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ORIGINAL PAPER

Collaborative Home-Based Therapy (CHBT): A Culturally Responsive Model for Treating Children and Adolescents Involved in Child Protective Service Systems

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Abstract Mental Health professionals are challenged with utilizing innovative treatment models to meet the needs of diverse communities. Enhancements in interventions have led to a reconceptualization of the role of mental health professionals, specifically, family therapists. This paper presents a collaborative, home-based model for working with children and adolescents involved in foster care. We begin by examining literature on home-based therapy. This review provides a framework to understand the need for a culturally responsive approach. A collaborative, home-based approach is presented along with unique issues and guidelines for practice. A clinical case is presented to illustrate implications for treatment.

Keywords Treatment · Culture · Foster care · Children · Family therapy

The foster care system is responsible for the physical and emotional care of a large number of children and adolescents. In 2003, approximately 2.9 million referrals for child abuse and neglect were made to Child Protection Service (CPS) agencies, and about 30 % resulted in substantiated cases of child abuse or neglect (National Clearinghouse on Child Abuse and Neglect 2005). Given the extraordinary number of referrals, the foster care population has grown nationally to over 500,000 children (Adoption and Foster Care Analysis Reporting System 2005). Many of these children, 46 %, are placed in non-relative care homes (Adoption and Foster Care Analysis Reporting System 2005). Children in these non-relative care foster homes are referred for mental health services to address issues related to the removal from their homes, such as attachment and adjustment difficulties,

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exposure to domestic violence, and trauma associated with abuse and neglect. These children present with unique therapeutic issues and often come from multi-stressed, disadvantaged, and ethnically diverse families.

The foster home environment can provide a non-intrusive, safe therapeutic environment to address issues related to removal from their home. The literature on working with multi-stressed, at-risk families supports therapeutic intervention in the least restrictive setting, such as in a home environment represented by foster care or local community (Boyd-Franklin and Bry 2001; Lindblad-Goldberg et al. 1998). Family Preservation and support services is one program that uses in-home counseling and we believe foster care falls in this category as well. As a result we have developed a culturally responsive, collaborative framework for therapeutic intervention with children and adolescents involved in the foster care system.

Family Preservation and Support Services

The Adoptions Assistance and Child Welfare Reform Act (PL 96-272) and the Family Preservation and Support Act of 1993 (PL 103-66) required that states provide funding for children and families to decrease out of home placements (e.g., foster care placements). The services were focused on "preserving families and preventing child placement" (Lindblad-Goldberg et al. 1998, p. 14), and many of the services were implemented in the family's home.

Research is lacking on home-based therapy for children in foster care systems, likely due to the difficulty in accessing the population for research purposes. The minimal research that does exist supports home-based interventions for multi-stressed and at risk families (e.g., Boyd-Franklin and Bry 2001; Lindblad-Goldberg et al. 1998).

Family preservation support services involve "services for children and families designed to help families (including adoptive and extended families) at risk or in crisis" (Westat Inc. et al. 1995, p. 3). These programs were established in response to legislation related to preserving the family and avoiding out-of-home placements. Family preservation often uses a team approach to deliver services to families. Westat Inc. et al. (1995) at the University of Chicago reviewed Family Preservation and Family Preservation Reunification Programs. They found that early preservation programs were based on family dynamic theories. Some of those theories included Homebuilders, Oregon's Intensive Family Services, Oregon's Intensive Home-Based Services, and the Iowa Family Preservation. The researchers found that of the programs studied, four programs used a team approach, and two programs had longer duration and less intensive approaches. These programs introduced an intensive, team based treatment approach for children and their families.

Chaffin et al. (2001) evaluated outcomes in family preservation and family support programs. The researchers examined 74 service programs at 28 different sites. In the study, attrition rates were high; however, the researchers found that there were no differences between program completers and program dropouts, and mentoring and basic needs programs were more effective than parent and child development oriented programs. On the other hand, Bath and Haapala (1993) examined group differences in the Intensive Family Preservation Services program by studying 854 children and 530 families. The researchers found that families with child neglect were more often composed of single headed households, more children, and more medical, mental, and substance abuse problems, placing those families at significant risk.

Family preservation and support service programs support targeted intervention with children and families identified as at-risk and in crisis. Some of the research found that supportive, collaborative, and team based treatment approaches were effective in preserving placement and preventing out of home placement. These results, thus, support the development of home-based therapy models.

Home-Based Therapy

The literature on home-based therapy (e.g., Cortes 2004; Cottrell 1994; Fraser and Haapala 1987; Fuller 2004; Johnson et al. 2002; Woods 1988; Zarski et al. 1992) has increased with the introduction of family preservation and support service programs. It highlights the unique, inclusive nature of home-based intervention and the integration of the individual, family, larger systems, and the community as part of the treatment system (e.g., Boyd-Franklin 2003; Lindblad-Goldberg et al. 1998). Traditionally, home-based services focus on the family and highlight the importance of "expanding the family's available internal and external resources to nurture and care for children" (Lindblad-Goldberg et al. 1998). The focus is on making connections and building relationships with the family's community, including community services and organizations (Boyd-Franklin and Bry 2001; Lindblad-Goldberg et al. 1998).

Home-based therapy has been applied to working with various populations (e.g., Becker and Curry 2008; Cherniss and Herzog 1996; Henggler et al. 1996; Schacht et al. 1989; Schmidt et al. 2006) and the literature is filled with diverse theoretical modalities, including Alexander and Sexton's Function Family Therapy (Sexton and Alexander 2002), Boyd-Franklin and Bry's ecological, systemic approach (Boyd-Franklin and Bry 2001), Lindblad-Goldberg's Ecosystemic Structural Approach (Lindblad-Goldberg et al. 1998), and Henggeler's Multisystemic Therapy (MST) for juvenile offenders and their families (Henggeler and Lee 2003). A team approach, as exemplified by Henggeler's MST approach, utilizes several members to serve the various needs of the family. The therapists enter the home to increase the likelihood of consistent family participation, a challenge that frequently occurs with families who have limited resources and/or who may mistrust mental health providers. The MST teams provide therapy to any family members present, and meet any other needs that may be a barrier to the child's ability to avoid legal and social problems. Similarly, Lindblad-Goldberg et al. (1998) present an Ecosystemic Structural Home-Based Services Approach that empowers families to identify and utilize their strengths. The approach, influenced by Salvador Minuchin's work at the Philadelphia Child Guidance Center, targets emotionally disturbed children and adolescents and their families, and highlights the need "to offer families support and guidance before they throw up their hands in despair" (p. 3).

Boyd-Franklin and Bry's (2001) structural and behavioral, ecological approach returns balance to the family and multiple systems and assists families in "prioritizing" their problems and intervening on several levels. Those levels could include individuals, the family, the extended family, non-blood kin and other close friends, church and community resources, and social service agencies and other outside systems (Boyd-Franklin and Bry 2001, p. 5). Guiding principles of the approach include: remember your own "home training"; the clinician is on the client's home turf; when in doubt join; never underestimate the power of praise; effective use of self is the most powerful technique; empowerment is the goal, not helping (Boyd-Franklin and Bry 2001, p. 40).

Home-based therapy and the Family Preservation and Support Act of 1993 resulted in the development of several effective programs and unique interventions for children and families, as well as specific home-based training and supervision issues (e.g., Adams and Maynard 2000; Snyder and McCollum 1999; Wasik and Roberts 1994; Woodford et al. 2006; Zarski et al. 1991; Zarski and Zygmond 1989). These approaches, while effective, were developed to prevent out of home placement for children living in multi-stressed environments. Further, these approaches highlight intervention with the children and the biological parents and/or caregivers. However, children involved in the foster care system present unique therapeutic challenges and needs.

Foster Care Treatment and Intervention

Foster care services provide (temporary) care for children and adolescents whose biological parents/primary caregivers are unable or un-willing to care for them properly according to government standards. The terms *foster care* and *out-of-home care* are used interchangeably and are most often used to describe single-family foster homes, group homes, and residential treatment facilities. Children and adolescents who reside in such placements represent an ethnically diverse population. According to child welfare reports, of the 500,000 children in foster care, 32 % are African American, 18 % are Latino, 8 % Other Races/Ethnicities, and 52 % are male and 48 are female (http://www.childwelfare.gov/pubs/factsheet/foster.cfm#race). Further, they are more likely to struggle with "chronic psychiatric and physical illnesses" than their peers (Yancey 1992). For instance, their behaviors may include socially disruptive acting out, tendencies toward the commission of minor and serious crimes, poor academic functioning, impulsive behaviors, inability or unwillingness to delay gratification, and irresponsible sexual behavior (Yancey 1992). Some of these behaviors may be the result of living in high-stress circumstances, while others may develop in attempts to adjust to living in unfamiliar surroundings (foster homes, etc.). Home-based therapy is often used to address the mental health needs of children and adolescents in foster care (e.g., Brymer and Phillips 2006; Chaffin 2006; Crenshaw 2004).

Given the presence of intense, diverse mental health issues and the disproportionate representation of ethnically diverse populations, there is a need to focus on ways to provide therapeutic services to ethnically diverse children and adolescents (Government Accounting Office 2007). However, many of the family preservation and support programs and home-based therapy models are informed by traditional, modernistic epistemological perspectives. Thus, we present a framework for home-based therapy that is grounded in a postmodern, collaborative epistemology, and is culturally responsive to the unique needs of children and adolescents involved in the foster care system.

A Collaborative Home-Based Therapy Model

There are several theoretical approaches that guide and influence our culturally responsive, Collaborative Home-Based Therapy (CHBT) model, including strength-based and collaborative approaches. We apply a strength- and resource-based perspective, built upon the ideas that come out of Solution Oriented Approaches (e.g., O'Hanlon and Berg). From this perspective, we highlight the client and community resources to facilitate transformation and therapeutic shifts. Further, we draw upon Anderson's collaborative language systems

theoretical framework, a framework that integrates the assumptions and ideas in social constructionism, hermeneutics, and narrative therapy (Anderson 1997). Similar to Solution Oriented approaches, this framework is a postmodern approach that questions modernist (traditional structured or hierarchical) discourses. The collaborative language systems approach "emphasizes the relational nature of knowledge and the generative nature of language" (Anderson 1997, p. 36). Further, the theoretical framework assumes that individuals are social and relational beings, and reality and meaning are experienced in conversation and through language (Anderson 1997). These assumptions contend that language and conversations are relational processes that create experiences (Anderson 1994, 1995, 1997; Boyd 1996; Gehart and Lyle 1999; Perez 1996; Seikkula 2002; Swint 1995).

Our CHBT framework is not only collaborative in theory and language, but in action. A collaborative atmosphere is established when the client's needs are addressed in the home rather than requiring that the therapeutic "work" occur in the therapist's office. From this perspective, it remains vital to be aware of the power and privilege of the therapist; therefore, it is essential to be constantly aware of creating non-colonizing conversations, especially when working with someone from a minority status.

Guidelines for the CHBT Model

Congruent with a postmodern approach, we offer four components of a CHBT model (see Fig. 1) for intervention with children and adolescents involved in foster care systems. We see these components as fluid and co-existing rather than stages or steps. The four guidelines include: (1) Building and Maintaining Relationships, (2) Contextual Assessment and Integration, (3) Collaboration and Communication, and (4) Treatment Planning and Therapeutic Intervention.

Building and Maintaining Relationships

One of the most powerful dimensions of effective therapy is developing a positive, supportive therapeutic relationship. However, building relationships is not a one-time event, but it is something that needs to be consistently nurtured and attended to, especially as difficulties arise in the treatment process. From the initial phone call to the termination session, acute awareness of the relationship is critical to successful treatment. For instance, steps to ensure development of a strong therapeutic relationship include attention to addressing the head of

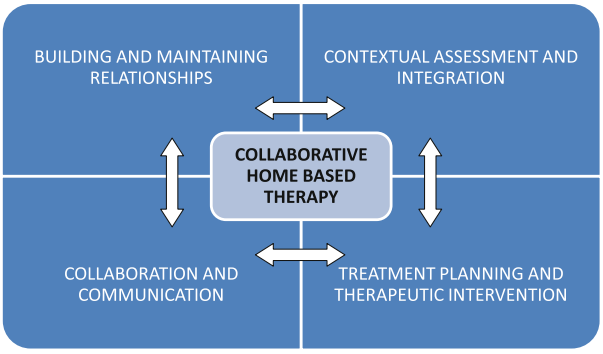

Fig. 1 Collaborative Home-Based Therapy Model

the household (Boyd-Franklin and Bry 2001); this may be informed by cultural norms and rules. For example, some African American clients may prefer to be addressed as Mr., Mrs., or Ms. followed by their last name unless you are given permission to use their first names (Boyd-Franklin and Bry 2001). Therefore, the use of a first name should come from them and not imposed or insisted upon by the therapist. Further, when engaging in family therapy, some cultures (e.g., African American, Asian) may prefer to have the oldest person in the family addressed before any other person, and each member of the family may need to be addressed and acknowledged no matter their age. In addition, when the family identifies as African American or Latino, respect may be demonstrated by discussing appointments, rewards, and visits with the foster parents before having the conversation with others. Thus, including the foster parents in any plans you have for the children or adolescents will help to build and maintain relationships. Overall, maintaining awareness of these cultural preferences can help build relationships with family members.

In addition to remaining mindful of cultural issues that may impact building and maintaining a therapeutic relationship, there other issues to consider. Often, therapists are hierarchical in their approach to working with families as demonstrated by their pathologizing language and/or directives. For instance, many times treatment in foster care is court-ordered and children and families may find the task of navigating mandated therapy, challenging. If a therapist believes that they know what the family needs without collaborating, the family can be lost to the therapeutic process. It is, therefore, critical to meet the family where they are at by encouraging a discussion of their experiences with therapists and listening to their objections and their input to enhance further engagement with the therapeutic process. Further, the child and family's concerns and hesitations regarding therapy should also be addressed. This can be an integral part of providing successful treatment because engaging in such conversations may allow the family to feel validated, which builds trust. This process also provides an opportunity for the therapist to better understand the family's worldview on therapy. Although attentive listening seems like a basic skill, it takes on special significance when working with families who are mandated to be in treatment. This process may take additional time, however, it has the potential to be extremely helpful in overcoming barriers to treatment, as well as providing new opportunities for children and other family members to feel heard and understood which may lead to greater engagement in the healing process.

Another issue to consider is related to children, adolescent, and family ideas, perspectives, and biases related to therapy. In non-dominant, collectivistic cultures it may be common to view therapy as being for "crazy" people. Taking the time to educate children and families about the purposes and possibilities of therapy may help gain cooperation and collaboration. Coercive rhetoric can occur when a therapist imposes their biases about the benefits of therapy on the clients. The use of coercive rhetoric may result in the unintended consequences of the family feeling unheard or unacknowledged. Those feelings could lead to a non-collaborative, colonizing experience for the client family during therapy.

Contextual Assessment and Integration

We are hesitant to use the word assessment as it conveys the notion of hierarchy, and the idea of being "assessed" may not convey a feeling of empowerment. However, we use this word as it is a common term used in practice and throughout the literature. We suggest providing a contextual assessment that highlights and deconstructs language and recognizes culturally bound terminology often used in assessments (e.g., words such as "enmeshment" and "parentified child"). Further, definitions of "family" vary across

cultures; therefore, the therapist should not assume that "family" means the traditional nuclear family. For instance, it is common in Latino families to consider cousins (*primos*) and godparents (*padrinos/madrinos*) as integral parts of the family system. Similarly, in African-American families, non-blood relatives are considered part of the extended families (Boyd-Franklin 2003). When conceptualizing "family" from these cultural perspectives, there is a "latent matrix of kin" that can be activated when crises occur and the family needs support. Therapists and supervisors need to be aware of how the "family" is being defined when assessing support networks.

Another area of assessment to consider is related to how therapists approach diagnosing and labeling of children and adolescents. The process of pathologizing children and adolescents from non-dominant cultures can occur when behaviors are not viewed through a cultural lens. Therefore, written assessments may be more accurate if therapists examine and get to know the person before the paperwork. The therapist may, however, be constrained by the agency or other employers, but allowing assessments to occur more naturally over time may benefit the child or adolescent as well as the therapist because it will become more integrative with the treatment. On the other hand, if the focus is on completing paperwork, the child or adolescent may lose interest by the time the therapist is ready to engage in the treatment process. A contextual assessment is a dynamic process that may occur over the course of several sessions and include taking environmental and cultural factors into consideration.

Collaboration and Communication

The next sphere of influence that should continually be present in the CHBT model is collaboration and communication. In the foster care system, there are multiple systems involved in a child's life. These systems may include attorneys, social workers from the county and foster family agencies, foster parents, biological parents, and other programs such as Court Appointed Special Advocates (CASA) who often act as advocates for the children with other systems. Effective CHBT, however, cannot be provided in a vacuum. The therapist is one part of the whole, a part of the team, a team developed to support the child or adolescent. Too often therapist make plans with the team, or the supervisor, but excludes the foster parents and the child/adolescent from the process. The power differential between the foster parents, children/adolescents and therapists makes it important for the therapists to take a collaborative stance when working with the multiple parts of the system. The importance becomes more significant with the awareness that foster parents are not always part of the child or adolescent's biological family and they may experience themselves as part of the solution. The therapist may capitalize on this willingness to support the child or adolescent and invite collaboration in treatment planning, intervention, and crisis management.

One way to infuse the therapeutic process with communication and collaboration is to have the child or adolescent and the foster family included when deciding the goals for therapy. Collaborative documentation can occur when the foster parent, child or adolescent, and therapist work in conjunction to determine goals and what will be included in the progress notes. This simple, yet powerful intervention is not only inclusive, but can invite a sense of control at a time when the child or adolescent often feels as though he or she has little or no control and power in their own life let alone the people who intervene to "help" them in their lives. The writing of reports to the court can also be treated in the same way, by allowing the child or adolescent to have legitimate input into what will be portrayed about their treatment and progress for court hearings.

The more communication and collaboration the therapist maintains with the various systems involved, the more effective treatment will be because all will have a better sense of the many contexts in which the child or adolescent navigates. Therefore, the therapist should maintain consistent contact with social workers since they often hold information related to the current status of the child or adolescent's case.

Treatment Planning and Therapeutic Intervention

Many therapeutic interventions can be tailored for home-based work (refer to Gehart and Tuttle 2003 for application of various family therapy models and interventions). Though it is beyond the scope of this paper to detail all the possible therapeutic interventions, it is pertinent to note that the impact of an intervention implemented in the home may differ from traditional office based intervention. Family interventions can be more effective in home-based therapy because you may have an opportunity to include foster family members and biological family members, such as grandparents, uncles and aunts, who traditionally may not come to office based therapy. Role plays and enactments may be highlighted in home-based work since family members can be invited to participate. The enactment may be more authentic since it can be done in the same location where the interaction originally occurred. You also may have access to much more information about the client. For instance, the child or adolescent can show you their room and you can observe the way in which they decorate their room. Often times, posters, pictures, and other decorative room fixtures tell much about the child or adolescents experiences and relationships. In the home environment, the therapist can also share the child or adolescent's favorite music or latest artwork since these activities are often done in the context of the child's home life.

It is also important to remain mindful of the challenges presented in implementing treatment interventions in the home environment. For example, a therapist may decide against art therapy with finger paints or glitter that may be difficult to clean. Though art therapy is an effective intervention, the home-based therapist should avoid use of therapeutic materials that may compromise the effect of the intervention and distract from the purpose of the intervention. However, if the therapist chooses to utilize such items, it is important to remember "home training" (Boyd-Franklin and Bry 2001) and be respectful and clean up before leaving the home.

Unique Considerations

Attention to the CHBT guidelines may assist therapists in providing effective home-based intervention with children and adolescents involved in foster care. However, providing services in the home, can be challenging and often presents unique considerations, including managing issues of confidentiality and maintaining appropriate boundaries.

Confidentiality

Confidentiality has been traditionally described as holding information provided by clients during sessions, in confidence, with the exception of information that would cause harm to the client or others. With some exceptions, home-based therapy presents a challenge because there may not always be a level of privacy that serves the keeping of information confidential. Foster parents consider therapists as guest in the home and parents maintain

control over what goes on in their home. Therapists want to be aware that they have "no authority" in the home and should ask and not make assumptions about where they will be able to work. Children and adolescents do not always have their own space within which to work and/or homes may not be large enough to accommodate space for confidential sessions. Further, foster parents may want to be included in the treatment process, as they may feel that they have information that is needed to assist the therapist in working with the child or adolescent. If foster parents are not acknowledged as important contributors to the therapeutic process, the therapist may experience challenges, such as multiple interruptions during a session. Therefore, it may be beneficial to set aside time to engage the foster parent in a discussion that renders additional information and addresses their concerns about the child.

Another issue of confidentiality occurs when children/adolescents reveal information that could create a crisis in the family, such as pregnancy, substance abuse, gang involvement, or chaotic family relationships. The information may be needed to address ineffective patterns of family interactions, but it may be difficult to introduce because it was revealed in a confidential session. While many therapists are aware of the standard statements of confidentiality, home-based therapy may require a greater level of sensitivity. For instance, it may be disconcerting to parents when children are separated from them in the initial session. The therapist may respond to this concern by taking additional time with the family to discuss what things will be confidential and how they will be handled. If it becomes necessary to file a mandated report, the therapist, as a courtesy, may make the family aware of what to expect. If information is revealed in session, which is not a safety issue but may require parental awareness, the therapist might work with the child or adolescent to help them discuss the topic with their foster parents.

A final area of consideration is the involvement of larger systems, i.e. Child Protective Services, Juvenile or Probation Court, school systems, etc. that may have some interest in the outcome of services to children/adolescents in foster care. The therapist should be aware of the child's relationship with these systems and be sensitive to the impact of releasing confidential information without the child's knowledge on the therapeutic process. As a way to strengthen the relationship, the therapist may discuss with the foster parents and the minor client each of the systems involved and the level of confidentiality the therapist will maintain for each. An explanation of HIPAA requirements should be given and the appropriate releases signed.

Boundary Considerations

Boundary considerations are likely to be very different when you enter into the home of a child or adolescent. In an office setting, it may be easier to maintain professional distance. Depending on the culture the therapist is serving, the therapist may be asked personal information, offered food and/or drinks, or given gifts. How the therapist responds to these requests may determine the course of therapy. For instance, there are cultures (e.g., Asian cultures) that may require the therapist to give personal information as a way for the family to feel comfortable with the therapist in their home. Giving limited personal information may help establish a less hierarchical relationship, especially when therapy is required or mandated. Other cultures, such as in an African American or Latino culture, may offer food, drinks, or gifts when therapy is terminated (Sue and Sue 2003). Refusal to accept limited offerings while in the home maybe be experienced as rude and disrespectful. Overall, the traditional professional persona, which clearly delineates the roles between therapist and client, is not as clearly defined in a home-based therapeutic setting.

Case Study

The following case exemplifies the CHBT model: a 17 year old African American male, John, who had been placed in foster care due to general neglect, was referred for therapy. He was placed in an African American home with Ms. Baker, a 45 year old female who had very little experience with adolescent boys. John was placed from a previous foster home where he lived with an elderly foster mother. At this previous foster home he was responsible for getting his needs met and did not turn to adults for assistance. John presented as very self-sufficient and capable of managing his own life. The home-based therapist was Miles a 55 year old Caucasian male who had teenage sons of his own. Miles was looking forward to this assignment. Miles had never worked in an in-home setting and also had little experience with African Americans. He was not aware of the cultural protocols for African American homes. When Miles made the initial call to the home, he failed to identify himself to Ms. Baker who was African American, and instead asked to speak with John and made the intake appointment directly with him. When the therapist arrived at the home, John was not there and the foster parent was surprised to see him. Miles introduced himself and used the foster parent's first name to discuss his disappointment about John's absence. Miles noticed that Ms. Baker's demeanor was less than welcoming.

Miles discussed the initial meeting with the foster parent with his supervisor. Miles was advised to change his approach by first calling the foster parent to make future appointments with John, and Miles was encouraged to ask the foster parent how she would like to be addressed. Miles followed the instructions, apologized to the foster parent for his oversight, and he scheduled the next appointment with the foster parent.

Over the next several appointments, Miles developed relationships with both John and his foster parent, Ms. Baker. It became clear that there were some communication issues that were not being addressed. John would complain in individual sessions that Ms. Baker was not giving him his allowance and did not provide food for his school lunch. These are serious complaints against a foster parent. Although John did not want Miles to address the issues with Ms. Baker, Miles had to explain the limits of his ability to keep this information confidential. Miles also encouraged John to speak with Ms. Baker about his complaints with Miles present.

Ms. Baker also had concerns about John and described him as disobedient and disrespectful because he refused to follow directions. Ms. Baker asked Miles to intervene by telling John to obey her rules. There was also pressure by the agency on Miles to come up with a billable diagnosis. A billable diagnosis is usually an Axis I or Axis II diagnosis that would be considered a medical necessity and be accepted by Medical/Medicare for payment. Miles could have given John a diagnosis of Oppositional Defiant Disorder based on the behaviors that had been reported but he was not sure that he understood the context in which these behaviors occurred. Miles wanted to discuss the situation with both Ms. Baker and John before deciding whether a medical necessity existed. Miles requested a conjoint therapy session with John and his foster mom to gather more information about the problems they were encountering. Miles believed that he would be better able to provide tools to enhance their relationship and resolve the communication difficulties once he fully understood the experiences (context) both John and Ms. Baker were having. At the meeting, Miles took time to explain his purpose and role- thus clarifying for Ms. Baker that while he could not act in the capacity of parent (which would constitute a boundary issue) he would facilitate a discussion of her concerns with John during their meeting.

In the first session, Miles listened and Ms. Baker listened to John's story. Miles understood that John had not felt he could rely on any adults to meet his needs. John had been abandoned by both of his parents and his first foster parent who was elderly could not respond to John in ways

that helped him feel secure. Anything that John wanted he had to find ways to get it for himself. John thought of himself as capable of not needing anyone because as he put it "I can take care of myself. I don't need nobody to do nothing for me." When Miles viewed the behaviors from John's experience, he believed that the behaviors were normal responses to a difficult life stressor. Miles decided he would not give John a diagnosis of Oppositional Defiant Disorder because his behavior was not at that level of intensity and was a direct result of John's desire to get his needs met. Instead, Miles decided to use a less intense diagnosis of Adjustment Disorder with Disturbance of Conduct. That diagnosis would be billable but would not carry the stigma of the more intense diagnosis and would fit within the context of John's experiences.

In the second session, Miles discovered that Ms. Baker believed that as a child she was always obedient to her parents. She said she did whatever she was asked to do because she respected her parents understood that their intentions toward her were positive. Ms. Baker trusted her parents to have her best interest in mind whenever they gave her instructions. Miles began to understand that Ms. Baker expected John to have the same response and did not understand that John's experiences with adults did not match hers.

Throughout their next meetings, Miles assessed the dynamics of John and Ms. Baker's shared experiences and integrated those experiences into developing interventions that fit for both Ms. Baker and John. Miles collaborated with both John and Ms. Baker to decide on desired outcomes as a result his understanding of their interactional dynamics. Ms. Baker wanted John to let her know what he needed and in return she would be clear about what she would do in response to his request. She would tell him immediately how she would honor his request or discuss alternatives if she were not able to fulfill John's request. John agreed to follow Ms. Baker's instructions or discuss his objections if he was unable to comply. Miles met with Ms. Baker and John on a weekly basis to review their progress and address any barriers that may have materialized. Through developing a collaborative relationship, Miles, John, and Ms. Baker were able to create effective change to meet each of their need and improve John's functioning.

Conclusion

Culturally relevant approaches are pivotal in providing effective therapeutic services and perhaps even more critical when conducting home-based therapy. Though each culture may require that the provider learn different skill sets, we have presented CHBT guidelines to consider when engaging in home-based therapy with children and adolescents involved in the foster care system. These guidelines may not be all that is needed to produce effective home-based therapy; however, they provide a framework for intervention and treatment from a culturally responsive perspective. The guidelines of establishing strong therapeutic relationships through collaborative communication will naturally lead to contextual assessment and effective treatment planning and interventions that involve the client and their family throughout the entire therapeutic process. This is especially essential in working with foster care youth who often feel powerless in making decisions about their lives. We find that a collaborative, home-based model is effective in bringing about empowerment and meaningful change in client's lives.

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