Beyond the Office Walls: Home Visits, Celebrations, Adventure Therapy, Incidental Encounters and Other Encounters Outside the Office Walls

By Ofer Zur, Ph.D.

Introduction

Interactions between clients and therapists outside the walls of the office, or what have been dubbed "Out-Of-Office Experiences" by Ofer Zur, are the focus of this chapter. Such experiences include home visits to homebound or bedridden clients or home visits to families who do not have the means or organization to travel to family sessions at the office. It also includes adventure or outdoor therapy and home visits that are part of a case management, child welfare or child abuse prevention program. Some clinical interventions are only possible outside the office space, such as going with an agoraphobic client to an open space, accompanying a client to a dreaded medical appointment to which he would not go on his/her own or going on a brisk walk with a depressed, medically non-compliant patient. These, and their like, fall under the heading of out-of-office experiences. This is true also of interventions where, for instance, a therapist attends a client-artist's gallery exhibition or, perhaps, a client's graduation, wedding, etc. There are many other clinical reasons to leave the office: joining an architect to view his/her new building upon its completion; going to see the performance of a young client who overcame shyness and is appearing in a school play, etc. Additionally, the paper discusses the complexities of incidental or chance encounters between therapists and clients that are quite common on college campuses and many other small and interconnected communities, examining particularly the issues of privacy, confidentiality and therapeutic relationships.

While there is limited information on incidental encounters, or what has also been called chance, there are many more articles which focus on home visits in the context of family therapy and case management. There is also a growing body of knowledge on Adventure or Outdoor therapy but there is no single text or group of texts that integrates all these out-of-office experiences. Professionals generally find that the resources needed to guide them in this important area are very thin on the ground.

In addition to describing the different types of out-of-office experiences, the chapter differentiates between and defines boundary crossings, boundary violations and dual relationships. Furthermore, it identifies and contrasts the relationships between out-of-office experiences and different therapeutic orientations. It also looks at the relevant cultural, ethical and standard of care considerations involved in leaving the office.

While analytically oriented practitioners and risk management experts are likely to frown upon any interventions that require departure from the office, this paper will document the differing

stances on such clinically driven and ethically sound boundary crossings by humanistic, family, behavioral, feminist, cultural based, adventure, child, geriatric or social worker therapists.

Home Visits, Home-Based Therapy, and In-Home Therapy

Therapists conduct assessments and treatments in clients' homes for clinical, pragmatic and other reasons. Some clients cannot make it to the therapy office because they are too ill, disabled or too poor. Some families are too disorganized, do not have the means of getting to the office or live too far away to bring all family members together for an office visit. Other families might derive special benefit from a home visit where the therapist can observe the complexities and hardships of their lives and become familiar with the context of their family life, support system (or lack thereof and neighborhood. In some cultures, such as that of certain Indian tribes, the home is a much more acceptable venue for mental health interventions than the medical office. Therapy or assessment at the client's home has been referred to as "in-home" therapy, "home-based" therapy or simply a "home visit".

Boyd-Franklin and Bry listed special opportunities, offered by home-based therapy in comparison to office-based therapy: meet important members of the family, friends, community who are not likely to attend an office session; engage the truly significant and powerful figures in the family; get a first-hand view of the family living situation, especially in regard to overcrowding, poverty, disorganization, etc.; observe the family culture as it manifest itself in food, icons, music, etc.; learn at first hand the family child-rearing practices; and experience the family home through the family members' own eyes.

Most of the literature on home-based therapy has focused on interventions that were either part of family therapy or some type of case management regarding abuse, neglect or foster child concerns. Home-based therapy has been reported with American Indian families, with families whose problems did not improve with traditional out-patient treatment, with drug-abusing adolescents and their families, with chronically mentally ill with juvenile offenders in danger of out-of-home placement, with teenaged mothers in conjunction with Head Start projects with disadvantaged families and Families in Extreme Distress. While home-based therapy is, in many situations, the only available option, there are actually very few studies that compare its efficacy with traditional, office-based therapy.

In the early years of psychotherapy, when analytic thinking was prominent, home visits were not considered a valid clinical option for clinical-tranferencial reasons. However, with the cultural and civil rights revolution of the 60's and the proliferation of psychotherapy in the 60's and 70's, family therapists became more likely to conduct in-home therapy and social workers viewed house visits as a routine part of case management practices. However, it was not until the passage of Public Law 96-272, also known as the Adoption and Child Welfare Act of 1980, that home-based family therapy became significantly more common. The law was enacted partly in an attempt to avoid out-of-home placement of foster children and to also increase their safety through case management and home-based family therapy. The proliferation of case management, primarily conducted by social workers as part of their assessments of child abuse, child neglect and domestic abuse, as well as the increased use of interventions since the early 80's, have made

home visits a normal part of case management assessment and intervention. However, the increased focus on risk management and defensive medicine in the 90's has generally made therapists of all orientations more cautious and less willing to leave the office with the resulting frequent avoidance of in-home therapy.

Let us look more closely at the various reasons for conducting in-home therapy:

Physical/practical reasons

The home visit is likely to be the only option open to many. One of the most obvious reasons for choosing home-based therapy is to treat a homebound, ailing or dying client who is physically unable to leave the house. This includes hospice clients, perhaps dying of cancer or AIDS, who choose to die at home. Then, too, there are such cases as the overwhelmed new mother who is suffering from postpartum depression, the acutely, and thus homebound, agoraphobic, paranoid or OCD patient. Also, sometimes clients or families are simply too poor, disorganized or chaotic to get to the office. Similarly, there are clients who are in acute crisis, which prevents them from coming to the office.

The family doctor making a house call to an ailing child has been a revered part of American mythology and actual medical practice for a long time. However, this practice has not been emulated by most of the psychotherapeutic community. This is largely because of the early domination of the world of psychotherapy by the traditional analytic approach which is strictly office-based due to its emphasis on neutrality and the relative anonymity of analysts.

The geriatric population is growing exponentially and the need for home visits is growing at a parallel pace. Untreated mental illness in elderly patients causes increased suffering and morbidity. In the United States, more than 3 million persons, age 65 and older, are in need of mental health care, yet over half of these individuals do not receive adequate psychiatric services. Traditional, clinic-based mental health programs have not been sufficiently responsive to the needs of mentally ill, elderly patients. Physical, economic, and social barriers may often prevent aged persons from receiving essential psychiatric treatment. Access to such services by homebound mentally ill, elderly patients is even more limited. In addition, elderly patients are generally more reluctant to seek out psychiatric care and are often less likely to recognize the signs and symptoms of mental illness. Too often, senior citizens' concern with physical disabilities may distract them from addressing their psychiatric needs and may limit their access to traditional psychiatric services. There is a need for innovative programs, such as in-home mental treatment, that reach out to the aged population and bring treatment to them. While telehealth is also a growing treatment modality, most older patients are neither inclined to seek such web-based treatment nor are familiar enough with the technology to utilize such services.

Clinical reasons

A home visit can also be a strategic clinical intervention and not one necessitated by the patient's inability to come to the office or connect with the therapist via the Internet. As touched on above, home visits provide the therapist with an expanded opportunity to become familiar with individual clients or family members on their own turf Speck. It enables her/him to observe the home and

get a first-hand sense of its organization, hygiene, atmosphere and resources or lack thereof. Therapists can also get to see what kind of neighborhood the house is located in and what kind of people visit or drop by. During such a home visit or in-home session, the therapist can personally assess neighborhood issues, such as safety, crime, recreation, transportation and communal support. Home visits reveal to the therapist an enormous amount of information in comparison to office-based therapy. This includes family religious and cultural symbols, sleeping arrangements, how people move and occupy different spaces within the house and the fluidity of boundaries in regard to visitors. And, as a guest in the home, the therapist will experience the customs and rituals of hospitality.

Family therapy has embraced in-home therapy more readily than most other orientations. Minuchin's work with slum families in the 70's has often been cited as an example where the home was the preferred venue. Minuchin also supported the inclusion of the larger community as part of family therapy, especially when the family is fragmented and a wider support network is available. Rueveni, in Networking Families in Crisis, outlines the network process, which begins with a home visit to the nuclear family to assess the potential and feasibility of mobilizing the family's network of support. Some family therapists have advocated combining office-based and home-based family therapy as a way to enhance therapeutic outcome.

Case management

Social workers and other psychotherapists regularly conduct home visits for purposes of assessment, crisis intervention, treatment in cases ranging from child abuse, child neglect to domestic violence and other family disturbances. The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272 legitimized and helped the proliferation of home-based mental health assessment and interventions. The law was enacted to address concerns that the foster care system had not done enough to avoid out-of-home placement of children. As a result of the law, numerous programs were developed where mental health and other professionals would work with families at home to help keep children safe in their own homes with their biological parents, siblings and extended families. The impact of the law went beyond foster child issues and, in fact, legitimized the shift towards increasing effectiveness of case management and child and family mental health intervention by working with the families within their natural milieu.

Cultural

Home-based therapy has been used extensively with ethnic minority clients and families, primarily due to the fact that members of these communities often do not trust, and even fear, "foreign" or "main stream" mental health professionals. There is often a reluctance to go to a strange place, such as a formal medical office, to talk to a stranger about personal problems. In addition, transportation concerns, distance and accessibility prevent some poor, minority clients from getting to the therapist's office. Making a home visit with a client from an ethnic minority can be an important component in getting a first-hand view of their home, icons, rituals, neighborhood, community and support system. It is likely to help break the ice, decrease suspicion and increase trust.

Creative Clinical Interventions Not Possible in the Office

There are many situations where interventions are only possible, or likely to be much more effective, if they are conducted outside the boundaries of the office. Some the most frequently cited examples for such out-of-office interventions are in vivo desensitization in the treatment of phobias. In these cases, a therapist leaves the office to go to an open space with an agoraphobic client or perhaps flies with a client with fear of flying as the final step in the behavioral therapy-based, systematic desensitization intervention. Similarly, the "anorexic lunch" and the 'bulimic family dinner" have been reported by family therapists to be highly effective clinical interventions. Going for an aerobic walk with a depressed client may be the only effective intervention with a client who is neither compliant with medication nor with exercise prescriptions and who will not discuss his/her resistance but is willing to go for a vigorous walk with the therapist. Sports psychologists often accompany their athlete-clients to the field in order to instruct, support or observe the clients' attitude and, most importantly, performance. Along the same lines, a therapist may choose to accompany a client to an important medical procedure to which the client would not go on his or her own even though it poses a health risk. Similarly, treating a client's complicated grief over a dead spouse, parent or child may require the therapist to accompany the client to the cemetery or to a funeral, if the client requests it and it is clear that he or she would not/could not go on their own.

Working with the chronically mentally ill outside the office has also been reported quite frequently. This might include walking on nature trails or going for a ride in a car or just sitting on a bench in a nearby park. Clients who have been diagnosed with Anxiety or Bipolar Disorders or schizophrenia are often too agitated, and, at times, paranoid, to spend an entire session in the office. Walking and talking seem to be effective with some of these clients as they neither feel confined to the office nor need to face the therapist but rather are able to walk side by side and are helpfully distracted by the passing scene. Working with restless or defiant adolescents in the office has also been reported to be challenging. Robin Williams playing the therapist in the movie, *Good Will Hunting,* decided to effectively break the ice by taking the highly resistive and distrustful young client, played by Matt Damon, to the riverbank for a walk. Similarly, Zur describes playing basketball with a very despondent adolescent male client who had maintained a hostile silence for a couple of months during therapy. Finally, a meeting was scheduled at the local gym rather than in the office. Meeting on the basketball court and sharing the love of the game melted the clients reserve and helped him open up and to actively participate in therapy. Along the same lines, Jourard writes, "I do not hesitate to play a game of handball with a seeker or visit him in his home - if this unfolds in the dialogue."

Zur illustrates another case of out-of-office experience:
Twenty years after Jill's daughter died in a car crash, I accompanied her, at her request, on her very first visit to her daughter's grave. The psychiatrist who Jill had seen immediately after the crash gave her Valium, to which she became addicted. Her second therapist dismissed her request to be accompanied to the grave as "resistance" and "acting out of the transference." Clearly neither was helpful in her hour of need and both proved to be harmful as they interfered with her grieving process.
In summary, the interventions described above are clearly part of the treatment plan for certain clients under certain conditions in certain contexts. Interventions, such as the in vivo

desensitization, are based on behavioral, evidence-based treatment protocols, while others are based on family, humanistic or biological approaches and are mostly implemented as an adjunct to office-based therapy. Obviously, regardless of the venue in which they are conducted, all are flexible and, at times, creative, clinical interventions that are aimed solely at increasing therapeutic effectiveness.

Honoring Clients' Accomplishments, Rituals and Life Transitions

Besides the situations where clients cannot make it to the office or the treatment plan is leaning towards an out-of-office intervention, there are other situations where the therapist's decision to leave the office is likely to enhance therapeutic alliance and clinical outcome. The therapist may accept invitations to attend significant life transitions and rituals or celebrations in clients' lives. Examples are: attending the wedding of a couple who finally decided to get married after many tumultuous years of pre-marital therapy or attending the graduation of a patient who never thought he would complete his studies. In their national survey, Borys and Pope reported that more than a third of the therapists stated that they accept invitations to special occasions with a few or more clients. Other examples are accepting invitations to the funeral or memorial service of a spouse or child or joining clients to celebrate christenings, confirmations, bar mitzvas and similar events.

Celebrating and otherwise affirming clients' lives and accomplishments is very important validation for many patients who often suffer from low self-esteem and have been lacking external validation or celebrations throughout their lives. Examples of such celebrations are: attending the first performance in a school play of an adolescent girl who, with the help of therapy, overcame her fear of public speaking, viewing the one-man show of a client-sculptor who finally overcame a severe artist's block, visiting a client's 'dream-come-true', newly built winery, and going with a landscape architect, who has overcome drug addiction and depression, to view the magazine prize-winning garden he designed and planted. Such special efforts on the part of the therapist have been reported to significantly increase therapeutic alliance and therapeutic effectiveness.

There are other events that warrant leaving the office. Therapists who work with different cultures inevitably join their Native American clients in some of their sacred rituals, their Latino clients in weddings, their Catholic clients at confirmations, or their Jewish clients for bar or bat mitzvahs. Refusing to do so, in certain cultures, is likely to cause irreparable damage to the therapeutic alliance, to nullify trust and is likely to render therapy ineffective.

The kinds of interventions that involve stepping outside the office confines and joining clients in celebrations and rituals are designed to actively support clients, affirm or celebrate their achievements and enhance therapeutic alliance. Without exception, outcome studies literature has always pointed to the same conclusion: the therapeutic relationship is one of the better, if not the best, predictors of clinical effectiveness and out-of-office interactions are believed to enhance that relationship.

Incidental Encounters

Incidental encounters have been also referred to as "chance encounters" or "chance extra-therapeutic encounters" and refer to unplanned, random or unexpected encounters between the therapist and a current client, which take place in public settings outside the therapist's office.

Incidental encounters are a common and unavoidable occurrence in rural areas and university and college settings. Incidental or chance encounters are also not extraordinary in small communities within larger metropolitan areas, such as political, gay and lesbian ethnic. In the practice of sport psychology and in the military, they are inevitable, especially on remote or isolated bases and aircraft carriers. Clinicians in these communities and settings randomly and frequently encounter their clients in a wide variety of venues from the local food market, social, professional and political gatherings, various community functions, gatherings and events at the local gym, swimming pool and in recreational leagues.

The earliest investigation into chance encounters was conducted by Glover, a psychoanalyst, who called these encounters "extramural" contact. Like Glover, most other psychoanalytically oriented authors focus on the transference ramifications of such encounters and, in general, view them as negatively effecting the clients and disruptive to the analytic process. Diverging from the analytic stance on the disruption of transference analysis caused by chance encounters, Zur asserts that meeting outside the office does not necessarily nullify or negatively affect transference analysis but instead the transferencial reaction is more reality-based and provides more 'grist' for the transference mill.

Chance encounters in college and university communities have received extensive attention. Due to the facts that most therapists in colleges and universities mental health centers are also students or professors, that the counseling center and students' housing are often located on campus and given the particular nature of university and college campuses, incidental encounters are common and unavoidable. Additionally, sports events, departmental social gatherings, graduations and other ceremonies significantly increase the probability of chance encounters between therapists and clients. Most of the concerns with chance encounters on campuses have focused on the issue of confidentiality. Unlike most common beliefs, Pulakod reported that students are not as concerned about confidentiality as their therapists and in fact wanted more interaction, not less, when they accidentally encounter their therapists on campus. Sharkin pointed out that therapists avoiding interactions might inadvertently expose the therapeutic relationships rather than protect its confidentiality. In a title that speaks for itself, Hyman entitled his chapter on chance encounters between therapists and students on campuses "The Shirtless Jock Therapist and the Bikini-Clad Client."

In dealing with chance encounters, most scholars agree that, when possible, and in situations where such encounters are expected, talking to clients and taking precautions is extremely important. These precautions usually involve discussing the possibility of accidental encounters with the clients at the beginning of therapy and understanding clients' preferred ways of handling them. Intake material and informed consent can also prepare clients for an inevitable, incidental encounter. Analytically oriented therapists tend to try to avoid incidental encounters all together and when that fails, at least to keep them to the minimum possible. In contrast, humanistic,

feminist and existential therapists are more likely to focus on a genuine, appropriate and respectful exchange rather than indiscriminately trying to avoid or minimize any exchange whatsoever. When encountering a client in public, several authors emphasize the importance of taking the cue from the client before choosing to ignore or address the client. Discussing incidental encounters with clients in subsequent therapy sessions can be beneficial. However, routine or brief encounters may not merit any lengthy discussion. The nature and importance of such discussions *depends* on the therapists' orientation and the frequency, predictability, type, length, quality and significance of such encounters, the nature of the therapeutic relationships and the type of clients.

Outdoor or Adventure Therapy

The proliferation of drug rehabilitation inpatient programs and remotely located alternative boarding high schools in the last couple of decades has resulted in a huge rise in utilization of outdoor or adventure therapy. This therapeutic approach is known by various names. It has been called Adventure Therapy, Wilderness Therapy, Outdoor Therapy, Camping Therapy, Outdoor Pursuits, and Risk Education. What unifies these programs is that they are conducted in the outdoors where patients are physically and emotionally challenged to overcome their fears and reassess their self-perceptions. They examine their beliefs in both their limitations and abilities and learn to rely on themselves and the group in order to carry out a variety of tasks assigned them.

Adventure therapy or Wilderness Programs are mostly conducted in remote settings but can also be located in urban settings where there are indoor facilities for rock climbing or trapeze structures and rope courses. Outdoors, they mostly include activities such as backpacking, hiking, biking, camping, canoeing, rope courses, navigating, vision quests, rock-climbing and repelling down cliffs. These forms of therapy are usually highly structured and are composed of individual and group challenges with a corresponding mix of individual risk taking, overcoming fears and group cooperation. It has been used extensively with high-risk adolescents in boarding schools and drug rehabilitation programs. It has also been used as an adjunct to therapy with long-term mental illness, intellectual disability, substance abuse, fearful, withdrawn or avoidance clients, rehabilitation of juvenile delinquents, families in crisis and the hearing impaired.

Participation in activities, such as backpacking or rock-climbing obviously does not constitute adventure-based counseling by itself. Adventure or outdoor therapy is differentiated from recreation or physical fitness in that it is geared specifically to eliciting therapeutic change and, like most clinical interventions, is designed for the purpose of changing one's affect, behavior and/or cognition. There are six qualities that generally characterize adventure therapy, they include: (a) establishment of individual and group goals, (b) building trust among participants, (c) providing activities that challenge and elicit fear and/or stress, (d) participating in activities requiring problem-solving abilities, (e) participating in activities that are fun to do, and (f) a peak experience which is the culmination of the program. Adventure therapy is based on highly structured, carefully planned, sequential, challenging activities where each activity has a specific goal that is often articulated and achieved before the next activity takes place. Consequences in adventure therapy are generally not specified by therapists or other authority figures, but are allowed to become apparent in the obvious consequences occurring in the natural unfolding of the exercise.

Overcoming one's apprehensions and faulty cognitions and perceptions of limitations by taking risks and relying on others is often the most essential part of these therapies. The outdoor setting is essential as such physical and emotional challenges are obviously impossible within the confines of the office.

Additional Out-of-Office Interventions

There are additional clinical exchanges, not mentioned above, that cannot be conducted in the office. These include hospital visits where the sessions are conducted neither at the psychotherapy office nor at the client's home. Another example is working as a military psychologist on an aircraft carrier or military base. In the situations, the psychologist is likely to treat the person as necessary, wherever they are. This can be on deck, in the mess hall, engine room, in the client's living quarters or even on the battlefield. Aircraft carriers, in particular, do not have space to spare, and psychologists may not even have an office. Psychiatric crisis teams obviously are not confined to the office or the client's home but instead are trained to meet the client wherever they are, whether it is on the street or under a bridge.

Dual Relationships in the Community

Dual relationships with clients almost always involve out-of-office experiences. Therapists and clients who happen to attend the same church, are active in local charities, belong to the same club or chamber of commerce or play in the same sports league inevitably face planned and unplanned encounters outside the office as part of these dual relationships. Dual relationships are common, inevitable, unavoidable, normal and a healthy part of communal life in numerous settings - rural, small town, ethnic and other interdependent communities. A detailed discussion of dual relationships is beyond the scope of this paper; however, the reader who wishes to pursue this topic may turn to the Lazarus & Zur of 2002 text *Dual Relationships and Psychotherapy and Zur's 2007 and 2017 texts* which provide the most comprehensive, up-to-date review of the nature and types of dual relationships and the legal, ethical and clinical considerations. Out-of-office encounters that are part of existing social dual relationships have much less clinical significance as the therapists and clients are already involved in relationships outside the offices' walls. For example, if therapists and clients are also members of the same congregation, chance encounters are expected and normal and considered a natural part of communal life.

Theoretical Orientations

The various clinical strategies to intervene outside the office, like most therapeutic interventions, are closely related to therapists' clinical orientations. As a result, there is very little agreement among psychotherapists from different orientations regarding the clinical significance and importance of such interventions.

Analytically oriented therapists who emphasize keeping the analyst's anonymity and therapeutic boundaries clear, consistent and distant, obviously are not likely to initiate out-of-office experiences. The analytic rationale is that such experiences are likely to taint the transference and countertransference analysis. Similarly, the effect of incidental encounters on the therapeutic frame is a concern for almost all psychoanalysts and psychoanalytically oriented therapists. Many

analysts conceive the effect of any boundary crossing to be intrinsically negative and hence believe that it invariably interferes with clinical work. According to traditional analysts, effective management of transference and other therapeutic work requires clear and consistent boundaries that enable the therapist to preserve the analytic frame of therapy. Transgressions that detract from therapists' neutrality, such as out-of-office experiences, are said to contaminate the transference and are a detriment to analysis. Along the same lines, Simon advocates, "Maintain therapist neutrality. Foster psychological separateness of the patient . . . Preserve relative anonymity of the therapist. While most psychoanalysts disagree, claims that out-of-office encounters do not, necessarily, interfere with transference analysis. In his words, "it is all grist to the transference mill".

Unlike the analytic tradition, humanistic psychology has a very different view on boundary crossing, including leaving the office, incidental encounters and dual relationships. Representing the humanistic view, Jourard admits that he does not hesitate to play a game of handball with a seeker or make a home visit if it enhances the therapeutic relationship. Similarly, Williams states that "Nothing in the theory of behavior therapy would or should preclude socializing with patients, taking meals with them, giving them gifts, or treating them at their homes, schools or offices". Humanistic and existential therapies emphasize congruence and authenticity of therapist-client relationships.

Behavioral and cognitive-behavioral therapists would also support leaving the office for clinical reasons, such as going to the zoo to deal with a fear of snakes or driving with a fearful client over a bridge. Many feminist therapists support any therapist-client interactions that reduce the traditional doctor-patient power differential and increase familiarity. Attending a client's graduation or joining a client at a political rally are likely to level the playing field, which are consistent with feminist ethics.

Culture-sensitive therapists and those who work with adolescents, the chronically mentally ill, the disabled and the disadvantaged, emphasize flexibility and respect for clients' traditions, culture, economic needs, etc. They endorse, when appropriate, home visits, going on hikes and accepting clients' invitations to important rituals or ceremonies. Many family therapists, social workers and case managers believe in the efficacy of home-based therapy and the importance of home visits for assessment and interventions. Obviously, adventure or outdoor therapists endorse the out-of-office experience as they carry on their entire therapy in the out of doors and in nature.

In summary, many theoretical orientations support leaving the office if it is likely to enhance assessment, therapeutic alliance and therapeutic outcome, as well as in the cases where clients are not able to come to the office for medical, physical, emotional, financial or cultural reasons. Behavioral and cognitive behavioral therapists endorse such interventions if they are likely to be clinically effective, primarily in the treatment of phobias and depression. Many family therapists consider home visits, in contrast to office visits, as highly effective in making assessments and a better place to conduct family therapy interventions. Humanistic, existential and feminist therapies are likely to endorse out-of-office experiences if they are geared to enhancing congruent and authentic relationships and reducing some of the authoritative power of therapists as

perceived by clients. Culture-based therapies endorse joining clients for rituals or making home visits as a way to respectfully meet clients in their normal surroundings.

On Boundary Crossings, Boundary Violations and Dual Relationships

All out-of-office experiences are boundary crossings as they obviously involve crossing one of the most fundamental boundaries of psychotherapy - that formed by the office walls. It is highly important to differentiate between boundary crossing, a term that refers to any deviation from traditional analytic and risk management practices, e.g., strict, 'only in the office,' therapy, and dual relationships, which refer to situations where two or more connections exist between a therapist and a client. It is just as important to differentiate between harmful boundary violations and helpful boundary crossings. A boundary violation occurs when a therapist crosses the line of decency and integrity and misuses his/her power to exploit a client for the therapist's own benefit. Boundary violations usually involve exploitive business or sexual relationships. Boundary violations are always unethical and are likely to be illegal. However, as this paper illustrates, boundary crossings are often part of well-constructed treatment plans and, as such, they can increase therapeutic effectiveness. Obviously, not all boundary crossings constitute dual relationships.

Except for the specific short section that discusses dual relationships, all other out-of-office experiences discussed in this chapter are boundary crossings, not dual relationships. Home visits, clinical interventions outside the office, honoring and participating in clients' accomplishments and life transitions, incidental encounters and adventure therapy do not involve a secondary relationship beside the clinical one. As the out-of-office interventions discussed in the chapter are designed to enhance clinical effectiveness and client welfare, they are considered boundary crossings rather than boundary violations.

Therapeutic Boundaries: Confidentiality, Time, Participation, Location and Safety Considerations

In the discussion of out-of-office experiences, one of the most frequently cited concerns is the issue of confidentiality. Concern with confidentiality has been discussed relative to home-based therapy, incidental encounters, in general, and especially incidental encounters in college towns where there is a good deal of incidental interaction on campus and in the community, as previously discussed. The concern in all these situations is that the therapist-client relationship can be revealed to other people in the community without the knowledge, consent or control of either therapist or client.

Home-based therapy presents a number of challenges to the privacy of the communication between therapist and client. Neighbors, friends and additional family members who may drop by the house or join a session or be invited by some family members to join the session are then privy to confidential communications. While these additional people are present at the therapy session with the family's, or at least some family members', permission, this situation still stretches the concept of privacy and confidentiality beyond the traditional professional view.

Some authors view the concern with confidentiality in out-of-office experiences as exaggerated and point to the widespread erroneous belief that "privacy" and "confidentiality" are synonymous. Lazarus underscored this after a critic claimed that the very act of socializing with a client is a

breach of confidentiality. Lazarus responded as follows: "When I am sitting at a lunch counter and socializing with a patient at his request, how does this violate his privacy or confidentiality? I get the feeling that [my critic] believes that I may be overcome by the urge to turn to the person alongside me and blurt out, 'This is Tim Smith, a patient I am treating for guilt over his extramarital affairs,'". Ebert emphasizes the importance of the constitutional right for freedom of association. Similarly, Zur also pointed out that it is the client's right to determine if s/he is comfortable with public knowledge of the therapeutic relationship or not and, as an example, reports clients who openly acknowledged his therapeutic role during a wedding ceremony. Pulakod discovered that many clients, during incidental encounters, are not as concerned about confidentiality as their therapists are, and Sharkin pointed out that therapists, by avoiding interactions, might inadvertently breach, rather than protect, confidentiality.

Length of sessions, and time of the beginning and end of sessions are often not under the control of the therapist during home visits, tour of a gallery or winery, attending a wedding or funeral, walking on a trail or participating in adventure therapy. While sometimes the therapist can determine the beginning of the therapeutic encounter, this is not always true for the end of sessions. In family-based, home therapy, some family members may have to leave or choose to leave in the middle of a session, others may respond to a phone call or a knock on the door which may cause them to leave the session. Therapists who choose to join clients in rituals, ceremonies, gallery openings or school plays have no control over how long these may last. Adventure therapy often takes unexpected turns that do not conform to the 50-minute hour or any other pre-determined time frame. Most trained therapists who conduct home visits or adventure therapy or who leave the office for a variety of clinical reasons, do not expect to exercise full control over the length of the sessions and, therefore, incorporate a more flexible approach to time and space. When appropriate, these therapists do not even try to determine the end of the activity but, instead, as often is the case with outdoor encounters, leave it open and let the process itself determine its end point. In the case of most chance encounters, therapists have neither control nor ability to even predict when and where the encounter may take place and how long it will last.

Determining who is and who is not part of a certain clinical encounter cannot be taken for granted once the therapist leaves the office and conducts therapy in a client's home or in public places. Conducting therapy at the client's home requires flexibility and tolerance for unpredictability on the part of the therapist. Even when only the immediate family has been scheduled for a session, a curious or concerned aunt or uncle may decide to join in, one of the teenagers may get a call on their cell phone and leave to join his/her friends or a boyfriend may decide to check out the home-shrink. Experienced therapists expect such unexpected changes and many view such unpredictable changes as part of the assessment and intervene according to what is presented and who is present. While these unexpected events can add richness to the session, they can also pose difficult challenges, as in the case when an abusive or violent boyfriend or controlling and intrusive relative decides to join in. Obviously, while attending a school play, ritual, wedding, graduation or medical appointment, the therapist has no control over who is part of the occasion. Even when a walk with a depressed person or a private one-on-one basketball game with a resistive adolescent or a lunch with a bulimic patient is intended to be private, there is no way to predict when a friend or acquaintance may interrupt or even join in.

The safety of the psychotherapist in the course of home-based therapy is a consideration that has also frequently been raised. Female therapists have reported concern with their physical safety when visiting a home where domestic violence has been reported. Similarly, visiting an unsafe neighborhood may pose a physical danger to therapists, especially if they are unfamiliar with the neighborhood and/or the local culture. The client's safety is also of concern in out-of-office interventions. Situations may conceivably arise with clients who become acutely panicked, anxious, psychotic or paranoid while on a walk or anywhere else outside the office. Therapists who leave the safety of the office environment are inevitably exposing themselves and their clients to increased unpredictability and possibility of surprise. Adventure or outdoor therapy with its physical challenges and risk definitely includes built-in safety considerations. While back-ups, cell phones, first aid kits and contingency plans are often available and established ahead of time in the office setting, more careful contingency plans must be constructed for encounters outside the office.

In summary, once the therapist leaves the boundaries of the office, defined by the office walls, there are several significant boundary issues that must be taken into consideration. Privacy may not be protected and confidentiality may be compromised. S/he may not have control over the time therapy starts or ends or who is or is not part of the clinical encounter. Leaving the office inevitably increases the level of unpredictability and, in certain situations, even physical risk. While these challenges to traditional therapeutic boundaries are overwhelming or even unacceptable to some therapists, many others, who routinely work in such situations, look forward to and welcome this level of flexibility, complexity and unpredictability and see these as a potential enhancement of the therapeutic process.

Ethics, Standard of Care, and Risk Management Considerations

Professional associations' codes of ethics, such as the American Psychological Association, do not directly address the concerns of out-of-office interventions and encounters. The standard of care is defined as qualities and conditions that prevail or should prevail in a particular mental health service and that a reasonable and prudent practitioner follows. The standard is based on community and professional standards, as well as on state laws, case law, licensing boards' regulations, a consensus of professionals, ethics codes of professional associations and a consensus in the community. The standard of care is not an objective yardstick to be found in any textbook, nor is it closely tied to one particular theoretical orientation. Home-based therapy, outdoor intervention or in vivo exposure, like any other out-of-office intervention that is part of a theoretically based treatment plan, are clearly within the standard of care of behavioral, humanistic, family, group and other non-analytic therapies. Similarly, attending a wedding, bar mitzvah or other ritual or visiting a patient in the hospital, all fall within the standard of care if they are done with planning, are congruent with the local culture, are grounded in the therapist's theoretical orientation and are executed with the client's welfare in mind.

Concerns with Risk Management have often been cited relative to out-of-office interventions. Meeting with clients outside the office has been frowned upon for legal, ethical and clinical reasons. They have been called boundary violations and boundary transgressions.

In response to an increase in client complaints and litigation, insurance companies, ethics committees, licensing boards, and attorneys have been advising therapists to "practice defensively" and to employ "risk management techniques". Similarly, consumer advocates advise against most boundary crossings, including leaving the office, in an attempt to protect the public from exploiting therapists. Simon, like many other risk management experts, does not differentiate clearly between boundary crossing and boundary violation and warns that, "The boundary violation precursors of therapist-patient sex can be as psychologically damaging as the actual sexual involvement itself". As a result of risk management warnings, attorneys' advice and licensing boards' words of caution, therapists are acting out of fear of lawsuits and board sanctions rather than according to what is effective and helpful. Consequently, clinical judgment and treatment are often compromised.

Out-of-office experiences have also been placed high on the "slippery slope" list of items. The term "slippery slope" alludes to a snowball dynamic and has been described as follows: " . . . the crossing of one boundary without obvious catastrophic results in making it easier to cross the next boundary." Gabbard cite meetings outside the office for lunch or dinner as examples of the first steps on the slippery slope.

The primary rationale behind the argument to abstain from all out-of-office experiences or dual relationships, thus avoiding the slippery slope, is that therapists may misuse their power to influence and exploit clients for their own benefit and to the clients' detriment. The argument is that the uneven balance of power enables and encourages therapists to exploit and harm their clients upon leaving the office. It is there that they enter into dual relationships that venture beyond the threshold of the purely professional therapeutic hour. This, in turn, fosters exploitation by the more authoritative clinician or counselor. In response to that argument, Tomm claims eloquently "It is not the power itself that corrupts, it is the disposition to corruption (or lack of personal responsibility) that is amplified by the power". Dineen had argued that the bias against boundary crossing stems in part from a cultural and professional tendency to sexualize all boundary crossings.

There is a debate as to whether risk management and its injunction against leaving the office is geared to protect consumers or therapists. Several authors have pointed out that, like defensive medicine, risk management guidelines are primarily engineered to protect the treating therapists rather than the clients has stated that, "One of the worst professional or ethical violations is that of permitting current risk-management principles to take precedence over human interventions". Following most risk management, defensive medicine or analytic guidelines by avoiding all out-of-office experiences and restricting therapy only to the office would leave millions of bed-ridden, home or hospital bound, poor, disorganized, addicted, chronically mentally ill and many other clients untreated. It would eliminate home-based family therapy and adventure or outdoor therapy. It would also lead to increased distrust among many minority and ethnic clients and many other clients who want their therapists to join them in celebrations, rituals or visits to their theater performances, gallery openings or any of those events in which they take great pride.

Contrary to most risk management warnings, Zur raised the concern that the rigid employment of only-in-the-office policies often increases therapists' perceived power and, therefore, increases the chance of exploitation rather than decreases it. Citing brainwashing techniques, cults and other mind control systems, as well as domestic violence research, he asserts that therapeutic isolation, like any isolation, can increase the likelihood of therapists exploiting their clients.

In summary, conducting therapy outside the office raises important and complex issues in regard to the standard of care, the acceptability of such intervention as a standard and its legitimacy as a reimbursable medical or mental health procedure. Also, it raises questions in regard to exploitation, power differential and defensive medicine. This section articulates how clinically driven, out-of-office interventions are clearly within the standard of care, bearing numerous legitimate CPT codes, and are neither unethical per se nor lead to exploitation or harm. Some argue that **not** leaving the office, even when it is clinically indicated, is unethical and immoral as it deprives clients of the best care possible.

CPT Codes for Out-of-Office Services

There are numerous Current Procedural Terminology CPT) codes that address different types of out-of-office experiences. Mental health home visits are covered under codes, such as Psychiatric Diagnostic Evaluation. Psychotherapy with patient and/or family member, Rest home, Established patient, Home Service, New patient, and Established patient.

Summary

Interactions with clients outside the office occur in different places and for different reasons. Many clinical interventions, such as adventure or nature therapy or family and child therapy can only be conducted outside the office. Similarly, therapy with bed-ridden or homebound patients or with poor or highly disorganized families can only take place at home. After the passage of Public Laws 96-272, also known as the Adoption and Child Welfare Act of 1980, home-based family therapy became significantly more common. The law was enacted partly in an attempt to avoid out-of-home placement of foster children by increasing their safety through case management and home-based family therapy. Some ethnic minorities and illegal immigrants are often reluctant to come to a formal office setting for a variety of reasons. There are also many instances where leaving the office is likely to increase therapeutic alliance and therapeutic effectiveness. These situations include attending clients' graduations, weddings, school plays or art exhibitions, for example. Attending cultural rituals and making home visits are viewed as essential in establishing trust and credibility with certain ethnic minorities.

Other forms of interacting with clients outside the office walls are incidental or chance encounters and interactions in public that are a normal part of communal living in small or rural communities.

While traditional analytic therapy has viewed out-of-office experiences as negative, other orientations, such as humanistic, family, behavioral, feminist, and cultural-based therapy acknowledge that such encounters can be valuable to the clinical process. Interventions that are performed outside the office, are based on theoretical orientation, are in consort with community standards and customs and are conducted with the client's welfare in mind are consistent with the

standard of care. Professional organizations' codes of ethics neither specifically mention out-of-office experiences nor state that they are unethical or ill advised.

Encountering a client outside the office often involves a different set of expectations and boundaries than the professional office represents. Therapists do not always control the start or end of these interventions or who is included or excluded. Privacy is often compromised in such interventions and safety considerations must be taken into account in certain environments.

In designing an out-of-office intervention, as with any other intervention, the therapist must consider the client's culture, history, presenting problem, personality, family situation, economic status, and any other element that rounds out the knowledge of the individual. Documentation of the rationale for leaving the office is important and so are consultations in complex cases. Always, as with any other intervention, the welfare of the client and the avoidance of harm are paramount.