on their progress and areas that need improvement”.

Ethical Dilemmas

Due to the nature of in-home counseling, maintaining confidentiality can be challenging. Jill reported:

> I’ve done some in-home counseling myself over the years and in-home sessions, and when you’re a guest in someone’s home, it’s very different than being a guest in your office. And what goes into making decisions is sometimes conflicting. For instance, how do you assure privacy and conduct a session with integrity?

Heather also described the difficulty of providing services when there is a lot of traffic in the house and little or no privacy. For example, in-home counselors reported to supervisors that they had significant difficulty when conducting counseling during unscheduled visits from friends or family or when siblings were in the home. “...counselors often found themselves in challenging situations when meeting with clients and a neighbor or friend stopped by and the client did not address it”. Thus, clinical supervisors discussed with their supervisees different methods to maintain privacy and the integrity of a counseling session during in-home sessions.

Boundary Setting

All participants described boundaries as an area frequently discussed in clinical supervision. Boundaries were further divided by the researchers into two categories: professional boundaries and metacognitions. Participants reported that the potential for boundary crossing was increased due to the location of the counseling sessions. Sheila reported:

> One hundred percent, all the time, [an] in-home [concern] is boundaries. The ethical problem in in-home is going to be boundaries, boundaries, boundaries, and the reason why is because you are in somebody's house. And because you are in somebody's house, and they're not coming to the office to see you, and all this kind of thing, so many lines can get crossed with that.

Heather also described challenges with boundaries: "But I think with in-home, it's definitely-- i-it can be very intense because you are in people's homes, and boundaries are constantly needing to be set".

supervision as a distinct professional competency, but also to protect the wellbeing of in-home counseling **Discussion**

The purpose of this study was to provide an understanding of the methods and strategies clinical supervisors implement in supervising in-home counselors. To date, there are no other studies that have explored this topic. This study provides an understanding of current clinical supervision practices and experiences of clinical supervisors at in-home counseling agencies.

As stated earlier, Hammond and Czyszczon (2014) made a call to act by the counseling profession, specifically to develop guidelines for clinical supervisors at in-home counseling agencies. Traditionally, counselors are promoted to be a supervisor without training or attention to the development that is needed (Rodriguez-Keyes et al., 2012). Clinical supervisors in this study reported that they never received formal training at the graduate or agency level in regard to conducting in-home counseling clinical supervision. Some of the clinical supervisors stated that they would have benefited from training in clinical supervision.

All of the participants noted that in their job description previous experience as an in-home counselor was sufficient enough to become a supervisor. This finding conflicts with

supervision best practices which recommend that the skills of a counselor and supervisor are different (Borders et al., 2011). Supervision literature consistently emphasizes formal training in clinical supervision, that supervisors monitor their level of competence through training and experience, and that supervisors continuously evaluate their competence based on role changes, differing responsibilities, and gaps in knowledge (Falender et al., 2013; Borders et al., 2011). Further, we support concerns outlined in the literature (Hammond & Czyszczon, 2014; Lauka et al., 2013) which claim clinical supervisors supervising in-home counselors often lack the competence to conduct clinical supervision and depend heavily on their previous experience as an in-home counselor to guide their clinical supervision practices. To address these concerns, state licensing boards are urged to require documented hours of clinical supervision training specific to the supervision setting. This approach should help educate those working towards a supervisory position regarding clinical supervisors' roles and responsibilities (Rodriguez-Keyes et al., 2012).

We recommend clinical supervision models and techniques specific to the home setting be developed, as suggested by prior researchers and best practices (Bowen & Caron, 2016; Gorman et al.,1995; Hammond & Czyszczon, 2014; Lawson, 2005; Lawson & Foster, 2005; Zarski & Zygmond, 1989). As outlined by ACES *Best Practices in Clinical Supervision* (2011), training focused on clinical supervision should include research and models of supervision. Models of clinical supervision provide a framework and structure for the clinical supervision process (Kelly, 2009). Clinical supervisors in this study were not able to report specific models and techniques they utilized, and often approached supervision with the same theoretical framework they used when counseling clients. Based on the descriptions of participants' clinical supervision practices, the supervisors aligned with the Integrated Developmental and

Humanistic-Relationship clinical supervision models (Bernard & Goodyear, 2014). This finding conflicts with clinical supervision best practices, which posit that theoretical frameworks used in counseling can be translated to clinical supervision (Borders et al., 2011). We believe that due to a lack of formal training focused on the in-home setting, clinical supervisors supervising in-home counselors are potentially acting outside of their level of competence and negatively impacting the clinical supervision triad- clinical supervisor, supervisee, and client.

The ethical issues identified by supervisors in our study highlight the complex ethical issues faced by in-home counseling supervisors (Christensen, 1995; Cortes, 2004; Glebova et al., 2012; Lauka et al., 2013). Maintaining confidentiality, noted throughout the in-home literature, is difficult when working in a client's home (Christensen, 1995; Cortes, 2004; Glebova et al., 2012; Lauka et al., 2013). Clinical supervisors in this study reported setting and maintaining strong boundaries as a recurring topic, in that supervisees struggle with maintaining the privacy and integrity of the counseling session. Unscheduled visits from family or friends or the presence of siblings/family members are common. These distractions, consistent with in-home literature, not only interfere with the therapeutic process but also create challenges not typically encountered in an office setting (Christensen, 1995). Thus, an in-home counselor's skill in observing and navigating these distractions as well as setting and maintaining appropriate boundaries is vital (Cortes 2004; Snyder & McCollum, 1999; Worth & Blow, 2010).

In addition to confidentiality, clinical supervisors need to be equipped to address boundary issues in supervision. Supporting previous literature, clinical supervisors in this study reported maintenance of boundaries as a frequently discussed topic in clinical supervision (Cortes 2004; Snyder & McCollum, 1999; Worth & Blow, 2010). The supervisors felt this was a recurring topic due to a change in the location of where services were provided. In an

investigation of ethical dilemmas encountered in home-based counseling, Lauka et al. (2013) found that outpatient and in-home counselors shared the same attitudes regarding ethical dilemmas encountered. The authors cautioned in-home counselors, highlighting that counselors providing more case management than counseling services may be acting unethically.

Implications for Clinical Supervisors

In the present study, clinical supervisors reported receiving no formal training in regard to conducting clinical supervision for in-home counselors. To address the training issue, clinical supervisors and in-home counseling agencies should identify supervision training opportunities which provide both a foundational understanding of clinical supervision and focus on the specific professional and ethical challenges faced by in-home counselors. This would include, but is not limited to: (1) supervisor roles and responsibilities, (2) models of supervision and counselor development, (3) formats of supervision, (4) relationship dynamics in supervision, (5) supervision methods and techniques, (6) multicultural considerations, (7) supervisee assessment, feedback and evaluation, and (8) ethical, legal, and professional regulatory issues, particularly related to the in-home setting (Borders et al., 2011; Hammond & Czyszczon, 2014).

Clinical supervisors also reported common ethical challenges within clinical supervision: confidentiality and maintaining professional boundaries. To address the issue of confidentiality, supervisors should provide opportunities in clinical supervision for supervised experiential activities to increase competence surrounding ethical decision making (Duys & Hedstrom, 2000). Forester-Miller and Davis (2016) and Frame and Williams (2005) models are frequently cited ethical decision-making models, however, critical attention to the environment would also need to be considered. For example, in step one of the Forester-Miller and Davis (2016) model, counselors gather as much information to identify the problem accurately. Supervisees can be

taught to observe the home and community environmental factors such as the culture of the community and home, and integrate relevant environmental and cultural factors related to the client into the ethical decision making process. Frame and Williams (2005) model of ethical decision-making includes considerations related to the environment. The first three steps of this model ask counselors to consider others involved, cultural and historical factors at play, explore the context of power, and assess acculturation and racial identity development for the counselor in the ethical decision-making process. Both models serve as a starting point for clinical supervisors to consider the environment, a critical issue for in-home counselors, in ethical decision-making.

Strategies for in-home counselors to maintain professional boundaries, inclusive of boundary crossings and violations, must be considered during in-home counseling clinical supervision. Research continues to demonstrate that boundary crossings, such as accepting gifts or food, are more likely to occur in the home setting (Knapp & Slattery, 2004). Developing a conceptual template to prepare the in-home counselor for these types of situations before, not after, they are encountered is critical (Welfare & Borders, 2010). Use of an ethical decision-making model, reflection of self, and discussion of boundary crossings and violations within clinical supervision can enhance the supervisee competency.

Implications for Counselor Education

Counselor educators are at the forefront of our counseling profession to train counselors. It is suggested that graduate counseling training programs address clinical supervision models and techniques appropriate for the in-home setting. The literature suggests clinical supervision is vital to the success of in-home counselors and in turn client outcomes (Bowen & Caron, 2016; Hammond & Czyszczon, 2014; Lawson, 2005). Graduate counseling training programs could

include courses or ensure topics of clinical supervision are covered within their program. Another recommendation for graduate counseling programs is to include a focus on in-home knowledge and skills throughout counseling courses. For example, professional boundaries were an area of clinical supervision frequently addressed for in-home counselors. Courses could teach and emphasize focus on maintenance of professional boundaries in various settings (ACA, 2014). Examples of boundary setting areas that could be addressed in counseling courses are: (a) extending boundaries; (b) accepting gifts/food from clients; (c) considerations of changing the setting of the counseling session; and (d) joining or collaborating with other professional or non-familial members of the family. The findings of this study and previous research portray a gap in preparation of training of counselors and clinical supervisors working in the in-home setting.

Limitations and Future Research

The current qualitative study took into account the limitations associated with the researcher as the instrument. Strategies such as triangulation, member checking, and stating the researcher's positionality were used to uncover and manage potential researcher bias. In order to accommodate the demanding schedule of agency supervisors, interviews were conducted by telephone. This may have prevented observation of nonverbal communication from participants. We addressed this limitation by transcribing interviews verbatim and including nonverbal communication that could be inferred from the audio recording. Due to this being social science research, social desirability must be taken into account.

Findings from this study demonstrated that the clinical supervisors receive little to no training when transitioning from an in-home counselor to a clinical supervisor. Further research could explore training topics from current supervisors that could then support the development of training for clinical supervisors in the home. It is strongly recommended that an investigation of

common ethical issues facing in-home counselors and strategies clinical supervisors and in-home counselors have used to mitigate these challenges be conducted. Two ethical topics were frequently discussed in clinical supervision with in-home counselors: confidentiality and boundaries. A future study could explore what methods could clinical supervisors and in-home counselors employ to handle ethical dilemmas.

Conclusion

This study highlights challenges faced by in-home counseling supervisors, specifically the lack of supervision models, techniques, and training. We review ethical issues routinely faced by in-home clinical supervisors, and emphasize the lack of evidence for in-home counseling supervision. While insight regarding the clinical supervision practices and necessary training for clinical supervisors was discussed, we call upon counselor education programs, in-home counseling agencies, and clinical supervisors to increase setting specific training and curriculum. As a rapidly growing modality, in-home services are likely to increase. While this discussion sheds light on the reality that new clinical supervisors do not receive training or transition support, it should not stop there. Without research, increased training opportunities, and supervision of supervision clients who receive in-home services are potentially at-risk, and client welfare could possibly suffer. Efforts to enhance the research base and increase training for incoming and current in-home counseling supervisors should be a top priority. Not only to advance the field and enhance the value attached to clinical clients.

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