

Psychotherapeutic intervention by telephone

Erika Mozer^{1,2}

Bethany Franklin^{1,3}

Jon Rose¹

¹Department of Veterans Affairs, Palo Alto Health Care System, Palo Alto, CA, USA; ²PGSP Stanford PsyD Consortium Palo Alto, CA, USA; ³Pacific Graduate School of Psychology Palo Alto, California, USA

Abstract: Psychotherapy conducted over the telephone has received increasing amounts of empirical attention given practical advantages that side-step treatment barriers encountered in traditional office-based care. The utility and efficacy of telephone therapy appears generalizable across diverse clinical populations seeking care in community-based hospital settings. Treatment barriers common to older adults suggest that telephone therapy may be an efficient and effective mental health resource for this population. This paper describes empirical studies of telehealth interventions and case examples with psychotherapy conducted via telephone on the Spinal Cord Injury Unit of the Palo Alto Veterans' Administration. Telephone therapy as appears to be a viable intervention with the aging population.

Keywords: telehealth, rural mental health, psychotherapy, healthcare delivery, telecare

Therapeutic intervention by phone

Telehealth may be described as the provision of health care services via a variety of modes including videoconference, internet and telephone. It has existed in some form since the 1960s, but became more commonly utilized in the 1990s with the rise of the internet and videophone technology. Data indicate that by 1999, approximately 100 telehealth networks were in operation (Winerman 2006). Services provided at a distance include teleassessment, teleeducation, telemonitoring, telesupport, and teletherapy by clinicians of various disciplines and backgrounds. Though telehealth may in part be driven by economic and political reasoning (Perednia and Allen 1995), medical care from a distance has been referred to as "one of the most promising applications of advanced communication technology," (Balas et al 1997, p. 2). Telehealth and intervention from a distance, specifically by telephone, allows flexibility and improved access to care and more specifically, access to specialty care (Perednia and Allen 1995) where there may otherwise be barriers to services such as psychology and mental health.

Related studies

Telephone intervention has already been implemented with a variety of applications and diagnoses. Following a successful 6-month pilot project, telehealth has been utilized with over 9000 patients receiving interdisciplinary rehabilitative care at the Integris Jim Thorpe Rehabilitation Hospital in Oklahoma City (Winerman 2006). In this large population, no difference in depression scores on the Mental Component Summary Scale were found compared with patients receiving traditional face-to-face therapy. Despite the wide range and varied modes of intervention intrinsic in rehabilitative care, evidence from teleintervention studies appears to support its utility with older adults. A study of self-report data collection found the telephone to be an accurate and viable modality for information collection (Rintala and Willems 1991). Patients with spinal cord injury in a rehabilitation hospital (N = 27) reported their activities in their own words twice weekly. One report was given over the phone, the other face-to-face. The authors found that measures from the two modes did not differ, supporting use of the telephone as an efficient mode of data collection (Rintala and Willems 1991)

Correspondence: Erika Mozer
Department of Veterans Affairs, Palo Alto
Health Care System, Palo Alto, CA, USA
Email emozer@stanford.edu

which may build confidence for practitioners' clinical work with patients via phone.

Tutty and colleagues (2005) analyzed telephone psychotherapy for the treatment of depression in adults who did not respond to pharmacotherapy. Findings reflect patient satisfaction with the modality. Six hundred individuals were randomized to 3 different treatment conditions (N = 198 in the telephone condition, N = 207 assigned to case management, and N = 195 to usual care). Sixty-four percent of the telephone intervention patients endorsed being "very satisfied" with telephone therapy at 12 months, compared with 48% in the case management condition, and 36% in the care-as-usual condition.

Continuing, Mohr and colleagues (2005) studied individuals with multiple sclerosis and comorbid depression (N = 120). These patients were randomized to one of three conditions: Sixteen weeks of manualized Tele-Cognitive-Behavioral Therapy (T-CBT), a control condition Tele-Supportive Emotion Focused Therapy (T-SEFT) or a control condition that provided no treatment. While both therapeutic conditions yielded change greater than the no-treatment condition, T-CBT correlated with a greater increase of positive affect than did T-SEFT (Mohr et al 2005). This finding suggested that those receiving the intervention benefited more than those that did not.

Last, Phillips and colleagues (2001) recruited patients with acute spinal cord injury (N = 111) from a rehabilitation center in Atlanta for intervention designed to reduce the incidence of secondary conditions among people with mobility impairment from newly acquired spinal cord injury. Individuals were randomized to one of three groups: video-based intervention for nine weeks; telephone-based intervention for nine weeks; or standard follow-up care, and followed for one year. The authors found that both telecare intervention conditions correlated with decreased length of hospital stay compared with the standard care condition. The authors concluded that telephone-based interventions do improve health-related outcomes.

Telephone intervention and the elderly population

Older adults constitute a growing population who face increased vulnerability to psychopathology and disability (Gatz and Smyer 1992; Blazer 1994; deBeurs et al 2005). Though there are only a limited number of published epidemiological studies with varied findings of incidence and prevalence of psychological disorder specifically with older adults (Gatz and Smyer 1992; Rummans et al 1997; Jeste et al

2005), there is evidence suggesting "[a]nxiety and depression are the most prevalent psychological problems in late life" (deBeurs et al 2005, p. 3). For example, epidemiological catchment area (ECA) studies have shown a prevalence of affective disorders in older adults ranging from 1.5 % to as high as 7% (Gatz and Smyer 1992). Depression rates in older adults have been shown to range from 0.5%–3%, though an estimated 10%–15% of older adults experience symptoms to a degree that diminishes their quality of life (deBeurs et al 2005). Older adults are even greater risk of experiencing psychiatric disorders such as depression if they have a general medical condition (Jeste et al 2005).

While exact prevalence rates may be arguable to date, risk factors for psychopathology in older adults appear cumulative with age. Individuals that have experienced previous episodes of psychopathology may be more vulnerable to development of successive episodes. Furthermore, those that have experienced prior episodes of psychopathology may have had more exposure to factors that could lead to future episodes. Moreover, older adults experience psychological symptoms differently than younger adults. Their symptoms may masquerade as neurologically based cognitive impairment (Blazer 1994; Rummans et al 1997; Jeste et al 2005) and as a result go untreated. At the same time, cognitive impairment secondary to anxiety or mood disorder may significantly impair an individual's independent function and/or ability to complete "functional" activities of daily living. The diagnostic variability in older adults underscores the importance of specialist care in a population that often lacks access to psychological specialists.

In concert with increased risk factors for and barriers to treatment, underutilization of services amongst older adults as a group has been clearly shown (Karlin and Duffy 2004). Differences in symptom constellations between older and younger adults may be one factor exacerbating underutilization amongst older adults. Aside from less typical clinical presentation, a number of other variables contribute to the trend in older adults' underutilization of appropriate services. Unfortunately, and also reflected by low utilization rates with older adults, it is not uncommon for older adults to have variable access to mental health providers. Fewer or compromised resources, cumulative effects of developmental and psychopathological risk factors associated with aging, and underutilization of psychological health resources may increase frequency of presentation for medical health problems, detract from independence, further compromise quality of life, and result in inappropriate healthcare resource utilization. Underutilization of mental health services can also result

in over- or inappropriate/ineffective utilization of emergency departments and other medical services (Karlin and Duffy 2004). Additionally, it has been suggested that older adults have relied on general hospitals for mental health care due to systemic incentive for inpatient treatment, and not to see a mental health professional (Gatz and Smyer 1992). Other factors compounding underutilization amongst older adults include stigma, cohort effects, and financial limitations, including unequal Medicare and insurance coverage for psychiatric diagnoses as compared with medical diagnoses.

Another significant barrier to care for elderly patients is geographical limitation. The use of the telephone as the primary modality for ongoing psychotherapy has increased over the years as an effective method to address the problem of geographical location. Shields (2001) discovered that over half (53.12%) of 800 randomly selected licensed psychologists had used the telephone as a primary method to conduct psychotherapy sessions. While several respondents indicated that they consider face-to-face therapy the preferred mode of treatment, results reflected that older and more experienced therapists initiated and conducted telephone therapy more frequently and with more patients, and rated telephone therapy more highly as a way to meet patients' needs. Situations necessitating telecare most frequently included patient geographic relocation, medical or physical problems, and transportation problems (Shields 2001; Tran 2004).

Teleintervention allows for increased accessibility of specialized care. In addition to serving as a viable method to overcome barriers to treatment, psychotherapy by telephone can be a valuable vehicle to support increase of perceived control and/or sense of mastery, facilitate resolution or remission of psychiatric disorders, prevent symptom relapse, and supplement medical care in general.

Use of telephone interventions at Veterans Affairs Palo Alto spinal cord injury service

Telephone therapy as provided at the Spinal Cord Injury (SCI) Service of the Veterans Affairs Palo Alto Health Care System (VA) has been a method useful to overcoming barriers that would have otherwise left patients without psychological treatment. The population of our outpatient spinal cord injury clinic (N = 470) ranges in age from 18 to 90 years old with a mean age of 59.3. Barriers to treatment we have been able to address via telephone intervention reflect barriers identified in the literature. To begin with, distance of the individual from the service site has frequently had the potential to limit

patients from therapy. Individuals eligible for services from the VA may not live in convenient or functional proximity to a facility that provides psychological services. Given that our population includes both acute and chronic injuries, we see a variable range of functionality that may be impacted by transportation, distance and resources. As a regional specialty care center, we see patients from as far west as Guam, and as far east as Nevada. We have found that some of our patient's home communities lack mental health resources to which we could make referrals. Mobility problems and a general lack of providers with offices accessible to those with a disability have also been barriers to treatment for SCI patients. Functional impairment can be a barrier to managing appointments, and it may also lead to a need to rely on others for transportation. Last, as per aforementioned reasons for older adults' underutilization of psychological services in general (stigma, cohort effect, financial cost) SCI Service therapists have encountered similar themes. Veterans in treatment, as well as those contemplating or indicating potential to benefit from treatment, present barriers such as cohort effects, geography, stigma, and lack of familiarity with resources and/or about what mental health could do for them.

Additional advantages may result as providers begin to use the telephone as a means to address service underutilization. Advantages for the individual and for healthcare payors for example; insurance providers, or, in our case, government, include that: telecare may be less-expensive, may reach patients on an outpatient status as opposed to an inpatient status, and may lead to decreased use of primary and emergency care for psychological problems. Upon treatment with SCI psychology, patients have indicated in varying ways that they too may not have otherwise engaged in psychological services despite finding benefit. Patients have reported not knowing the function or importance of mental health care and that tele-intervention introduced them to mental health services by making psychological treatment possible. Next, some patients have endorsed that they would have otherwise been unable to make weekly appointments. Additionally, engaging in psychotherapy via telephone appeared to be less threatening, and thereby helped patients get past inaccurate and/or stigmatized views of mental healthcare.

Patients have also experienced indirect effects of telephone psychotherapy such as improved relationships with their natural support systems. Phone intervention allowed these patients to get help, yet not feel like they were further burdening their supporters by requiring assistance getting to and from appointments. This alone may contribute to a sense of independence and autonomy.

Our experience with telephone psychotherapy has not been without its limitations. Some patients have appeared to be less invested in psychotherapy, as if they felt their sessions were of a more friendly nature rather than a health care visit when the telephone was the modality. We found that it was necessary to verbally establish expectations and an environment that might be established nonverbally were we face-to-face. For example, we found it helpful to remind individuals of session time and duration, and encourage them to conduct the session from a room in their home that was private, and free of noise and other distraction. Maintaining session structure and regularity also seemed a helpful support of both provider and recipient's investment in the session.

Model at VA Palo Alto health care system

The VA attempts to identify and locate all US military veterans with spinal cord injuries or diseases (SCI/D), regardless of when the injury was acquired. These veterans are referred to regional SCI centers such as ours for annual comprehensive evaluations to prevent and treat SCI/D and complications. Psychological evaluations are an integral part of this process, in addition to being a resource available to patients by referral or request. We have found that incorporation of psychology with a general medical evaluation helps to decrease stigma around psychology and counseling issues, increase familiarity with psychology as a resource, and incorporate the idea that emotional well-being and physical well-being are linked. Annual psychology evaluations help us to identify, understand and address social and functional concerns common to our patients. We are also able to identify veterans' psychological concerns or diagnoses meeting DSM criteria. To our experience, individuals appropriate for treatment with telephone psychotherapy show good initial rapport in person, are motivated for treatment, are not a danger to self or others and are not in crisis, nor likely to be in crisis. After appropriateness of psychotherapy by phone was determined, psychotherapy via phone was conducted by SCI-Psychology clinicians from a private office or examination room on the outpatient unit.

Case illustrations of telephone psychotherapy intervention at Palo Alto VA SCI

Clem

Clem is a veteran in his early sixties with a complex psychiatric history that includes childhood trauma, PTSD related to his experience as an army medic, and polysubstance

abuse. In 1986, Clem acquired incomplete quadriplegia with considerable use of his arms after a driving accident. In 1997 he acquired a systemic infection and lost all use of his arms. Though a large disability payment had allowed him to purchase and move to a ranch where he could care for his frail mother, declining health made it necessary that both Clem and his mother move to nursing homes. In his nursing home, Clem met his wife who was on staff. After dating for some time, they married in 1998 and moved back to his ranch although his mother had died. In 2003, Clem described his wife as the best thing that ever happened to him. He said she was a dedicated caregiver, who refused his offer to pay an attendant because she did not believe anyone else could care for him properly.

In 2005, Clem called the social worker he had met in the hospital two years earlier and told her his wife had spent all of his considerable savings after he insisted that she manage their finances. He said he did not believe she loved him anymore, but that he did not want staff to report his situation to authorities. Clem also accused other people of stealing money and real estate from him. His wife was upset by his accusations and phoned a staff member to request that Clem be admitted to evaluate him for delirium.

Clem met his telephone therapist while hospitalized for stable but unhealing pressure sores and a neuropsychological evaluation. Neuropsychological assessment found Clem clear of cognitive dysfunction. During Clem's hospitalization, his therapist diagnosed major depressive disorder with narcissistic traits. Medical necessity required he stay in bed for all but four hours per week. Clem and his therapist developed close rapport that assured the therapist that they could continue to work together by phone upon discharge. Clem's treatment illustrates how telephone therapy can be integrated with other forms of treatment to provide care for someone who might otherwise need to remain in a hospital.

Rather than delirium, Clem appeared to be struggling with emotional overwhelm which resulted in impulsive, disorganized, ineffective problem-solving, and paranoid ideation. Because he required continued bed rest to heal his skin, telephone therapy using a client-centered approach was initiated along with antidepressant medication. Marital therapy was attempted at a local facility, but his wife refused to return after the initial session, stating she found it too embarrassing to discuss their problems with others. After a few sessions devoted to ways he could begin to repair his relationships with his wife and others, Clem began to talk about his many childhood traumas. He eventually explored the events of his military experience that caused

his PTSD. The telephone therapist worked with Clem's psychiatrist, who offered consultation as well as increasing his antidepressant. The combination resulted in a substantial decrease of his paranoia. Clem's intrusive thoughts became much less traumatic in nature though they would occasionally return. The therapist taught Clem cognitive therapy skills that allowed him to control his remaining thought intrusions.

With treatment, Clem had more energy. He hired people to fix things and improve landscaping around his ranch. He began to appreciate the knowledge his wife was gaining from her new job, and their relationship improved. Unfortunately, as Clem's depression subsided to mild, his paranoia increased. His wife reacted by withdrawing her affection and refused further marriage counseling. Clem continued to participate in weekly client-centered therapy by phone. His symptoms gradually subsided, and after six months, he achieved near-complete remission.

Alan

Alan is a married man in his late fifties who had a potentially terminal co-morbid medical condition that had been operated on with a successful outcome. He, however, experienced residual difficulties after the procedure. Alan was diagnosed with depression during an annual examination with the SCI Service. Alan faced significant geographic barriers to treatment and was therefore unable to see a therapist for weekly psychotherapy. Mood episodes and interpersonal issues were addressed via weekly telephone psychotherapy sessions. Advantages of telephone intervention in this case included psychotherapy process advantages that may have otherwise been absent. Telephone psychotherapy required that Alan engage in dialogue about his depression, whereas in person he brought his wife with him and appeared to prefer that his she speak on his behalf. The long distance from Alan's home that made weekly sessions too difficult to do in person allowed consistency of contact when conducted by phone.

Although Allen's wife appeared firmly committed to their relationship, Allen maintained fear that she would leave him due to his disability in spite of over twenty years of marriage. Allen tested the therapist's willingness to abandon him by repeatedly ending the telephone sessions early saying he had nothing to talk about. The therapist's demonstrated loyalty after these truncated sessions eventually allowed Allen to feel safe enough to examine his cognitive distortions about his wife. Moreover, psychotherapy by phone averted reliance on a significant other for transportation, and promoted

one-to-one interaction that would in turn assist the patient with relationships and his own self-concept.

Limitations of telephone therapy

Therapy via phone is not without its limitations. We have found that working with individuals in environments outside the therapist's control can entail treatment interferences. For example, some individuals have appeared to take the appointment time less seriously. Keeping session lengths and times consistent can be more difficult if telecare is viewed differently than a visit to a clinic. Next, as Haas and colleagues (1996) described, while the telephone has recently been promoted as a method for service delivery, drawbacks to the method can include increased difficulty of providing for patient safety in crisis situations, increased risk to privacy, and many remaining questions about long-term cost efficiency. Balas and colleagues (1997) reported that a study of the medical care of elderly persons did not show significant and/or beneficial difference compared to the protocol control group. Moreover, it is noted that questions have been raised about the degree to which effective treatment in the best interest of the individual can be carried out without direct experience of the other person in the encounter, and without a specifically designated and designed location (Haas et al 1996).

In addition to some of the limitations of providing psychotherapy via telephone, other issues that psychotherapists may need to give special awareness and attention to include: professional liability for an individual's safety, provision of psychotherapy to an individual residing in a state other than that in which the psychotherapist is licensed, and confidentiality. First, it is important to emphasize that providers take a great degree of care and caution when considering provision of therapy by phone, and which individuals may be appropriately suited with telephone treatment. Appropriate candidates for telephone intervention are those with whom the clinician has already met in person and with whom a therapeutic rapport was established, and those who have been assessed thoroughly: including for suicidal or homicidal ideation, thoughts of harming oneself or others, and grave psychiatric disability. Next, it is feasible that treatment scenarios arise that are unique to phone therapy provision. For example, an individual might request therapy from a provider in another state. Providers must act in accordance with the regulations of the state in which they are licensed and practicing. Provision of psychotherapy at distances as large as that between states may not be an appropriate treatment approach for many reasons, including but not limited to safety concerns.

Explicit discussion of terms and alternatives for local support and emergency planning are recommended at the onset of the therapeutic alliance. Last, confidentiality in the digital age poses a concern. Confidentiality may be threatened via electronic transmission of information, and possibly via unsecured telephone connections. The issue of confidentiality is recommended as part of a clinician's assessment of whether a particular case is appropriate for telephone intervention. The risks and benefits of psychotherapy by telephone should be considered thoroughly and found to be in an individual's best interest prior to treatment alliance.

Conclusion

Psychotherapy conducted over the telephone offers advantages to patients including increased access to and increased comprehensiveness of care. Telephone therapy is a modality that decreases stigma around psychological treatment, affords treatment to those to which it is geographically otherwise unavailable, and can be combined with other treatment interventions to decrease length of and/or need for inpatient hospitalization. As technology advances and becomes increasingly more accessible to a greater portion of the population, videoconferencing may become a practical option in addition to psychotherapy by telephone. Alternatives to face-to-face psychotherapy include risks and benefits that could be associated with any new modality, and more-so as newer and therefore less-familiar technologies are utilized. On the other hand, individuals who may otherwise have gone without treatment can engage in psychotherapy with appropriate, efficient and effective outcomes.

Older adults as a group underutilize appropriate psychological services, and oftentimes rely instead on hospital and emergency care for psychological intervention. As the field of psychology becomes more attuned to the diagnostic differences and psychological needs of older adults, barriers to treatment can be better addressed. Though there

are limitations to conducting psychotherapy by phone, its advantages may outweigh its disadvantages in many cases.

Disclosure

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