CREATIVE MOMENTS & CHALLENGING EVENTS IN THERAPY -- BENDING RULES TO HELP

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INTRODUCTION

From the New York Times, Metropolitan Dairy section, 22 December 2005

Being asked to perform a psychiatric consultation on a hospitalized adolescent is rarely pleasant. Fortunately, this teenager seemed placid as I approached his bed. His mother was seated nearby, immersed in her knitting.

I walked over and introduced myself to him. He looked right through me and started screaming at the top of his lungs: "I can't see! I can't see!"

I had never before seen such a dramatic example of hysterical blindness. I tried not to betray my concern as I casually asked his mother, "How long has this been going on?"

She never even looked up as she replied, "Ever since you stepped in front of his television."

Isaac Steven Herschkopf, M.D.

Yes, there are all sorts of boundaries challenges in professional work.

On occasion I tell my students and professional audiences that I once spent an entire psychotherapy session holding hands with a 26 year old woman together in a quiet darkened room.

That disclosure usually elicits more than a few gasps and grimaces.

When I add that I could not bring myself to end the session after 50 minutes and stayed with the young woman holding hands for another half hour, and when I add the fact that I never billed for the extra time, eyes roll.

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Then, I explain that the young woman had cystic fibrosis with severe pulmonary disease and panic-inducing air hunger. She had to struggle through three breaths on an oxygen line before she could speak a sentence. I had come into her room, sat down by her bedside, and asked I how I might help her. She grabbed my hand and said, "Don't let go." When the time came for another appointment, I called a nurse to take my place. By this point in my story most listeners, who had felt critical of or offended by the "hand holding," have moved from an assumption of sexualized impropriety to one of empathy and compassion. The real message of the anecdote, however, lies in the fact that I never learned this behavior in a classroom. No description of such an intervention exists in any treatment manual or tome on empirically based psychotherapy. **Gerry Koocher, Ph.D., President, American Psychological Assn.**

From Pope, Sonne, & Greene (2006) **What Therapists Don't Talk About and Why**.

BACKGROUND

Through the years our staff at the Walk-In Counseling Center (**www.walkin.org**) have utilized training exercises in ***Boundaries in Professional Relationships: A Training Manual*** (Milgrom, 1992). Through the vehicle of these exercises it has become clear that there are few things which are "never OK. Furthermore, in reality it is exceedingly difficult to define clear boundaries which would be in effect across various service modalities and practice styles (with the exception of avoiding sex with clients).

When one looks at a variety of programs, settings, and clients, it is clear that a wide range of "rules" do not apply across the board. It is equally clear that there are numerous instances which workshop participants can identify in which some sort of a boundary crossing might be appropriate, or even the best approach to a clinical situation. Lazarus & Zur (2002) raise a number of such issues, and Zur (2005) discusses this in detail in an article entitled "Beyond the Office Walls: Home Visits, Celebrations, Adventure Therapy, Incidental Encounters and Other Encounters Outside the Office Walls which can be accessed on the internet at **Http://www.drzur.com/outofofficeexperiences.html** .

Although I myself have many times referred to "the slippery slope" when discussing boundaries, I am inclined to agree with Dr. Jerome Kroll (2001) that the concept of the "slippery slope" is itself quite a slippery concept. In many instances the so-called slippery slope is in actuality a sequence of boundary crossings or violations done by a professional who is focused on his or her own needs, or who is quite impaired. The well-adjusted and thoughtful practitioner for the most part does not appear to be at great risk of suddenly finding him or herself on a "slippery slope" from which escape is not possible.

Furthermore, these issues become more complex when viewed in a forensic context – that is from the perspective of how boundary crossings may be misperceived in the context of treating a difficult situation. Well worth reading are Gutheil (2005) and Dvoskin (2005). Others have written about the challenges some clients represent such as Caudill's (1996) article "The Dangerous Myth of the Predatory Therapist.

To clarify this challenge, I will briefly note several workshop exercises which are discussed in depth in Milgrom's (1992) **Boundaries in Professional Relationships: A Training Manual**. These are described in more detail in the handout ***Tools for Preventive and Remedial Boundaries Training*** which was prepared for a symposium on *Boundaries Education: An Expert Update on Diverse Approaches & Settings* chaired by Dr. Gregg Gorton at the 2003 APA convention in San Francisco. However, for the purpose of the current presentation, I will briefly describe these exercises in hopes of not only sharing a training aid, but in more clearly illustrating how these boundaries work.

PERSONAL vs. PROFESSIONAL

This exercise requires a blackboard, flip chart, or overhead projector. At the top of the page write the word "Personal" on one side and "Professional" on the other side of the page.

PERSONAL vs. PROFESSIONAL

The task is to provide characteristics or descriptions of relationships which might differentiate ***personal*** from ***professional*** relationships. The responses are written down as in the example below:

No payment	***Fee paid, or service provider paid***
Can be forever	***Time-limited***
Can meet anywhere	***Generally meet in office***

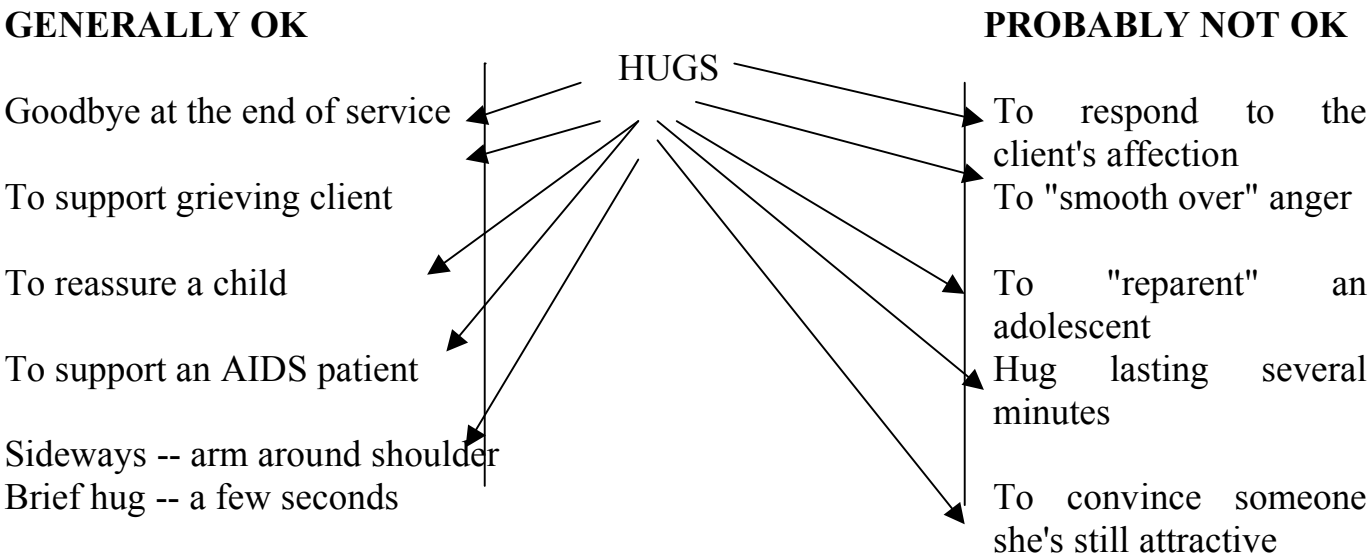
What should be apparent is that there is not a line or barrier down the middle of the page and depending on the nature of the service lines may be draw at varying spots on each of what are obviously continua.

WHAT'S OK, MAYBE OK, NEVER OK?

This exercise requires a blackboard, flip chart, or overhead projector. The presenter creates three columns -- with "Always OK" on one side, "Maybe OK" in the middle, and "Never OK" on the other side:

ALWAYS OK	MAYBE OK	NEVER OK

The presenter then asks for something that is "Always OK" in a given type of professional relationship. Whatever is given, the presenter then asks the audience if everyone agrees. Most end up in the "Maybe OK" column. **Most behaviors end up in the middle column -- Maybe OK.** An example is given below of how a discussion about the propriety of hugging can lead to the articulation of a variety of principles:



SOME NOTES ON ETHICAL ISSUES

Decisions about boundary crossings can be weighed using five ethical principles:

(1) **BENEFICENCE: likelihood that it will help, or benefit the client.** Can you articulate potential positive goals or outcomes from this boundary crossing?

(2) **NON-MALEFICENCE: likelihood that it will <u>not</u> harm the client.** Can you describe possible negative outcomes and discuss how you will minimize these risks, or explain how the risks are trivial compared to the potential benefits?

(3) **AUTONOMY: likelihood that it will foster the client's autonomy.** Does this boundary crossing reinforce the client's independence or personal choices? (Bear in mind that some boundary crossings undermine this by increasing the care-taking by the therapist.)

(4) **FIDELITY: the degree to which it is true to what was promised.** Does this carry out the <u>professional</u> role and is it faithful to the <u>helping contract</u>, or does it stray from the therapist role?

(5) **JUSTICE: balancing the needs or rights of one versus another -- those of your client vs. others in their family or in the community.** This principle is very challenging because it moves away from simple consideration of what is best for the client and takes into account the welfare of others. There are several potential components:

(A) Risks to Others: Is someone else at risk of harm? The issue of a duty to warn third parties of danger from a client, involves the competing principles of Justice vs. Autonomy. The same is true for child abuse reporting.

(B) Resource Allocation: Doing more for one client -- giving them extra time, favored appointment slots, or extra services -- must be balanced against needs of others. For example, giving a client extra time in an appointment must be weighed against the needs of someone who is waiting. Bending a requirement for one client must be weighed against the fact that another may not have access to a service. Attending a celebratory event for one client may drain time which could have been spent helping others.

The issue in most complex situations is **not what is ethical -- it is the comparable *ethicality* of the various options for action. How is each of the five ethical principles impacted in each option which is under examination?** In each situation the analysis of how each of these principles would be met may produce a different pattern of positive vs. negative outcomes.

The goals of your action are critical here, since the ethical clinician must be accountable for the outcomes. The key issue then becomes: <u>Given what I hoped to accomplish, how successful was this intervention or approach? And, what negative consequences occurred? All of us have both a professional and an ethical duty to evaluate these choices and decisions both before and after the fact to examine potential consequences, and then actual consequences.</u>

A DECISION-MAKING TABLE

Another way to examine this is via a decision-making table. With complicated decisions I find it is necessary to actually write down the anticipated outcomes in order to be able to decide on a course of

action. Whether you do this formally or not, the question remains as to whether whatever risks are inherent in the boundary crossing, did the results -- anticipated or real -- appear to outweigh the negatives so that the net result was beneficial to the client.

Likely Positive Outcomes	Likely Negative Outcomes
Option A	
Option B	

One can have more than two options. Sometimes there are many options. One could have many more boxes to fill and analyze. Below are two cases for illustration purposes.

CASE 1: You are providing services to a single mother with a child. She has told you about behavior which clearly passes the threshold for child abuse reporting. You have decided to report. Do you tell the mother, and if so when do you tell her, that you are going to report.

	Possible Positive Outcomes	Possible Negative Outcomes
(1) Don't tell mother		
(2) Call while mother Is there		
(3) Tell mother after You call		

CASE 2: You have been treating a 17 year old young man who is a college student. He is struggling with depression, but also with emancipation from controlling parents. He has made one suicide attempt in the past which was a relatively serious one. You have received a phone message at the end of the semester that he is heading home to his parents place. In the phone message he sounds as depressed as

you have heard and sounds suicidal. You phone his roommate who says he just left and was very depressed when he left town. The roommate is concerned he is suicidal. The drive to his parents is 6 hrs. long. You have spoken with his parents once before and know how to reach them, but the release you have is no longer valid. It is unclear when your client will arrive at their home. What are the options and how would you compare them?

	Possible Positive Outcomes	Possible Negative outcomes
Contact the state police and Have them stop the car		
Call his parents and explain The situation		
Call his parents and if they Ask, explain the situation		
Call his parents and leave A message he should call Right away		
Leave message to Phone you -- no urgency		
Leave no message but Phone back when you Think he may have arrived		
Don't call -- wait Until he calls you		

Such decisions are clinical judgment calls which attempt to maximize benefits for the client, while minimizing harm, and to the degree possible avoid undermining his autonomy. Clinicians need to be accountable for what choices you make and to evaluate the outcomes. All options in Case 2 involve boundary crossings with varying implications.

PRACTICE IN CLOSE QUARTERS

Small towns, rural areas, college campuses, and other such settings involve **practicing in close quarters. All sorts of *overlapping relationships* may occur.** This is also true when **the therapist and client share**

membership in a racial or cultural minority group, a religion, or even by both having children of about the same age in the same schools.

Sometimes the key issue is maintaining collegial relationships vs. the client's privacy.

Case 1: **You work in a student health service. A residence dorm counselor refers a student to you for therapy. That counselor then runs into you on campus and wants to know what you have found out about the student's problems and what he/she can do to help. Your working relationship with the residence counselors is important to your being able to be effective.**

Sometimes the issue avoiding conflict of interests or perceived loss of objectivity.

Case 2: **You are a consultant to the schools in your community, and at times are brought in to consult where there is a dispute. Sometimes your input plays a role in a teacher being disciplined or having his/her work supervised. You are considering running for the City Council and that council has hiring & firing powers over the school personnel. The council role is very part – time and council members continue their professional work. Do you run for office, and then if elected, can you continue that consulting work you love?**

Sometimes you are facing issues of your family's welfare vs. that of a client.

Case 3: **You practice in a small town. A mother comes to see you late Thursday afternoon, very concerned about privacy of the consultation, because her concern is that her son might be date-raping girls. She isn't sure and wants your help. Thus far he has refused to come see anyone, and the "evidence" is not clear and there have been no formal complaints. You return home and your 17 yr. old daughter is very happy because this "really neat" guy has asked her out for Saturday night and all the other girls are jealous. She's been dating for some time and has agreed to go out. Then she mentions his name -- he is the son of your new client.**

NOT AS A STRANGER

The 1955 film, ***NOT AS A STRANGER***, presented the dramatic interplay of personal relationships and the practice of medicine.* Although we like to try to avoid this in the psychotherapy professions, *in health care it is commonplace to end up working with and treating people you know and encounter in everyday life.* For example, if one is called upon to help an impaired colleague one can find oneself in a complex set of interactions which span professional and personal life.

Also of importance is the reality that **friends tend to refer friends to health care professionals who have helped them, or whom they trust.** So it is not uncommon to end up treating people who know each other, even if one is not in a small area geographically. This creates all sorts of potential boundaries challenges.

With members of minority groups, from small religious groups to cultural or ethnic groups, the likelihood of referrals within a friendship or social network is quite likely.

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* While dated, it is still worth renting and viewing. It was the directorial debut of Stanley Kramer and was based on a Morton Thompson novel. Its wonderful cast includes Olivia de Havilland, Frank Sinatra, Robert Mitchum, Charles Bickford, Gloria Grahame, Broderick Crawford, Lee Marvin, Lon Chaney, and Harry Morgan.

(1) Question: When do you take on a referral from a client of one of their "friends"? When do you not do so?

(2) Question: Under what circumstances do you agree to see a family member of a client?

CULTURE

A therapist was working with a 4 year old boy from an African family. He was very hyperactive and the therapist asked the family how they controlled this behavior at home. The couple began to talk in their own language, and then turned to the therapist. The mother said "my husband has given me permission to tell you how we control our son, and also we will give you permission to use this same technique with him yourself." The therapist was pleased and asked what this method was, indicating that she was grateful that they would let her use it with the son. The mother responded: "I breast feed him, and you can do it too." The therapist indicated that she appreciated this but probably would not do so.

The expectations in a given cultural group about things such as the acceptance of gifts, attendance at a wedding or funeral, may be quite important. **Cultural expectations alone may generate a rationale for crossing a boundary….however, they can also place more stringent limits on boundaries.** Some actual cases illustrate some of the issues:

CASE 1: A child is dying and it has been determined that there is no hope. The parents and their family have discussed this and are in agreement to turn off life support and let nature take its course. The plan is for the parents to participate and hold the child as he (presumably) dies. But the parents refuse to sign the consent form saying that to sign such a document violates their faith (Hindu).

CASE 2: You interview a 17 year old girl from a Middle Eastern culture who reveals that she has had pre-marital sex with an older person she met. This meets the child abuse reporting standard in your state. She indicates to you that if her family learns of her sexual activity, her male relatives will put her to death, probably by stoning her. You investigate this and find out that she is probably correct.

CASE 3: You have an African refugee family. The 4 year old son is hyperactive and you ask the parents for any "tricks" they use at home to help him calm down. They go off in a corner and conference in their native tongue, and then the mother tells you that her husband has given her permission to reveal how they calm him down, and to also give you the family's permission to do this. The family's "trick" is that the mother will breast feed him and they are quite willing to have you do this.

CASE 4: The parents have limited command of the English language and you do not speak their language. You do not have an interpreter and you wonder if their young daughter be the interpreter given that she has typically done this for them when they go for medical care. How does one weigh the options of use of a child…..or another relative……or a friend…….or a neighbor? [Note: If this care is provided through Medicaid or Medicare funding, you are actually expected to provide interpreter services *at your expense, without any charge to the family.*

There are a number of general "words to the wise" that we recommend in terms of preparing to work with someone from another culture or ethnic group. Our center works with many immigrants and many refugees and these have proven to be quite useful.

(1) When working with a refugee, immigrant, or client from a culture with which you are not familiar, do you do preliminary research about cultural expectations? Do you know, for example, what expectations may exist around a wedding invitation?

(2) If you are asked to attend a graduation, or a wedding, or a christening, do you know what the impact of attending, or not attending, would be

(3) What are the cultural expectations about payment for services, or the giving of gifts to service providers?

(4) What is the role of barter in the local economy? Are there times when accepting goods might be more ethical than treating for free?

DUAL & MULTIPLE RELATIONSHIPS

For two decades there has been a growing concern about the "dual" or "multiple relationship," but these are rarely clearly defined. Originally the concept was a rubric under which the psychologist's code of ethics forbid sex with clients. The intention was to first forbid, and now more recently, caution practitioners against relationships in which a conflict of interest is obvious and where the treatment role might be undermined. However, many discussions of "dual" or "multiple relationships" seem to imply that a range of contacts outside treatment may be objectionable. I am going to propose the use of three terms: **encounter, overlapping relationship, dual relationship.** For example:

> **You park your car in the church parking lot and notice one of your clients is also parking their car. This is an encounter with the main boundaries concerns being how you greet each other, especially in front of others. Neither of you has realized this before, but it turns out you are members of the same church. This is now an overlapping relationship.** Challenges are possible and are greater than with just an encounter, but normally such a situation is manageable. But if you are on opposite sides of a congregational fight, this might not work.
>
> **The pastor announces a study group, with mainly the pastor lecturing to a large group. Again, this is overlapping.** Obviously, challenges are possible if you and your client end up interacting, getting into theological arguments, etc.
>
> **The pastor announces a "parent-support group" in which parents are to share their parenting problems. For you and your therapy client to be in this together is probably a dual relationship and not a good idea.**

AREAS OF POTENTIAL CREATIVE BOUNDARY CROSSING

(1) **Telephone contacts:** Calling the client at home. Giving out or simply having a listed home phone number. (Interesting issue with HIPAA for Americans: If you phone your client on a phone with a blocked number, and the client has a phone which will not accept calls from phones with blocked numbers, you may fail to reach a client in an emergency.)

(1a) Dialectic Behavior Therapy (DBT) involves programmed calls in the evening as part of treating clients with Borderline Personality Disorder -- the very group about whom one often has concerns about boundaries.

(1b) Checking on a client who is at risk but who you are attempting to keep out of the hospital if they can stabilize.

(2) **E-mail:** When is email a helpful way to contact a client, learn of a need to change an appointment time, etc.? How do you respond to emails from your clients? What are the limits of email interchange? Do you print out your email interactions and save them? Do you think that your clients might be doing this?

(2a) Contact initiated by you when you are unable to reach the client by phone.

(2b) With services provided by telemedicine - type hookup, as a way of having homework assignments sent to the client or returned to you.

(3) **Attendance at a funeral:** What are the implications of attending a funeral, or of not attending? -- What about your client's own funeral? Does it make a difference if there was a suicide? Funeral of your client's spouse? A child's funeral?

(3a) In the oncology unit of a pediatric hospital it was considered a duty to attend the funeral of a child who had died on the unit, or even in home care after a hospitalization.

(3b) What happens with a patient suicide -- does one attend the funeral? If so, with what degree of visibility are you present?

(4) **Attendance at special events which celebrate a client's achievements or attainment?:** How about attendance at a graduation ceremony for an adolescent client? Or an adult who has returned to college after many years and then graduated? What about an awards ceremony of some sort?

(4a) Attendance at the ceremony for the graduation of a special education student whom you have helped since he was 12 years old. He is graduating as a mainstream student with his class. What if you are invited? Or can you simply decide to go?

(4b) Attendance at a party afterwards at the family home of a Hispanic family who has invited you to come celebrate this achievement and made it clear that it is important to all of them.

(5) **What about Weddings or other family celebrations?** Does it make a difference if you had worked with the couple? Or interviewed the new spouse?

(5a) You have worked with the bride for 6 years and seen her through the death of her first spouse, and then an abusive rebound marriage, and a cancer scare. You did premarital counseling with her new husband and have genuine feelings of affection for them which are mutual. If you attend a wedding, what about the reception? What about a gift? Do you stay and mingle, or just "put in a show" and depart politely?

(5b) Do you send a gift, or a card, in lieu of an appearance?

(6) **Giving a client a gift.** When might this be therapeutic with an adult? Adolescent? Child? If you work for an institution -- e.g. a pediatric hospital -- what about having a budget item to

pay for the gift. Or should it be personal?

(6a) Giving the client a book or other item related to the therapy.

(7) **Therapist self - disclosure:** Can one err by self-disclosing *too little*? Case examples of self disclosure by the therapist. (Illness or pregnancy and upcoming leave time; Personal issues of the therapist which impact; Reasons for lateness or missed appointments)

(7a) Client has been seen for six months. She is historically distrustful, but trust has been established. Struggles occur and through supervision therapist realizes that counter-transference is the issue -- some unresolved feelings towards his mother. He has decided that this is a good time to do a referral, but decides, after thought and consultation, that he must share some detail about the nature of the counter-transference or the client will feel betrayed.

(7b) Analyst tells client, who is struggling with upset that his girlfriend is being pursued by other men due to her general attractiveness and tendency towards hysteroid - type seductiveness, about an event when he was a boy that was parallel to this.

(8) **Sharing a meal with a client or family:** A family is having struggles around the dinner table and invites the therapist to come visit and have a meal and see for himself. [This was depicted in the movie ***Mumford***.]

(9) **Services done outside of the office.** In - home family therapy. Visiting during meals in treatment of eating disorder. Treatment of home-bound agoraphobic.

(9a) Long term client is disabled for a time due to surgery followed by illness. Client asks if therapist might come to the home, and the therapist does sessions in the client's home -- possibly in the bedroom at first. [This is the case in many nursing homes.]

(9b) Long term client is on his/her death bed. You visit and do sessions in their home or facility.

(10) **Services performed over the telephone other than crisis intervention.** How much "therapy" should be done over the phone. What about follow-up by phone instead of by multiple face to face sessions? What about the client who has left town?

(11) **Handling personal business in front of the client or allowing personal calls to come through under some circumstances.** Of course in the general case this is considered a boundary crossing or violation, rudeness, or just plain bad professional practice. But are there times when it is permissible? What do you do if this is necessary?

(11a) Dr. Anita Melfi in the TV series *The* Sopranos, while generally a stickler for boundaries, permits a call to come through related to her car repair. What about a call about your child or some family emergency? How much can be transacted in front of the client? Do you send the client out of the room? Do you exit?

(11b) With a resistant client, is it permissible to do some "desk work" rather than sit there waiting for them to participate? A number of people who work with rebellious adolescents do this from time to time. It is portrayed with a sailor who is a resistant client in the movie *Antoine Fisher.*

(12) **Touch:** While there are many bad reasons to touch a client, or to alter ones normal boundaries around touch, there are times when extending these boundaries may be helpful and have minimal risk.

(12a) Brief hand on shoulder or sideways or even frontal hug when a client has suffered a major catastrophe -- loss of a child, spouse, etc.

(12b) Handshake or brief touch of a client who is HIV positive and who feels like a leper. Some who work with AIDS patients, especially in hospice situations, indicate that this makes a major difference for the client.

(12c) We have heard several therapists who have "held" a dying patient who felt very alone and was in need of comfort. Several therapists at workshops have told of doing this more than once -- meaning in a series of sessions.

THE FORMER PATIENT

How do any of the aforementioned areas of challenge play themselves out following termination of the professional relationship with a client. Beyond the prohibition against sexual involvement with a former client, what sorts of hazards or risks are there in any of those other arenas?

Encountering a former client and having a cup of coffee, discussing how things have gone in the past several years. Termination was 4 years earlier and the client is doing well.

PUBLIC AWARENESS & EXPECTATIONS

One of the great challenges is the fact that many members of the public get distorted notions of boundaries from TV shows or movies. ***Prince of Tides, Good Will Hunting, Mumford, Antoine Fisher, Analyze This, The Unsaid, K-Pax, Don Juan de Marco, Anger Therapy,*** and many other films depict professional relationships characterized by a failure to maintain boundaries consistent with current practice standards (See Gabbard & Gabbard, 2001). In most the boundary crossings are presented as a combination of innovative therapy and a means through which not only the client can heal, but the therapist can heal.

Clients may even request that such “techniques” be used and be angry if you are not willing to. One family left therapy when the psychologist was unwilling to use the techniques used by Robin Williams in *Good Will Hunting,* (It was unclear if they included in this his choking of the client near the end of the first session.)

The attachment “Working Out With Patients” which follows the reference section below illustrates how boundary crossings may be featured in a newspaper story about an innovative therapy, and again can create a challenge for the clinician seeking to set boundaries.

A related challenge is that many clients have no clear concept of what are acceptable boundaries in the psychotherapeutic relationship. In fact, many clients are appreciative when a professional crosses boundaries and behaves in what they see as a "friendly" or "informal" manner. They may even be personally flattered.

FINAL NOTE: Although the literature focuses on involvements with clients with whom you have a natural liking or attraction, in my experience far more boundary stretching occurs in cases with difficult clients who don't get better. I usually ask people why they do this work – did they get into this field for the money? Nobody does, but they do in order to help people get better. So the client who has command of your time and energy is often the one who does not get better. Any sign that something is helpful to them gets your attention. You self-disclose unwisely and they respond with positive feedback about "how much it helped." It is very easy to slip into trouble gradually.

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ATTACHMENT – WORKING OUT WITH PATIENTS

The story below presents an example of a therapeutic approach involving exercising with patients. What boundary issues would exist if the psychiatrist him or herself did the work-out, or if he/she authorized it and employed a staff member to do it, or if he/she made a referral for this service?

Working Out Your Issues; The Latest Twist in the Exercise-Mental Health Movement: Do Crunches While Talking Through Problems

John Briley -- ***Washington Post***

The body of evidence supporting exercise as a treatment for depression and other mood disorders continues to grow. Many psychiatrists and psychologists urge their patients to get more exercise and make other lifestyle changes. But perhaps no one takes this idea further than District therapist Jane Cibel, a licensed clinical social worker and certified personal trainer who conducts traditional talk therapy while clients walk on a treadmill or crank out dumbbell curls. In an hour-long therapy session, patients get their weekly counseling session along with a high-heart-rate, sweat-inducing workout.

Cibel, 40, works from a large room in the basement of her Foxhall home. One side is a handsome office, complete with comfortable couches, a fireplace, a desk and a wall full of heady books. The other side of the room has a treadmill, a multi-station weight machine, a rack of dumbbells, a Bosu balance ball and a small trampoline.

Mixing the two disciplines offers several benefits, Cibel said: First, by putting clients on a treadmill during therapy, they begin to see, via their physical accomplishments, that they are capable of "self-bettering behavior." In addition, people talk more freely when they're moving: "If you're just sitting and talking, you are not as stimulated as you would be when moving." (She said the workouts are kept at a "challenging conversational pace" so clients can speak without struggling for breath.)

Finally, Cibel seeks to exploit the generalized positive feelings that occur as a result of exercise to help rewire the brain. Exercise is known to increase levels of dopamine, serotonin and norepinephrine, neurotransmitters that affect mood. These are the same brain chemicals whose levels are controlled by such antidepressant medications as Prozac, Paxil and Zoloft. Positive thoughts triggered by exercise-driven higher levels of brain chemicals can help reinforce positive emotions and behaviors, she said.

"You can restructure your brain with exercise," Cibel said.

The theory behind this is known as "neural Darwinism," a concept advanced by 1972 Nobel Prize winner Gerald Edelman, who asserted that people become optimistic or pessimistic based on habits of mind reinforced by specific neural connections.

"Your brain is made of cell clusters, and the thoughts you attend to dictate the connections between clusters," explained Cibel, who has a PhD in social work from the University of Maryland along with certifications in personal training and sports nutrition from the International Fitness Professionals Association. "So if you have a lot of negative thoughts, those [pessimistic] connections are strengthened."

The converse is also true, she said. Positive thoughts, including those derived from the exercise experience, reinforce the positive neural connections.

A typical client will warm up on a treadmill at around 55 to 70 percent of maximum heart rate, do some upper- and lower-body strength training (on machines or with dumbbells), maybe some core training and balance exercises, then more treadmill.

"We're talking the whole time, working things out," Cibel said.

She provides towels, but her office doesn't have a shower. She said she will soon move to quarters where clients may shower and change if they wish. Let's Go to the Data Numerous studies in the past decade have shown that exercise lifts mood and can relieve various mental disorders.

The most recent major study, published in the January issue of American Journal of Preventive Medicine, showed that adults aged 20 to 45 with mild to moderate depression who participated in 30-minute aerobic exercise sessions three to five times a week reduced their symptoms by almost 50 percent.

The study, conducted at the University of Texas Southwestern Medical Center in Dallas, involved 80 people divided into five groups. One group performed moderately intense aerobic exercise five days a week, and another group did the same workout three days a week. Two other groups mimicked that schedule but did lower-intensity aerobic activity. The fifth group did 15 to 20 minutes of stretching exercises three days per week.

Participants in both moderately intense groups experienced a decline in depressive symptoms by an average of 47 percent after 12 weeks. Those in the lower-intensity groups showed a 30 percent drop in symptoms, and those in the stretching group averaged a 29 percent decline.

James A. Blumenthal, a professor of medical psychiatry and psychology at Duke University, has studied exercise and mood disorders. He called Cibel's approach "interesting," but he wondered if the exercise would distract a client who was trying to discuss serious issues with a therapist.

Overall, though, he endorses exercise as a treatment for depression. Blumenthal conducted oft-cited studies, published in Archives of Internal Medicine in 1999 and 2000, that treated older adults suffering from a major depressive disorder with 30 minutes of exercise three times a week or the antidepressant Zoloft, or both.

The exercise group showed better improvement in symptoms than the other two groups. Blumenthal said he was not shocked that exercise outperformed Zoloft alone, but was somewhat surprised to see that those who only worked out did better than those who exercised and took Zoloft.

"I don't really know" what might explain that, he said. "Maybe [the exercise-only] people are gaining a sense of self-mastery" without any help from a drug, he said. "I can't help but think that's a part of it."

Case Study: A 34-year-old woman who has been seeing Cibel since December said she started therapy with "a lot of problems. I've struggled my whole life with being slightly overweight and having body-image issues, and I was ready to do something about it." To protect her privacy, she agreed to be interviewed on the condition that her name not be used.

The woman said she had taken a diagnostic test, which indicated she was "slightly depressed," and her psychologist suggested she go on medication. "But I was not comfortable with that," she said. "I don't like to take drugs."

The client said Cibel's combination therapy has produced a "dramatic turnaround" in six months," she said. "I've lost 23 pounds" -- of a 35-pound loss goal -- "but that is just one part of the whole thing, taking control of my life. This has really worked well for me."

Cibel's sessions have reacquainted the client with fitness. She used to walk every day but in recent years her exercise habit had dropped to at most one workout per week. Her mood declined at the same time.

"Now I try to work out six times a week," aiming for an hour of cardio exercise on most of those days, with weight lifting three days a week, she said. "If I miss a workout, I feel mad at myself. This is very empowering for me, knowing that I turned this around myself."

Some of Cibel's clients have eating disorders; others have a variety of mood disorders, including depression and anxiety. Some see psychiatrists as well, but, Cibel said, only for "medication management" -- i.e., getting prescription drugs, which Cibel is not licensed to prescribe.

"I really work with people on their diet -- eating the right foods, six [small] meals a day, that type of thing -- because it is such a huge part" of feeling good about oneself, she said.

John Ratey, an associate clinical professor of psychiatry at Harvard Medical School and a specialist in mood disorders, said as little as 10 minutes of exercise at 60 percent of one's maximum heart rate -- that is, walking briskly enough to just begin sweating -- "has an effect. [But] the more intense the exercise, the better, especially if you're only going to do short bursts." (Of course, it's not safe to work out intensely until one has achieved a basic level of fitness. And no one should exercise intensely without a doctor's approval.)

With exercise, one begins to see improvements in depression markers after a few weeks, Ratey noted, about as long as it takes antidepressant drugs to begin working in many people. "And we are talking about seriously ill people here -- the clinically depressed. They are responding to exercise."

Asked if there was any population for whom he would not recommend exercise as a component of treatment for a mood disorder, Ratey paused briefly. "No," he said. "I can't think of any."