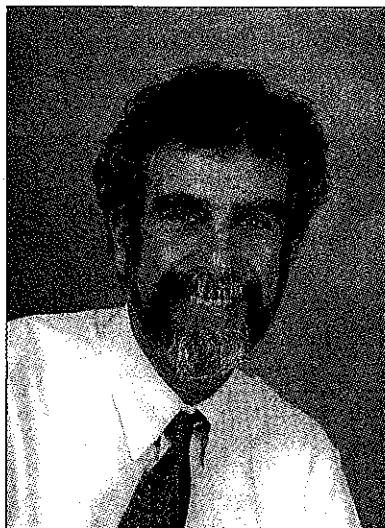


Out-of-Office Experience: When Crossing Office Boundaries and Engaging in Dual Relationships are Clinically Beneficial and Ethically Sound

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Introduction

Conducting therapy outside the office, leaving the office with a client, and having non-therapeutic contact with clients out of the office have been frowned upon for legal (Bennett Bricklin, & VandeCreek, 1994), ethical (Gottlieb, 1993, Pope & Vasquez, 1991) and clinical (Borys & Pope 1989, Simon, 1991) reasons. They have been called



boundary violations, boundary crossings, and boundary transgressions (Gutheil & Gabbard 1993; Keith-Spieger & Koocher, 1985).

Out-of-office experiences, whether part of a treatment plan or not, have also been placed high on the "slippery slope" list of items (Gutheil & Gabbard, 1993; Simon, 1991; Strasburger, Jorgenson, & Sutherland, 1992). The term "slippery slope" alludes to a snowball dynamic and has been described as follows: "... the crossing of one boundary without obvious catastrophic results (making) it easier to cross the next boundary." (Gabbard, 1994, p. 284). Kenneth Pope, a leading expert in ethical matters, makes a claim that not only supports the "slippery slope" idea but has become a strict standard of therapeutic ethics and law: "... non-sexual dual relationships, while not unethical and harmful per se, foster sexual dual relationships." (1990, p.688). Following this line of thinking, the conclusion is, "Obviously, the best advice to therapists is not to start (down) the slippery slope, and to avoid boundary violations or dual relationships with patients." (Strasburger, et al., 1992 p. 547-548).

Interacting with clients out of the office has traditionally been placed under the broad umbrella of dual relationships. A dual relationship in psychotherapy occurs when the therapist, in addition to his or her therapeutic role, is in another relationship with his or her patient. Since the early nineties, the ethical codes of the American Psychological Association (APA) (1992) and all other major professional associations no longer impose a strict and uniform ban on dual relationships. Instead, the changed codes acknowledge that dual relationships may not always be avoidable or unethical. While the absolute ban has been lifted, the belief in the prohibition is still prevalent (Faulkner & Faulkner, 1997; Gutheil & Gabbard, 1993; Strasburger, et al., 1992). The revised code of ethics calls on therapists to avoid dual relationships only, "... if it appears likely that such a relationship reasonably might impair the psychologist's objectivity or otherwise interfere with the psychologist's effectively performing his or her function as a psychologist, or might harm or exploit the other party." (APA, 1992, p.1601).

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". (Bennett et al., 1994; Keith-Spiegle & Koocher, 1985; Pope & Vasquez, 1991; Strasburger, et al, 1992). Simon (1991) induces even more dread with his, often quoted, chilling, and ludicrous statement that, "The boundary violation precursors of therapist-patient sex can be as psychologically damaging as the actual sexual involvement itself." (p. 614). As a result, therapists are acting out of fear of lawsuits and boards sanctions rather than according to what is effective and helpful. Consequently, clinical judgment and treatment are often compromised (Ebert 1997, Lazarus, 1994a, b, 1998, Tomm, 1993; Williams, 1997; Zur, 2000a, b).

Consumer advocates advise against leaving the office and against dual relationships in an attempt to protect the public from exploiting therapists (Barnett, J. E., 1996; Bennett et al. 1994). This argument is primarily based on psychoanalytic theory, which asserts that all clinical contacts must be strictly confined to the office. According to this theory, leaving the office interferes with the transference analysis, the hallmark of analytic work. While only a limited segment of therapists practice psychoanalysis, all the rest of the therapeutic community is unfairly held to this standard (Williams, 1997). Holding therapists to such standards, which they neither believe in nor practice, is one of the biggest impediments in the field of psychotherapy (Lazarus, 1994a, b; Zur, 2000a).

This paper attempts to shed a new light on the rarely discussed issue of deliberate and strategic crossing of the office boundaries. It argues that leaving the office may not

only be ethical and effective but may actually be clinically mandated in certain situations. This paper describes how leaving the office can be consistent with behavioral, systems, humanistic, cognitive-behavioral, multimodal, and other non-analytic orientations. The paper discusses three types of out-of-office experiences. The first type is where the out-of-office experience is part of a thought-out, carefully constructed, research-based, treatment plan. The second is where the out-of-office experience is geared to enhance therapeutic effectiveness. The third type is comprised of encounters that naturally occur as part of normal living in one's community. While the first two types do not constitute dual relationships, the third one does.

Out-of-office experiences as part of a treatment plan

By the time he sought my services, John was on the brink of bankruptcy; his business was suffering gravely due to his debilitating fear of flying. I outlined behavioral, biological, and psychodynamic treatment options for him. His sense of urgency induced him to start with systematic desensitization. Following the standard behavioral protocol, I introduced him to gradual, progressive exposures to anxiety-eliciting images culminating with an in-vivo experience of flying. To carry out this last step, he booked us on a round trip flight from San Francisco to Los Angeles with an hour layover in LA. He was able to fly thereafter and salvaged his business.

Jean was anorexic and bulimic. She had undergone both cognitive and psychodynamic therapy without success. Wanting to try a different approach, we developed a family-systems and behavior-based treatment plan which included individual lunches and family dinners in which I participated. We discussed privacy concerns and ways to deal with the possibility of friends or colleagues approaching us during our restaurant meetings. Jean attributed the success of our therapy to the multiple approaches and the flexibility of the in and out-of-office experiences.

I saw Mary and her husband over the course of a year for marital therapy. During therapy, Mary revealed a long history of abusive relationships with men, which included sexual molestation at a young age and, more recently, sex with a therapist. As we had achieved our original treatment goal of strengthening the marital unit, Mary requested to shift to individual therapy, aimed at dealing with the abuse issues. She set some clear conditions for her individual work with me. My suggestions for her to continue therapy with a female therapist were rejected. For obvious reasons, she would not meet with me, initially, alone in my office; therefore, we agreed to meet at a coffeehouse where she would feel safe due to its public nature. As with Jean, we discussed the potential ramifications of meeting in a public place. As with Jean, significant progress was

achieved within a few months and we were able to shift therapy to the office.

Max was a young mechanic with unusual Schizotypal features characterized by connecting with machines rather than human beings. He came to see me at the insistence of his mother who was concerned with his increased isolation and suicidality. He clearly did not like my office. Five minutes into the first session, on his way to the door, he offered to show me his newly restored car. I had to choose between stopping treatment before it had even started or accepting his offer. For the next couple of years, he would enter my waiting room punctually and from there we would depart to various destinations. As he welded and tinkered, learned about his relationships with his parents, and between carburetors and distributor caps I found insights into his distrust of people and love of machines. As our "under the hood" therapy progressed, he gradually came to trust me and a few others. He even developed his first (arm's-length) relationship with a woman. Since that first day, he has never entered my office.

Jerry has suffered from Schizophrenia since childhood. Over the many years that we have been working together at his request, we have spent many of our sessions walking and talking and marveling at the natural beauty of a nearby trail. In my office, he is often withdrawn, anxious, and distracted, while on the trail he is much more open and relaxed.

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.

Spending several years with John in psychoanalysis exclusively in the office, immersed in transference interpretation or in an existential exploration of the meaning of his fear of flying would not have helped John avoid bankruptcy. Since Jean's eating disorder had not been helped by a couple of legitimate approaches, it was time to try something else. Refusing Mary's coffeehouse arrangement might have been good risk management practice, but would also have constituted abandonment - an ethical violation. Max would not meet anywhere but "under the hood". There was no choice in the matter if I wanted to help him. Jerry's requests for "walking and talking" sessions proved to be the most effective approach. Jill needed support and guidance in her grief, not drugs to numb her pain or analytic schooling. Other situations that would require leaving the office and making a home visit are working with those who are homebound, such as the elderly or those who are sick and bedridden.

The intent of the above examples is not to advocate for therapists leaving the office indiscriminately or habitually. The intent is to present instances where leaving the office was part of a clearly articulated treatment plan which constituted the most effective intervention for the specific situation. Such interventions are consistent with behavioral, humanistic, and cognitive-behavioral orientations (Lazarus, 1974a; Williams, 1997). They neither constitute dual relationships nor violate the APA's, or any other professional association's, ethics code. I could have followed numerous writers' advice to practice defensively by staying in the office no matter what. However, by following that advice I would have been providing substandard care and, in fact, I would have been committing ethical violations of the mandate to "... improve the condition of both the individual and society." (APA, 1992, p. 1597) and the mandate of "avoiding harm" (APA, 1992, p. 1601).

When out-of-office experience enhances therapeutic effectiveness

After three months of pre-marital, system-based therapy, a couple invited me to their wedding. I accepted the invitation and was surprised and honored when they publicly acknowledged my role in cementing their nuptial commitment.

An adolescent girl sought therapy to help her with her fear of public speaking, which prevented her from participating in her school play. Her performance on opening night, to which she invited me, was magnificent.

A sculptor came to see me for a severe artist's block. After three years of in-office, intensive, psychodynamically oriented therapy, he invited me to his first one-man show at a local gallery. It was an impressive exhibit.

After a couple of months of dealing with issues of work, creativity, and drug addiction, a landscape architect suggested that we spend a session viewing the actual gardens he had designed. The tour increased my understanding of him and my capacity to help him.

Several couples and individuals, over the years, have invited me to their house-warming parties, weddings, anniversaries, and funerals of loved ones. When appropriate, I have accepted these invitations.

It is important to note that I do not always accede to clients' requests to leave the office. In fact, there are just as many reasons not to leave the office including intentional manipulation and avoidance by the client. I declined to do so, for instance, in the cases of a Borderline woman, a man in the midst of a paranoid breakdown, a relapsing drug user, and a woman who was overwhelmingly attracted to me.

All of the interventions where I left the office were preceded by thorough consideration, were consistent with behavioral, humanistic, and existential treatment plans (Williams 1997) and were geared to enhancing client wel-

fare. All resulted in an increase of therapeutic alliance, knowledge of the clients and, most importantly, enhanced effectiveness of treatment. Similarly, 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. None of these interventions constituted dual relationships or ethical violations. The "slippery slope" did not turn out to be slippery at all as neither exploitation nor harm nor sexual relationships resulted. Like the first type of out-of-office experience, none of these interventions comply with analytic or rigid risk management standards. After all, clients do not pay for defensive therapy, but for effective therapy.

Out-of-office experiences as part of healthy dual relationships in the community

Susan and I have children the same age. We have chaperoned field trips and sat on committees together at school. At the outset of therapy, we discussed the complexities and potential difficulties of our multiple relationships. She made it clear that she chose me *because* she knew and trusted me and appreciated my parenting methods and the importance I attach to marriage, family and community. She thought that my knowledge of her would speed up therapy. The daily "Good morning" greetings at school neither interfered with therapy, which progressed well, nor with psychodynamic and transference work.

Sue is a retail clerk at one of the local stores that my wife and I frequent. Unbeknownst to me, she chose to tell my wife, as she checked us out of the store, how I "saved her marriage and helped her children." (My wife is used to it.)

David and Esther were a Jewish couple who had just moved to town. They sought my services due to marital and spiritual concerns. I invited them to my annual Chanukah party where they established several long-lasting connections and reported that the party was an important milestone on their spiritual and communal path.

The American Psychological Association's Ethics Code states clearly that: "In many communities and situations, it may not be feasible for psychologists to avoid social or other non-professional contacts with persons such as patients, clients,..." (APA, 1992, 1601). Several authors have acknowledged that therapists who practice in rural, military, and small communities, or in subcultures of gays, the deaf, or other minorities, often have ongoing, unavoidable, yet not unethical, social and other exchanges with their clients outside the office (Barnett, 1996; Keith-Spiegel & Koehler, 1985).

Unlike the first two types of out-of-office experiences, these community connections with clients constitute dual relationships. They are part of communal life where peo-

ple are connected and interdependent in a healthy way and are neither isolated nor insulated from each other. Not only were these relationships non-sexual, non-exploitive, and non-harming, they enhanced therapeutic alliance, trust, and effectiveness. Still, therapists should be thoughtful when taking on clients within their community. Some situations and people are not suited to this kind of work. Such were the cases of a hostile man whose son did not get along with my child, a jealous colleague, and a close friend of an ex-lover. A couple of times I had to terminate treatment because the complexity of dual relationships unexpectedly interfered with the clinical work. These terminations provided valuable learning experiences to clients about the importance of re-evaluating plans and rethinking boundaries.

While the analytic approach will eschew socializing with clients, the humanistic, cognitive, or behavioral approaches may not (Williams, 1997). Marquis (cited in Williams, 1997) describes having good clients as friends and good friends as clients. Lazarus (1994a) states, "I have partied and socialized with some clients, played tennis with others, taken long walks with some . . ." (p.257). 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." (Cited in Williams, 1997, p. 242).

Re-Thinking "Slippery Slope" and Boundaries in Therapy

Contrary to popular dogmatic expectation, I did not slide uncontrollably down the "slippery slope" and did not end up sleeping with John, Jean, Max, Susan, Sue, Jerry, or Jill. In fact, the out-of-office experiences reduced the probability of exploitation because they were carried out in public. The tyrannical creed propounding the 'only in the office' policy and the isolation it imposes on the therapeutic encounter, is one of the main contributors to exploitation and sexual misconduct (Zur, 2000a).

Leaving the office is not the norm in my practice. It occurs only when there is clinical evidence that it would enhance effectiveness of treatment or it is unavoidable in the community. Like most professions, therapy involves contacts and reputation. Almost all of my clients chose therapy with me because they either know me personally or heard about me from a trusted friend. It may surprise the reader that one of the several therapeutic modalities I use with my clients is psychodynamic therapy and that none of the out-of-office experiences described in this article have interfered with transference and psychodynamic work when they were applied. Meeting outside the office, like knowing me personally, makes the transference more reality-based and just provides more "grist" for the (transference) mill.

Lazarus (1994a) has stated succinctly that, "One of the

worst professional or ethical violations is that of permitting current risk-management principles to take precedence over human interventions" (p. 260). Indeed, in some situations not leaving the office, due to defensive practice consideration, can constitute substandard care and an ethical violation.

One of the goals of this article is to free therapists to intervene according to clients' specific situations and presenting problems and not according to fear of attorneys licensing boards or analytic dogma. There are situations where interacting with clients outside the office is the best intervention and there are situations where it is clearly counter-indicative. As Lazarus (1994b) summarizes it simply: "It depends."

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References

- American Psychological Association (APA). (1992). Ethical principles of psychologists and code of conduct. *American Psychologist*, 47, 1597-1611.
- Barnett, J. E. (1996). Boundary issue and dual relationships: Where to draw the line? *The Independent Practitioner*, 16 (3), 138-140.
- Bennett, B.E., Bricklin, P.M. & VandeCreek, L. (1994). Response to Lazarus's "How certain boundaries and ethics diminish therapeutic effectiveness." *Ethics & Behavior*, 4 (3), 261-266.
- Borys, D.S., & Pope, K.S. (1989). Dual relationships between therapist and client: A national study of psychologists, psychiatrists, and social workers. *Professional Psychology: Research and Practice*, 20, 283-293.
- Ebert, B. W. (1997). Dual-relationship prohibitions: A concept whose time never should have come. *Applied & Preventive Psychology*, 6, 137-156.
- Falkner, K.K. & Falkner, T. A. (1977). Managing multiple relationships in rural communities: Neutrality and boundary violations. *Clinical Psychology: Science and Practice*, 4, 225-234.
- Gabbard, G. O. (1994). Teetering on the precipice: A commentary on Lazarus's "How certain boundaries and ethics diminish therapeutic effectiveness." *Ethics & Behavior*, 4 (3), 283-286.
- Gottlieb, M.C. (1993). Avoiding exploitative multiple relationships: A decision-making model. *Psychotherapy*, 30, 41-48.
- Gutheil, T.G. & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk management dimension. *American Journal of Psychiatry*, 150, 188-196.
- Jourard, S.M. (1971). *The transparent self*. New York: D. Van Nostrand.
- Keith-Spiegel, P., & Koocher, G. P. (1985). *Ethics in psychology*. New York: Random House.

- Lazarus, A. A. (1994a). How certain boundaries and ethics diminish therapeutic effectiveness. *Ethics & Behavior*, 4, 255-261.
- Lazarus, A. A. (1994b). The illusion of the therapist's power and the patient's fragility: My rejoinder. *Ethics & Behavior*, 4, 299-306.
- Lazarus, A. (1998). How do you like these boundaries? *The Clinical Psychologist*, 51, 22-25.
- Marquise, J.M. (1972). An expedient model for behavioral therapy. In A.A. Lazarus (Ed.), *Clinical behavior therapy*, pp. 41-72.
- Pope, K. S. (1990). Therapist-patient sexual contact: Clinical, legal, and ethical implications. In E.A. Margenau (Ed), *The encyclopedia handbook of private practice*. New York: Gardner Press, Inc. pp 687-696
- Pope, K.S., & Vasquez, M.J.T. (1991). *Ethics in psychotherapy and counseling*. San Francisco: Jossey-Bass.
- Simon, R. I. (1991). Psychological injury caused by boundary violation precursors to therapist-patient sex. *Psychiatric Annals*, 21, 614-619.
- Strasburger, L.H. Jorgenson, L. & Sutherland, P. (1992). The prevention of psychotherapist sexual misconduct: Avoiding the slippery slope. *American Journal of Psychotherapy*, 84 (4), 544-555.
- Tomm, K. (1993). The ethics of dual relationships. *The California Therapists*, Jan./Feb., 7-19.
- Williams, M. H. (1997). Boundary violations: Do some contended standards of care fail to encompass commonplace procedures of humanistic, behavioral and eclectic psychotherapies? *Psychotherapy*, 34, 239-249.
- Zur, O. (2000a). In celebration of dual relationships: How prohibition of non-sexual dual relationships increases the chance of exploitation and harm. *The Independent Practitioner*, 20, 97-100.
- Zur, O. (2000b). Going too far in the right direction: Reflection on the mythic ban of dual relationships. *California Therapist*, 23 (4), 14, 16.