Psychotherapy Guidebook

Therapy via Telephone

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DEFINITION AND HISTORY

Since the advent of the telephone, the use of this device between patient and therapist has played an increasing role in the therapeutic process. Often, initial contact with the therapist is made via the phone, and first impressions are established on both sides of the therapeutic fence. Telephones can allow a patient access to the therapist at moments of emotional intensity and crisis. Telephone calls can be an integral and planned part of individual or group therapy. Telephone contact is used exclusively for therapeutic contact when distance or medical problems are present. Finally, crisis centers dealing with problems of suicidal intentions, drug abuse, and alcohol have made widespread use of twenty-four-hour-a-day telephone service for crisis intervention and support. Telephone Therapy, then, offers a technique that lacks visual contact and the controls of an office setting, but does provide the patient with much easier access to the therapist. This article will discuss some of these uses of the telephone.

TECHNIQUE

Telephones are used in both structured and unstructured ways in psychotherapy. An unstructured format is as follows: the patient is given the therapist's phone number and encouraged to call "when you feel bad." The "bad feeling" should be defined as explicitly as possible; e.g., "I feel like hitting my kids," or "I feel like drinking again." At times, the patient's anxiety is immediately relieved. He has been reassured that support is close at hand. The therapist, for his part, has stated he is capable of handling emergencies and is not afraid of a patient's anxiety needs.

The telephone so offered will be used by patients in various ways. A patient who feels dependent can get support, at times, in place of acting out mechanisms such as pill taking. Some patients will attempt a pseudo-intimacy by phone, discussing material they have not brought up in regular sessions. The phone helps by blocking the nonverbal overload of the conversation, and by providing a safety valve for the patient — he can always hang up. Patients with significant interpersonal difficulties, such as schizoid individuals, will use the telephone to achieve closeness while simultaneously maintaining distance. Individuals with difficulty controlling hostility will use the phone to express anger at the therapist. The telephone allows a safer anger, one that is at a distance. Finally, and often late in therapy, some patients will call to talk things over with the therapist. They discuss decisions, ask advice, and in general borrow from the ego of the therapist.

All of these occurrences can provide useful input into therapy. The patient is able to document what heretofore have been vague episodes and can often conceptualize his problems in a manner that is helpful to him. The job of the therapist is to bring the material into the total therapeutic setting: to convert a crisis to a process.

If a patient abuses the use of the phone, the therapist should discuss this directly with him. Is he aware of the inconsiderate side of his personality, and can he bring it under control? Often, it is helpful to set up a regular time for telephone sessions, and to work out a fee for them. In my (John A. Childs) experience, patients rarely abuse telephone access.

The telephone as a planned part of therapy has several aspects to it. Telephone follow-up techniques are routinely used for alcohol and drug abuse problems. Patient and therapist have used the phone exclusively when illness or distance rules out face-to-face contact. Our clinic has frequently used the phone as a planned, daily part of therapy designed to enhance the self-image of patients by asking them to report a behavior they considered, prior to the onset of therapy, as beyond their capacities. An example of this technique is given in the “Applications” section.

A discussion of these telephone techniques must include the person who calls in a crisis and is unknown to the therapist. There are two things he

must do. First, he must get identifying information: name, phone number, address. Second, he must speak to the side of the ambivalent patient that is positive. A person with a gun at his bedside or one who has just taken an overdose is calling the therapist because the outcome is uncertain. The therapist might tell him, in the case of an overdose, that he is now hanging up to call an ambulance, that the "client" open the door, and that he will call him back immediately. The therapist should act positively. A crisis call is not a good time to weigh pros and cons.

APPLICATIONS

In addition to those applications discussed above, here is a more specific example of how telephone use can be of benefit. The following case was handled in an out-patient clinic, where the majority of the therapists were psychiatric nurses.

A fifty-two-year-old woman was referred to the clinic by another agency as a "psychotic telephone user." She had had a twenty-year history of multiple inpatient and out-patient runs at treatment and was currently on the phone many times a day with various doctors and social services, voicing multiple somatic complaints. She was talking to everyone, and in therapy with no one.

The initial interview revealed a chronically depressed and quite angry individual. She was in a very dependent relationship with her thirty two-year-

old son and felt explosive and bitter toward her lover of about ten years. She had few ways of coping with these two men. Her days consisted of lying in bed until noon, fitfully calling various people until the evening, fighting with the men in her life until late at night, and drinking herself to an uneasy sleep. She needed ways of expressing anger, ways of dealing with those who made her angry, and, above all, a structure to her life that would make it seem useful.

The patient was instructed to call the clinic daily to express her complaints and anger, and it was agreed with other agencies that this was the only place she would call. The time for her daily phone calls was set at 8:00 A.M. with penalties — fines the first two times and then discontinuation of therapy — for missing the call. Quickly she was able to achieve the hitherto "impossible" task of getting up in the morning. Concomitantly, a new problem was created: what to do with these four morning hours that had appeared in her life? Twice-weekly sessions at the clinic dealt with structuring this time, and for a while she was charged with making daily phone reports at 10:30 A.M. on the progress of mutually agreed-upon tasks. After three weeks the patient was seen in joint therapy sessions with her lover and her son; after several months this resulted in greater freedom and satisfaction among them all. After a year the patient was working and reported a happier life. Although when she first came to the clinic she was taking several psychiatric drugs, she was not on a well-kept schedule. She therefore came to the clinic about once

every four weeks for drug follow-up and was continuing to telephone daily. The calls lasted from about 8:00 until 8:05 A.M. and she talked to one of four or five staff members, all of whom she had come to know quite well.