ANALYSIS AND PSYCHOTHERAPY BY TELEPHONE: TWENTY YEARS OF CLINICAL EXPERIENCE

Psychoanalysis via telephone is becoming increasingly prevalent while remaining an area of comparatively little study. The author's early telephone treatment of a series of patients living some distance away or engaged in business travel, and his subsequent telephone treatment of nine analytic and five psychotherapy patients following his own geographic move, are discussed in detail. The mechanics of beginning and carrying out such treatment are examined. The theoretical implications of the shift to the telephone and the ambivalence with which it is often met by clinicians are also explored. The role of nonverbal communication in both in-person and telephone analysis is considered, as is the concept of the analytic office as a literal space and a psychological container. Suggestions for future research are advanced.

After being virtually ignored in the analytic literature (Lindon 1988 being an early exception), telephone psychoanalysis has recently emerged as an area of considerable interest. Zalusky's 1998 paper and a volume edited by Aronson (2000) are examples of this growing interest. Telephone analysis has recently been the subject of a series of discussion groups of the American Psychoanalytic Association, a panel of the American Psychological Association (A.K. Richards 2001), and a report of an ad hoc committee of the American's Board on Professional Standards (Benson, Rowntree, and Singer 2001), the last addressing the more specialized question of training analysis. Seventy-four percent of the 120 psychologists surveyed about their experiences with telephone treatment by Richards and Goldberg (A.K. Richards 2001) were

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currently conducting therapy by telephone, and 83% had done so at some time within the previous two years; of those who had had no experience with this treatment modality, 50% said they would conduct therapy by telephone if circumstances required it.

What makes telephone treatment a subject of importance? First, we live in a mobile society: patients move, often not by choice, and analysts occasionally do as well. If a relocation were to result in either a transfer or a compromise termination, it would entail either significant additional analytic work for the patient or a less than optimal analytic result. Choosing not to move instead would represent such a life compromise on the part of the patient that it could permanently impair the analysis. Although all of these options can be grist for the mill, they all too often leave in their wake aspects of loss and longing that are not analyzable. Moreover, when the "fit" is good and the analytic pair has a well-functioning therapeutic relationship, it is not something to be lightly discarded or easily replaced; for some patients with a history of severe trauma or loss it can never really be replaced. Finally, psychological pain does not respect geography. There are many people who badly need analytic therapy but live in areas where it is not available. In the absence of telephone treatment, psychoanalysis has been available chiefly to people living in larger cities. Patients can, of course, travel great distances, and some do—but relatively few can afford to, and the life compromises involved in pursuing treatment in that way are great.

In 1983 as a recent analytic graduate, I moved halfway across the country to a small, developing analytic community, and, sixteen years later, in 1999, I moved approximately the same distance again. Prior to the first move I either terminated with or transferred all of my patients to other analysts; following the second, I continued to work with most of them, in both analysis and psychotherapy, by telephone. How this striking change came about and the considerations that informed it are the subjects of this paper.

My experience with telephone work falls broadly into four kinds of clinical situations: (1) intermittent or partial telephone treatment occurring as a result of plan or circumstance to meet the needs of patients living at a distance from the office, (2) extended periods of work over the telephone with patients away for business reasons, (3) the continuation of eight analyses and five psychotherapies via telephone following my move, and (4) the beginning by telephone of an analysis that

continues in person following that move. These experiences are summarized in the table below.

Telephone Patients Grouped by Treatment Situation

	Group 1 Intermittent Telephone Treatment		Group 2 Extended Telephone Treatment		Group 3 Treatment Continued by Telephone		Group 4 Treatment Begun via Telephone	
	Therapy	Analysis	Therapy	Analysis	Therapy	Analysis	Therapy	Analysis
Number of Patients	4	1	2	1	5	9	0	1
Years of Treatment	2–14 years	3 years	4–6 years	7 years	2–15 years	2–18 years	N/A	2 years
Duration of Telephone Treatment	¼–7 years	¼ year	¼ year	1 year	2½ years	2½ years	N/A	¼ year
Successful Termination	2	0	1	1	1	2	0	0
Treatment Broken off	0	0	1	0	0	0	0	0

Although there are some differences, the basic procedures for starting and conducting a telephone analysis when the analyst moves are essentially the same as those that apply when the patient moves. I cannot discuss or present detailed individual case material because my patients all come from a small community. Although disguise might be possible, it could easily lead to speculation and erroneous identification. Gabbard (2001) has recently discussed the problem of balancing the maintenance of patient confidentiality against the importance of presenting clinical material for the purposes of illustration and study. One of the ways he suggests dealing with this problem that fits the needs of the material presented here is the use of composite case vignettes and clinical process.

THE USE OF THE TELEPHONE

Beginnings

During the 1970s, I treated a number of more severely disturbed patients who required and made telephone contact between sessions. They had deficit-based pathology involving profound ego disturbances and instabilities in self- and object representations. At times we scheduled telephone calls when I was away from the office for more than a

day or two. Such contact, kept as brief as possible and not viewed as sessions, declined in frequency and eventually ceased as treatment progressed. By contrast, a much more intact patient in analysis was required to spend two months out of the area because of work; in that case, treatment was suspended except for one session in the middle of the enforced break.

When I moved in the early 1980s, telephone treatment still had not appeared as an option and patients were either terminated or transferred to other analysts in decisions arrived at mutually. Some of the transfers did not go well and some of the forced terminations were premature, requiring subsequent referral. Two factors were involved in my not considering the use of the telephone at this stage. First, the period spanned the years of my analytic training and practice as a recent graduate; I felt very much caught up in the orthodoxy of the times and concerned as well about adhering to some idealized standard of treatment. Second, societal attitudes toward telecommunications were not what they are today. Twenty years ago, long distance calls were harder to make and more expensive, and available equipment was far less comfortable. "Long distance" was still imbued with a leftover specialness from a time when it was reserved for important and infrequent communications. Today, a forty-five- or fifty-minute telephone call is taken for granted and often costs less than what a patient would spend on gasoline and parking for a face-to-face analytic hour.

After I moved, my practice included a number of psychotherapy patients who lived in small cities or rural areas hours away from my office. It was unrealistic to see them more than once a week, as they had to spend most of a day traveling to and from a therapy session. I decided to try splitting up the work, having one session in the office each week and another by telephone; since roads were sometimes impassable in winter, the schedule could vary based on travel conditions. The therapy went well for these patients. They made different things of the telephone, but the content of their associations always involved issues of meaning, subject to interpretation, rather than problems with the use of the telephone as a vehicle for conducting therapy. Some patients found their face-to-face sessions more intense by comparison while others found working without visual contact of any sort to be a profound experience itself. Again there were individual meanings: one patient felt less in contact over the telephone; another found it possible to talk more freely at a distance about material that was either intense or perceived as shameful.

The first extended telephone case. In the late 1980s, Ed, a somewhat narcissistic college professor in his fifties, had been in four-times-weekly psychoanalysis for a number of years when an opportunity surfaced for him to do a sabbatical out of town. He was an only child whose analysis had revolved around his disappointment in a series of women with whom he had been involved and his feeling that he had been disliked and passed over in his department. While neither of us wanted to suspend the analysis, the opportunity presented by the sabbatical could well have been crucial to his career. Based on my experience with psychotherapy patients, I decided to suggest the possibility of continuing the analysis by telephone while he was away. He readily accepted.

My reaction was twofold. First, I felt some anxiety that my patient and I were heading off into entirely new territory. Second, my institutional countertransference was that I was doing something "forbidden"—something that would certainly raise the eyebrows of many, if not most, of my colleagues. I do not believe that those reactions were unusual. At that time, deviations from standard technique were seen largely as questionable, provoking intense debate and often criticism, although there were, and to some extent certainly still are, considerable differences between what people actually did and what they were willing to write or talk publicly about doing.

I insisted in advance that Ed return on a couple of scheduled occasions during his sabbatical so we could also meet in person,[1] and stressed that we should both evaluate the efficacy of the telephone work as it proceeded. The analysis continued to go well by telephone and I breathed a sigh of relief. With this particular patient there was essentially no difference from the in-person work. By that I do not mean that the content was necessarily the same. Ed would, for example, always locate himself for me early in the hour: "I'm in my hotel room lying down," or, "This may be difficult today. I'm late and using an office here, so we may have to wing it." (I have only recently understood the references here to space; they are discussed below.) Sometimes he took obvious pleasure in the sessions. "This is pretty special, doing an analysis on the phone," he said from his office one day. "You can't be

[1]It has been my observation that analysts doing telephone work for the first time seem to handle the issue of scheduling in-person sessions in this fairly rigid way. They do so partly, I think, because of anxiety and partly because of the sense of violating a technical prohibition.

doing many of these; I'm probably the only one." I listened and eventually said, "Just like you were so special to your mother that no other woman has ever been able to make you feel as special and important as she did," pulling together themes that had developed over a number of weeks. What I mean about the work not being different is rather that the telephone sessions produced analytic process material that, as such, could not be distinguished from that of any session conducted in the office. For this patient and his analysis, use of the telephone was a positive experience.

Further experience. Over the next several years I continued to do telephone work as the need arose. Only two patients found it impossible. In both cases, working at a distance either had some particular meaning that rendered it unworkable or verbal contact alone was not "enough" to create a session. One case in particular went very badly. Bill was a young lawyer, the son of a passive, absent father and an intrusive, borderline mother. He sought treatment for his inability to form a successful romantic relationship. After several years of twice-weekly psychotherapy that focused more on his contempt for his father than his ambivalence toward his mother, some change in those feelings had begun to manifest itself. At this point, Bill was assigned a case that would require several periods of travel.

I suggested that we try telephone work instead of interrupting the therapy. Initially there was little change in the manifest content of the sessions, but there followed a period of intense anger at the therapy and even more intense contempt for me and my perceived inadequacies. Although it proved possible to interpret this negative paternal transference when Bill returned from his travels, the feelings subsequently flared up even more intensely and he impulsively broke off therapy. I had felt, and to some extent was, immobilized by the intensity of his projection of his father into me. I realized after the fact that the distance and experienced absence, perhaps even amplified by our use of the telephone, had violently mobilized his hatred of his father and catastrophically reestablished a massive and little-explored maternal identification. Had I more clearly understood Bill and the issues involved for him in the telephone work, or had the treatment instead been suspended during this period, the outcome might have been different. I must stress that this was in part a result of the meaning of travel and the telephone for this particular patient (in much the same way that the meanings of other aspects of analysis have led to less than

optimal outcomes), and in part a product of issues of technique and the particular transference/countertransference interplay. My experience with Bill does not reflect on the usability of the telephone as an instrument for carrying out a viable analysis. On careful reflection, his did not seem to be a response that was in any way predictable. As a result of it, I learned to precede any first period of analysis at a distance with a controlled trial of the telephone prior to the patient's leaving the city. Since then, I have found cases in which the telephone was not useful to be exceptions.

Each of these experiences grew out of a patient's need to be physically absent and evolved as an adaptation of the treatment situation so that the therapy could continue. I developed considerable confidence in telephone work and began to talk to colleagues about it. They reacted in one of three ways. Some supported the use of the telephone with varying degrees of enthusiasm; they had done, were doing, or became interested in doing it themselves. Others were opposed, some of them intensely and globally so and some only for themselves. This latter group thought the process perfectly reasonable but felt that they as individuals lacked some "knack" for doing it. I concluded that telephone analysis was a kind of analytic work, like working with children or certain other kinds of patients, that some analysts felt able to do and others did not. At the time I was not able to see that I was not doing enough telephone analyses to be able to compare across them and draw broader and more informative conclusions concerning precisely what issues were being raised by working in this way.

Moving a Practice

In 1998 I decided to move back to the area of the country in which I had trained and spent most of my life. The decision was complicated by my having a large analytic practice, with patients mostly in the middle phases of analysis and psychotherapy. Only a small number would be ready to terminate by the time of the planned move a year later. The analytic community I was leaving was a small one; I could not make referrals for many of my patients, and, even where I could, I felt reluctance and not a little guilt at the prospect of interrupting their successful analytic work. The outcomes of the forced terminations and transfers resulting from my move nearly twenty years before made me even more reluctant to do so. I began to consider other solutions.

One possibility that suggested itself, only to be rejected, was for me to commute and continue to see patients several days a week on an interim basis. This did not seem to be a viable option. Perhaps some analysts could manage such a travel schedule but I could not; moreover, there was the very problematic effect that an "interim" solution would have on the work. I next thought that I could suggest to some of my patients that we continue the treatment by telephone; at this point I did not think systematically about identifying those patients to whom I would offer the option. By then I had been doing telephone work for over fifteen years. But it had always been because of patients' needs, not mine, because of a change in their lives, not mine, and the reversal did not sit well with me. Abandoning my work with them seemed an even worse choice, however. I felt that I had made a commitment to see that work through and, while such a commitment is not a guarantee, I was loath to break it.

I eventually decided to inform everyone of the possibility of continuing by telephone although I also decided to make a negative recommendation about its advisability in some cases. To have done otherwise in a small community, where word of this possibility would quickly spread would have been to inflict a narcissistic injury and de facto rejection on those patients to whom the offer was not made. I would not have felt able to consider such a broad expansion of my original, loosely formulated plans were it not for my previous extensive experience with telephone work over the years. Eight months prior to leaving I told my patients that I was moving and planned to continue my practice in a new location. If they wished to, we could continue their analysis or therapy by telephone; if they did not, I would do everything I could to make a referral to another therapist and facilitate the transfer. I told them as well that the offer to continue was not an interim one, that I was prepared to work with them as long as necessary to see the analysis or therapy through to a successful conclusion. In cases where termination was already in progress, I added that my leaving could affect or not affect the date of their termination, as they chose or as the work determined.

Patients responded in surprisingly similar ways. "I'm surprised, shocked," one man observed. "I would hope to finish by then or some period thereafter," he concluded, and then he went on to summarize quite accurately the problems he had yet to resolve. A woman was silent for a while, then said, "First I was sad, then angry. The telephone

seems like a pale alternative. It's like when my mother took my brother to a meeting with her; he got to go, I got only a movie to watch." Another patient, who had already set a termination date, said, "It makes me very sad. I had planned to end by summer but you're supposed to be here just in case."

The offer to continue the treatment initially provided most of my patients a rationale for suppressing or directing elsewhere the anger and sense of betrayal they felt towards me for leaving. In the countertransference I experienced their lack of anger or betrayal as a relief: I thought I was being "let off" easily. This was a phase that, fortunately, passed quickly and was followed by intense work on the issues. As would be expected, specific material was consistent with patients' core conflicts or deficits. A number of patients with specific, intense issues around loss said, "You can't do this to me; it won't be the same, ever. You wouldn't leave if you cared about me at all." Early losses were now recurring not only in the transference but also in reality. Work with these losses proved difficult and varied. It was, after all, a peculiar kind of loss; indeed, with the option to continue by telephone, it was not exactly a loss at all. It soon became clear that this would be a long process that would overlap the move itself.

As it had different meanings for different patients, I found that the move also had different meanings for me as I worked with each of them. As might have been expected, to the themes of loss, abandonment, and betrayal, exploitation was soon added. Was my offer really for them, or was it for me—a way to move with a ready-made practice? This was a more important theme for some patients than for others. "This will be a pretty good deal for you," said one, while another worried, somewhat intellectually, "I'm just concerned that you don't dump me once you get settled." Those patients for whom exploitation was an important genetic issue reexperienced it around my leaving and struggled the longest with making a decision about if and how they wanted to continue their treatment.

Susan, a single graduate student in her early thirties, had come to me three years before to continue an analysis that had begun with another analyst in a different city and had been interrupted precipitously. Her childhood compliance with a beloved, somewhat sadistic older brother and an arrogant and demanding father had landed her in a series of exploitative and masochistic situations throughout her life. We had just begun to catch rare glimpses of hostility beneath her wish to

please when I told her of my plans to leave. "This is for you, not me," she angrily threw at me, "I don't know what I'll do, maybe stop; I'm not trying the phone." There was a rigidity and certainty to this that hadn't appeared before. Given her nuclear issues, her words and behavior evidenced new adaptations and a new way of relating to me that I did not want to trample on or damage. Eventually, I said to her, "You are not about to treat me like your brother, using the phone just to please me." "You can bet on that," she snapped back. I did not bring it up again. Susan eventually did decide to try continuing her analysis when I moved. (Her particular difficulty with it will be discussed below.)

After some exploration and preliminary working through had been accomplished, I suggested to each patient considering continuing that he or she actually try out using the telephone while I was still in town so that we could assess what it felt like and how well it worked. It would be impossible for either patient or analyst to make an informed decision without such a trial, I explained. If the trial proved unsuccessful there would still be time to deal with termination or transfer; the time to find out that the treatment situation was unworkable for someone was not after the move had taken place. The trials would also serve to inform the work about leaving and continuing and provide a sound reality basis for the decision. This trial work went well. Again, there were issues about the telephone but they were much the same as would be expected around any change in the analytic situation. That is to say, they focused on the content and meaning of the change, not the substance of working by telephone.

The process evolved differently for three of my psychotherapy patients. One, who had been in weekly psychotherapy on and off for many years and for whom my concrete physical presence had always been of central importance ("I feel better just walking in," he had said when beginning one period of therapy), never considered continuing and arranged to terminate. A second, also in weekly therapy, lived out of the city and had already used the telephone when travel was impossible but experienced it to be a poor substitute for working in person. We agreed that transfer to another therapist was feasible and the better solution. The third patient, whom I had seen for a number of years in a mixture of supportive and insight-oriented psychotherapy, had used the telephone successfully on many occasions because of scheduling issues. However, I had real doubts about her doing so on a permanent

basis. This fragile patient was on medication and I relied (to a far greater extent in this case than in others) on my visual sense in evaluating how well it was working and whether it needed to be titrated; I doubted that I could maintain a "fix" on her through the telephone. For this reason I recommended transfer, but she objected so violently that I worried about a serious decompensation. The solution we worked out as acceptable to both of us was that we would continue the therapy on a trial basis by telephone and that a colleague would take over the medication, seeing the patient monthly. (The work has continued in its usual somewhat stormy fashion, but, interestingly, it has been enhanced by the addition of the second therapist managing the medication and working from a cognitive-behavioral perspective.)

All of the patients who considered continuing by telephone and went on to try it ultimately decided to continue. With some there was considerable, often intense, back-and-forth movement on the decision. One or two waited until almost the last moment to decide. None thought seriously about transfer; each saw the decision as a choice between continuing by telephone or terminating. Nearly all of the patients who were actively working on termination before I told them of my plans did terminate during the month or two before I moved. Most of them also chose to try the telephone, to "see what it would be like" as part of their termination. They did so to test out the viability of working on the telephone if they needed to return for further treatment at some point in the future. A majority of these patients found ending their treatment intense and extremely difficult, much more so than I had usually seen in analytic and psychotherapy terminations. This was true across diagnostic categories.

For terminating patients, there was in effect a double loss, the first being ending, the second my leaving them and making continuing, or returning in the old way, impossible. Significantly, they also had a particularly difficult time post-termination. I knew about their problems because most of them contacted me in the months immediately following my move. I had seen this infrequently in the past and, when it did happen, it was always diagnosis- or conflict-specific, occurring in patients with either more serious pathology or issues and conflicts specifically related to object loss. None of these correlations was true of these patients. At their request or my suggestion they all "returned" for further analytic work by telephone. At the start, I had no sense of how long this work would take. I believed that they had all had sound

analyses and did not anticipate the appearance of new areas of difficulty or conflict requiring significant amounts of time to work through. In all instances the additional treatment turned out to be very brief, amounting to one or two months. It centered on issues connected with my move, stayed focused almost entirely in the present and included brief historical connections made by the patients themselves. They seemed to require a firsthand demonstration that I was analytically "there" for them, could be relied on in the future if necessary, could be worked with, and, most important, was still interested in working with them.

The Mechanics of Working by Telephone

What follows is a description of how I conduct an analysis or psychotherapy by telephone. It addresses the therapeutic, mechanical, and logistical issues that must be dealt with. It developed gradually over time and is certainly not the only way to go about it; individual needs or style can vary considerably, much as they do in the wider realm of analytic technique.

Taken as a body, these techniques are considerably more evolved and specialized than what would be required in order to continue the analysis of a single patient who had moved to a distant city and for whom transfer or termination was either not feasible or not desirable. For example, I added a telephone line exclusively for telephone sessions; it is often in use for long periods of time each day and is not available for messages or other business. I experimented briefly with a high quality speakerphone but found it eerie; the echo of a patient's voice in the empty office felt somehow a violation of the patient's privacy. As I found that with the use of a lightweight headset my awareness of the telephone effectively disappeared, I advised my patients to try this themselves and many did. For those who did not, the reasons often involved varieties of resistance; they were dealt with as any other resistances in analysis would be. Some patients held onto the handset to emphasize contact with me while the refusal by others was a non-compliance that expressed anger at my leaving or an unwillingness to acknowledge that the analysis would have to take place by telephone.

The patients make the calls to me; their doing so is analogous to their coming to the office and acts to maintain their autonomous position in the analysis. To initiate the call myself feels like a "summoning" or an intrusion into the patient's space. This procedure raises an issue

around time. Being a few minutes late presents a problem with telephone work; the call is missed or there is a busy signal and the patient experiences much more of a disruption than he or she would if kept waiting for an extra a minute or two. The disruption can, however, be avoided.

An analysis that began by telephone. Two months before I was to move, I was referred a patient for analysis in the city to which I was moving. The patient was in considerable turmoil and needed, if at all possible, to begin sooner. I arranged a telephone session and, when this seemed productive, suggested that we continue once or twice weekly until we could begin meeting in person. I added the proviso that I was not entirely sure how it would work and that, if I felt it necessary, I would ask her to fly in for some sessions in person. (This reaction to my inexperience in beginning a case in this way is consistent with my earlier footnoted observation linking the rigid scheduling of in-person sessions with anxiety and the violation of technical prohibitions.) These telephone sessions turned out to be a kind of extended history taking that was both meaningful and settling to the patient.

It emerged that Mary, a divorced liberal arts professor in her early forties, was deeply involved in a relationship with a man she loved and admired. He was in analysis, he spoke enthusiastically about it, and she was impressed with the changes that had taken place in him. Mary had always had difficulty in knowing or having access to her feelings: in spite of caring deeply for him, if he pushed her to talk about her feelings, which he frequently did, she would shut down completely, feeling stress, anxiety, irritability, and, sometimes depression. She also felt a sense of emptiness, a void within her. For a number of years she had taken Zoloft to blunt these feelings, titrating the dosage to protect herself against breakthrough bursts of the irritability and anger. These symptoms, which she was increasingly aware of and pained about, had begun to cause difficulty in the relationship, increasing her anxiety and depression.

The second of four children, Mary was the only daughter of an angry, chronically dissatisfied father and a narcissistic and inadequate mother who abandoned the family emotionally and, at times, literally. While Mary appeared to seek out warm relationships with women as replacements for the mother she emotionally never had (and could be expected to do the same in the transference), she had unconsciously defended herself against the risks of an even more painful abandonment and had thus never allowed herself to succeed in her search.

Relationships with men, until the present one, had been equally painful and disappointing, albeit for different reasons.

Our telephone sessions were much like any opening consultative sessions in an analysis, with the history emerging over the first couple of hours. Aware that Mary was a person whom I had never seen and who had never seen me, I asked after a few sessions, "What's it like for you, working on the phone like this?" "I've thought about it," she replied. "It's odd. I have no sense of what you look like. You seem sensitive and you ask very careful questions. I'd rather be talking to you face-to-face but this is all right." I found her to be thoughtful and articulate, and, more important, I experienced a sense of connectedness over the telephone that made beginning the work in this way possible. A mutual rapport developed quite easily and foreshadowed a developing positive transference/countertransference configuration that, after a year, would begin to take on defensive functions.

Mary began the first in-person session two months later by taking the chair and saying, "So this is what we both look like," acknowledging my curiosity as well as her own. She could say little about any expectations of me either before this session or after and continued her analysis in much the same way as she had begun it over the telephone. I wondered if she suppressed or avoided her thoughts about me much as she did her feelings generally and how much of that was conscious. It is still an open question. The analysis has continued in a productive way over the past two-plus years. She decided to wean herself off of the Zoloft over the first six months and has not needed it since. The transference and her resistances to it have always remained a focus of the work. The positive feelings that first developed over the telephone gave way to secretiveness and anxiety, in keeping with Mary's overall conflicts over the dangers of risking a connection to a potentially abandoning mother; I experienced corresponding feelings of being shut out and not having anything to offer that she would, or could, use. We have been intensely involved with this material for some months.

I have since been told anecdotally of patients who have actively sought analysis by telephone because they felt freest talking to someone whom they had never seen and who had never seen them, and also of patients beginning treatment in this way because there was something about themselves that so embarrassed or shamed them that they wanted to be known before they were seen. Finally, A. K. Richards's (2001) panel report includes a case of telephone therapy described by

Zarem in which her patient, an obese African-American woman living in the same city, used the telephone because she could not bear to have her body seen by her slim white therapist.

The place of face-to-face sessions in telephone analysis. Those writing about telephone work, doing it, or evaluating it for administrative or educational purposes seem to prescribe some amount of regularly scheduled in-person work, often fairly rigidly. This prescription can result from a combination of factors. An analyst may be inexperienced in telephone work, perhaps having never treated a patient in this way before. There may also be a related concern that pure telephone work is, at best, a limited approximation of the genuine article, in-person analysis.

As a result of my prior successful experiences I decided not to impose such a requirement. I have no doubt that my reluctance to add a significant expense to patients' already having to deal with my move was also a factor in this decision. Be that as it may, I simply suggested that some periodic in-person sessions probably would prove beneficial to their analyses, that they were always welcome to come, but that I would recommend it much more strongly if I were to see a particular need to do so. Perhaps a third of my patients began commuting periodically for sessions; I arranged my schedule to allow for extra hours during these visits. The work in these hours was not substantially different from that which was done by telephone. What distinguished the patients who chose to come from those who did not was a need to be able to locate me again in a physical and psychological space or to feel more directly in contact with me. (One patient who expressed this need but could not afford the expense of coming asked for photographs of my new office, a request with which I complied.) They were mostly able to identify the need for this themselves. Patients who did not come, at least during the first year, expressed only a pro forma interest in doing so.

The fact that all of my telephone patients were in the same city offered still another possibility, one not usually available for a single case: I could visit periodically for sessions with them. Although the idea of doing that had occurred to me from early on, the telephone work had been going well and it was not at all clear now that such a trip was necessary or would make a difference. Largely to find out, I undertook a visit a year after the move, seeing each patient for at least two treatment hours over a three-day period.

This first trip demonstrated that face-to-face contact was mutually important and needed to be renewed periodically, for its own sake as part of the foundation for the analytic work. It involved seeing and being seen, a kind of "re-tuning" of the analytic situation on both my part and my patients': how did we look? had we changed? were we still the same? Unexpectedly but in keeping with this re-tuning, a number of them brought something to show me, something relevant to what had occupied their lives and come up in their treatment over the intervening months. Susan, for example, brought several poems she had written and finally been able to have published. I invited patients to use either the couch or a chair; all chose a chair for at least part of the time.

One salient feature of the sessions I conducted on this trip was more complex and difficult to understand fully at the time. Every patient did a great deal of work; it seemed as if I was being treated to a series of "good hours" (Kris 1956), in that insights emerged, transferences evolved, and aspects of meaning appeared, across diagnostic categories, in these few sessions. I wondered with some concern whether I was in fact seeing a compression into a few hours of analytic work that had not been done during the months of telephone sessions, something that would not bode well for this process. The fact that I had observed no such effect when patients had visited me made me doubtful of this, but, at that point, I simply could not tell. The material itself was of little help in answering the question; however, I did know that nearly everyone was grateful for my coming. Did their appreciation figure somehow into what I had observed? In any case, the importance to the work of the contact led me to decide to schedule such trips twice a year. Future visits would also shed light on what had occurred on the first trip.

The second visit took place six months later. Again the in-person sessions were important, but this time they were simply analytic hours; their contact/re-tuning function continued but minus the intensity and synthesis of the hours during the first visit. I had several ideas about what may have happened. The work might not have been compressed by the use of the telephone but rather by the length of time, a year, that had elapsed before my first visit. The fact that those patients who had come to see me in the interim had the same kinds of good hours during my visit mitigated against this explanation. It seemed more likely that the exceptional work represented a "gift" to me for coming or some

effort to insure that I would come again. It may also have involved what some patients later told me was their experiencing my visit as a commitment to seeing the work through, a commitment that they had, apparently, not been entirely certain of before. As one patient confessed at the end of a session, "I thought you were coming to tell me you wouldn't continue doing this on the phone."

A third visit has now taken place and it repeated the pattern of the second. Collectively, the visits changed my views of the place and importance of some in-person sessions in a distant analysis, and I plan to continue them with this group of patients. Hereafter, as I start work with new or continuing patients who live in some other area, I plan to incorporate in-person sessions on at least a semi-annual basis as a part of the therapeutic contract.

OBSERVATIONS

The Telephone as an Instrument of Analysis

What is telephone work really like and, as a colleague asked, how is it different from an in-person analysis? At first glance, the similarities are far more striking than the differences. I have found that the telephone becomes operationally transparent almost immediately. Doing the analysis feels the same to the analyst and, in most cases, to the patient. By this I mean that both members of the dyad rapidly loose any special awareness of the manner in which the analysis is being conducted, and that, when such awareness does periodically emerge, it does so in precisely the same fashion as would the awareness of any other aspect of the analytic situation.

A change in the process itself that also becomes transparent is that the treatment becomes an analysis of words and voice: the verbal comes to carry all of the contact and interaction, replacing appearance and visual contact. This is not to say that the telephone doesn't have meaning, sometimes great meaning for patients; for most, it does. Once the therapeutic work gets into that meaning, however, we are simply doing analysis, analysis about the telephone; the fact that it is also taking place by telephone is irrelevant. Zalusky (1998) implicitly describes the same findings as she traces out the way the telephone emerges as an issue and is dealt with in the analysis of one of her patients, Annie, who moved away and continued her analysis by telephone. I have found that the meaning of using the telephone and its effect on the process is

an individual one depending for its uniqueness on both the particular patient and patient–analyst dyad.

A small number of patients have had difficulty continuing their analyses by telephone and have struggled with doing so. They are similar in that they had all developed intense and ambivalent transferences characterized by such deep and painful longings that my leaving felt to them like an irreparable abandonment. Their feelings about it frequently focused on the telephone as an unsatisfactory substitute that neither made up for my going nor took the place of my presence. This dynamic seemed not to be about the telephone as the means of analysis per se, but rather about the patients themselves and their particular issues. Had the work not continued, their reactions would have been the same—only I would not have been there to listen. They would also have been the same in the event of a transfer, were transfer to have been either possible or accepted; transfer of such patients commonly has a far from optimal outcome, however. In these cases, the telephone has often taken center stage and the transference has played out around it. For these patients, the in-person sessions were often painful, blocked, and filled with longing. "Your coming here will just end in one more desertion," a patient sobbed, as he partially worked through his despair from visit to visit.

Most patients did not experience either such intensity of feeling or such preoccupation with the telephone, although at some time or other a majority have said that they would rather be meeting in person. Bob summed it up fairly typically, "The telephone is not the same; it works, but it's different from being here." Interestingly, by no means all patients felt this way. One observed, "I've really gotten to like the telephone part of it; I don't know if it's because it's safe, but I can say anything—not that I couldn't before, but I feel I'm saying more things. There are lots of times I'm really embarrassed by what I say." For an analysis to be viably conducted over the telephone, it is necessary both that an analytic process develop or continue and that the impact of the telephone not impair or disable its content, meaning, or progression to a successful termination. Bob had been involved in a period of intense analytic work when he brought in the following dream: "We're in bed together side by side. I'm talking and you're listening—pleasant, feeling good to be talking, conversation." The dream could be interpreted on a number of levels. "I took it as positive," he observed, "a feeling that we're in this together and getting somewhere. It's been an impor-

tant few days for me." He went on to describe how he had broken free of a passive infantile position for the first time.

My current views of telephone analysis were foreshadowed by a number of years' experience with a series of single cases and then deeply influenced by a rapid and very broad immersion in work with many patients. This experience has both informed and affected my work. What I convey to a patient explicitly in an interpretation and implicitly in my attitude toward the telephone is different now than it was when my perspective was more limited, and it significantly affects the analysis. With only one or two cases available for observation, it can be very difficult to tease apart what has to do with the telephone as a vehicle for conducting an analysis from what has to do with individual dynamics or self and object experience. Consultation with a colleague who has more experience in this area, or participation in a discussion group formed for that purpose, would be helpful in overcoming this problem. Wider experience also brings into focus aspects and problems in the use of the telephone that would not be at all apparent in one or two cases.

The Literal and the Psychological Analytic Space

The most important such aspect to emerge has been the impact of the use the telephone on the literal analytic space, the meanings and repercussions of the reality that the analysis is no longer taking place in the analyst's office. The office has been so much a part of the analytic setting that its meaning and presence for analyst and patient alike have not been previously explored or examined. The most immediate difference in a telephone analysis is that the responsibility for maintaining the space shifts from the analyst alone to both members of the patient–analyst dyad.

Patients' capacities for participating in this task logistically, but, more important, psychologically, vary considerably, as does the effect on the process of making the shift. For some, it is a special convenience and a comfortable way of experiencing themselves in control of the analysis. "I like this," one such patient observed. "I can have my analysis right at home, just for me. I don't have to go anywhere; I just call when I'm ready to start." For others, the loss of a place where they can safely give up having to be in control or permit a regression to occur is painful. Still others have great difficulty in defining a safe place for themselves in which to "do" the analysis. While this difficulty sometimes

derives from a physical limitation, it always possesses psychological meaning.

There are patients who seem somehow unable to make the space in which the analysis may occur. Susan, who was discussed earlier, was one such patient. From the very start of the telephone sessions, what kind of telephone to use and where to do the analysis were problems. Getting a headset was an intolerable submission; there was something wrong and irritating about all the locations available to her. Furthermore, the times were not right, and when alternates that fit better with her schedule were suggested, there was something wrong with them too. Not infrequently, Susan would find herself simply unable to get to some place from which she had planned to call; not a few sessions took place via cell phone from her car in a park or a parking lot. There seemed little logistical reality to her difficulties despite her angry insistence that the problem was entirely logistical. She experienced an empathic failure in any suggestion from me that it could be otherwise. Although some of the problem involved an acting out of her hurt and angry feelings at me for deserting her, it became clear that at times she simply could not make the space for the analysis. There were equal elements in her behavior of "I won't" and "I can't."

No less important considerations arise from the recognition that the office and waiting room constitute the physical container in which the analysis takes place. It is against the office as a backdrop and within its physical boundaries that analyst and patient together construct the psychological space of the analysis. Its quality inevitably and intimately reflects aspects of the analyst and can be experienced as continuous with him or her. Consistent with this, it is a dynamic container, not a static one. It changes objectively as the analyst changes it over time but also subjectively as the patient absorbs and experiences it. A patient's asking the question, "Is that new?" about either some object that has always been present in the office or one that was added the day before or years before is as familiar to the analyst as are its various implications. The office also serves to locate the analysis in ways that have ramifications for the developing or evolving transference.

As part of the shift to a shared responsibility for this container function, most patients wanted to locate me in my space when I first moved. They asked me to describe my new office, the new whereabouts of particular furnishings from my old office, and the circumstances of my practicing out of my home. They now often want to

anchor or locate themselves for me in their space as well as me in my own. They describe where they are at the time if, like Ed (who would begin each hour in this fashion), they have become accustomed to doing their sessions in more than one place. They comment about the local weather, ask me about mine, and often convey an expectation that an earlier patient has already told me about it. If there is some event affecting the area where I now live that has made the national news, I am usually asked about it several times during a day.

In face-to-face analysis, the office functions as both a constituent of, and a foundation for, the psychological container upon which the analysis depends. We tend to take that role for granted even as it becomes a component of wider theoretical formulations of the analytic milieu. This is true whether that milieu is conceptualized purely as environment (Winnicott 1960; Bion 1967; Modell 1968) or as space: transitional space, play space, or intersubjective space. The loss of the office as container would thus represent a potential challenge to the efficacy of telephone work, a challenge that could compromise the analyses of some patients and render the undertaking impossible for others. In order to avoid such consequences, analyst and patient must, in effect, psychologically reconstruct the analytic field without the physical office but including the telephone as the connection. Some psychological functions of the office must be taken up and internalized by the patient, others replaced by the telephone link to the analyst, and still others subsumed under changes in the timing, dosage, and quality of the analyst's activity and interactivity. Usually, a variable combination of all three is involved.

Some patients are able to share in this reconstruction almost as a matter of course while for others it is a painful, incremental process that is sometimes accomplished only with the greatest of difficulty. How do these patients differ? It seemed at first that the former group would be somehow better integrated or that the latter must have had some subtle but previously unnoticed ego deficits or failure of function. That did not prove to be the case.

Susan was the first patient to manifest this problem with the analytic space, but her insistent angry denial made it impossible to study. Over time it became clear that a few other patients had the same difficulty, although less glaringly; they were able and often eager to talk about it. They did not have either deficit- or integration-based pathology but they did share a particular kind of boundary problem

characterized by inhibition, conflict, and, sometimes, early trauma. This was not an issue of boundary violation but rather of boundary maintenance. Susan had been a bright, very compliant child always trying to win the approval of a loving but passive and retiring father and a highly controlling mother. She grew into a woman frequently exploited by others; in her extreme compliance, she did not feel entitled to anything for herself, including any kind of claim to space that was her own. Two other patients had, as young children, witnessed but not been the objects of sexual abuse. In the analysis and in the transference, these patients did not believe they were capable of constructing or maintaining space that was safe from potential violation. For them, the space problem was both logistical and psychological. One of them even asked if other patients had the same difficulty and wondered if for some it was masked by easy access to an office of their own. I told her I had not thought of this before but that I now wondered too. It is perhaps stating the obvious to note that rather than constituting an analytic "detour," the shift out of the office to the telephone led to an important line of analytic inquiry.

Silence and the Analyst's Activity in Telephone Psychoanalysis

The subjective experience of conducting a telephone analysis is one of being more focused and working harder to maintain a connection to the patient. I find myself paying particular attention to the hour's first words; experientially, they become analogous to what happens when showing a patient into the office. I listen more carefully to the non-content parts of the patient's speech—tone, inflection, volume, interruptions, and word choice. I also listen to the silence when it occurs and do so with more active intent. Sometimes I have a feeling or experience, usually accompanied by mild anxiety, that the mechanical/psychological connection itself has been lost or broken. Patients may experience the same thing, asking, "Are you still there?" or saying, "I'm not hearing you." This is a kind of rupture of the analytic space. I respond to it as such but also inquire about and explore the thoughts and feelings immediately preceding it. If I feel troubled by a silence or experience a sense of having "lost" the patient somewhere in it, I am more likely to interrupt it with a neutral question such as, "What's going on?" or "What's your thought?" or, more specifically, "I feel I've lost you." At other times I will simply bear these feelings and see what I make of them and what the patient does before saying something. In periods of my own free association, differences in these aspects of

listening are no longer conscious. I have noticed that how I work over the telephone has gradually come to affect the ways I listen and think with patients in the office; my work has felt enhanced by it.

I would stress that I do not think that this change in perspective on analytic silence, combining as it does an elasticity about not interrupting a silence with a willingness to interrupt it actively and fairly quickly, particularly in sessions via telephone, constitutes a deviation from analytic technique. Rather, it is simply an adjustment in dosage and timing in the service of the analysis. For some patients the activity provides necessary evidence of both the analyst's presence and empathic contact, while for others it can remove a silence that could verge on a traumatic pressure to say too much too soon.

The Issue of Nonverbal Communication

The primary objection usually raised to the use of the telephone in analysis is that it interferes with nonverbal communication, making the process more difficult at best, limiting or crippling it at worst. This concern is most cogently stated by Benson, Rowntree, and Singer (2001) in their report on training analysis[2] via telephone. They observe that the "in-person format has been a fundamental part of the . . . psychoanalytic situation and seems crucial to the intimate dyadic nature of [psychoanalysis]" (p. 1). They find "something essential about the physical presence of the other person, his or her non-verbal communications including glances, gestures, body postures breathing patterns and other expressions which can be 'read'. . . ." (p. 1). They acknowledge that "it might be possible that some analytic dyads can achieve the necessary intimacy and tension over the telephone, but on a *prima facie* basis this would be more difficult due to the physical barrier of distance and a reduction in the possible modes of communication" (p. 2; emphasis added). Benson, Rowntree, and Singer appropriately suggest an in-depth study of these issues but seem to base their conclusions primarily on careful discussion.

This report raises important questions concerning telephone analysis. As of this writing, it is the only published source to raise them in such detail. It seems best to respond to those questions by describing

[2]An in-depth discussion of the role of the telephone in the training analysis is beyond the scope of this paper. I am, however, in general agreement with the conclusions reached in the Benson, Rowntree, and Singer report, but that agreement applies to the *educational*, not the *therapeutic* functions of the training analysis.

what is known and not known about nonverbal communication in telephone analysis and by illustrating with both my own experiences and those of others.

Strictly speaking, the term "nonverbal" is something of a misnomer in psychoanalysis. It is intended to refer to the complex interplay of factors and communications, both conscious and unconscious, that occur between analyst and patient, excluding only what is contained in the content and syntax of the hour's spoken language. Components of speech such as rate, tone, volume, inflection, and even phrasing are treated in the same way as is the nonverbal environment of gestures, body language, appearance, and sounds. This is true even though the speech components are "verbal." The only thing known with certainty about the effects of the telephone on the nonverbal analytic interchange is that it removes the visual portions. Curiously, the couch is, of course, used in psychoanalysis for the very purpose of reducing that visual interchange between patient and analyst, and this reduction is seen as a useful and usually necessary feature of the process. What can be said, then, is that the telephone, like the couch, alters the dimensions of the nonverbal environment; it deemphasizes or eliminates some of them while emphasizing others. Those characteristics do not make it a physical barrier any more than reducing visual interchange makes the use of the couch inimical to communication, certainly not on a prima facie basis.

No argument with any critique of telephone analysis based on the notion of a damaging reduction in the visual interaction between patient and analyst can be complete without at least touching on the related clinical situations of the blind analyst, the blind patient, and the blind analyst treating the blind patient. If such analyses can be successful—and their viability does not appear to have ever been called into question—it must in part be because the participants have adapted to the absence or reduction of the visual. The same kind of adaptive process occurs when the telephone is used. Indeed, one could as easily argue that removing the visual by using the telephone results in a purer, more intensely verbal, even hyper-analytic process in which the participants, of necessity, must put everything into verbal utterances. That is, after all, a central goal of any analysis.

The experience that my patients and I have had of the telephone rather quickly becoming transparent would also speak against the notion of a "barrier," and it is consistent with other reports in the litera-

ture (Lindon 1988; Zalusky 1998). The effects of the telephone on the ability of analyst and patient to "read" each other would depend on the particular individuals and the particular analytic dyad. If either or both are especially "visual" people in the sense of perceptual style, character, or organization, "reading" without seeing one another could of course be more difficult, perhaps critically so. Both analyzability and the ability to conduct an analysis presuppose, however, a considerable degree of adaptability. Analyst and patient alike accommodate to the new environment and to the absence of some channels of nonverbal communication by unconsciously changing emphasis and at times consciously substituting verbal for nonverbal communication. In the panel reported by A. K. Richards (2001), Manosevitz describes a case he continued by telephone after moving away. The patient, a recovering alcoholic who had experienced multiple childhood abandonments, had always made frequent use of gestures in his analysis to indicate bodily states. The analytic work involved connecting these states to emotions he could not otherwise put into words. Yet this patient was able to make the shift from the visual to the verbal that was necessary for the success of this particular telephone analysis. In fact, he described great satisfaction with the telephone work and manifested intense transference emotion within it—hardly evidence of what Benson, Rowntree, and Singer claimed is "essential about the physical presence of the other person" (p. 1). Further examples of the requisite adaptability by telephone patients include those managing to describe an emotion verbally while noting that they are not being seen and those whose speech becomes more affectively laden.

Contraindications to Telephone Analysis and Psychotherapy

The question of contraindications to telephone treatment is, as of this writing, an open one. Initially it seemed likely that those conditions—diagnostic, structural, or emotional—that would preclude such treatment would be more or less the same as those precluding any other rigorous or demanding form of treatment like analysis. If the patient had significant ego deficits, problems with damaged or defective self or object representations, or a history of severe emotional trauma, telephone treatment would have seemed inadvisable. However, a recent clinical experience with just that kind of patient called that assumption into question. Barbara, a middle-aged woman with a childhood history of sexual abuse, sought weekly, largely supportive psychotherapy with

me in my office shortly after I moved. A veteran of twenty-plus years of psycho- and pharmacotherapy with a number of therapists, often several times a week, she had little to show for it other than a misdiagnosis of schizophrenia. I found her a workable supportive therapy patient, best diagnosed with PTSD and a mood disorder. After two years she announced a trip to a rural area in a distant state along with plans to move and settle there. With considerable trepidation but also mindful of her therapeutic history, I very tentatively suggested that we might try some telephone sessions on her trip with the possibility of continuing her treatment in this fashion following her move. To my surprise Barbara responded, "The telephone will be fine. I feel I can talk more; I can just think about things and talk about them." She did indeed launch into the telephone sessions on her trip in just this way.

It is not at this point clear what will ultimately happen with Barbara's therapy after she moves. Nor should this vignette in any way be construed as a suggestion that telephone work is for everyone. What is clear, however, is that attempts at diagnostically categorizing patients are not of much help in making advance decisions about the likelihood of their suitability for telephone work. It is my current thinking that, ultimately, subjective criteria will prove to be the most reliable. If the patient feels uncomfortable with the telephone or is strongly and often matter-of-factly opposed to it after some exploration, its use should not be undertaken. Similarly, if the clinician feels that he or she just cannot get a "fix" on, or feels somehow out of contact with, the patient over the telephone, then the work would not be indicated. In very rare instances of the latter, some arrangement such as I made for the patient who saw a co-therapist locally for medication may be attempted.

DISCUSSION

The telephone has been in use in psychoanalysis and psychotherapy for some time. At best, it has not been well studied and is viewed ambivalently, not only by those analysts more or less opposed to it but also by those making use of it. Tradition and its role within the analytic superego and ego ideal may be factors in this ambivalence. Prior to the last two decades or so, the whole issue of analysis at a distance was discussed almost entirely in connection with training analyses. These first occurred when American psychiatrists sought analysis in Europe and returned home, with enormous prestige, to

instrumental roles in the establishment of psychoanalytic communities. Later, some candidates commuted considerable geographic distances for coursework and training analyses that involved four analytic hours scheduled over a two-day period. These travelers also became founding leaders of their communities. In both cases the hardships and excitement of their training were incorporated into the analytic ego ideal and would have cast the supposed ease of an analysis by telephone in an unfavorable light.

There is a longer history within psychoanalysis of initially treating variations in standard technique as deviant and dealing with them either as acting out of the countertransference or as boundary violations.[3] These experiences, beliefs, and, at times, myths have long since been taken up by the psychoanalytic culture where they have become part of the developmental heritage of the analytic superego.

The manner in which telephone analysis first appeared and is now becoming more widespread is unusual in the history of the evolution of psychoanalytic technique. Previous developments have always resulted from a failure of standard technique or theory. Telephone analysis, to the contrary, constitutes an innovation in technique based on positive experience and outcome. It goes beyond that, however, in that it redefines and extends the therapeutic setting that can be called analytic. This kind of change understandably gives rise to ambivalence and controversy.

Bergmann's (1993) categorization, expanded on by A.D. Richards (1994), of psychoanalytic innovators as heretics, modifiers, or extenders, provides a context in which to make sense of the extent of this change. They describe heretics as formally breaking with the standard theory and methodology of the times, whether or not they remain organizationally under the umbrella of psychoanalysis. Heretics also define new criteria for validating the efficacy of their views or approach. Modifiers present a revision or reformulation of theory or technique but do so without leaving the framework of current theory or its methodology for the validation of hypotheses. Finally, extenders take current theory into unexplored areas but do not demand a modification of theory, theory of technique, or means of validation.

[3]Benson, Rowntree, and Singer (2001) recommend the possibility of an independent, non-reporting consultation by an outside training analyst before analyst and candidate make a final decision about seeking to continue a training analysis by telephone.

There is a tendency to present telephone analysis as if it were only an extension of technique while it is uncomfortably thought of or felt by many to be heretical. It is in fact neither, but rather a modification, in that it proposes a re-definition of the analytic situation while at the same time having recourse to, and making use of, the body of current psychoanalytic technique and theory of technique to evaluate its validity and efficacy. Telephone analysis is, in a sense, more than it is sometimes presented as but less than it is accused of being.

CONCLUSIONS

At this point it seems clear that telephone analysis is with us regardless of the controversy that surrounds it. Its established presence only serves to underscore the need for systematic research into its practice. Ideally, research should include in-depth case review with some cases taken to termination, and surveys or studies to examine prevalence and differential attitudes toward telephone analysis in both those analysts who practice it and those who do not. The study reported by Goldberg (A. K. Richards 2001) is an excellent first step.

In summary, I have found that, for my patients and myself, telephone analysis and psychotherapy are valid modalities of treatment. Most of my patients, but, surprisingly, by no means all, prefer face-to-face contact, as do I. The expression of such a preference, however, does not mean that analysis is impaired without it; it is not. Like Zalusky (1998) and Benson, Rowntree, and Singer (2001), I have found telephone analysis to be a compromise, one requiring neither guilt nor apology, but far less of a compromise than they seem to consider it to be. We make many compromises in doing analytic work: some involve frequency, extra sessions, or allowances for patients' business travel; transfer or early termination necessitated by a geographic move is also a compromise.

To a therapist considering the telephone treatment of an established analytic or psychotherapy patient faced with a geographic move I would recommend informing that patient of the option of continuing treatment via telephone (unless, of course, it seems contraindicated by diagnosis or circumstance). I would do so only after the process of dealing with the move was well established. In the case of a patient meaningfully engaged in the treatment, whose history includes a series of interrupted therapies or a bad experience in a past treatment (particu-

larly if accompanied by significant internal problems with loss), I would consider strengthening the option to a recommendation. In all cases I would, of course, thoroughly discuss alternatives.

The subjective attitudes of both participants towards telephone therapy, together with a therapeutic trial in advance of the move, should be of central importance in making a final decision. I would be willing to evaluate new patients for telephone treatment if they either lived in an area where treatment was not otherwise available or felt unable to use whatever resources were present in their community. Such evaluations should consist of a combination of in-person and telephone sessions followed by a therapeutic trial. In cases where regular travel is really feasible, two in-person sessions on the same day and two or three telephone sessions spread out over the rest of the week seem far preferable to four in-person sessions scheduled over two days and allowing for no analytic continuity over the remaining five. In all cases of telephone treatment, some face-to-face work is either necessary or desirable; I would be flexible about its frequency, however. And, finally, for an analyst who has not done telephone work before, consultation with an experienced colleague for technical rather than countertransference purposes can be very helpful.

In conclusion, I fully expect my views to develop and change as I continue to treat my current telephone patients through to termination and perhaps begin work with others. Given the constraints and demands of modern life, its increasing mobility, and the evolving breadth of telecommunications, psychoanalysis must adapt in an informed and thoughtful way or risk stagnation. I hope that I have added to the discourse about such an adaptation.

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