Telephone, Psychotherapy and the 21st Century

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Created in the United States of America

About the Author

Sharon Zalusky, PhD is a member of the California and Southern California Psychoanalytic Societies and has written extensively on the issues raised in the conduct of psychotherapy and psychoanalysis by telephone.

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Rebecca, a young analysand whom I have been seeing four times a week for seven years marries. Her commute to my office triples in time. Coming in four days a week, three hours on the road, a demanding job and a new marriage seems torturous. She doesn't want to cut down, but she cannot spend her whole life in a car. We agree to see each other three times a week in the office and once a week on the phone.

Annie applies to graduate school. She is placed on a wait list and is told that

it is unlikely that she will be accepted this year. At the last minute, a space opens and she has an opportunity to pursue a dream. She doesn't want to leave her analysis yet she wants to pursue her career.

Ray, an unknown actor, lands a leading part in a movie that is filming outside of Los Angeles. He wants to continue his analysis on the telephone to help keep him grounded during this important, though stressful time in his life.

Diana because of serious complications during pregnancy is required to stay in bed. She feels she is in crisis. She wants to continue her analysis.

John, now 22 and away at college in Australia is a young man whom I first started treating when he was 14. Each developmental step has been met with reluctance. Recently, unexpectedly, I

> turn on my computer to find an e-mail from him. He tells me he loves going to school abroad, but finds himself fantasizing about one of his male friends. He does not know what to make of it. He finds it both exciting and terrifying. He wants to know if we can communicate via e-mail. I recommend the old-fashioned way, sessions via the telephone until he returns.
>
> (Zalusky 2003)

It is obvious we are living in a rapidly changing world where advances in telecommunications, travel, and biotechnology are changing the way our patients and we live, travel, and communicate with each other. Technologies expand our

boundaries by creating an extension of our bodies and/ or our physical presence (Rifkin 1998). The world, as we know it, is getting smaller and closer, and in the process we are becoming more interconnected and interrelated. Technologies are impacting almost every aspect of society, including our relationship to our self and to others. It is no wonder in this changing world that psychoanalysis and psychoanalytic psychotherapy have overwhelming shifted their focus from a one-person psychology to a relational psychology

(Friedman 2004). Being wired is being connected, albeit in new and interesting ways.

Over the years I have pondered the use of the telephone and its meaning in clinical practice both for the patient and the therapist. Our first connection with our patients and theirs with us, more often than not, takes place either on the telephone or on voicemail. The telephone is ubiquitous. It has become an essential part of our clinical life. We use the telephone as an extension of our office and our self.

The telephone itself has become mobile and unwired. With global satellite technology we can take our telephone along with us wherever we are in the world. It no longer needs to be situated in our office, but can literally go where we go. In practical terms you call my unique number and I have the potential of responding, if I desire, whether I am in Los Angeles, New York, London, Paris, Rome, or Beijing, or whether you are. With this fact our notion of availability expands. Our ability to simulate ourselves in different forms (telephone, e-mail,

videoconferencing) at different times opens up the field in which we, as therapists or patients, can and do operate.

As the technology changes, our attitudes about the telephone also change. For example, when I started my analytic training, almost everyone had an answering service. Today such a practice would be anachronistic. It would feel intrusive to have a third person, a stranger, respond to the need of our patients. We would question confidentiality, the propriety of it all.

But twenty years ago it was common practice.

By now we have grown accustomed to our voicemail. Not only is voicemail used for messages, but also some patients call us knowing that we will not answer. They do not need to talk to us directly, nor might they even want us to know that they called. They need only to hear our simulated voices in order to assure themselves that we continue to exist in our shared absence. Our patients may use our voicemail in an effort to self-soothe.

We may never learn directly about that need, or the way in which a particular patient gratifies it, but that does not stop the fact that a form of technology, may be used as transitional space (Aronson 2000) and has the potential of helping certain patients manage their own anxiety during times of separation. As clinicians we have grown to appreciate voicemail's potential auxiliary function in the psychotherapeutic treatment. As we incorporate it into our practice, we also integrate it into our theory of change. I believe for some patients voicemail

may be used to reinforce a budding inner representation of the available (soothing) therapist.

At times technology is accepted by one element of society before it has truly been incorporated into the social consciousness of the whole of society. E-mail is a good example. At first I was taken aback when I would turn on my computer and find e-mails from any number of my younger patients requesting scheduling changes. Initially I saw their e-mails as a resistance to intimacy until I realized

that e-mail is our young patients' mode of quick information exchange. E-mail to them is like voicemail is to me and the answering service was to my older colleagues. Society changes and our mode of communication changes and with it expectations change.

As my experience working on the telephone has increased and I have seen positive results with a number of patients, my attitude about the telephone in psychoanalysis and psychotherapy has significantly

loosened. Originally when I started writing about the use of the telephone in psychoanalysis, I did so in an apologetic manner (Zalusky 1998). At that time there had only been one article written about its use in psychoanalysis (Lindon 1988). I underlined the conflictual nature of telephone analysis, because it almost always represented a therapeutic compromise. In the land of the ideal, continuing on the telephone would never be the treatment of choice. However, we rarely live in the land of the ideal. Treatments are inherently

complex and messy. Certain patients have special life histories that require special adjustment in technique. When treatments are long, life often intervenes in our work and we need to come up with flexible and creative solutions.

Up until recently, there seemed to have been a don't ask, don't tell policy about analysts' use of the telephone in clinical practice.[2] Privately one would hear as an aside, 'I have to go now, I am about to do a phone session with a patient.' However, that seemed to be

the extent to which this matter was ever discussed. It was as if telephone sessions were to be revealed, if at all, only to one's closest friends and colleagues. The subject of the telephone in analytic practice was not brought up in seminars. Nor was it ever written about in case studies. It was clear that our past traditions and prejudices were preventing many analysts from openly considering telephone analysis as a potentially viable treatment option at the right time with the right patient for the right reasons.

The topic of the telephone in psychotherapy and psychoanalysis has recently moved out from behind the closed booth into the open. As of today there have been several articles (Leffert 2003; Zalusky 1998, 2003), an edited book, *Use of the Telephone in Psychotherapy* (Aronson 2000), and a dialogue written in *International Psychoanalysis* (2003), the official newsletter of the International Psychoanalytical Association, on the topic of telephone analysis. There have been panels, and there have been presentations at both the meeting of

the American Psychoanalytic Association and Division 39 of the American Psychological Association, as well as at a number of local societies.

I believe we have come to the point where many clinicians would agree that the telephone can be an important and effective tool in psychotherapy and psychoanalysis, even though the majority of our work still takes place in the traditional venue of our office. The loudest of the critics against using the telephone in clinical practice admit

to never having tried it. Their arguments are often based solely on abstract theoretical concerns. Though their concerns may be interesting, they do not seem to take into account the contemporary world in which we live.

THE PROCESS: SIMILARITIES AND DIFFERENCES

Many of the authors who have written about telephone analysis (Lindon 1988; Leffert 2003) have stressed the similarities, without adequately discussing the differences between the process that takes place in

the office and the process that takes place over the telephone. I believe that is because these pioneers were concerned with demonstrating effectiveness and felt that was the best way to put forth their argument. I take a different tack. I believe, embedded in patient and analyst communications is often a recognition, conscious or unconscious, of what each gains and loses, the feelings evoked and the meanings attributed by doing analysis with only data from the verbal realm available. By being sensitive to what we are losing, we help our patients be

more open about their own feelings of loss. We find that by analyzing the differences, the loss, that often they lead us, as we might expect, into the internal world of our patients and by doing so we add to our therapeutic effectiveness.

The two forms of treatment, though very similar, could never be the same. Because we do not have the physical presence of the other available, each participant of the psychotherapeutic dyad has to create and sustain mental representations of the other in fantasy.

Because the work takes place without the visual presence of the other, something interesting has the potential of happening. The transference, rather than being diluted as many have suggested, may instead be intensified, because it develops without the benefit of reality interfering with the transference (and I add countertransference) distortion. The analyst in fantasy and the patient in fantasy are never the same as those two that have met in the office. On the telephone we create a new analytic dyad. Along with it, a new analytic

process emerges. If, as Freud (1913) suggests, the couch induces a regression in which the analyst as a person does not interfere with development of the transference, then the telephone should be a vehicle par excellence in this regard. Without the visual interference the transference is allowed to ripen. It is not until we see each other again that these fantasy distortions actually stand out. In order to take advantage of this phenomenon I have found it important to schedule occasional office visits. Elsewhere

(Zalusky 2003) I reported the following example:

> It had been 8 months since I last saw Rebecca. During this time, Rebecca openly explored her feelings about me in the transference. She dealt frequently with her experience of not being in the room with me, and her great loss of not having me literally there to see her. Rebecca would ask, 'How can I know if you are paying attention to me. If I was in the room with you, I could turn around and see you looking at me.' Reliving these feelings in the transference, allowed her to remember her childhood experience of believing her parents, though physically present, never really saw her. During this time, we both felt we were doing productive analytic work. And we were. Yet, it was not until we actually laid eyes on each other during an office visit that it

became clear that another powerful aspect of the transference remained hidden from both of us. Upon seeing me, I noticed Rebecca was visibly disturbed and I asked her about it. 'You look so different. You aren't my analyst who's with me on the telephone,' Rebecca stated. 'In my mind you are so much older than you really are. *My analyst* is old and frumpy. You are neither.' We were able to use this opportunity to understand why she needed to create me in that manner. She revealed to herself and to me how she doubted her own attractiveness. Instead of feeling competitive, she turned the tables in her mind. It was much less painful, Rebecca imagined, than dealing with her own sense of inadequacy. That evening she dreamt that I took her shopping for bras. She associated to how her mother used to cut her hair short when she was young. People often confused her for

> a boy. In fact, her mother hid her own femininity to the world. Secretly, she wished I could teach her how to be a woman.
>
> (Zalusky 2003: 15)

As we worked together again in the office, Rebecca and I were struck by the poignancy of our physical reconnection. Rebecca could literally see how she created me in fantasy. She did not need me to interpret her transference. It stood out for her in bas-relief. She and I both were curious to understand the reasons behind her desire to keep me in fantasy the way she did.

Another interesting aspect of telephone work is that in many ways therapy taking place on the telephone focuses, concretizes, and condenses such basic analytic issues as separation, loss, availability, the needs of both patient and analyst and the analytic frame and deviations from it. The patient does not need to wonder whether or not you will remember them when they are not with you. Each time they talk to you on the phone, they remember that you remember. Hearing the voice of the other, repeatedly over time, while there and

not there, helps to create a mental representation of the caring other. The telephone serves as transitional space. It may very well function for some patients who are in the process of developing object constancy as an adaptive defense against separation anxiety.

There are obviously some problems working on the telephone. One that requires special attention for some patients who have difficulty taking care of themselves is helping them provide a safe environment to do the

work on the telephone (a quiet private room where they can be free to say whatever is on their mind). We are used to providing that for our patients. Recently I have had patients call me from their car. Just as I would not knowingly allow a patient to come to session drunk, I will not have sessions while a patient is driving. It is certainly not safe and definitely not therapeutic. One difficult, angry patient of mine who does not regularly have phone sessions called me from the car when it was clear he would not be able to make it to the office on time.

Instead of falling apart and disintegrating which he often did when he feared that he was going to miss time with me, I suggested to him, 'Why not do something different? Call me when you get home (which was a few minutes away) and we can do a phone session.' He did, but initially could not let go of his anxiety. When I asked him about it, in an outburst he yelled at me that he did not want to dirty up his house with our work. Naturally his remark became grist for the mill and also helped me to understand why some disturbed

patients cannot tolerate working on the phone.

Clearly working on the telephone is not for everybody. I believe it is most appropriate for patients whose intense or regressed transferences make it impossible to terminate or transfer without causing some degree of harm. It may also be extremely important to patients whose early life was characterized by inconsistent and emotionally unavailable caregivers. To have one special person witnessing one's life through disappointments and

victories can be extremely meaningful. The ability to maintain consistent emotional contact with the same analyst, rather than interrupting or terminating treatment, has the potential of creating an analytic space where the patient's transference could be analyzed and worked through. As more than one patient has told me, you are not interchangeable. Therapists are not like goldfish.

One of the benefits having done telephone analysis is that I feel comfortable using the telephone with

certain patients who have a difficult time with self-regulation and ultimately intimacy. Many of these patients have had extremely complicated and traumatic early life experiences and losses. For these severely traumatized people the telephone may allow a necessary space in which they can begin to tackle the fears associated with intimacy.

I was referred Margie, 25, from a colleague in another city who warned me that though Margie is a delightful young woman, she rarely came to

sessions. In the first session, I meet Margie, this bright, vibrant, adorable person who gives me a history that is packed with death, illness much pain and anguish. As a child Margie suffered from early deprivation at the hands of very nice parents who were struggling with their own extraordinary grief and illnesses. They certainly did not mean not to be there for their baby daughter, but people cannot help the cards they were dealt.

Margie and I arranged to see each other three times a week. For many

months Margie's treatment was mostly an analytic game of hide-and-seek. Margie would disappear and I would call and try to find her. She would be happy to be found and would tell me that she meant to come to session, but she was sleeping. No matter what hour of the day or afternoon, she could and usually did sleep through our appointment. Then one day I tried to engage her on the telephone. She spoke to me of her difficulty taking care of herself. She explained she slept when people were up and was up when the rest of the world slept. She did not

eat normally. She smoked cigarettes and self-medicated. Nothing about her was regulated. At the end of her telephone session I told her that I would really like to see her in person. She agreed to come to the next session. Though extremely late, she arrived nonetheless. For many more years, I had to live with the uncertainty. Sometimes Margie came to sessions (always late). Other times she slept through them. And still other times Margie, from her point of view, had more pressing matters that kept her away from me, her therapist. I

would interpret to her that I thought she was doing to me what had been done to her. She never knew when her parents would be available either emotionally or physically. I too would wait for her not knowing if today was the day Margie would come to her therapy session or not. The interpretation seemed to have a far greater impact on me than on her. It seemed to help me be accepting of her.

At some point when I became more important to Margie, she would call after her missed sessions, usually at

two or three in the morning, to apologize for not being there. I would return the call later and leave her a message letting her know that I hoped to see her at our next session. As time went on and her affection for me grew, she would leave me messages before her missed session, apologizing in advance for not being able to make our appointment. At some point we would always reconnect: at times on the phone, at times in the office. Then Margie began to call me at the exact hour of her session. We would have a telephone session.

After having sessions with her on the telephone for a period of time, I could feel our connection was deepening. Margie was very attached to me both in her absence and her presence. One day she called and I took it as an opportunity to up the ante. Instead of having a telephone session, I told her I thought she should probably come to session today in person. She stated the obvious, 'By the time I get there I will only have five minutes.' I replied, 'Five minutes in person, I think it would be worth it.' Margie did not complain, instead she

got in her car and drove to my office. She arrived with a smile on her face. It was obvious Margie was happy to see me, but also pleased that I wanted to see her. Sometimes she would use her sessions to tell me about what was happening in her life. Intermittently we would do some very deep painful work and predictably Margie would then disappear again. For a while she was coming to her sessions three times a week, but for many reasons, some of them internal others external, she would become overwhelmed and the process would have to start over again

—with the hide-and-seek, telephone calls, short sessions. Recently, she went through a serious crisis in which she disappeared as she had in the beginning. We now schedule sessions for five days a week. Margie says that helps because when she leaves she does not feel so abandoned by me. Interestingly enough, with the security of the five-days-a-week treatment, she has dared to express her anger and her disappointment in me.

I report this vignette, because I cannot imagine how one could treat

Margie, or many of our patients like Margie, without the telephone. Without the telephone her self-imposed separations most likely would have been experienced as my total abandonment of her. The telephone allowed me to seek her out, which was for her a necessary condition to do the work. The telephone allows her to know that I continue to exist, even in her absence, and, more important to her, that I continue to care about her as a person, not just as a patient. The telephone is used as a way in which Margie can control and modulate a

level of connectedness that she is able to tolerate. When the office sessions become too much, she can talk on the telephone. When the telephone sessions are too much, we can touch base. When she hides, I can find her. With the telephone we are able to reach out and touch each other metaphorically.

CONCLUSION

Initially many analysts, like myself, were apologetic about the use of the telephone in clinical practice. Our past traditions and prejudices were

preventing many of our colleagues from openly discussing deviations from the traditional frame. Because we never exposed our more creative approaches to our disapproving colleagues, we were unable to evaluate the effectiveness of our approaches or the limits from which we could generalize from one patient to the next. However, times really are changing. Gabbard and Westin (2003) wisely conclude in their article in *the International Journal of Psychoanalysis*, 'Rethinking Therapeutic Action', that analysts

must stop asking whether something is analytic, but rather whether it is therapeutic. Reviewing the literature on therapeutic action, they conclude what most sensitive clinicians already know, that there is not one type of therapeutic action, no matter how complex the theory, but many.

Today the telephone is viewed by many as an important tool in our therapeutic armamentarium. Depending on the need of the client (and sometimes the need of the

analyst) the telephone has the potential of both creating and removing space.

We are living in the era of technology. Rapid changes in the way we communicate are having enormous rippling effects throughout society. As therapists we have the opportunity of using advances in communication to help people we might not have been able to reach before. If we take as a given the premise that we therapists are interested in helping our patients deal with their suffering and lead more meaningful lives, then I believe we

must be open to unusual circumstances. Originally, I could not have imagined how a therapist could ever do telephone work with a patient he or she has never met. Then I read a paper (Gelman 2001) in which an analyst was contacted by a person living in Asia, where there were no therapists who spoke English. The patient was in crisis but was not moving to Los Angeles for another three months. Gelman decided that the best option was for them to begin a treatment over the telephone, even though they never had met, and when

the patient moved, they would, if it seemed to be the right decision, continue in person in the office—unusual; yet it worked.

For me psychoanalysis remains a transformative experience for the patient, for the analyst, and for culture in general. It goes without saying that when we transform our patients, we are transformed in the process. The aim of analysis or any psychoanalytic psychotherapy concerns itself with new ways of relating to oneself, to others and most broadly to the world

in general. It begins often with new ways of relating within the analytic relationship. To help our patients adapt to a changing world, we too need to take advantage of what that world can offer us. How can our theory be the only thing that stays static?

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[2] It may be true that analysts have been reluctant to talk about almost any deviation from the traditional psychoanalytic frame.

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