Home Office:

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Table Of Contents

Self-Disclosure
Emotional Elements
Safety
Suitability
Screening
Managing Time, Places and People
Ethical Considerations
Standard of Care

Boundary Crossing
Risk Management
Informed Consent
Privacy & Confidentiality
Benefits & Burdens
License, Taxes, Insurance
Summary
References

The home-based psychotherapy practice presents practitioners, clients and practitioners' family members with a number of clinical and familial complications and boundary challenges that are unique to this type of practice setting. The primary factor regarding such complexities is related to the increased crossover of the professional and personal life that occurs with a home office practice. Main concerns include how the increase in self-disclosure might affect clients and the process of therapy, as well as how an in-home office affects the quality of family life. While there are certain conveniences and financial benefits to practicing at home, there is also the prospect of deciding how to place boundaries regarding people, places and times.

Therapists seeing clients from their own homes is clearly a boundary issue as it involves professional relationships outside the traditional place of business and the blurring of the personal and professional aspects of therapists' lives (Gutheil, & Gabbard 1993; Zur, 2003, 2007). The home office arrangement invites clients into the therapists' most personal domain, their homes. It exposes numerous aspects of the therapists' lives to their clients, which would not be exposed in a traditional psychotherapy office. It also can easily expose clients to therapists' family members, neighbors, pets or whoever else resides in or near the house and vise versa, although this will vary from practice to practice.

Home offices come in different formats and arrangements. Some offices are located in detached units with separate driveways and entrances, distanced from the main residence. On the other end of the spectrum are the offices that are located in the therapists' living rooms, offices or converted bedrooms within the homes. In between these two arrangements, there are many variations in regard to which entrances or which bathrooms clients use and what part of the therapists' private home they get to see. The ages of the people who reside with the therapists will also vary significantly. The presence of young children or teenagers, who are often less conscious of physical and time boundaries, may also be more apparent to clients, creating not only more self-disclosure but potentially more disruption or background noise.

The predominant concerns with home-based therapy include the impact of home-based practice on the efficacy of the therapeutic process as it primarily relates to self-disclosure and privacy and the fact that clients are invited into the therapist's private space (Woody, 1999). Additional concerns include safety and privacy for therapists and their families and the impact of the practice on the therapist's personal life and that of the family. This paper will describe the boundaries and concerns related to the home office practice. These include self-disclosure, emotional aspects of home office practice, safety, suitability, screening, managing time, places and people, privacy and confidentiality, informed consent, benefits and concerns for therapists and, finally, ethical considerations (Zur, 2007).

The private practice of psychoanalysis began when Freud started a practice in his own home (Keisner, 1990). There are additional general references to home practice by Mahler, Jung and other forefathers and foremothers who practiced, at least sometimes, from their homes. Winnicott, as one example, took young patients into his home as part of their treatment (Gutheil & Gabbard, 1993). Despite this long history, and the fact that interest in home sessions has not waned over the years, there is no body of formal literature that examines the conscious or unconscious motives of a therapist who chooses to practice in a home office setting nor the emotional consequences to the therapist, the therapists' family or the client. A few exceptions to the scarcity of resources are Maroda (2007), Langs (2007) and Pepper (2003). This absence of focus is interesting in light of studies from ecological psychology that have identified setting as the best predictor of human behavior (Barker, (1965). In contrast, industrial psychology has developed a general work-family theory to describe how the complex relationships between work, home and family effect the general satisfaction of the individual and family (e.g., Clark, 2000; Kanter, 1977).

Self-Disclosure

The concept of self-disclosure relevant to clinical practice has a long history of research and discussion, very little of which addresses the issue of self-disclosure as it relates directly to home office practice. Among the earliest, most popular modalities, psychodynamic therapy and behavioral therapy were in agreement that therapist self-disclosure was out of place in the therapeutic relationship (Auvil & Silver, 1984; Jacobs, 1999). Therapist self-disclosure gradually gained increased acceptance with the rise of the humanist movement in the 1950s and 60s. With this new approach, came the possibility that therapists might give information about themselves to clients as part of a therapeutic process that valued the congruence and

transparency of the therapist in relation to the client (Jourard, 1971; Rogers, 1951; 1961). A political dimension was added by the feminist movement in which self-disclosure was viewed as supporting the development of a more egalitarian relationship, allowing a client to choose a role model (Simi & Mahalik, 1997). Some modern psychodynamic therapists have also considered the possibility of a positive role for self-disclosure in their modality (Bridges, 2001; Jacobs, 1999). Although professional attitudes towards self-disclosure have been generally tied to theoretical orientation (Williams, 1997), a clear evolution can be detected where self-disclosure has been becoming, clinically and ethically, an increasingly more acceptable therapeutic tool (Lazarus & Zur, 2002; Zur, 2007).

Simply defined, self-disclosure, as it relates to home office practice, occurs when psychotherapists reveal personal rather than professional information about themselves that would be unlikely to be revealed in a traditional medical or business office setting. Such information can be biographical, familial or any other aspects of the therapists' personal life. Self-disclosure is usually discussed in terms of therapists' deliberate and intentional *verbal* expressions of personal information. From a broader perspective, self-disclosure is the process where therapists reveal, intentionally or unintentionally, any personal aspects of themselves to their clients (Barnett, 1998). Under this broader definition, self-disclosure is neither always a deliberate action nor by choice of the therapists. A certain amount of self-disclosure is unavoidable in any practice setting and a large majority of psychotherapists (93.3%) admit to utilizing self-disclosure to some degree (Pope, Tabachnick & Keith-Spiegel, 1987). Even for those analysts who strive to maximally minimize self-disclosure, it is generally conceded that every intervention hides some things about the analyst and reveals others (Chused, 1990; Greenberg, 1991). Thusly defined, the issue is not whether to disclose, but how to manage the unavoidable condition of constant disclosure, regardless of the practice setting (Livingston, 2000). The degree of non-verbal, and in some cases unintentional, self-disclosure is automatically elevated when a clinician practices within his or her home.

The home-office situation automatically reveals where the therapist lives, the price range of their residence, the socio-cultural aspects of their neighborhood and how well kept their homes and gardens are. Depending where the office is located the home office may also reveal how therpists' living rooms are furnished and kept and what these things might possibly reflect about their level of functioning and what they value. Depending on planned boundaries, or accidental occurrences they might reveal how clean the bathrooms are, their domestic partnership status, how many children they have and how they behave, or how the therapist behaves in relationship to family members or pets (Maeder, 1989).

The Woody Allen movie, *Deconstructing Harry,* while true to the producer's exaggerated style, has illustrated how a home office can reveal intimate details of a therapists' marriage. In this particular movie, Woody Allen is married to a psychoanalyst working out of their home. When she discovers her husband had an affair with one of her female clients (whom he had originally met in the living room-waiting room) she cannot contain herself. She leaves her client on the couch in the middle of the session, bursts in on her husband in another room and roundly curses him for his transgression. The client, of course, can hear the screaming and every word of the argument from the couch. The therapist intermittently, returns to the therapy session and makes a poor attempt to appear concerned and focused on the well being of the client. Although grossly exaggerated for effect, the movie illustrates how private information about a therapist's marriage and emotional life, especially at times of crisis, can more easily be revealed to clients in a home office environment. It highlights the issue of

greatly diminished role transition time for the therapist working in a home office setting, and clearly illustrates how therapists may sometimes be so distracted by their personal issues, that thoughts of the clients' well being recede into the background.

Prime, another movie that touches on the home office situation is also a film which abounds with issues related to dual relationship, confidentiality, therapists' need for professional consultations, boundaries and ethical considerations. The therapist in this movie is surprised to learn that her son is dating one of her clients. This epiphany dawns on her well after she has created a strong therapeutic bond with her client and has heard much more about the intimate aspects of the client and sons' relationship than any of them would choose. The therapist finds her own neurotic features leaking into the therapy and finds her personal needs clashing with her ethical intentions as a therapist. In one scene, her son walks out of the front door, carefully timing his exit from 'home' because his mother tells him a client is arriving at the 'office'. The therapist looses track of time and the two narrowly miss running into one another as home and office almost collide. In another scene, the therapist, seeing the son's middle school picture displayed, jumps up in the middle of a session to turn it face down. The film blends humor with touching gravity. Finally, the therapy is terminated, with the client feeling betrayed, then subsequently being received through the "family" door as the girlfriend of the therapists' son.

When practicing from a home office, a therapist has a responsibility, which involves a series of conscious decisions about what categories of things will be communicated through non-verbal self-disclosure. This includes, among other things, whether or not clients come into contact with family members, which parts of the home are available to clients, or how art, family pictures, or other objects visible to the client may indicate aspects of the therapists' values or personal relationships (Zur, 2007). The therapist has the additional responsibility of maintaining an awareness of how these aspects of self-disclosure might impact individual clients and their unique treatment needs. A variety of unexpected events can arise at the home office. There may be children's fights, loud music, and interruption of the session by family members or unwitting neighbors or friends. Children, in particular, are likely to innocently cross boundaries, drawn by curiosity or when seeking company, support and help from the therapist-parent. The concern is that for some clients, such exposure can be too overwhelming (Pepper, 2003).

Another category of non-verbal self-disclosure addresses the communication issue of "metacommunication" in which an intentional or unintentional interpersonal meaning is received along with the literal message itself (Perlmutter & Hatfiels, 1980; Schwartz, 1993). For example, the literal message, "I work from my home office" holds the simple literal meaning regarding an office in the building in which one lives, while the metacommunication may very well be "I am willing to allow you into part of the personal space of my self and the elements of my own life".

Emotional Elements

In the absence of data from formal studies on the emotional impact of a home office practice, several authors have addressed the topic and offer some intriguing possibilities for

consideration. An in-depth discussion of transference is beyond the scope of this paper however Gordon (1997) offers the following practical considerations with regard to this issue relevant to home office practice. Freud coined the term transference and generally defined it as a distorted perception of an individual based on one's past significant relationships. He believed that transferences are particularly activated with differences in power, which tend to recapitulate the powerfully ambivalent child-parent relationship. The term has made its way from psychoanalytic circles into mainstream psychology. Although therapists from some modalities, cognitive-behavioral therapists for example, do not utilize the concept of transference, therapists from many modalities share a general acknowledgment that most relationships can be seen as objective and subjective, real and symbolic at the same time. The increased self-disclosure, as well as other elements of the setting present in home office practice, might complicate this process. The primary way by which a therapist of any orientation can manage these perceptions, which are distorted by earlier experiences, is to provide "reality clarification". In it's simplest form, this involves reminding the patient about the reality of the present therapeutic relationship by clarifying the reality of the roles, tasks, boundaries and ground rules of treatment, thereby bringing them back to the present from feelings transferred from their past child-parent relationship. The reality clarification serves to restore the reality of the person, the role of the therapist, and the reality of the therapeutic work.

Keisner (1990) has written one of the very few articles devoted exclusively to the home office setting. He suggests that, in addition to, the more conscious motives for a home office choice of venue, such as financial and various increased conveniences, there may be unconscious motives related to the therapists' personal issues of separation anxiety, individuation, narcissism or dominance. The therapist can literally go to work without leaving the security of home, having all of the comforts and pleasures of home instantly available between sessions. Security objects in the form of satisfying people, pets, food, ones own bed etc. are constantly available. This provides almost instant gratification for a variety of needs. Hence, according to Keisner, home practice may support the gratification of certain symbiotic needs and help to defend against separation anxiety.

Mahler, Pine, & Bergman (1975) suggest that working from ones home may also relate to a therapist issues regarding stages of the separation/individuation process as it involves "coming home and going to work", "leaving and returning to" security people and objects multiple times each day. The process shares familiar features of the rapprochement phase of separation/individuation.

Both normal and pathological narcissistic needs may also be in play as therapists working in the home setting are "showing" their clients the level monetary, social and class success they have achieved. The therapist can ask him or herself how much the admiration is needed to support ones sense of self-esteem. With regard to the clients' experience, it is helpful to note, that when therapists share the most satisfying aspects of their lives with clients, it can trigger issues related to envy. While many clients fantasize that therapists possess what they want for themselves, actual confirmatory data can be deeply humiliating. Also, paradoxically, sharing certain information with a client can decrease the client's sense of what is shared because it is experienced as a flaunting of differences (Schwartz, 1993).

Territoriality research suggests that people are more powerful and dominant when they are in their own place (Martindale, 1971). Although this is true of a traditional business office, a home office presents far less neutral territory to both the therapist and the client. The therapist

can consider this aspect relative to their own internal dynamic while also being aware that it might create an obstacle to their client freely expressing their own power and natural dominance.

Safety

Safety considerations are of paramount importance in the home office setting, as it normally does not provide the therapist with the same level of protection as a standard medical or business office (Zur, 2007). When working with potentially violent clients in a standard office, there are often other therapists, staff or receptionists in close proximity. In extreme cases, therapists may resort to the use of panic buttons, the door to the consulting room may stay open or another therapist may be present during the interview. These options are not very readily available or even advisable in the home-based setting.

Safety issues go beyond the therapist's well being as the home office setup may expose children, spouse or other family members and pets to potentially volatile or violent clients. The concern with a dangerous client in the home office is that if he or she was not screened out on the phone or identified in the course of some other pre-therapy interview, that client has become privy to the location of the therapist's residence and with whom the therapist lives, who lives nearby and even the layout of the house. Screening for violent, dangerous, paranoid, intrusive, psychopathic individuals or any client who may pose a danger to therapists or their families is extremely important in the home office practice. Such patients are never acceptable for treatment in the home office.

Suitability

Suitability of clients to be treated in the unique setting of a home is a matter to be judged carefully. While this often less formal setting can benefit some types of clients, it is not appropriate for several others. Issues of parking, entrances, waiting areas, etc. are usually clearly defined in a standard medical practice but are often much less defined in the home office arrangement. Clients need to be informed of boundaries and respect them. They must honor instructions in regard to where to park and which entrance, waiting area or bathroom to use. In the home office, a client may encounter family members or pets and may overhear personal or phone conversations by members of the therapist's family. In the home office, clients may be able to wander about the house, accessing areas that are highly private and inappropriate to be accessed by clients. Experience in complying with these boundaries may serve as a growth opportunity for clients who need to develop a stable sense of separateness between themselves and others (Keisner, 1990). Therefore, patients who manage boundaries poorly are not likely to be good candidates for a home office sessions. These include, Borderline Personality Disordered, those who have interpersonal or physical boundary issues and those mentioned above. For the same reasons, patient who are highly dependent or

reactive or those who develop intense emotional, erotic, sexual or hostile attachments may also not be suitable for a home-based office configuration.

Some clients have reported feeling, initially, as if they were intruding upon the therapist's private space, fearing that they were being asked to cross a boundary from a professional into a personal relationship. They sometimes, too, wondered about the professionalism of the therapist. If these feelings are dominant for a particular client's personality or character, the home office may not be suitable. On the other hand, average and highly functional clients and those who can benefit from the warm and casual ambiance that home offices often exude, and the significant self-disclosure involved, are likely to be good candidates for such a setting.

Suitability can neither be accurately assessed ahead of time nor always predicted from the screening process. Therefore, therapists must continue to assess the appropriateness of this location for clients' treatments.

Screening

Screening of clients for suitability, safety and possible threat is vital in the home-based office. While the issues of suitability and safety are always part of screening in psychotherapy, they take on heightened importance when the office is located in the therapist's home. In order to assure suitability and safety for clients, therapists, therapists' family members, etc., the screening process must be more rigorous and effective than the standard one (Zur, 2007).

There are several ways to increase the effectiveness of screening. The most common way to screen is via a phone interview. Some therapists combine such standard telephone interviews with a detailed questionnaire that is emailed, faxed or mailed and reviewed prior to setting the first appointment. Such questionnaires often include detailed questions regarding prior psychotherapy, hospitalizations, suicidality, psychotic episodes, domestic violence, criminal activities, criminal convictions, addiction and use of medications. When red flags go up due to suspect responses regarding volatility or past violent, psychopathic or criminal behavior in the background questionnaire, therapists may consider obtaining an authorization to release information and obtain additional information about the potential client before they decide to interview the person in their home. Carefully reviewing the responses and the collateral information can help therapists make informed decisions regarding the suitability of the clients to the home office setting.

Another part of the screening process involves acquainting clients with how the home office is organized. The therapist will explain what they will encounter or may encounter in the office itself and in regard to where the office is located, the other inhabitants of the home and, when relevant, the neighbors and the neighborhood. Some clients may be allergic to cats, birds or flowers and therapists should incorporate this information into the screening process.

Some therapists who work out of their homes choose to take referral clients only and do not advertise through public channels, such as the Yellow Pages. Other therapists choose to arrange initial intake sessions in a local clinic or in a traditional medical or office setting and then transfer appropriate clients to the home office setting. Yet, others maintain two offices,

one at their home and one in a traditional setting and, after conducting an initial interview in the standard office, make a decision as to which location is most appropriate for the client.

Managing Time, Places and People

Running the home office is a high work-family integration system because work is constantly accessible and clients visiting the home can impact upon family routines. The relationships between work, personal life and family involve careful management of three components: time, place and people. These three aspects are crucial in determining the degree of segmentation or separation and integration involved in the home office arrangements (Ahrentzen, 1990) Work Family Theory, which has primary dealt with the general issues of complex relationships between work and family, also has a direct application to the home office practice. The theory concludes that a "good fit", with regard to the unique preference combinations of each family member, provides the best predictor of well-being outcomes such as work and family satisfaction (Edwards & Rothbard, 1999; Kanter, 1977; Pleck, 1977).

The hours when clients are received impact directly on the degree to which the home-based practice may interfere with family life. If the therapists' spouses or partners work during the day and their children are of school age, seeing clients during school hours is likely to cause very little disruption to family life. However, seeing clients during afternoon, dinner or evening hours can have significant effects. Besides the fact that the therapist may not be present at dinner time, there are other effects: young children may need to keep quiet, teenage children may be asked to play their favorite music at a much lower volume than they would wish to play it. Along the same line, therapists who are aware that their children and significant others are nearby and that unpredictable yelling, sibling fights or dogs' barking may take place any time may constantly worry about it, reducing their sense of presence to their clients. Maeder (1989) reports on the effect of home offices on children of psychotherapists. He describes the distress expressed by adult interviewees recalling the problems of avoiding their parents' clients coming and leaving the home office. Some recalled with anger the limitation on their movements during the last 10 minutes of each hour when clients arrived for or left 50 minute-hour appointments. Work-Family theory (Ahrentzen, 1990) concludes the obvious: the less the family is required to adapt their behavior to accommodate the boundaries of the clinical practice, the higher the probability of individual and family well-being. Highest family satisfaction is related to clear, consistent boundaries with very little variation so that family members know what to expect and there is consensus regarding what is expected of them. On the therapists' part, they are most likely to be aware when their family members are around and concerned about intrusion of their family life on the therapeutic process.

Obviously, the location of the office is a prime factor in regard to the successful operation of the home office. Segregated offices, which are located on another part of the property and have separate driveways, parking and entrances, may result in very little interaction and interference between the home and work activities. However, if the home office is located in the living room or in an office in the house itself, the impact is likely to be much more significant to family members and clients alike (Zur, 2007). Highest degrees of satisfaction

are correlated with maintaining spatial boundaries that delineate client area versus family areas as well of some that may be accessed by both. When the office is located inside the home, therapists must take into consideration everything that the clients may be privy to and assess its potential clinical effect. These include family photos, heirlooms, art and furniture. Quality, style, orderliness or cleanliness, even the cooking smells wafting through the house, may all have an impact on some clients. Such impact does not mean that therapists must alter their internal design to fit their clients; it only means that they should be aware and conscious of the potential influence on their clients and integrate it into the wider clinical picture and treatment planning. Offices that are located within the house itself allow the therapists to interact with their family members in between sessions. This can be a helpful way to stay connected and in touch or can be disruptive due to the rigid timing determined by the therapeutic hours rather than by the flow of family life.

Time and space significantly affect the degree of separation between people in the home office setting and how many interactions there are between clients and family members. Additionally, some therapists inform or instruct their children or spouses of the level of interaction they feel is appropriate or that they feel comfortable with. This can range from complete separation, where clients and family members neither see nor hear each other, to a free flowing interaction before and after sessions. Of course, different clients have different needs and desires and therapists are equally diverse in the level of familiarity and contact they wish their clients to have with their family members.

Achieving a balance between the two dynamics can only be done by carefully managing time, places and people and paying careful attention to the personal preferences of the clients, therapists and therapists' family members (Kossek, 2003). A general personal preference for structure places one closer to the segmentation end of the continuum and would manifest itself in a home office that is located in a detached unit with family members either not around or far enough away not to be seen or heard. A general preference for fluidity of structure and ease of transitions would place one toward the integration end of the continuum and would manifest itself in a home office that is located in or close by the main residence where clients have some interaction with the therapists' family members. Research indicates that a "good fit" between the practitioner's personality, preference or style, family members' style and preference and the degree of segregation/integration practiced is the best predictor of work and family satisfaction. Conversely, lack of careful attention to boundaries between personal and work life has been associated with work-family blurring and negative consequences such as work-family conflict, stress, depression, burnout, anxiety and dissatisfaction with both work and family life (Clark, 2000; Kanter, 1997).

Ethical Considerations

From an ethical point of view, there is no injunction in any of the major professional organizations' codes of ethics against home-based practice. Such practice conforms to the standard of care. The American Psychological Association [APA] (2016), National Association of Social Workers [NASW] (2017), the California Association of Marriage and Family Therapists [CAMFT] (2011), and almost all other professional organizations' codes of ethics neither regulate home office use or the related self-disclosure. Of course, they all

have a mandate to avoid harm and exploitation and respect clients' integrity and autonomy (Lazarus & Zur, 2002; Zur, 2004a). The well being of the patient and preclusion of harm are, as always, the first consideration for the therapist. Consulting in therapists' home is neither unethical nor below the standard of care but requires augmented sensitivity to the ethical issues of confidentiality, privacy, safety, suitability, disclosures and informed consent.

Back in 2002 American Psychological Association's revised Code of Ethics and defined the previously ambiguous word "reasonable" in the code to mean the " . . .prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time". This wording still exist in the 2016 Code. The importance of this section is that it can reduce risk to therapists who practice from their own home from the hands of the licensing boards and courts. The hope is that the APA code establishes that it is ethical for therapists who practice from their home when it is appropriate and non-harming even though home office often accompanied with significant unavoidable self-disclosure. Therapists who maintain home offices, according to most codes of ethics, must be judged by standards and practices that are commonly applied by therapists with similar circumstances, similar orientations, comparable types of situations.

Standard of Care

The standard of care is defined as qualities and conditions that prevails 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 (Appelbaum, 1991; Caudill, 2004; Reid, 1998; Zur, 2004b). The standard of care is not an objective yardstick to be found in any textbook. It is closely tied to a theoretical orientation (Williams, 1997). The boundary crossings involved in appropriate home office psychotherapy practice, including the related extensive self-disclosure, clearly fall within the standard of care.

Boundary Crossing vs. Boundary Violation

Boundary issues mostly refer to the therapist's self-disclosure, home office, home visit, touch, exchange of gifts, bartering and fees, length and location of sessions and contact outside the office (Guthiel & Gabbard, 1993). Boundary crossing in psychotherapy is an elusive term and refers to any deviation from traditional analytic and risk management practices, i.e., the strict, 'only in the office,' emotionally distant forms of therapy (Zur, 2004a). While most analysts, ethicists, attorneys and "experts" may use a broad brush in describing boundary issues, it is important that psychologists 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, boundary crossings are often part of well-constructed treatment plans and, as such, they can increase therapeutic effectiveness (Lazarus & Zur, 2002). Obviously, home office practices always involved boundary crossing.

Critics of the use of home offices for psychotherapy practice express concern that practicing from a home office might involve boundary violations. The concern is that the use of a home office for psychotherapy may result in harmful boundary violation as this setting is seen as contact outside the office, and involves significant increase in self-disclosure. Although conducting therapy in a home office definitely involves a boundary crossing, as the boundary between work and private life becomes somewhat permeable, it cannot automatically be conceived as a boundary violation. Home office practice can be conceived as a helpful boundary crossing, and perhaps even the superior environment, when treatment in this setting functions to increase the therapeutic bond. Outcome research has documented the importance of rapport and warmth for effective therapy, and that rigidity, distance, and coldness are incompatible with healing. Appropriate boundary crossings are likely to increase familiarity, understanding, and connection hence, increasing clinical effectiveness (Lambert, 1991; Norcross & Goldfried, 1992).

Risk Management

Risk Management, in general, is the name given to the process of identifying and planning for the risks inherent in any action, activity, project, event, etc. It often involves the processes of risk identification, risk assessment, risk analysis and risk control. In psychotherapy, risk management refers to the practice of minimizing risk to clients and/or psychotherapists. In principle, it is reasonable and even important to manage risk to either clients or to ourselves, the psychotherapists. For example, it is the therapists' clinical, moral, ethical and legal obligation to minimize the risk of mentally ill clients hurting themselves. As mandated, it is also the therapists' duty to reduce the eminent risk posed by clients to identifiable others. Similarly, it is a professional and ethical obligation to minimize risk and harm to abused children, battered wives and any client who is in harm's way. Equally appropriate is the commitment of the therapist to reduce physical, emotional, professional or financial risk to him or her self as a practicing psychotherapist. This is similar to construction workers wearing hard hats and painters wearing facemasks.

Also relevant to the concept of risk management is the obvious fact that all actions involve some risk. Driving, taking a shower, practicing medicine or painting a house all involve some risk, however minor. Practicing psychotherapy is not any different. What is often ignored is the fact that inaction can be risky, as well. Avoiding certain foods or medication, neglecting to pay taxes, not your brushing teeth or buckling up are examples of inaction that may increase health or financial risks. Similarly, this paper argues that not making a needed home visit and avoiding touching or bartering with clients may also pose a risk.

While risk management, in general, and particularly in psychotherapy, is undeniably reasonable, this paper will show that it has been largely implemented in an unreasonable manner. From the playground to medicine to psychotherapy, risk management has gone too

far. Risk management in psychotherapy is an appropriate practice if it is done thoughtfully, employing critical thinking, applying sensible clinical and ethical judgment and assuring that the welfare of the client is the prime commitment.

Risk management has been defined in realistic and pragmatic terms by Gutheil, Gabbard (1993) and Williams (1997, 2003) as the course by which therapists refrain from implementing certain interventions because they may be misinterpreted and questioned by boards, ethics committees and courts. This approach is similar to what has also been called preventive medicine. These practices generally aim to protect the practitioners, not the consumers. The stated aim is to prevent or preemptively defend the health care provider against lawsuits, criminal charges or allegations by licensing boards or ethics committees. This approach seems to dominate all aspects of medicine, including behavioral health, and has evolved as a reaction to a litigious culture. In order to minimize risk, this approach advocates several reasonable steps that therapists should consider. These steps include the employment of good record keeping, use of clinical, ethical and legal consultation and establishing well-articulated treatment plans. Risk management advice often focuses on avoidance of certain therapists' behaviors, such as self-disclosure, regardless of their scientific basis or clinical effectiveness. Home Office has also been cited as an important risk management consideration (Woody, 1999) due to al the complexities discussed in this paper.

The home office setting can give rise to heighten concerns regarding risk management. These concerns include issues of privacy and confidentiality (Woody, 1999) and informed consent. As was discussed above it also involved safety issues to client, therapists, therapists' family and anyone else who reside at the therapists' homes. Concerns with sexual attraction are also important. It is important for therapists to avoid misunderstanding by a client who expresses attraction to them; it is best to carefully consider these issues when scheduling the last client of the day, especially if the therapist is single and living alone. Therapists need to be clinically thoughtful when it comes to any client who expresses attraction to the therapist or who expressed a desire to be treated as 'one of the family'.

Doverspike (2004) describes an ideal situation where "Reasonable clinicians protect themselves by protecting their patients" (p. 210). While this may be easier said that done, this should be the goal of therapists in general, including those who practice from their home. Clinical records which document our assessment of suitability of clients to the home office practice and include informed consent that is geared to the home office, treatment plans, records of consultation, etc, can help the therapist practice ethical risk management in which the clients' welfare as well as the therapists' personal and professional safety is addressed.

Informed Consent

Most home offices provide rather different environments than traditional medical offices or office buildings. The detailed discussion of these differences must take place prior to the beginning of therapy at the home office. At the minimum, clients should be informed, verbally, during the screening interview, of what they can expect in the home office with respect to the neighborhood, parking, neighbors, family members, pets, whether the office is located in the house or in an attached or detached unit, etc. (Zur, 2007). Clients should know

in advance who they may have contact with. Some may need to know ahead of time if they are going to share a bathroom with the rest of the family. Concerns with privacy and confidentiality must be discussed in detail, as these are highly important issues in psychotherapy. It may be advisable to incorporate the home office informed consent into the general consent to treatment that clients sign before treatment starts.

Privacy & Confidentiality

HIPPA guidelines are applicable as they would be in a more traditional office setting practice. Additionally, the dynamics of time, space and people are directly related to issues of privacy and confidentiality. Most medical or office buildings are designed to offer a relatively high level of privacy. Homes are not usually built with such concerns in mind. Most obviously, people who share the home with therapists are aware that the therapists serve psychotherapy clients (Pepper, 2003; Woody, 1999). Neighbors are also often aware of the type of business that psychotherapists conduct and therefore reasonably assume that people who show up to appointments are psychotherapy clients.

In some cases clients' confidentiality may be even more protected, as they are seen by others as arriving or leaving a home residence rather than the business office setting of a psychotherapist. At most, observers might be left to wonder which visitors are friends and which are clients, if it is well known in the neighborhood that a therapist practices from a home office. This may be particularly relevant in rural or small town settings.

As in the traditional office, the concern with privacy and whether others can overhear conversations in the consulting room is an important issue. Sound proofing the home office or using systems like sound machines in the waiting areas are as important in the home office as they are in the standard office. However, a serious privacy issue is a concern if therapy involves yelling or other loud sounds that can be easily heard by family members. Therapists must also take care that curious children do not try to overhear private and confidential conversations in the consulting room.

Benefits & Burdens

Working out of the home office provides therapists with benefits and burdens. Therapists working from home experience the benefit of escaping many of the frustrations encountered by most people who commute to an office. These benefits include avoidance of traveling in inclement weather, negotiating traffic, the effects of air or noise pollution or high social density. Hence, therapists who work from home offices enjoy automatic stress reduction (Pepper, 2003). As some therapists put it, they are "at home." This includes being available to tend to the home and family members between sessions. Some therapists report that family members indicate that their "at home" presence is felt even during working blocks of time, resulting in a greater sense of family unity. Other benefits that effect individual and family

well-being include significant financial savings and the elimination of the need to negotiate with office building management, while unifying many management tasks such as bill payment. Working from home also supports ease in household management, as household tasks can be accomplished between client hours and the physical location places them closer to children's schools and other community obligations. Some therapists also report that they appreciate being able to actually spend more time in, and enjoy, the home they work so many hours to support.

On the distaff side, obviously, keeping appropriate boundaries is an ongoing challenge, especially if children of all ages are involved. Music, play chatter or arguments are often disruptive if the office is within earshot of such sounds. Most therapists' concerns revolve around their family members who may complain about lost privacy, restricted movement, needing to keep noise to a minimum, needing to pay constant attention to which doors must be closed or open, which areas kept tidy, etc. While the home office relieves therapists from the rigors of commuting, it also denies them time to make the transition from work to home since these two domains are united. This may result in increased stress for therapists requiring them to frequently shift gears or change hats from the therapist mode to parent, spouse or friend. Many therapists in private practice are already quite isolated from other professionals. The home office setting can only increase such isolation since there are no colleagues next door with whom to converse, consult or socialize between sessions, during lunch or over a drink at the end of the workday.

License, Taxes, Insurance

Running a home-based practice often involves additional attention to zoning, tax and insurance considerations. Therapists who work from their homes should be aware of local zoning rules and codes regulating conducting a business from a residence, and in residential, agricultural or mixed-use areas. Psychotherapy practice is relatively low volume and non-intrusive to a neighborhood. Although a busy practice will result in an increased flow of visitors to the home and neighborhood, there is very little impact on the neighborhood other than parking considerations. Some locations may require compliance with homeowner association rules, as these associations can be more restrictive than city or unincorporated area rules. Tax implications for a home-based practice often mean that therapists may be able to deduct a portion of their house as a home office deduction. Generally, the amount deducted depends on the percentage of the home used exclusively for business. Expenses that can be deducted for business use of the home may include the business portion of real estate taxes, mortgage interest, rent, utilities, insurance, depreciation, painting and repairs. The IRS has a publication to help with this information, called *Publication 587, Business Use of Your Home,* available at www.irs.gov. Needless to say, a consultation with a tax accountant or tax attorney is highly recommended. Therapist should verify if they need additional insurance besides the home policy to cover office equipment and protect the business from personal injury or medical claims. Such home or additional home office insurance is usually supplementary to the standard malpractice insurance.

Summary

The home office setting presents several challenges to therapists, clients and those who reside at the therapists' home. First and foremost, consulting at the home office is boundary crossing as it crosses the boundary of the traditional therapy office, normally located in a medical building, clinic or office complex. The most pronounced feature of the home office arrangement is the fact that clients are invited to the therapist's home, thus crossing the boundary dividing the therapist's professional and personal lives. This invitation intrinsically creates significant self-disclosure on the part of the therapist as it reveals a wide range of personal information to the clients. Being invited to the therapist's home may be, at least initially, intimidating for some clients; others may feel they are intruding on their therapist's family and others may view it as unprofessional. The therapists' conscious or unconscious emotional motives for the choice of home office practice can be considered as well as the possible effects to the emotional experience of the client.

The home office arrangement can vary significantly in regard to how much interaction and mutual awareness there is between clients and family members and how much is disclosed to clients. This in turn is dependent on the proximity of the office to the family. Some home-based offices are located in a detached unit completely separated from the house. In others, consulting rooms may be in the living room, den or a designated bedroom inside the main residence.

Therapists who work out of their homes must screen rigorously for client suitability to this venue while also guarding the safety of clients, themselves and whoever else resides in the house. In addition to attending to clients' needs, therapists working at home must also pay attention to their family members' needs. While some adjustments are always required on the part of family members, major adjustments may place an undue burden on them and create stress on the part of the therapists. Privacy and confidentiality must be attended to as the home office inherently exposes clients to others who will be aware of their client status. However, in some cases clients' confidentiality may be even more protected in the home office setting than in a traditional business office setting.

Therapists must inform their clients in detail about the specific organization of their home office prior to the first session. Before the start of therapy, therapists must be clear with clients about where to park their cars and where to enter the house. Clients also need to know the location of the waiting area, the bathrooms and which area of the house they can use. If they may run across members of the household, they should be informed of this, as well. They must also learn if clients are comfortable with the venue. Therapists will do well to assess the propriety of home-based therapy for clients, themselves, their family members and the neighborhood on an on-going basis. Even though clients and family members may initially embrace or agree to such arrangements, they may later discover that it does not work for them.

Being invited into their therapist's private space gives many clients a sense of comfort and trust. While this home setting is not appropriate for several types of clients, others can benefit from the significant level of self-disclosure and warm, more relaxed feeling characteristic of the home office. It is up to the therapists to conduct a thorough screening and make sure that the arrangement is beneficial for clients and therapists and the family. In this setting, boundaries must be negotiated not only between therapist and clients but also between

therapist and family members and at times between clients and family members or even pets. Negotiating the boundaries is not a one-time event prior to therapy; it is often a continuous process and as such can also be part of the clinical process, as well.

The home office presents a unique set of opportunities and complexities to clients, therapists and therapists' families. It is the therapists' responsibility to make sure that clients are fully informed as to the nature and ground rules of home-based therapy and that they are suitable for treatment in such a setting, thus ensuring that it will benefit them rather than the reverse. This done, it can be an enriching, gratifying experience for both therapist and client.

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