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Attitudes of Counselors Regarding Ethical Situations Encountered by In-Home Counselors

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Abstract

In recent decades, in-home counseling has gained popularity as a cost-effective method of treating individuals and families who would otherwise not have access to counseling services. Unfortunately, this treatment modality has not yet been widely researched, and educational and professional requirements for practitioners are ill defined. The unique situation of in-home counseling increases the potential for ethical challenges to arise. This survey study explored attitudes of in-home and outpatient counselors in Virginia regarding ethical situations encountered by in-home counselors. Differences between in-home and outpatient beliefs were examined. Although no significant differences were found between the two, an interesting pattern emerged regarding the ethical rating of situations related to the situation's potential to harm the client. Findings from the study, including rankings of items are presented. Implications for the training and practice of in-home counselors are discussed.

Keywords

home-based therapy, in-home counseling, ethical issues, counselor training

In recent years, the field of mental health has witnessed the proliferation of counseling services provided within the homes of clients (Adams & Maynard, 2000; Wasik & Bryant, 2001). Contributing to this demand for in-home counseling services was the passage of the Adoption Assistance and Child Welfare Act of 1980, which emphasized the maintenance of intact and safe families as opposed to the then-prevalent practice of placing children in foster homes (Christensen, 1995; Nelson, Landsman, & Deutelbaum, 1990). This law has led to a rapid emergence of *family preservation services,* wherein clinicians provide concrete services and encourage family empowerment while attempting to keep children in the original household (Wells & Biegel, 1992).

Today, in-home counseling services are provided by mental health professionals from various backgrounds to treat a wide array of presenting problems, including mood and psychotic disorders (Kalucy, Thomas, Lia, Slattery, & Norris, 2003), antisocial behavior (Curtis, Ronan, & Borduin, 2004), and substance abuse (Gruber & Fleetwood, 2004). While clients most commonly treated are children and adolescents with emotional and behavioral disturbances (Liddle et al., 2001; Mattek, Jorgenson, & Fox., 2010), in-home counseling has also been shown to be effective with families (Curtis et al., 2004; Yorgason, McWey, & Felts, 2005) and older persons (Cabin, 2010; Maxfield & Segal, 2008). Typically, clients who receive in-home counseling are referred to as *multichallenged* or *multistressed families,* possessing multiple problems that are chronic and severe in nature (Adams & Maynard, 2000; Lawick & Bom, 2008). In-home counseling has been found to be a cost-effective treatment (Crane, Hillin, & Jakubowski, 2003), reducing hospitalizations and out-of-home placements of children (Yorgason et al., 2005). Additionally, by providing more accessible counseling services to clients who would not be willing or able to receive counseling in an office setting, the counseling field can serve vulnerable and marginalized members of society.

Along with the benefits of this rising modality come challenges as well. Specifically, the literature has documented concerns in safety (Christensen, 1995), environmental distractions (Worth, 2004), counselor training and preparation (Adams & Maynard, 2000; Stinchfield, 2004), and supervision (Lawson, 2005). Families generally engage in very personal activities, conversations, and experiences within the household. Coupling the home environment with the very intimate nature of the counseling relationship can potentially result in emotionally charged and problematic situations (Reiter, 2000;

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Stinchfield, 2004). Pope and Vasquez (2007) noted the inherent power that mental health professionals possess in the counseling relationship, eliciting profound feelings from the client of love, rejection, shame, guilt, approval, dependence, and panic. Counselors eliciting these emotions in a client's home may prove to be a foundation for unethical situations to occur. Furthermore, because the practice of in-home counseling is in its infancy stage, there has not been a considerable amount of research conducted on this modality (Thomas, McCollum, & Snyder, 1999), particularly regarding ethical challenges.

Moreover, the minimal requirements and qualifications for in-home counselors present additional concerns. While most in-home counselors possess at least a bachelor's degree, the Medical Assistance Programs (Medicaid), which provide reimbursement for in-home services, require only an associate's degree with 3 years of experience (DMAS, 2008). The combination of undereducated and undertrained in-home counselors, the very challenging population of clients being served and the unique environment of the clients' home may create conditions in which unethical and dangerous situations could easily occur. Such ethical and boundary-related issues have recently been given considerable attention (Christensen, 1995; Knapp & Slattery, 2004; Lawson, 2005; Thomas et al., 1999; Woodford, 1999); however, the exact nature of these ethical issues encountered by counselors has not been adequately captured, requiring further scrutiny.

This study seeks to investigate the attitudes of in-home and outpatient counselors toward ethical dilemmas that may be encountered by in-home counselors. It also aims to explore whether any relationships exist between perceptions of in-home and outpatient counselors and variables such as gender, education, credentials, experience, or mental health field. The overall lack of required education and training of in-home counselors, the very challenging population of clients that is commonly served in their homes, and the unique environment in which clients are served lends support to the significance of this study. By understanding predictive factors and trends of counselors' attitudes toward ethical situations, the mental health field can better prepare in-home counselors to treat individuals and families effectively.

Method

The primary purpose of this study was to explore the attitudes of in-home and outpatient counselors in the commonwealth of Virginia regarding ethical situations typically encountered by in-home counselors. More specifically, this study sought to determine whether any differences exist in responses between in-home and outpatient counselors. Additionally, the independent variables, gender of counselor, mental health field, highest degree obtained, employment status (part-time, full-time), years of experience as an in-home counselor, years of experience as a mental health professional, license and certifications, and percentage of work providing in-home counseling compared to case management were examined to determine if they were predictors of in-home and outpatient counselors' attitudes about ethical situations typically encountered by in-home counselors. Finally, these variables were examined to determine if they exclusively predicted in-home counselors' attitudes about ethical situations. Currently, there is no research that captures the attitudes of in-home counselors along the entire spectrum of training and education levels.

Research Design

This was a nonexperimental survey study. The research packet sent to participants included an informed consent form, a personal information form, and the survey instrument. Ethical situations salient to the in-home counseling field were presented in the survey, and participants were asked to rate the degree to which they believed the situations were ethical or not ethical. Participants were pooled from a cross-sectional convenience sample of various counseling agencies in the commonwealth of Virginia. Utilizing the recommendations of Cohen (1992) as a guideline and assuming medium effect size of .15, $\alpha = .05$, a minimum of 107 participants was determined to be needed for this study.

Survey Instrument

The survey instrument created for this study contained three sections in addition to an informed consent form displaying approval by an Institutional Review Board. The first section of the study examined the attitudes of in-home and outpatient counselors regarding 21 ethical situations typically encountered by in-home counselors while in the field. Participants were asked to rate these 21 situations regarding the degree to which they believed them to be ethical or not ethical. The responses were rated on a 5-point Likert-type scale, (1 = *never ethical*, 2 = *ethical under rare conditions*, 3 = *ethical under some conditions*, 4 = *ethical under most conditions*, and 5 = *always ethical*). For the second section, participants were asked to provide personal demographic information. The final section consisted of an open-ended question concerning other in-home counseling ethical issues the participant may have observed or encountered while providing in-home counseling.

Ten of the 21 survey items generated were adapted from a dissertation by Roberts (2006), who explored the differences between in-home and office-based counselors regarding ethical violations. Roberts' (2006) scale asked participants to rate the frequencies of ethical behaviors they believed other therapists engaged in within a year. His survey was developed from several surveys (Borys & Pope, 1989; Epstein & Simon, 1990; Pomerantz, Ross, Gfeller, & Hughes, 1998) and included items measuring four defined spectrums (confidentiality, role confusion, client diffusion, and unintentional witnessing).

Of the remaining 11 items on the survey, 2 were adapted from a survey developed by Milliken and Neukrug (2009), which is an updated form of Gibson and Pope's (1993) survey administered to National Certified Counselors. The remaining

9 items were developed from a thorough examination of the peer-reviewed literature that illuminated issues most salient to in-home counseling. These items included issues of safety, witnessing violence, distractions, and participating in nontherapeutic family activities (Adams & Maynard, 2000; Christensen, 1995; Cortes, 2004; Thomas et al., 1999; Wasik & Bryant, 2001). To establish validity, this initial list of items was sent to an expert panel of in-home professionals and experts in the counseling field. The expert panel included directors, clinicians, and researchers. Following the expert review, a pilot study was conducted with 20 participants. A preliminary exploratory factor analysis was performed to determine whether scale items were appropriate for inclusion in the instrument. Feedback from expert reviewers of the instrument and counselors who participated in the pilot study along with discussions among the research team yielded a final version of the instrument.

Participants

The directors of 96 agencies licensed by the Department of Behavioral Health and Developmental Services in Virginia were asked to distribute the survey in this study to counselors employed in their agency. Of the 96 agencies contacted, 21 directors agreed to forward the survey to their counselors. From the information provided, approximately 821 counselors were asked to complete the survey. Of the 821 counselors to whom the survey was sent, 120 responded ($N = 120$), equating to a response rate of 14.8%.

Data were first screened for univariate and then for multivariate outliers. Mahalanobis' distance was computed. None of the cases exceeded the critical chi-square value of 27.89. Next, multivariate normality and linearity were examined by way of scatterplot matrix, which revealed shapes that are close to elliptical. Additionally, multivariate homoscedasticity was examined by way of residual plots.

Upon completion of data screening, the 108 participants whose data were valid were found to possess the following demographic characteristics; 71% were female, 66% identified as in-home counselors, and 83% reported working full-time. Of the 107 participants who responded, the majority, 61%, reported having a master's degree, while 18% reported having a bachelor's degree, and 9% of participants reported possessing a doctoral degree.

Regarding the mental health field of the participants, 38% reported having a counseling background and 31% reported social work. Furthermore, 10% of the participants reported coming from the mental health field of psychology, while clinical psychology, education, and human services were each reported by 6% of participants, respectively.

Pertaining to licenses and certifications held, descriptive data showed that the majority of the respondents, 50%, reported that they possessed the certification of a qualified mental health professional. The second largest credential reported was licensed clinical social worker at 22%, and close behind was licensed professional counselor at 20%.

Results

Descriptive Data

Outcome data consisted of the participants' responses regarding ethical situations on a Likert-type scale from 1 to 5 (1 = *never ethical*, 2 = *ethical under rare conditions*, 3 = *ethical under some conditions*, 4 = *ethical under most conditions*, and 5 = *always ethical*). All of the 21 items had the maximum range of 4, meaning that for every item there was a respondent who scored the item 1 (*never ethical*) and another respondent who scored the same item 5 (*always ethical*). Table 1 displays the 21 items in ranked order of means.

Research Questions

Research question 1 asked, "What is the difference, if any, between in-home and outpatient counselors' attitudes about ethical situations typically encountered by in-home counselors?" To answer this question, an independent sample *t*-test was conducted. Results revealed that there was not a significant difference in the scores for in-home ($M = 2.33$, $SD = .42$) and outpatient ($M = 2.22$, $SD = .43$) responses; $t(106) = 1.231$, $p = .221$.

Research question 2 asked "To what degree do the independent variables predict in-home and outpatient counselors' attitudes about ethical situations typically encountered by in-home counselors?" Standard multiple regression was conducted, indicating that the overall model did not significantly predict counselors' attitudes. However, one independent variable significantly contributed to the prediction of this model: 25% counseling, 75% case management ($t = -1.987$, $p = .05$).

Respondent Comments

Section III of the survey instrument asked participants to comment on their own personal experiences regarding ethical issues observed while providing in-home counseling. Of the 108 complete responses, 41 participants provided comments in Section III. Several participants stated they had encountered situations similar to the items listed on the survey, including: observing illegal activities performed by clients, family visitors arriving unexpectedly, having clients contact their counselor after termination, having a meal with a client, and counselors being invited to birthday parties and events.

Ethical situations reported in this section but not mentioned in the survey included the following: inadequate supervision, inadequate risk assessment of families, unqualified supervisors, small community resulting in a natural ongoing relationship between client and counselor, counselors with only bachelor's degree and thus being unqualified, donating items to a client in need, and billing issues when two counselors are working in the home.

The most frequently mentioned items in this section pertain to unqualified counselors and a lack of competent supervision.

Table 1. Attitudes of Counselors Regarding Ethical Situations.

	Combined Modalities *M* (*SD*)	In-Home *M* (*SD*)	Outpatient *M* (*SD*)
13. Continuing to provide counseling even though you are in a state of fear for your personal safety and subsequently distracted from the session	1.35 (.66)	1.30 (.55)	1.46 (.84)
20. Continuing to provide counseling to a client after it becomes apparent that the client has a serious problem (e.g., schizophrenia, major depression) for which you have not been trained to provide services or treatment	1.60 (.91)	1.65 (.90)	1.51 (.93)
7. Purchasing items from a client or a client's family member (e.g., raffle tickets for a church fundraiser, Girl Scout cookies, etc.)	1.67 (.95)	1.69 (.95)	1.62 (.95)
16. Providing counseling to the client while someone not in the family (e.g., neighbor, houseguest, relative) is within hearing distance	1.78 (.89)	1.85 (.84)	1.65 (.98)
3. Visiting, calling, or sending e-mail messages to a client or a client's family member after termination	1.80 (.83)	1.72 (.78)	1.95 (.91)
5. Accepting an invitation from a client to attend a personal event (e.g., Christmas dinner, hospital visitation for a family member who is ill, etc.)	1.83 (.85)	1.79 (.81)	1.92 (.92)
4. Talking to your friends or your family members who have no professional role in the case about the situation of a client or a client's family members without revealing identifying information	1.90 (1.12)	1.82 (1.00)	2.05 (1.31)
10. Providing individual counseling to a relative, friend, or significant other of a current client or of a client's family member.	1.93 (1.03)	1.93 (1.02)	1.92 (1.06)
14. Consoling a distraught client by cradling or holding him or her.	1.96 (.95)	1.90 (.91)	2.08 (1.01)
2. Giving a client or client's immediate family member a ride in your car to do an errand that is not related to the client's therapeutic goals (e.g., to the bank or grocery store)	1.98 (.95)	2.08 (.97)	1.78 (.89)
6. Disclosing details of a personal nature (e.g., your own health problems, future employment concerns, family history issues, etc.) to a client or a client's family member	2.01 (.88)	196 (.93)	2.11 (.77)
15. Eating a meal with a client or a client's family member when an invitation is offered	2.31 (1.00)	2.38 (.99)	2.16 (1.01)
21. Providing counseling to a minor when his or her parents or guardians are not at home	2.32 (1.02)	2.44 (.97)	2.11 (1.10)
18. Providing counseling to a client in a public location where privacy cannot be guaranteed (e.g., coffee shop, park, or library)	2.36 (.90)	2.46 (.83)	2.16 (1.01)
11. Answering questions regarding nontherapeutic issues outside of a counselor's role (e.g., "Where do you think is the best place to get a car loan?" "Could you tell me how to set up my DVD player?")	2.44 (.98)	2.51 (.98)	2.32 (.97)
9. Counseling a client in the client's bedroom to minimize distractions during the counseling session	2.49 (.95)	2.58 (.91)	2.32 (1.03)
19. Providing advice that is requested by a client about how to help an individual whom the client knows who has a mental health problem (e.g., "I have a friend who I think is Bipolar, how can I help her?")	2.81 (1.21)	2.69 (1.20)	3.03 (1.21)
17. Not being a member of a professional association in counseling or related field	3.18 (1.51)	3.21 (1.53)	3.11 (1.49)
12. Observing or acquiring direct evidence that a client or his or her family members are involved in criminal activity (e.g., selling drugs in the house) and reporting the criminal activities to law enforcement authorities	3.26 (1.40)	3.48 (1.34)	2.84 (1.42)
1. Providing a snack item for the client (e.g., a candy bar, soda, or pack of gum) for which the counselor is not reimbursed	3.35 (.91)	3.41 (.94)	3.24 (.86)
8. Telling a client or a client's family member to apply for needed services (e.g., applying for food stamps, applying for a psychiatric or medical evaluation, etc.)	4.04 (1.04)	4.11 (.96)	3.89 (1.20)

- I believe the biggest issue currently is that many in-home therapists may only have a bachelor's degree, and are terribly unqualified to provide counseling.
- People in positions of authority in the agency often have zero direct service experience as a residential counselor and have no idea how client-centered programs are run.
- I have observed a lack of adequate preparation and supervision of in-home counselors.
- I have seen supervisors who have less clinical experience than workers.
- I have seen counselors given cases they were not clinically qualified to handle.

Discussion

A review of the descriptive statistics from the 21 ethical situations shows several interesting trends. First, the vast majority of items (17 of the 21) had a value less than 3. The value 3 equates to ethical under some conditions. It appears that most participants believed these situations typically encountered by in-home counselors are more unethical than ethical. However, it is also worth noting that every single item had the maximum range of 4, meaning that for every item there was a respondent who scored the item as a 1 (*never ethical*) and another respondent who scored the same item a 5 (*always ethical*). These

findings lend support to the amorphous and uncertain nature of ethical situations with in-home counseling.

When viewing the ranked item means, an interesting trend emerged. The ACA Code of Ethics (2005) Section A.5. charges counselors to avoid ethical situations unless the interaction is potentially beneficial to the client while weighing the anticipated consequences (A.5.c.). For items with means between 1 and 2 (*never ethical* or *ethical under rare conditions*), the items seemed to focus primarily on how beneficial entering into the situation would be for the client. These lowest ranked items involved situations that would be difficult to ever justify engaging in to the benefit to the client. The two lowest items, numbers 13 ($M = 1.35$) and 20 ($M = 1.60$), involved counseling while impaired and counseling beyond one's scope of competence. Similarly, the fourth lowest ranked item, item 16 ($M = 1.78$), involved counseling a client while someone not in the immediate family was within hearing distance. Item 4 ($M = 1.90$) involved talking about the client to family members and friends who have no professional role in the case. It is difficult to imagine scenarios where it would be helpful to the client to engage in these situations, which was reflected in the low scores from participants.

The trend of evaluating and contrasting ethical situations in light of potential benefits and anticipated consequences to the client continued throughout the range of responses. For items with mean responses of approximately 2.00 and above, higher responses were associated with the more benign anticipated consequences. Because many of these items diverge from the therapeutic treatment, they may be perceived as not inflicting direct and immediate harm to the client.

The independent samples *t*-test computed between in-home counselors ($n = 71$) and outpatient counselors ($n = 37$) revealed no statistically significant differences between the two. Although this is contrary to my hypothesis, a further examination of the population sampled may provide further illumination on this subject. The majority of both in-home and outpatient counselors possessed master's degrees even though the minimum education requirements to provide in-home counseling is a high school diploma and most outpatient counselors require a master's degree.

The open-ended responses from participants concerning their own personal experiences regarding ethical issues observed while providing in-home counseling yielded valuable data. Multiple comments referenced unqualified counselors and incompetent supervisors, suggesting the salience of the constructs of training, competence, and education when providing in-home counseling.

Limitations

When interpreting the results of this study, several limitations should be considered. One threat to this study is that of selection, which occurs when participants are selected who "have certain characteristics that predispose them to have certain outcomes" (Creswell, 2009, p. 163). Since the participants were recruited by contacting agency directors and supervisors, the pool of clinicians whom the supervisors recruit may possess special characteristics that may skew the data. Additionally, both the convenience sample that was taken for this study and the low response rate limited the generalizability of the results. Unlike a random sample, each individual did not have an equal probability of being selected (Creswell, 2009), but relied on the agency director's agreement to participate. Those agencies that agreed to participate may have had attitudes that differed dramatically from underrepresented agencies that chose not to. Furthermore, of those directors who chose to participate, the low response rate may have caused a response bias (Creswell) that further reduced the generalizability of the results.

These limitations may have led to the homogeneity of the population of in-home and outpatient counselors who participated. The majority of respondents shared several traits (e.g., possessed master's degrees, were female, and reported a similar ratio of counseling to case management). Concerning the two groups of in-home and outpatient, many of the agencies provided both in-home and outpatient counseling services, so the participants from each group may have interacted, consulted, and participated in training with one another. Furthermore, 72% of the outpatient counselors surveyed had provided in-home counseling in the past. In light of this, it is not surprising that these two groups did not possess significantly different attitudes regarding ethical situations encountered by in-home counselors.

Implications

The results of this exploratory study offer several points to consider for the counseling profession. Results from the second research question found that the percentage of counseling compared to case management that counselors provide may predict in-home and outpatient counselors' attitudes regarding ethical situations encountered by in-home counselors. Counseling in an office-based setting provides clearer structure and boundaries in a variety of domains compared to in-home counseling and case management services (Slattery, 2005). Historically, mental health professionals have had a difficult time reaching a consensus regarding what constitutes appropriate and inappropriate boundaries for outpatient counselors (Gabbard & Lester, 1995; Glass, 2003). One might imagine the greater complexity involved in grappling between the boundaries and ethics of two distinctly separate helping modalities (counseling and case management) intertwined into one (in-home counseling).

Counselor educators may find it beneficial to instruct their students on the differences (with regard to purpose, service delivery, boundaries, and theoretical framework) between outpatient counseling and case management services, as well as in-home counseling.

The scores from item number 20 on the survey suggest the importance counselors place on working within their competency. Viewing this in light of several concerns raised in participants' comments regarding unqualified counselors intensifies the beliefs that competency, level of training, and

qualifications are salient issues with regard to in-home counseling. Current supervisors and directors of in-home counseling agencies may benefit from evaluating training and supervision standards, as well as examining client outcome data as it relates to counselor performance and qualifications. Furthermore, a more formalized partnership between counselor educators and supervisors of in-home counseling agencies should be explored. As previous research has demonstrated (Stinchfield, 2004), the gap between counselor education programs and in-home counseling practice is significant and both institutions may benefit greatly from one another.

Conclusion

This survey study explored the attitudes of in-home and outpatient counselors in the commonwealth of Virginia regarding ethical situations typically encountered by in-home counselors. Results showed that there was not a significant difference between in-home and outpatient counselors' attitudes. Furthermore, of the independent variables, only one variable, 25% counseling, 75% case management predicted in-home and outpatient counselors' attitudes about ethical situations encountered by in-home counselors. In general, most counselors were in agreement concerning the ethicality of situations that in-home counselor encountered.

Results of the multiple regression, descriptive statistics, and open-ended comments led to several conclusions. The provision of counseling and/or case management services is an important factor in determining the attitudes that counselors hold regarding ethical situations that in-home counselors encounter. The results from Table 1 depicting the item means ranked from lowest to highest revealed an intriguing trend. For the means of the lower ranked items, items appear to be indicative of harmful situations for the client or situations in which there is little or no value to the client. Conversely, items ranked higher appeared to be more benign situations that may be interpreted more loosely under ethical guidelines.

The qualifications and competence of both in-home counselors and supervisors are salient domains that future research should explore. The level of importance that counselors hold in affiliating with a professional association has also been called into question and warrants greater scrutiny. Further research surrounding these constructs are suggested, as well as the interaction between in-home counseling supervisors and counselor educators and the attitudes they hold concerning to in-home counseling and ethics. The results of this study also suggest that the attitudes counselors hold regarding ethical situations common to in-home counselors are similar to one another and congruent with the ACA Code of Ethics (2005). The higher education level of in-home counselor participants in this study (60% master's degree, 11% doctoral degree) may have contributed to this consensus. Future research with participants from more diverse education levels may reveal different attitudes concerning ethical situations with regard to this modality.

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