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THE IMMORALITY OF THE HOME OFFICE

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The implicit immorality of the home office is examined on the basis of concerns that it exploits patients as a result of privileged analyst self-interest and usurps patients' control over environmental factors that could be potentially distressing or therapeutically harmful. The author argues that the inherent nature of physical space is not grounds for ethical concern and is only relative when juxtaposed with professional action. The case for a prescriptive ethics is further discussed in light of ethical consequentialism, concluding that the pursuit of providing an ideal treatment ambiance is an illusion. Strictures against the home office further compromise the individual liberties of both the analyst and the patient.

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Karen Maroda (2007) recently offered a thoughtful and evocative critique of the psychological parameters of having a home office and the ethical implications it generates. She persuasively argues for three noteworthy points: (a) Home offices are largely maintained for the financial incentives and personal convenience of the analyst motivated by self-interest versus providing optimal patient care; (b) home offices are also preferred by some analysts because of unconscious needs for recognition as well as narcissistic proclivities, including the analyst's desire for admiration, exhibitionism, and envy; and (c) home offices strip patients of having control over what is foisted on their inner experience without choice or consultation as a result of potential intrusions encountered in this particular treatment setting. What is impressive about her inquiry is that not only did she ask us to justify the home office arrangement and the potential repercussions this has for our patients' psychic lives, but she furthermore implies that it would be unethical to engage in or continue such a practice. Although she does not make this claim directly or as forcefully, what follows from her position is that it is immoral to maintain a home office where an analyst receives patients and, by extension, the professions that regulate mental health clinicians should ban such a practice because of the potential for patient harm.

Let us first take up the initial proposition, namely, that it is immoral to have a home office. One might immediately object to the charge of immorality because we must consider the analyst's intent or state of mind when maintaining a home office, and unless

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the home office is inherently harmful, abusive, or countertherapeutic in itself, then the charge of immorality is misguided at best or simply amoral at worst. Attributing inherent immorality to physical space and unforeseen arbitrary events that transpire in that space appears to me to be a tough row to hoe. If an ethical argument against space itself is to be successful, then it would necessarily have to entail the professional behavior and actions of the analyst in that space. This totally shifts the argument away from the location of the office, whether this be in the analyst's home or in a professional building, and relocates the issue within the activities of the analyst's professional comportment.

Because Maroda has largely based her argument on the psychological impact a home office can have on a patient's mental economy, her position is that of *ethical consequentialism*. What matters here is not the analyst's intent but the consequences of his or her actions or failure to act in certain ways. In Langs' (2007) terms, this amounts to not procuring a secure or appropriate treatment frame. Hence, the charge of immorality is based on how unforeseen (and possibly unforeseeable) events that could occur during the therapeutic hour in the analyst's home office—such as the sight of the analyst's house, car, children playing, delivery personnel ringing the door bell, and so forth—are inherently unethical because we have no way of knowing how these events will be received by patients or what impact they will have on their mental health and adjustment. In short, if the consequence is negative and countertherapeutic to the patient, then the home office is unethical. But if we base an ethical argument solely on future possibilities, then any environment or physical space is susceptible to the same charge of moral impropriety. Just because something *can* happen does not mean it *will*.

If immorality cannot be attributed to physical space without importing the professional conduct of the analyst, then having a home office is not inherently immoral; it would only become so if what transpires in that space is ethically objectionable according to professional standards of practice. This issue brings up a second major proposition; namely, that if maintaining an independent practice within a home office is unethical, then the regulated health professions should ban such a practice a fortiori. The success of this argument would have to rest on the justifiability of making a categorical statement that a patient would be psychologically harmed in that environment. This would selectively ignore the personal needs, autonomy, rights, desires, rationale, and freedom of the analyst to determine his or her mode and parameters of practice. Although this may safeguard against potential abuses, it does not lend any credibility to the argument that the home office is inherently immoral in itself. I think it is important here to maintain the distinction between the environment itself and what transpires in that environment. The implications of Maroda's inquiry into the ethics of the home office is actually based on a stance of therapeutic ideality and optimal sensitivity to the patient's needs that should dictate professional practice. This is a prescriptive ethics and not simply a descriptive enterprise of examining how events that transpire in the home office need to be examined within the context of the therapeutic relationship.

Central to Dr. Maroda's thesis is that the analyst's desire and self-interests compromise optimal professional relatedness on the basis of the analyst's self-preference of privileging his or her needs over the patient's, whether this be a result of rationale justification, professional self-reflection, unconscious acting out, or all three. Of course, all analysts have their own unconscious vulnerabilities that are coextensive with any conscious reasoning for maintaining a home office, but does that in itself negate legitimate arguments that justify a home office arrangement? And even if unconscious dynamics or narcissistic motivations were analyzed and acknowledged as countertransference enactments or simply accepted as self-preferences, would this necessitate abandoning a home

office practice? If the case for a home office is based purely on the analyst's self-preference because of personal entitlement and pragmatic self-interest, would this automatically mean that this constitutes an unethical practice, or simply that the analyst has needs, too? Is that inherently a bad thing?

The main objection Maroda has to a home office is that it reclaims a patient's sense of control over what is presented in the analytic encounter. Her point is that the patient reserves the right to determine what kind of personal information the analyst should exhibit or disclose. And if this transpires it should be initiated by the patient when he or she feels a desire to know and inquire into the matter directly. Put laconically, nothing should be foisted on the patient outside of his or her control. But is not the element of control always a potential issue in any relationship, professional or otherwise? And certainly there is always a power differential when it comes to the analytic dyad. Under ordinary circumstances, we trust that the analyst will behave ethically and be guided by good professional sensibilities. The issue of control is ubiquitous and operative wherever we are, from the consulting room to being at home or in public, and is therefore proportional in any environment in which we can imagine ourselves to be. Would the courier ringing my doorbell be worse than the fire alarm going off in the clinic during session? We can easily think of countless examples—from the benign to the extreme—where physical space can be compromised in innumerable fashions, but we would not logically ban professional practice in such space for such reasons alone.

If the issue of control is a central thesis against the home office, then it surely is being offered under the rubric of providing an ideal treatment environment in which the patient's needs are put above the analyst's. Of course this is a noble and virtuous pursuit, one that should be applauded. But what exactly is an ideal treatment environment? Does this not beg the question of what is optimal both as a viable clinical theory as well as a methodology informing practice? Furthermore, is it ethical to attempt to structure an ideal environment when this may be counterproductive to living and functioning in the real world, where ideality is hardly the norm? Is it reasonable for the analyst to provide a controlled environment where being in control is the main issue against a home office? Is not the ambiguity of control part of real-world events everyone must encounter and negotiate in the face of objective social reality? Does not the reality of a home office reflective of the personal needs and preferences of the analyst offer the patient something he or she will indubitably encounter in every aspect of psychosocial life by virtue of being in the world? Should the illusion of ideality in the service of gratifying patients' needs and wishes be the standard on which the ethical edifice of the home office question rests?

What is certainly of value is the sensitivity and clinical reflectiveness Maroda has given to this seriously neglected subject matter within psychoanalysis. The question of whose needs are privileged in the analytic dyad and what constitutes best practice is what I think her main contribution to this debate has to offer us. This is a professional attitude based on clinical thoughtfulness, care, and compassion toward our patients' needs. Of course, this position must contend with the fact that there are competing needs, agendas, desires, and preferences that define the intersubjective field, which consists of two subjects and two subjectivities that inhabit both physical and psychical space in relation to one other. Are not the analyst's subjectivity and needs important here as well?

Does this not compromise a greater principle of freedom that both the analyst and the patient inherently have the right to exercise? Not only does the threat to the analyst's freedom on how to govern his or her practice become questionable and tenuous, but this furthermore assumes that the patient is not free to determine how he or she wishes to enter into a therapeutic relationship to begin with, presuming that the patient *has* a choice of

whether to see the therapist in his or her home office. It also assumes that the patient is not free to determine how he or she wishes to interpret and process events that transpire in the home office setting even when they are not entirely within the patient's control. Moreover, would we want our individual liberties curtailed by regulating professional bodies on the basis of a fear of patients' loss of control, not to mention potential boundary crossings when none have actually been committed by a hypothetical analyst who maintains or is contemplating opening a home office? In the service of contributing to her inquiry, I hope Dr. Maroda will consider these reflections when she offers her forthcoming research findings based on her ongoing investigation into this important topic.

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