The Uses and Considerations of Home-based Therapy

Nola Nordmarken, MFT interviews Ofer Zur, Ph.D.

Nola Nordmarken: Welcome to the Zur Institute LLC audio recording on home-based therapy, or what is also called In-Home Therapy, or Home Visits. I am your host, Nola Nordmarken, MFT. In this program I will be interviewing Dr. Ofer Zur on his views and understanding of home-based therapy. This recording is part of an online course on home-based therapy by the Zur Institute at www.zurinstitute.com.

I, myself, am a marriage and family therapist in southern California with practices in Santa Monica and Pasadena. I have co-authored several articles with Dr. Zur, including, "Critique of the DSM," "Home Office Practice," "Touch and Psychotherapy," and "The Professional Will."

Ofer Zur is a licensed psychologist, fellow American of the Psychological Association, instructor, lecturer, ethics consultant and expert witness in private practice in Sonoma, California. He has been in practice for over 20 years, and is Director of the Zur Institute, LLC at again, www.zurinstitute.com, which offers over 140 innovative and challenging online continuing education courses for psychologists, counselors, social workers, nurses, and other mental health practitioners.

Dr. Zur is most known for his efforts to humanize the field of psychotherapy and counseling, and as a fierce advocate of appropriate and flexible application of therapeutic boundaries. Dr. Zur has been a visionary in the field in the 1980s warning us about the potential problems with managed care, and he has taught many of us how to practice outside managed care on a fee-for-service basis.

In the 1990s he advocated strongly for humanizing the field of psychotherapy and counseling and taught us how to apply therapeutic boundaries with flexibility and care, rather than rigidity and fear.

In 2002, he saw HIPPA coming our way and wrote the HIPPA Compliance Kit. These days he has shifted his attention to tele-health, or tele-mental health, which he views as one of the most important developments in our field of psychotherapy and counseling.

In this unique audio, Dr. Zur will explore the issues and complexities involved in home-based therapy.

Let's start, may I call you Ofer?

Dr. Ofer Zur: Of course.

Nola Nordmarken: Ofer, how would you define or what would you say is included in home visits?

Dr. Ofer Zur: The definition of home-based therapy is very simple. It's when the therapist, counselor, social worker conducts a clinical assessment evaluation treatment in the home of the client. This name's being used interchangeably, will be using interchangeably here as well, will be home-based therapy, in-home therapy or home visit. All three are referring to the same idea, the same concept.

Traditionally looking back, it started with 2 main aspects of our field. Family therapists in the '60s and '70s had a focus on home therapy, so it is a special advantage of conducting therapy in the context of when therapy life takes place.

The second one was evaluation of children and family, again, evaluating it in context. While the former, we don't hear as much about even though we see it still happening, sometimes in Europe, Australia, in other parts of the world, the child assessment, evaluation, treatment, interventions are happening in large numbers in home therapy.

Nola Nordmarken: What are some of the other populations that are seen in in-home therapy?

Dr. Ofer Zur: There are many kinds of populations that can benefit highly from in-home therapy. Let's start with ... What kind of mental health condition may be conducive to in-home therapy? Obviously those with agoraphobia or social anxiety will be benefited from tele-health or from in-home therapy. Those with contamination phobia and other paranoia or paranoiac ideations that stops them from leaving the house, some people with developmental disabilities, those with hoarding and sometimes those with depression, agoraphobia, social anxiety, sometimes suicidality, can also highly benefit. Even drug abuse, this would be the mental health type of conditions, situations, disorders that would be conducive to in-home therapy.

Then there are an array of evaluations and education that takes place in the home. Primarily it's child abuse, neglect and issues of child safety. Pre and post adoption issues often need to be addressed within the home to see what context the child lives in or may live in, placement issues, of course needs to be assessed in the home. Sometimes drug abuse evaluation, nutrition and cooking education cannot really happen in the office, and parenting education sometimes, hands-on parenting education, should be taking place in the home.

Then there are physical or medical conditions that may bind people to the home. It may be severe autistism, home bound elderly, paraplegic, patients with infectious disease, late stages of age or HIV, STD evaluation, and of course those who are terminally ill and dying, hospice type interventions will not happen in our nice offices or not nice offices, those with severe cases of dementia or Alzheimer, or any other disabilities that makes people be home bound.

Then there are cultural components that may direct us to some populations that prefer a home visit. For example, the American Indians have high stigma regarding mental health treatment by Western ways, because many American Indians have their own traditional way of dealing with difficulties, mental, spiritual. They look at the mental primarily as spiritual, so home visit with the American Indians and other minorities sometimes may be helpful.

Then some people just don't have the funds or are not organized enough. You can't get a family of 7 people into the office but you may get perhaps 5 out of 7 at home. Some people cannot leave the children at home or cannot leave the family member at home who is sick or needs constant attention.

There are numerous areas that will be much more effectively dealt with in the home. Sometimes the only way to deal with then are by home visit, so all these ideas that you hear in ethics workshops of ‘don't leave the office’ are kind of idiotic and impractical and out of touch with many populations that they're cited about.

Nola Nordmarken: It really limits the benefit to the client.

Dr. Ofer Zur: Absolutely, if we're not flexible. Now some of these things may start being treated by tele-health, which we will not cover in our interview today, but we just need to keep it in mind.

Nola Nordmarken: What would you say are the most important advantages of therapists providing services within the home, just within the general living environment of the client?

Dr. Ofer Zur: Sometimes it's more comfortable for the clients to be seen on their turf. For therapists, for social workers, for MFTs, counselors, psychologists, we can treat people in the patient's environment and we can see really where are ... What is the condition, where do the children sleep, are there 53 cats in the house, what's the sanitation situation, and neighborhood? So we can really assess and intervene in context in a way that perhaps we wouldn't be able or often we can't do in our offices because we just don't understand the context of the lives of our clients and we are ineffective in trying to imagine it or just to rely on clients' report in some situations.

Then the other benefits and advantages are that it can cut emergency room and specialization cost because you can see things coming. It can really intervene before a full-fledged crisis occurs. These are the main advantages. I would say the context would be probably one of the most important ones.

Nola Nordmarken: I'd like to address the issue of boundaries in the home visits. I'm sure that it must be very unique and complex in the issues that are related to this topic. Could you address that issue, please?

Dr. Ofer Zur: Oh my goodness, this is a huge issue. Let me start with the general and then perhaps you can guide me a little bit of what we want to focus in on with this interview. In general, the home visit presents, as you just mentioned, a complex set of boundaries. Unlike the office where there's a clock beginning and ending and furniture and soundproofing, home visits provide an unpredictable kind of a setting, and much more flexibility and unpredictability of the setting creates a whole slew of boundaries. I'm not sure where would you like me start, perhaps you can guide me on that.

Nola Nordmarken: I think when I consider that the one that seems most challenging, and you may want to address this first or later in your answer, but it has to do with how the power distribution might be affected in the relationship. Does that fit here, or would it fit ...

Dr. Ofer Zur: No, under boundaries, perhaps I'll talk more about space and role and these kinds of issues. Let me start with space. Space is a boundary issue and in offices, we know where treatment takes place. It takes place in our office, whether we work for the Department of Mental Health or we

work for ourselves, it takes place in our office. But in the house, is it in the living room, in the bedroom, on the porch? Do we go to the backyard because a house is stinky, or there are weapons in the house and dogs in the house, or dirt in the house or germs in the house or lice in the house? Do we just go to a nearby trail, and so where therapy takes place is much more fluid and unexpected sometimes in the home office.

The second issue of boundaries we can talk about, and we can definitely talk about power later one because it's a very important issue, but let's cover the boundaries first if it's okay with you ...

Nola Nordmarken: Sure.

Dr. Ofer Zur: The role is much more complex in the home-based therapy, because a therapist is, of course, a mental health professional, a clinician. But also is he or she our guest, because sometimes I am being treated as a guest? It's sometimes helping with parenting. Does the therapist refuse to eat or to drink coffee or tea because when you are offered? Sometimes it's much more small talk or informal conversation in the home base. Sometimes a therapist may take a client to an important medical appointment or take a child to school, or sometimes you need to take the child to school so you can talk to the mother.

Is the therapist a friend on top of being a therapist, a driver, sometimes taking the mother to buy diapers? Are they helping with hygiene? Are they a nurse? I talked to a therapist who actually had to kill a skunk who was very sick and was threatening a child in the middle of a home visit. Therapists may need to help a disabled or elderly client get dressed or get out of bed.

The roles are very confusing and very rich.

Nola Nordmarken: I can imagine how this is altered by the expectations of different cultures, as well.

Dr. Ofer Zur: Absolutely, because some cultures if you won't join them for tea or coffee or food, it could be very insulting, and sometimes they expect you to help with the old granny getting dressed or drive the child to a medical appointment

Nola Nordmarken: In another culture that may be really off limits.

Dr. Ofer Zur: Absolutely. Absolutely. It is cultural bound, it's good you're adding that in.

The next boundary has to do with time. When they come to our offices, to yours or mine, we start at 1:00 and finish at 1:45 sharp, and if you're on top of it you finish at 1:50 sharp, and even if you slack, you may go to 1:59, but then you better be out of the session so you can start the next session on time. The sessions in the home office are very fluid because many things happen. You start driving people around or neighbors come in or ex-husbands show up or a former wife calls, so there are so many unpredictable issues, including the starting time. Sometimes a family is not ready. I've heard of situations where the family just won't open the door for the first 20 minutes when the therapist is knocking on the door.

Sometimes a therapist is late due to traffic issues in school. Sometimes you drive the child to school first. Some people are drunk and sessions cannot even take place. Timing of the sessions has a completely different flavor when it comes to in-home therapy.

Then the next boundary issue is who's present. We have control of who's present when you come to our offices, but in the in-home sessions, the abusive boyfriend may drive by. People may leave in the middle or decide to answer the phone, to go to another room or to watch their favorite show. The neighbors may drive by. The neighbors may be very curious. Who is this woman with this car coming to my neighbor and just knocking on the door and coming in?

It's extremely unpredictable, and not always controlled by any means. Therapists need to be flexible about these issues. Later on we can talk about confidentiality with these issues of who is present. But who is present is really flexible, unpredictable and fluid.

Nola Nordmarken: I can see how flexibility and fluidity would be so important for home practice in so many ways.

Dr. Ofer Zur: In so many ways. We talk about time, role, and who is present, and you are absolutely right. Fluidity and flexibility are super important and people who cannot tolerate this kind of fluidity and flexibility are not suited for this kind of work.

Nola Nordmarken: It takes rapid adaptation, many times I would imagine.

Dr. Ofer Zur: Absolutely. If you are not good and light on your feet, you are not suited for this kind of work, as well.

Then comes the issue about suitability that is also relevant to the next boundary issue of self-disclosure. People ask you a lot of personal

questions. What are you like to eat, where are you from, they treat you as friendly guests sometimes. They give you gifts and then accepting or not accepting is self-revealing. They get to see what car you drive. I've heard therapists say that clients notice if they have a baby seat in the car or that they don’e have a baby seat. Is the car clean or not clean, expensive or not expensive?

There are a lot of therapists, whether intentional or unintentional, planned or unplanned, conscious or unconscious, whose responses create a huge amount of self-disclosure. We also have to say disclosure because the dress code is much less formal in this kind of a setting.

Then another boundary issue is the issue of food. Often people are invited to join the family for meal and in Chinese, Middle Eastern, Latino, African American cultures, to refuse food can be insulting. Then the question becomes, is eating a part of therapy? Does it give the impression of friends? It's really a complex boundary issue.

Do you go shopping sometimes, teach mothers what are the healthy, basic things to buy for a child, teach them how to properly store meals, as part of the treatment plan and evaluation and assessment? Food is an issue that we often don't see much in our offices unless they give us some cookies or we offer them coffee or tea.

Then some people say they were offered alcohol in the home visit. That’s not unusual in some cultures. You come at 4 or 5:00, it's cocktail time and grandpa has his cocktail. They may think it's rude not to offer you one.

Another boundary issue is gifts, how to respond when people offer gifts. Sometimes it's simple when children giving you a drawing. I have talked to many therapists who got inexpensive pornographic gifts that were highly inappropriate. So what's ethical or unethical? Sometimes it’s clear and sometimes it isn't.

Nola Nordmarken: I could see too where it's about receiving gifts with all of those aspects of consideration, but it would also include the question of gift giving, the therapist giving gifts.

Dr. Ofer Zur: Absolutely, you have a child born, do you show up to the next session with a gift or somebody went through a confirmation, a bar mitzvah, or marriage, so gifts can go on both ends and again, some cultures would expect you to somehow bring a gift.

More boundary issues, I'll try to be fast with that, there are so many of them.

Interferences, sometimes children wandering in the room, you don't have a sense of privacy, uninvited neighbors, friends, strangers, you cannot believe the stories that I've heard from people who do home visits. What kind of unpredictable occurrences happened. Then of course interference, such as dog barking, people talking, fighting dogs in the house, cats all over the place, and needless to say, radio, television, computer, cell phones at the home. People do not even hesitate twice to continue to watch their favorite TV program, check their emails on their cell phones, etc.

What else? Boundaries. Sometimes driving a client, as I mentioned, driving a child to a foster home, to another temporary home, to an emergency room, to school, to a grocery store, to a pharmacy, medical appointment, to the bus stop. I've talked to many therapists and so many of them have different stories. Some agencies give special insurance for the cars for the therapist to drive. This would be another kind of risk management, ethical or legal issue that somebody needs to think of. If you drive your clients places, especially if you drive them regularly, there must be some kind of agencies that will cover you insurance-wise because you're doing it in your line of work.

Then there are just numerous opportunities for the client to challenge the boundaries. Sometimes people are dressed inappropriately. Somebody talked about coming to a house and the client was in the middle of masturbation to a pornographic video, or internet video. They sometimes are not dressed appropriately. Sometimes they smoke dope or the methamphetamine is being cooked in the kitchen.

We talked about using cell phone, television, computer, food, type of language, people tend to use language much more comfortably in their own home, whatever the language is. They may ask therapists for ride, to write a letter, to listen to phone calls, to make a call, to advocate. Sometimes they ask them for money, I mean they need money just for the bus, for child to go to school, how do you resist that?

Sometimes therapists open the door and see a naked client opening the door. Sometimes they are threatened physically by a client or somebody else in the neighborhood. Drunkenness, as I mentioned. Scary dogs. Some people have seen weapons, loaded guns, sitting on the kitchen table, just lying in full view. Some clients even try to seduce the therapist sexually, so, complicated, complicated, complicated. This should not deter from

doing this important work, but somebody needs to think about these boundaries. People are not often trained and do not really think. Not much literature is being written about it, either.

Nola Nordmarken: Does this take us to the point where we can talk about the power distribution?

Dr. Ofer Zur: I think you are absolutely right. Everything I said so far will have an impact of the power distribution. It's clear that a therapist has some power in the office of perhaps knowledge or information. Of course the clients have their own power, even in the traditional office, but in the home office, clients have much more power. They are the host. They know the neighborhood. They can decide the beginning and end of sessions. They can control the television, who's present, who's not. They can ignore the therapist. They can leave the therapy session in the middle.

They have so much more power and control in the home visit than they have in the office. Again, not that they are powerless in the office, by no means, but there's definitely much more power that can manifest in many ways, in control the clients have in the home visit. They cannot open the door if they just don't want to talk to you. They cannot ask you to come later. All this is happening on a rather regular basis in the home visits with certain populations.

Nola Nordmarken: As I'm listening to you, it's really amazing how much is involved in what the therapist has to quickly adapt to and make decisions about, and one of the things that I think might also be very different in home-based practice rather than in-office practice would be the issue of confidentiality. You referred to self-disclosure earlier, but how could you speak to the issues of confidentiality?

Dr. Ofer Zur: You know, in our offices we have soundproof rooms and a music or noise machine in the waiting room. Imagine sitting in the living room and everything you say can be heard throughout the house. For some reason a neighbor decides to join cocktail time and you are in the middle of a session, and, as I mentioned, the former abusive wife or boyfriend … how do you deal with confidentiality issues? Neighbors are curious about who is coming into this house with this car at this time.

Issues of sound. A client being present or in earshot, confidentiality has a different flavor in the home-based therapy or in-home visit. It requires thoughtfulness, strategic thinking. Sometimes people go for walks in the park or for a drive in the car to a local private place, maybe church, to

conduct a session so they have some kind of, some sense of confidentiality and privacy, which is not a given at home. Therapists often do not have this kind of control over the situation.

Nola Nordmarken: You've spoken about scary dogs and loaded weapons and maybe an abusive boyfriend showing up. I imagine that there are all kinds of different security and safety issues that have to be considered as well, in addition to those things.

Dr. Ofer Zur: You are absolutely right. There are many, many safety issues that I've talked to therapists about who do home visits. There were areas where they couldn't leave the child, or even the home where they were visiting, because there was shooting in the neighborhood so the police wouldn't allow anybody in or out.

Sometimes you go to a high crime area, to housing projects. They may not be safe. Women are vulnerable in general in a physical dangerous situation. Sometimes you walk into domestic violence situation. We know from police records that this is one of the most potent and lethal situations for police to walk into, a situation to try to deal with domestic violence. The volatility is so much more potent.

Besides high crime areas, loaded guns, fighting dogs, there are situations where the child may need to be taken away from the home. In this case sometimes policemen need to be involved in escorting the therapist and the child if you do an evaluation. Some people get upset if you don't help them enough. Some people get upset if they feel you are threatening that you will take the child away. They can get hostile and you are on their territory.

This is something that really needs training, needs to be evaluated. Do you send the therapist alone? Is it the right place for a woman therapist to be alone? Are there weapons present? What kind of neighborhood is it? Is it late evening, is it an appropriate time or not, even though sometimes it's the only time to see the entire family?

Some people Google for safety issues, some therapists Google their clients or Google the neighborhood of the client so they can get exact view of how to drive in and how to drive out. Some therapists have access to criminal records, which can be very important and, in some situations, can be part of the agency guidelines. Therapists may be privy to the criminal record if they need to for clinical reason or for safety reasons. We need to remember, therapists have the right to protect their physical safety. This is true for all of us and we forget about it. We have

the right to protect ourselves and not necessarily to put ourselves into a dangerous situation if we choose not to.

We need to screen for weapons, vicious dogs and other safety issues. Sometimes not coming alone or coming when necessary with the police, is something that somebody needs to think about. We talk about women wearing flat shoes so you are more mobile, strategically parking your car in the direction in which you would be able to leave so that you are not heading into a dead end or something.

It requires quick assessment. It requires people who know how to be light on their feet and traditional social workers are a little bit more adept with that. They have a little bit more history and kind of the right personality for this kind of work because, traditionally, this is what social workers have done more so than psychologists and MFTs or counselors. We see very capable, competent social workers doing this kind of work attending to the safety issues. Many other therapists need to train and may not be very suitable for this kind of work.

Then we need to remember, sometimes you can do a home visit where there are no safety issues and not necessarily any boundary issues. I've gone sometimes into upper class or upper middle class neighborhoods that were safe. I did a family visit to a situation where we sat in the living room and it was as confidential and private as in our offices. So we need to remember, there's a whole range of situations and many of the items that I brought up in this interview may not be present in many of my in-home family therapies. Many are 100% safe and 100% confidential, as far as I can tell, and so it again depends on the situation.

Nola Nordmarken: I'm wondering if there are any other particular screening considerations that you haven't mentioned, or if there are any screening considerations that you haven't mentioned that would be more related to the types of therapy you were just referring to?

Dr. Ofer Zur: When you talk abiut screening, are you talking about screening clients or screening therapists?

Nola Nordmarken: Both.

Dr. Ofer Zur: Okay. So screening, you absolutely right, screening is important at both ends. We screen clients, whatever it takes, and hopefully we get good support in the agency or whoever you work with. Sometimes we do Google Earth and to get the lay of the land and that is a right thing. Sometimes criminal records can help. And screening therapists, that's a

whole new issue because you need to get people who can adapt and are capable of working in this kind of situation. Many therapists aren't. It's like, who can work in jails or prisons? Some therapists go past the metal detector and just freak out behind the barbed wires, and they cannot work in a jail situation.

You need to have the right personality, the right experience, and so you need to screen candidates before you send them and, of course, before you start training them. Some people can really learn to enjoy and to be effective in this situation and some people just don't fit personally and personality wise. With the best of training, they'll still not be able to adapt to this kind of work.

Screening for the personality and style of people, as well as screening for clients, are both very, very important. That can be true even without issues of dangerousness. Some people just don't feel comfortable in other people's homes. This has to do with the cultural component. I think some people have a much wider cultural experience. People who travel the world may be even more comfortable walking into people's homes of other cultures and adapting with ease. So it depends on your life experiences as well.

It's not always issues of safety and dangerousness. It's also, do you feel comfortable walking into people's homes and conducting therapy, assessment, evaluation there. It has to do with more than danger and safety. It has to do with personality, style, culture, and comfort zone of therapists.

Nola Nordmarken: I can really see, as you're speaking, how it would take a particular type of almost a sub-type of training and supervision because there are so many essential factors that are unique to this kind of work.

Dr. Ofer Zur: Absolutely, the training, it just super important here. It's a unique modality, as you just said, and requires ongoing support. Uncertainties, unpredictabilities, ambiguities that people face. They need support. I work with some departments where people can de-brief on a daily basis and have twice a week peer support groups. It can be so important when people can just get together and say “let me tell you what I encountered”. Just venting out.

Nola Nordmarken: I think that would be so important.

Dr. Ofer Zur: Absolutely. This would be something that’s part of supervision. There are many ways to supervise people. Individual supervision, group

supervision, peer supervision, peer support. I advocate that people who start in this line of work go to the first 1, 2, 3, or 4 visits with a mentor, with somebody who has done it many times before, to help them navigate the complexities of the home visit. Role play is good, videos sometime if there are any and there are actually some, modeling, as I just talked about, senior, junior therapists going together, and then of course teaching, assessment, etc. The de-briefing is extremely important in preventing burnout and reducing stress which reduces absenteeism, and definitely we need de-briefing when appropriate in traumatic situations, which is not that unusual in some of the population that you work with.

Training, screening and ongoing support must be much more intense than regular private practice. People who have managed care or people that have individual private practice outside of managed care require much more work and intensity and continuity.

Nola Nordmarken: You have mentioned social work and cultural sensibilities. What types of therapeutic orientations are found to be most effective when utilized in home-based therapy?

Dr. Ofer Zur: Family therapy, I mentioned before, CBT very appropriate in home-based, hospice needless to say, and a slew of medical conditions from hospice, nutrition, medication management, and so many other things. The medical field is moving into home-based therapy as a way to save a lot of money and prevent hospitalization. These are some of the orientations that would be highly conducive.

Nola Nordmarken: What about record keeping and billing, are there any differences with home-based therapy?

Dr. Ofer Zur: The record keeping should include what's clinical, meaningful, as well as the issues of safety and security, ethical issues, confidentiality, legal issues around child abuse and others ... It's basically the same with different codes which we won't get into. There are, of course, their own CPT code for home visits.

Nola Nordmarken: Would you say that home visits increase or decrease the cost of treatment?

Dr. Ofer Zur: Oh good, before we end I really want to cover this issue. You know, it's an interesting question. It can do both. It can avert ER visits, it can avert psychiatric hospitalization, sometimes you need less support of stuff, and less overhead because you don't have big offices, and sometimes it can be used with tele-medicine. So some people say it costs less. But then it

can be much more expensive because you have to drive there, it takes much more time, driving calls, driving time, you see fewer clients in a day. So it can go really both ways in this regard. It depends in what context you use it.

Nola Nordmarken: I'm wondering, is there anything else that I have not asked you that you would like to say before we stop?

Dr. Ofer Zur: You know, you covered a lot. You definitely did your homework with this one. I think it's a very rich environment, I think it's a fascinating environment. As the baby boomers grow older, it makes sense to think we'll see more home visits and we'll see more tele-health, so we see these 2 things are going to grow.

It requires special attention and special personality and definitely a lot of clinical, ethical flexibility.

Nola Nordmarken: As I've been hearing you speak to these issues, I just want to say I really take my hat off to those people who are there in the trenches doing that work. It really is challenging and meaningful and so valuable and important.

Dr. Ofer Zur: Beautifully said. Thank you so, so much, Nola.

Nola Nordmarken: Thank you.