Psychotherapy with Psychotherapists

LONG-TERM TELEPHONE PSYCHOTHERAPY

Kenneth M. Padach, M.D.

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EDITOR'S COMMENTARY THE EFFICACY OF A VERY SPECIAL PHONE CONNECTION

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LONG-TERM TELEPHONE PSYCHOTHERAPY

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The near-maddening pace of technological advances, the development of multitudes of large companies with offices in many major cities, and the weakening of family ties have made the population of the United States one of the most mobile in the world. Lifelong friendships fade with distance, neighborhoods are fragmented, and many children reach college age only after attendance in numerous different school systems.

In the context of this endless circle of motion, the slow but steady development of a therapeutic alliance between therapist and patient is still possible. The relationship, once fragile, untrusting, and superficial can become, over time, strong and productive. Yet, seemingly in an instant, one of the two participants may be whisked off to a distant city. To put this occurrence into proper perspective, it is known that more than 40 million people, constituting over 20 percent of the population of this country, move each year (Zwerling, 1980). That treatment is interrupted by such a circumstance is by no means an isolated event.

The most common reason for transferring patients 20 years ago was the therapeutic impasse resulting from insurmountable transference-countertransference problems between therapist and patient (Wolberg,

1954). Termination or transfer were the only viable options available. But what does one do when treatment is interrupted prematurely by a move of either therapist or patient? To many, transfer or termination are unacceptable alternatives. However, in the last ten to fifteen years, an alternative has been slowly developing, namely, the use of the telephone for continuing psychotherapy when the patient or therapist moves to another locale. This chapter examines the rationale for utilizing the telephone in structured, interpretive, long-term psychotherapy and the unique applicability of this mode of treatment for psychotherapy trainees and practitioners.

LONG-TERM TELEPHONE PSYCHOTHERAPY

When one speaks of continuation of long-term therapy by telephone, one must differentiate between formal and informal procedures in the use of the telephone. Many authors have written on the informal or periodic use of the phone following discontinuation of face-to-face contact (Chiles, 1974; Miller, 1973; Rosenbaum, 1974). The usual procedure is that the patient is allowed to call with no specific time established, and no fee is charged. Presumably, these calls are for "checking in" and follow-up and usually last for less than ten minutes. In a study by Rosenbaum (1977) of 45 analysts who had continued contact with one or more patients, only two had charged fees for the phone sessions. The calls to these two analysts ran more than

ten minutes.

There exist two broad classes of telephone usage in psychotherapy:

1. Unstructured, unscheduled, intermittent, fee-free calls that serve the purpose of "touching base" and reassurance that the therapist still exists and cares, and

2. A structured, scheduled, fee-for-service, longer duration call that more closely resembles an actual face-to-face session.

Langs (1974) believes that the first type of call might foster regression, dependence, or acting-out, if abused. I agree and suggest that the structure provided in the second type of call can also avoid the intrusion the therapist might feel from phone calls made on a more impulsive basis. Scheduling the calls and charging a fee is more apt to limit these difficulties and help sustain the objectivity and structure that the therapeutic relationship requires. Whether the therapist should structure continued contact by setting a time and a length for the call with a fee or should permit ad lib contact is a matter for joint decision and responsibility of both the therapist and the patient. Whatever the choice, it must be adhered to lest the abuse of privileges undermine the relationship. Phone sessions henceforth will refer to structured, prearranged appointments for which a fee is charged, similar in mechanics to face-to-face treatment. This is the preferred option when it is important to maintain contact with the same therapist for a continued

period of time, especially if uncovering, insight, and interpretive work rather than just supportive care are to be continued.

One may question at the outset whether the telephone can be used at all for long-term psychotherapy. Inherent in this mode of communication are factors that do not normally arise in regular face-to-face sessions. Foremost in this regard is the total lack of available visual cues, leaving communication of feelings and ideas solely in the realm of speech. Since it has been estimated that two-thirds of social meaning is conveyed between two individuals by nonverbal cues (Birdwhistle, 1974), a lack of these cues is likely to intensify the need to listen (Grumet, 1979). Indeed, for adequate communication of emotions to occur, feelings, covert thoughts, and body cues would have to be converted into speech. Wolf (1969) speculated that a large amount of concentration and attention might thus be demanded. It is hypothesized here that if this could be accomplished successfully by patients, a valuable avenue of insight and affectual self-assessment could be developed, giving patients substantially greater access to their feelings. However, if this task is not successfully accomplished, the lack of visual cues could be expected to have a detrimental effect on the interaction.

Without face-to-face contact, there is a tendency toward a decrease in the awareness of reality factors (Wolf, 1969). This may allow visual fantasies by both the patient and therapist to go unchecked and transference to

develop more readily (Grumet, 1979; Rosenbaum, 1974). This effect can be likened to the use of the analytic couch to shield the therapist from the patient's view, allowing the latter to fantasize and project without distraction. Thus, the therapist can remain relatively opaque over the phone, and the expression of transference material can be facilitated. However, it has been observed that when telephone participants were deprived of visual cues, anxiety arose that provoked defensive maneuvers in a variety of directions, such as blaming bad telephone reception for not hearing a confrontative comment (Wolf, 1969). Hence, forces facilitating as well as inhibiting expression of sensitive material exist when using the telephone, so that the effect of this stimulus barrier will be different depending on each patient. Those patients made uneasy by the lack of visual cues will be expected to respond with an inhibited expression of sensitive issues, while those more comfortable with the particular arrangement might show an increased willingness to open up.

The spatial arrangements afforded with telephone therapy can offer several distinct advantages over conventional face-to-face therapy. By maintaining a physical distance from the therapist, a sense of safety is created, allowing more vulnerable areas to be revealed (Daniel, 1973). Telephone patients have a unique advantage in being able to control just how much of themselves is revealed. Without the visual cues, the therapist is dependent upon the patient's cooperation to disclose verbally what might

otherwise be conveyed through nonverbal behavior. This can present a difficult problem with patients who resist strongly. The opportunity to exclude and elude the therapist successfully is compounded by the use of the phone. A telephone patient has more opportunity to choose just how much to tell the therapist than does someone in a face-to-face session.

The distance offered by the telephone may also help in "shielding" the patient from the therapist during the expression of overwhelming transference affect (Grumet, 1979). Indeed, the telephone might reduce the overwhelming feeling of a powerful transference to an intensity the patient can better tolerate (Saul, 1951). This could allow a more continuous flow of powerful affect, since the patient would not be distracted by the therapist's presence. Particularly in regard to hostile and aggressive emotions, the protection phone therapy offers can facilitate fuller effective expression without the possibility of physical acting on the impulse or fear of immediate physical retaliation by the therapist.

Although the factors just discussed play a significant role when the telephone is the medium for psychotherapy, probably the most substantial and most overlooked reason for continuation of therapy by phone after a premature interruption is the very nature of the therapeutic process; that is, gradually building a therapeutic alliance and slowly uncovering layer upon layer of conflict and defense. It is well established (Keith, 1966; Langs, 1974;

Saul, 1951; Wolberg, 1954) that it can take a considerable amount of time before enough trust is established for very sensitive material to emerge. Building a strong therapeutic alliance takes time. Kemble (1941) discusses the development of this alliance; there is minimal intensity of the relationship at the outset, followed by a period of considerable engagement and work, and then a gradual decline in intensity as termination nears. The time that it takes in the therapeutic process to reach the middle work phase and the depths of exploration to which it can transcend is contingent on many factors, including resistances of the patient, his or her rate of change, the magnitude of the problems, and the degree and manner with which the therapist participates and his or her therapeutic skill. Rather than prematurely terminating treatment while the patient is in this work phase, especially if it has taken a long time to arrive at this stage, the patient should have the opportunity to continue by telephone to maximize the benefits of that laboriously developed alliance. When a patient has exceptional rapport with the therapist, the time required to begin again and to develop such a relationship, if at all, with a different therapist must be weighed with the few disadvantages of continuation by telephone. If the limitations of phone therapy are kept in mind, the continuing relationship can provide the additional necessary time to maximize the work that can be done. For those patients who have been in productive therapy for years, the option of continuing that fruitful relationship is not only warranted, but advantageous.

The consistency achieved by keeping that same relationship throughout treatment is well worth the price paid for not being able to continue in person.

LONG-TERM TELEPHONE THERAPY FOR THERAPISTS

This brings me to the area of discussion around which this text is focused, namely, *psychotherapy with psychotherapists*. In by far the majority of cases, students pursuing careers in the mental health field, regardless of what discipline of training they enter, must move several times during their training. High school may be in one town, college in another. Then graduate school, practice and/or internship come, followed by residency and possibly a fellowship, all usually in different locations. Psychotherapy trainees are vulnerable to premature rupture of their therapy because they are often assigned to more advanced students in clinics; this can mean turnover from either side of the therapy-therapist pairing. For a psychiatry resident, telephone therapy might be a viable consideration to preclude the necessity of changing therapists every year when the senior resident moves on. The possibility of being able to maintain face-to-face contact with the same therapist throughout an extended period of training is at best exiguous. Of course, transfer should be effected when a change of therapist is warranted and when there are no compelling reasons for continuing the existing alliance. (This is discussed later in detail.)

It is expected that graduate therapists will have worked out their own conflicts to a point where these will not surface to interfere with their work. This can take time, time that can be realized using telephone therapy. Likewise, it can be tremendously beneficial to be exposed to a long-term treatment relationship in one's own therapy to see how such a relationship develops and changes and why it can take a long time to do so while still being valuable throughout; it provides an excellent en vivo model of the therapeutic relationship and process.

Another option phone therapy can provide for trainees especially, but also for other patients, is the opportunity for periodic, "crisis oriented" treatment *with the original therapist*. In these situations, the therapeutic alliance has long been established. Similarly, senior graduate clinicians may choose to go into therapy for a second, third, or even fourth time, to work on issues not dealt with in the past or on new ones that have arisen. The benefit of picking up with the original therapist and having the treatment relationship already firmly established can save considerable time and money, in addition to providing valuable continuity in treatment. The thought of the time and effort required to establish a new relationship could serve as a deterrent, while this process might encourage therapists to seek brief treatment for minor issues.

Case Presentation

Let me now present a case that illustrates many issues discussed in this chapter.

F. is a 34-year-old social worker who is an only child. F.'s mother is a distant, compulsive woman who never showed much affection. Her father is an insurance executive who is intelligent, hard working, but also unavailable.

After a relatively atraumatic childhood, F. entered school, where she excelled. She was fiercely independent and chose not to confide in anyone, never having a best friend. Her first serious sexual relationship was at age 17 and lasted two years. It, like her subsequent relationships, was characterized by rapid attachment, clinging and mutual dependency, perfectionism, and immediate withdrawal at the first sign of threatened loss. The breakup of this relationship precipitated a serious depression, and she saw a college counselor for one year, twice monthly, and terminated treatment on the grounds that "everything was worked out." Following the disruption of a subsequent relationship, F. again became depressed and began using drugs. She then entered weekly therapy with a psychiatrist for fourteen months. This ended when F. graduated from college and relocated in another city, again feeling that everything had been resolved.

After several years of working, F. realized that she was still experiencing considerable difficulties in her life and entered treatment with

Dr. H., a female psychologist. During the next sixteen months, it became apparent that F. had the following conflicts: extreme perfectionistic attitude, depression with tremendous difficulty expressing anger, and a relationship history characterized by dependency and enormous separation anxiety.

During the months of face-to-face therapy, excellent rapport was established and some good exploration of some superficial issues ensued. However, F. was unable to explore fully any dependency or aggressiveness issues. Sexual themes were touched upon but again not explored fully because of F.'s sexual ambivalence and inhibition about discussing this very personal issue. When it became known that Dr. H. was to leave town to take an appointment in another city, the therapy sessions were flooded with new material in an attempt to stop the termination. For once, it was not F. who was ending the relationship. It was now out of her control. In lieu of the past history of difficulties in ending relationships and flights from therapy, and also in consideration of the excellent rapport that had developed, Dr. H. suggested the possibility of continuing therapy by telephone. F. did not want to transfer to another therapist, for she did not feel that she could again readily establish such a strong and meaningful alliance as she had with Dr. H. She also, for the first time, was able to admit that her treatment was not finished and that she desired to continue. It was agreed to continue weekly 50-minute sessions over the phone with the same fee.

Therapy continued for two more years, weekly for the first year, then irregularly (once or twice a month) in the second year as issues would come up. F. reached the point where she worked intensely on her own between sessions and would arrange a call with Dr. H. when she needed clarification.

What happened to the therapy after switching to the phone deserves special attention. It was anticipated that the disruption of the relationship, at the time of the move, might set off severe depression. What followed in the months of telephone therapy was F.'s ability to express directly to Dr. H. her intense rage at Dr. H.'s leaving her and F.'s overwhelming fear of being abandoned. For the first time, F. was able to see that her rage would not destroy the other person or the relationship and that warm, close feelings still existed underneath.

With the safety provided by the distance of the telephone, F. was able to discuss her wish to be cared for by Dr. H., which enabled an avalanche of preoedipal material to emerge. F. said herself that she felt much safer expressing these feelings over the phone and would not likely have done so in person. With the relationship able to last the length of time that it did, F. eventually began to see her dependence on Dr. H., which had been denied to this point. In time, she was able to accept it and eventually work it through, being aware of the acceptance, support, and continued interest of her therapist in her fine progress.

INDICATIONS FOR LONG-TERM TELEPHONE PSYCHOTHERAPY

This case illustrates several general situations where continuation of treatment by telephone might be useful. A first area of consideration pro phone therapy is that of separation anxiety and object loss. Pumpian-Mindlin (1958) describes three types of patients with respect to various amounts of separation anxiety and how a transfer might affect them. Type 1 patients are those with little separation anxiety to whom a transfer would be rather benign. With these patients, there seems to be little attachment to the particular therapist. They may be more attached to the clinic (Reider, 1953). Type 2 patients are those with moderate separation anxiety in whom a transfer will create definite difficulties. He suggests that preliminary arrangements, including an appointment, should be made with a specific therapist. The majority of patients fit into this category. Type 3 patients are those with marked separation anxiety in whom transfer will create serious problems. He suggests arranging a joint meeting with the new therapist to introduce the patient and try to prevent premature rupture of treatment at a time when termination is contraindicated, thus aborting a flight into a hospital or severe regression.

I agree with Pumpian-Mindlin on the first group of patients, but disagree with him as to the treatment of the latter two groups. Most strikingly, in the third group is the possibility that the transfer will have a

negative therapeutic effect in that the patient may resort to utilizing earlier ineffective defensive patterns to deal with the separation. This may include a suicidal gesture or attempt, marked regression, need for hospitalization and/or any number of pathological defense mechanisms to deal with the stress to which the patient is incapable of adapting. The opportunity to face and cope with this separation by continuing therapy through the phone lets the patient deal with his or her feelings *directly* with that very person whom he or she is losing and, more importantly, with that person with whom he or she has a solidly established therapeutic alliance. The opportunity to challenge the feelings of rejection and abandonment can only be enhanced when confrontation is with that very object one has lost. I would put the social worker in the case cited earlier into this third group, since her object loss history is quite traumatic. For that large second group, I would recommend examining the probability of how each patient will handle the transfer, given his or her object loss history. If that history is traumatic, I would recommend continuation by telephone, if only to work through adequately the impending object loss. If that is successful, transfer might be implemented later.

A comparable argument can be brought to bear when the patient has problems of object constancy and tenuous object relations. The patient without an integrated sense of object constancy needs a therapeutic relationship that will endure over an extended period of time. For our social

worker, who was already on her third therapist, there was minimal possibility of maintaining a therapeutic relationship over sufficient time to allow a high enough level of trust to develop so that deeply repressed material could emerge. One cannot add up individual time spent with consecutive therapists. Likewise, those patients with tenuous object relationships, who have difficulty establishing and maintaining relationships, may have built a truly special relationship with their therapist. The opportunity of maintaining this relationship, even if only by telephone, can have lasting therapeutic gains for that patient and his or her future relationships. Certain borderline and narcissistic patients could be considered here, as well as chronic schizophrenics.

There exist specific situations when telephone therapy might not only be considered, but may actually be the treatment of choice. Ambivalent patients, such as some schizophrenics, dealing with the issue of closeness versus distance, or hostile and controlling patients, who need a safe distance in order to express hostility, may find phone therapy a superior medium in which to work (Miller, 1973; Grumet, 1979). The obsessional or schizoid patient may find appealing the impersonal property of the telephone together with the dependence on verbal communication (Miller, 1973). Those individuals fearing face-to-face experiences might more productively use the telephone, which enhances their control over the situation (Daniel, 1973). Chronically depressed individuals might be better able to break out

of isolation using the "action-at-a-distance" quality of the telephone versus more strenuous face-to-face contact. In those patients for whom the transference issues are too intense to be dealt with in person, using the telephone may help to dilute the intensity and expedite expression (Saul, 1951). Finally, although this chapter deals with psychotherapy of the uncovering and insight genre, I will just mention continued, longterm, supportive therapy by telephone for following discharged alcoholics (Catanzaro & Green, 1970) and discharged psychiatric patients (Cantanzaro, 1971), and counseling homosexuals (Lester & Brockopp, 1973), to name a few possibilities.

CONTRAINDICATIONS TO LONG-TERM TELEPHONE THERAPY

The discussion of contraindications to long-term telephone therapy necessarily centers around the issues of transference and countertransference. Since the potential for misuse of this mode of therapy owing to countertransference is considerable, it is taken up separately subsequent to this discussion.

Foremost in regard to transference issues is the threat of fostering excessive dependence on the therapist (Kemble, 1941; MacKinnon and Michels, 1970; Miller, 1973). Whether this is desirable and appropriate to the therapist's and patient's treatment goals needs to be evaluated. In the

case presented, the dependency needs were not only gratified, they were encouraged. What was crucial for this strategy to be effective was to have a relationship that could endure until such time as F. was able to face and work through these needs. But, if this is not done properly, inappropriate narcissistic demands of the patient may be gratified and grandiose or infantile fantasies may be promoted (Langs, 1974). Tendencies of the patient to regress as treatment time runs out in order to undo the planned ending should be taken as just that and not misinterpreted as a decline in the patient's functioning. Granted, the thrust of this chapter is that therapists should judiciously "keep their doors open" to patients, but a blanket open-door policy can only invite clinging and dependent behavior.

Langs (1974) suggests several other issues that apply to transference reactions specific to the patient's wish to continue treatment with the departing therapist. These include the patient's pathological wish for control over the therapist, especially if it occurs when it is the therapist's departure that forces the break in the treatment relationship. Also, the patient may resort to omnipotent denial of the impending loss. Gratifying requests to continue treatment based on these issues without prior close scrutiny can make it extremely difficult to work these issues through in subsequent treatment.

A few final points on the contraindications to phone therapy illustrate

some of the more practical limitations of its use. Patients who have difficulty articulating their feelings and thoughts are poor candidates for treatment over the phone. Likewise, those patients with fragile reality testing who need the visual input face-to-face therapy provides will not be likely to profit from phone therapy. Last but not least, there must exist a willingness on the part of the patient (and the therapist) to translate their nonverbal behavior and covert thoughts into speech. Without this ability, too much valuable material will be lost.

Another important contraindication for phone therapy can emanate from countertransference issues. There are those therapists, especially among those medically trained, who need the "laying on of the hands" aspect of face-to-face therapy in order to feel effective (Pisani, 1968). In a study comparing initial interviews done by telephone with those conducted face-to-face (Antonioni, 1973), it was found that therapists preferred face-to-face contact while patients found it easier to talk about their conflicts over the phone. Miller and Beebe (Miller, 1973), studying 58 psychiatrists, found that 38 percent of them found the telephone easy to use as a mode of communication, 45 percent were equivocal in their responses, and 16 percent found it difficult to use. That so many therapists found the modality unsatisfactory may reflect a feeling of loss of control by the therapist, who is unable to see the patient, and a frustration at the distance of the patient. It is a bias of many therapists that contact by the telephone, initiated by the

patient, is a manifestation of resistance (MacKinnon & Michels, 1970). Although sometimes this may be true, it might help at times to permit this resistance in the hope of allowing more sensitive material to emerge.

A second controversial countertransference issue centers around the therapist's feelings about the premature interruption of therapy and how he or she might inappropriately choose to atone by continuing treatment by telephone. If it is the therapist who must leave the relationship, a sense of guilt may arise over "deserting his patients" (Dewald, 1965). On the other hand, if it is the patient who must leave the relationship, the therapist may feel betrayed insofar as he or she had invested so much in the relationship and will not be able to see it through. Therapists must deal with their own separation anxieties. Indeed, it is possible to see the therapist experience symptomatic manifestations of object loss concomitantly with the patient (Keith, 1966). The therapist may be overly possessive of the patient and be unable to let go (Kemble, 1941). Inability of the therapist to deal with the patient's anger, overidentification with the patient, or the need to feel that his or her work is so important that treatment could not possibly end at the time of interruption can all affect the therapist's judgment (Dewald, 1965). If any or all of the above predicaments exist, the therapist must endeavor to deal with these feelings adequately and objectively in order to be in a position to decide if telephone therapy is a better course to pursue than transfer or termination.

In a study of forced interruptions of therapy with psychiatric residents, Pumpian-Mindlin (1958) found a direct correlation between the negative attitude of therapists towards their next assignment and their ability to deal with terminations or transfers adequately, in that the more reluctant the therapist was to take the next assignment, the more difficulty there was in separating from the patients. Keith (1966) delineates a "Transfer Syndrome" among residents facing interruption of treatment that includes:

1. denial—through delay in telling the patient about the impending separation, leaving too little time to resolve conflicts,

2. self-denigration—devaluing the therapist's own effectiveness with the patient, and

3. losing sight of the therapeutic process—the therapist feels guilty that the treatment goals have not been reached.

This last point may be exaggerated by the therapist who assumes automatically that the patient needs continuing treatment (Dewald, 1965), distorting the picture of the patient's total functioning through underestimating the patient's ego strengths and overestimating the degree of malfunctioning (Pumpian-Mindlin, 1958).

Another point about countertransference is raised by Scher (1970) regarding the relationship of the patient with the new therapist. When the patient is transferred, he or she is likely to talk a great deal about the old

therapist to the new therapist, perhaps distortedly, with little chance of defense for the former therapist. Knowing this will occur may influence the old therapist when recommending a replacement. The potential therapist, on the other hand, may find that he or she does not want to see this patient and hear about a friend or colleague through the patient's comments, thus, perhaps, being forced to reject the patient at a time when the patient is still recovering from separation from the old therapist.

THE TRANSFER PROCESS

It would be beneficial at this time to examine the transfer process itself. Specifically, what are some potential negative and positive consequences of a transfer following a premature rupture of therapy? First and foremost is whether the transfer will, in fact, take root. Keith (1966) raises two questions on this issue: will the patient be able to grieve over the departing therapist? and will the patient try to persuade the departing and replacement therapists that the problems that brought the patient to treatment no longer exist and that termination is in order instead? A second problem is presented by Feldman (1968), who reports of circumstances, although rare, of strong positive transference to the original therapist making transfer difficult, if not impossible. In this event, if the patient accepts the idea of transfer, he or she may not follow through, and some patients may even decompensate over the loss and need to be hospitalized

(Rosenbaum, 1974).

Scher (1970) describes a therapeutic triangle that can develop between the departing therapist, the patient, and the new therapist. The patient may feel uncontrollably exposed to the new therapist, especially if the previous therapist tries to aid the transfer by sharing information about the patient with the new therapist. The patient may have no control over how much is revealed to the stranger therapist. To complicate matters even further, the patient may succumb to a dilemma: if he or she gets better, there may be feelings of disloyalty to the former therapist; if he or she gets worse, there may be the feeling of having failed the very person who rescued him or her from desertion; and if he or she stays the same, all three are defeated. "For better or for worse, the interaction between the patient and his new therapist will forever be influenced by the relationship which each of them had with the departing therapist" (Scher, 1970, p. 282).

A final perplexing issue is that of the disconnected nature of therapy some patients receive, especially those who are being treated at teaching institutions or training facilities where patient transfers are a common occurrence (Keith, 1966) at the end of each academic year or trainee rotation. Although it has been suggested (Reider, 1953) that some patients might be better able to tolerate this stress by forming their attachment with the institution or agency rather than with the specific therapist, those

patients being seen privately cannot use this option. It must be remembered that transfer to another therapist involves ending with the original therapist (Pumpian-Mindlin, 1958) and that clumsy, unwanted terminations that predate completion of therapy may often nullify therapeutic gains (Kemble, 1941).

Now that potential risks of patient transfers have been discussed, it is also essential to recognize that transfer need not be looked upon only as an unfortunate but inescapable happenstance. Indeed, it has the potential of becoming a critical therapeutic event, allowing an opportunity for the patient to reexperience, rework, and resolve earlier object losses (Scher, 1970). The new therapist should use the opportunity created by the transfer to explore feelings about separation from previous significant others in addition to the therapist, including anger, rejection and abandonment, and loss. By no means is the opportunity to do this limited to change of therapists occasioned by transfers because of relocation. Feldman (1968) reports that some patients find it advantageous to change therapists and then compare them. A stagnant or sluggish therapeutic process might be rejuvenated with a new relationship.

A distinct but related issue is the rotation of student therapists while in training. It was stated earlier how such an experience can be detrimental to the clinic patient. Here the priorities between training benefits and

therapeutic gains must be carefully considered and weighed. For example, how is a trainee to learn to treat a diverse population of patients with a myriad array of therapeutic experience and exposure to different modalities and, at the same time, give the patient the opportunity to work over the extended period of time necessary to resolve sensitive and complex issues? With the rotation system now in practice, the former is accomplished, but at the price of discontinuity of therapy for both the patient and therapist. This disconnectedness the patient and therapist experience can only increase with the diversification and subspecialization that psychotherapeutic practice is currently experiencing. Transferring patients, then, is not a benign procedure; if not handled properly, potentially serious consequences may ensue and do, sometimes, even if handled properly. Indeed, a termination or transfer might be the most antitherapeutic event a patient can experience if unable to work through his or her rage and feeling of rejection (Langs, 1974).

PRACTICAL ISSUES

I would like to close with a discussion of some practical issues inherent in the use of the telephone in psychotherapy. The first issue is that of third-party payment for telephone treatment. In one case I know, a private insurance company refused to pay for telephone sessions between a graduate student, who moved to pursue her educational goals, and her

analytically oriented psychiatrist in her former home town. It was stated that, "Psychotherapy by telephone is not necessary to medical care of illness. By not necessary we mean any service or supply that is not commonly and customarily recognized throughout the doctor's profession as appropriate in the treatment of the patient's sickness....psychotherapy should be face-to-face, direct, personal contact between the patient and the physician at the same physical location,..." (anonymous, 1982).

Mental health professionals must address this issue formally so that a policy can be established asserting that telephone therapy can be effective, warranted, and accepted practice under certain circumstances when transfer or termination are contraindicated. Until such a stance is taken, the effect of nonreimbursement for this kind of treatment will be to hinder its development and use.

The second issue of feasibility centers around the needs of the mental health or psychiatric clinic. If therapists, whether trainees or not, were to "take" patients with them through continuation by telephone when they left the clinic, the clinic might suffer financially. This, too, may discourage use of this mode of treatment. In a similar regard, however, a community suffering from a lack of available treatment-time could benefit from such a shift of patients. Patients could well be presented with the options of transfer, termination, or continuation with their therapist and be permitted to

participate in the decision making—for one of the ultimate goals of therapy is enabling patients to be more self-directing.

Last is the issue of professional ethics. Is telephone therapy ethical? There is no mention of telephone therapy in the ethical principles for psychiatrists (APA, 1973) nor, to my knowledge, for the other mental health disciplines. Perhaps this idea is still too novel. The only question I can see being raised is whether psychotherapy, which is a one-to-one human relationship, is violated by the telephone being between the participants. I feel that it is not. Granted, telephone therapy is not for everyone. Nevertheless, for those who can benefit from its use, it provides another alternative route to that final common goal of all therapies, improved mental health.

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EDITOR'S COMMENTARY
THE EFFICACY OF A VERY SPECIAL PHONE CONNECTION

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Padach presents a persuasive case for the judicious use of telephone therapy as an alternative to termination or transfer when patient or therapist relocate. Padach's discussion challenges the reader to rethink the kind of rigid dictum against this practice that is prevalent in many professional training programs and institutes and which is certainly valid for some patients at some times; but not for all patients at all times. There may be compelling reasons to continue the particular therapeutic alliance, such as when a patient has already had several therapists and would respond poorly to one more abandonment or when disruption of the process at a crucial phase would be detrimental and precipitate a set-back of many months. The therapist's decision that neither termination nor transfer is advisable is not always an inability to let go, or a refusal to recognize that another therapist may also offer the patient excellent treatment.

In my own experience, when I relocated from Pennsylvania to Florida several years ago, I terminated or transferred 95 percent of my patients. But two were deeply involved in profound transference relationships and dealing with extremely charged content that we had been working to release

for a long time. The clinical data militated against transfer. Subsequently, one of the patients, a bright and handsome male in his late twenties, was able to deal with heavily laden sexual issues surrounding masturbation, the desire for and fear of homosexuality, and the sometimes intense and extreme behavior he exhibited in sexualized heterosexual relationships. He spontaneously indicated how much more comfortable he was dealing with this material behind the protective screen afforded by the phone than he would have been in person. After numerous sessions devoted to sexual themes, during which he reached some insight and resolution as to how he now wished to comport himself, he stated that he thought he might have been too embarrassed and overwhelmed to ever have gotten to this material in face-to-face treatment.

About a year later, a male psychologist I had been treating for several months on a biweekly basis for double sessions-—because of the long distance between my office and his home town—called to say that he was extremely busy and could not spare the extra hours for commuting that week. He wondered if I would be willing to allocate his regularly appointed time for a telephone session instead, since he did not wish to cancel. His request seemed legitimate and not like an attempt to manipulate, and I concurred. Although he had abreacted the traumatic death of his younger sister and completed his delayed bereavement work, and worked intensively on attachment and individuation from his family of origin, he had not

considered his dating and other peer-level interpersonal relationships a problem. Here, too, as in the case cited above, a tremendous amount of overt sexual material poured forth during the phone session—ambivalence about the orgies he frequented and his bisexuality. At the close of the phone hour, he volunteered that he had not planned to discuss this today, but somehow the safety provided by not being visible was the trigger which unleashed this content that he had felt too ashamed and frightened to share earlier-—especially since, despite the different locales in which we live, we are still part of the same professional network.

I was intrigued by the similarity in the utilization of the phone sessions and by the patients' interpretation of why it became possible for the sexual material to surface in this form. In both instances, considerable relief from their gender identity confusion was experienced and greater clarity and comfort achieved. Also, it caused me to wonder whether I had inhibited their expression of this material in vivo and I shared this question with them. Neither of them thought so and since numerous other male patients have been able to bring up sexual concerns, I discarded this hypothesis. Although an n of 2 is too small for any generalized statement, these clinical deductions regarding the efficacy of telephone therapy raise further the possibilities for the utilization of telephone therapy. Not only can this be an alternative to termination or transfer, but it can be a way to afford safe distance when particularly difficult issues need attention. And, perhaps, it can be used by

geographically isolated or nonambulatory individuals who find accessibility to therapists quite limited.

The economic issues Padach alludes to will need to be debated and resolved if this form of therapy is to become accepted as feasible. Is it ethical and just for an agency or institution to cling to patients whose therapeutic progress might be better if they continued by phone with their departing therapist? Who is to make this determination a priori? The potential loss in agency income may be the "bottom line" concern rationalized by arguments against the efficacy of phone therapy. Another dilemma is the lack of insurance reimbursement for phone therapy. But perhaps this, too, could be overcome if the major professional associations were to agree that phone therapy is another viable modality in our treatment armamentarium.