20

The Use of the Telephone in Counseling and Crisis Intervention

David Lester

In the last decade, there has been a tremendous increase in the use of the telephone for counseling people. This development has two main sources. First, the suicide prevention movement, following the opening of the suicide prevention center in Los Angeles in the 1950s, adopted the telephone as the primary instrument because of its accessibility. Any individual in crisis could usually get to a telephone to call for help. The telephone offers a number of other advantages over traditional modes of counseling, particularly the relative anonymity afforded the distressed individual.

The second stimulus to telephone counseling came from the development of poison information centers. Here, the telephone has the assets of immediacy and accessibility. If a person accidentally (or intentionally) ingests some chemical, immediate counseling about antidotes and treatment can be obtained. The telephone serves to transmit information quickly to people.

These two models of immediate counseling, twenty-four hours a day from a trained staff, have been applied to numbers of other areas. The number of centers now operating is easily over 1,000.

THE USE OF THE TELEPHONE IN COMMUNITY SERVICES

It is useful to review, briefly, some uses to which the telephone has been put as an instrument of counseling and advising.

This paper contains elaborated and updated ideas discussed by the author in previous publications (Lester, 1974a, 1974b; Lester and Brockopp, 1973).

1. *Suicide prevention*. The telephone has been the major treatment medium of suicide prevention centers. In many centers, counseling by telephone only is offered.

2. *Crisis intervention*. Many suicide prevention centers soon found they were being asked to help in all kinds of crises, not just suicidal crises, so some centers changed their orientations toward more general crisis intervention.

3. *Teen hotlines*. Telephone counseling services soon became directed toward particular groups of the population, most commonly teenagers. The teen hotline functions similarly to a crisis intervention center, except that the problems it handles differ. Many teen hotlines do not attempt to provide twenty-four-hour service but are open for counseling late afternoons and evenings.

4. *Services for the elderly*. Another population selected for special concern is the elderly. Boston's Rescue, Inc., runs a service for senior citizens where a call is placed every day to each member. This protects the members in case of illness or emergency. If the call is unanswered, a volunteer visits the person's home. The calls are made by senior citizens, so social contacts are initiated and renewed in the process of maintaining the service. In Boston the service is free. New York City's service, financed by fees from participating senior citizens, differs from the Boston service because it restricts the socializing aspects. New York City limits calls to roughly a minute and serves a mainly protective function in case of illness.

5. *Services for individuals with particular needs and problems*. For example, Boston's Rescue, Inc., started a special telephone counseling service for homosexuals, with supporting clinic service. Services now exist for abortion counseling, victims of rape, parents who have a history of abusing their children, and so on.

6. *Services of a more general nature*. Buffalo's Suicide Prevention and Crisis Service opened a "problem in living" service to encourage people to call with any kind of problem.

7. *Drug hotlines*. These provide information about drugs and their effects, plus counseling to those involved with drugs. They not only provide general counseling but also help individuals currently on "bad trips" or in states of acute panic.

8. *Poison centers*. Poison control centers provide immediate counseling on treatment procedures. Although these centers

were generally originated by pediatricians to aid in treating children who ingest poisons, the focus has shifted. It has become increasingly obvious that in many cases of "accidental" poisoning, self-destructive tendencies are at work. As a result, the suicide prevention centers and drug hotline services must work closely with the poison control centers to facilitate treatment.

9. *Rumor control centers*. These services were primarily motivated by the riots of the 1960s and the need to quiet the rumors accompanying such social upheavals. Now they have extended their information-giving service to other areas of community concern.

10. *Community problems*. A recent development has been cooperation between radio stations and community groups. In Call For Action, originated by WMCA in New York City, trained counselors tried to help listeners with specific problems: garbage removal, rat and pest control, low-standard housing, voter registration, consumer fraud, traffic safety, pollution, taxes, etc. Stations have occasionally focused upon specific problems: WMCA in New York focused on housing, WWDC in Washington, D. C., on garbage removal.

11. *Counseling*. Last year, Dr. Lloyd Moglen, a psychiatrist, started a program on radio station KQED in San Francisco, where listeners call in with problems. Dr. Moglen counsels them while the conversations are broadcast. His program differs from most radio call-in programs because his aim is counseling.

12. *Minimal services*. Finally, there is a growing number of minimal services which are nonetheless related to the above: the Dial-A-Prayer service, Wake-Up Services, etc.

The telephone plays a central and important part in a large range of services and has proven particularly suitable to the goals of these services. If there is a community need, a relatively cheap telephone counseling service can be set up in a short period of time. The service provided, once advertised, is available to everyone, because most people have a telephone or easy access to one. When the community no longer needs the service, it can be easily dismantled.

The proliferation of such services raises some serious issues. Is it better to have many separate services, or are they better localized in one agency? Can quality control be assured when many unlicensed, uninspected services exist? One central agency, with trained and supervised staff, would provide better quality counseling. Yet would victims of rape, for example, call a general counseling service? Doesn't the provision of a special service, directed toward those victims and manned by sympathetic counselors, who are themselves perhaps victims of rape, facilitate use of the service?

One possible solution is to have separate telephone numbers and individual advertising campaigns, but situating the lines in the same agency. The Suicide Prevention and Crisis Service in Buffalo, at one point, had its counselors answer four different services, each with its own telephone number and advertising program (a suicide prevention service, teen hotline, problems in living service, and drug hotline). In this case, however, it proved difficult to have counselors switch from service to service quickly, turning from a seriously depressed elderly citizen considering suicide to a shy teenager who did not know how to ask out the girl who sits near him in class. Perhaps it is most sensible to coordinate services (and if possible, locate them together) but have separate groups of counselors for each service.

A second issue regarding the proliferation of telephone counseling services is whether any counselor can counsel any caller. Must a counselor be homosexual to counsel homosexuals, a rape victim or female to counsel rape victims, a teenager to counsel teenagers? Or can any competent, trained counselor handle any client and any problem? There are no pertinent empirical data here and opinions differ. Usually, however, when community needs arise, specific interest groups initiate the service, which results in like counseling like.

THE TELEPHONE IN PSYCHOTHERAPY

The telephone, in increasing ways, is used by qualified professionals engaged in individual face-to-face psychotherapy. For example, Robertiello (1972) reported two cases of psychoanalysis in which a patient who was temporarily unable to visit the psychoanalyst's office (due to travel and illness) continued the sessions by telephone. He reported that the telephone made no difference in one case (where much of the psychoanalysis consisted of discussion of the patient's dreams) and actually helped

in the second. In the latter case, transference had been so disruptive that the patient could not stand being in the same room with the analyst. Her emotions interfered with integration of insights into her ego. The telephone sessions enabled her to experience the emotions and also reflect upon the transference.

Beebe (1968) reported on use of the telephone to begin the schizophrenic patient's integration into his family. He regarded the first goal to be the patient's return to involvement in difficult family situations, rather than temporary isolation from them. Physically returning him to his family may be too stressful, but the telephone often provides the right amount of distance. Calling permits contact without closeness, and curbs the fantasies that take over when there is no exchange. In return, the family feels involved and permitted to help undo whatever they have done to the patient.

Beebe reported a case of an acute schizophrenic psychosis in a sailor forced into the service by his parents, who wanted to get rid of him. Early in training he became anxious, confused, and felt he had sinned. At the height of his confusion, he believed he had killed his mother. The call home was a great relief to him, and he became quite lucid and free of psychosis.

Owens (1970), a dentist, demonstrated the effectiveness of inducing hypnosis by telephone, when he called a number of his previous hypnosis patients and used a standard induction procedure to cause a mild state of hypnosis. In all cases, he was successful. He also had success with two patients he had not previously hypnotized. Owens' intent was to explore whether hypnotic states could be induced by telephone, but because his patients reported feelings of relaxation and reduction in dental pain after hypnotic induction, the procedure may have some utility.

The telephone has been used to follow up discharged alcoholics (Catanzaro and Green, 1970), to speed up consultation between patient and counselor, and to permit case supervision for counselors by their supervisors (Wolf et al., 1969). Chiles (1974) used telephone contact to reinforce behavior modification procedures with patients. Each day a call lasting a few minutes is made so the patients can report briefly on aspects of their behavior, such as eating, consumption of alcohol, hostile behavior with relatives, etc. Telephone contact, by maintaining the behavior modification program and reinforcing the patient's self-image, facilitates continuing the behavior modification regimen.

Miller (1973) surveyed a number of psychiatrists and found out that 97 percent used the telephone for handling emergencies, 45 percent used it as an adjunct to face-to-face psychotherapy, and 19 percent used it as the primary mode of treatment. The psychiatrists differed in how easy they found the telephone to be as a mode of communication. It is important, Miller noted, for psychotherapists to know their own reaction to the mode of counseling, the reaction of patients, and the suitability of particular problems to the mode. Miller also noted that generally depression was most difficult to treat by the telephone, while anxiety was comparatively easy.

THE UNIQUE CHARACTERISTICS OF TELEPHONE COUNSELING

As experience with telephone counseling and psychotherapy has grown, it has become apparent that such counseling has unique characteristics not shared by other modes of counseling.

Client Control

When a client walks into a counselor's office, the counselor has most of the power. There may be a receptionist to receive the client, and once past that the client faces a counselor who usually sits behind a desk. Perhaps a difference in status is reflected in the counselor's dress, or in the difference between the luxury of the counselor's office and the client's home. The client cannot remain anonymous; even if giving a false name, the client can be recognized again and is often required to give personal information while the counselor, of course, is not. Further, it is difficult to terminate the contact because the client must stand up and leave the office, allowing the counselor time to intercede and discourage the client's departure. As Williams and Douds (1973) have stated, it is very easy for a face-to-face counseling contact to provoke anxiety and humiliation for a client.

With telephone contact, in contrast, the client has much more control, because he can remain anonymous. He need give no information about himself, and he remains unseen. (Even if a counselor could obtain permission from the telephone company

to trace the call, this process can take over an hour and a public telephone could have been used.) The client can terminate the contact quite easily by hanging up. (This method of abrupt termination is often the most immediate, effective comment on a counselor's performance.)

This equalization of power was arranged in face-to-face psychotherapy by Nathan et al. (1968). Nathan arranged for client and psychotherapist to sit in different rooms, communicating only by closed circuit television. To see and hear the counselor, the client must repeatedly press a button (at a high rate of 120 times per minute) to maintain maximum volume and clarity of picture. To blot out the counselor the client decreases the rate of button pressing, causing the television picture and sound to fade; the counselor has similar control.

This equalization of control often produces anxiety in the counselor, but it has a facilitative effect for the client. The client who is anxious, feels threatened, or is reluctant to walk into a counselor's office, may be willing to call the counselor. On the telephone, the client maintains a feeling of freedom and a sense that he cannot be hurt or victimized.

This equalization of power is useful for clients in crisis calling a counselor for the first time and for patients in psychotherapy. MacKinnon and Michaels (1970) reported a phobic housewife who revealed disturbing thoughts about her psychotherapist when a snowstorm that prevented her office visit forced her to call him by telephone. She subsequently sought a telephone session when difficult material emerged again.

Client Anonymity

The client can remain anonymous when talking to a counselor via the telephone, and the possibility of anonymity encourages greater self-revelation and openness. Anonymity minimizes the feeling of possible ridicule, abuse, censure, or hurt because of the counselor's evaluations. The effect of anonymity is an example of the common sociological observation that it is easier to discuss problems with strangers than with acquaintances.

Positive Transference

The counselor can also remain anonymous. In face-to-face counseling, any client fantasy about the counselor is checked against

reality, and it is likely that the counselor may not live up to the fantasy. A distressed individual may not be able to tolerate this shattering of illusions. Those illusions may give him enough security to make the contact for counseling. The telephone counselor may also fail to live up to the client's fantasy, but since the client is presented with only a voice, the counselor will be more similar to the client's ideal than in a face-to-face contact. If the client can make of the counselor what he *will*, he may also be able to make of the counselor what he *needs* (Williams, 1971). This may enable the client to move out of his distressed state.

Of course, there are dangers in allowing a client to dwell too long in a world of fantasy. Situations can easily occur where the development of fantasy works to the disadvantage of the client (and of the counselor). The client must then be forced to face reality. However, a skilled counselor can use positive transference to help the client move to a stronger psychological state and then subsequently move to a realistic acceptance of what is happening in the counseling process.

Reduced Dependency

The counselor's anonymity has an additional advantage for clinics employing a number of counselors. In these clinics, counselors usually use a first or assumed name only. The counselors are told to discourage clients' dependency upon particular counselors. Thus, the client become dependent upon the *clinic*, not the *counselor*: if a counselor leaves, temporarily or permanently, the client is less upset than when dependency has been directed to one counselor. This helps suicidal clients, who often respond to a therapists's vacation or absence by attempting suicide.

Accessibility

Most people have low-cost access to a telephone, and this is critical for clients in crisis (especially in suicidal or homicidal crisis), the elderly, and the infirm. Many are bedridden or too weak or senile to visit a counselor for face-to-face psychotherapy. For such people, the telephone is often the only source of counseling.

MacKinnon and Michaels (1970) noted this advantage with cases from a private psychotherapy service. Psychotherapy was maintained, in one case, with a female client twice weekly

while she went to Nevada to obtain a divorce. Another female client was treated for three months while bedridden on her obstetrician's orders.

Immediacy

Because there is an immediacy to the telephone, many clinics maintain twenty-four-hour counseling services so that distressed individuals can locate a counselor quickly. Psychotherapists refer patients to such services at night, on the weekend, and while they are on vacation. It is helpful if the psychotherapist formulates a treatment plan with the agency for patients in these situations.

Miller (1973) has noted five properties of the telephone for use in counseling that overlap with those discussed above. Its "spatial property" breaks down barriers between the counselor's office and client, corresponding to the accessibility noted above. It permits a more distant relationship than in face-to-face counseling, but one which is quite intimate because the patient's voice is close to the counselor's ear and vice versa.

Its "temporal property" means that the counselor may be called at any time (although, of course, he may bar complete accessibility by having an unlisted number or by disconnecting his telephone). The patient is not limited to counseling sessions for contact with the counselor.

A third property is that it is single-channeled, carrying audio communication only. This allows greater freedom for client fantasy.

Its fourth property is being a "machine," a concrete and rather impersonal object to relate to and through. However, recent studies indicate that patients do not find that it is excessively impersonal for a computer to administer psychiatric intake interviews. In fact, many patients preferred to have a computer, rather than a human, interview them (Greist et al., 1973). So the telephone's being a "machine" may not necessarily make the patient uncomfortable. The fifth property of the telephone noted by Miller is that it is dyadic. Most conversations are between two people and telephone contacts are more often dyadic than are face-to-face contacts.

Miller explored the effects of these properties on the telephone's characteristic uses. The spatial property appeals to patients with oral and dependency needs who can reassure themselves that support is at hand. Ambivalent patients (such as some schizophrenics) may use the telephone to maintain distance and control in the therapeutic relationship. Hostile patients may be able to express their emotions because they feel safer doing so at a distance. The spatial property often makes the counselor feel that he has less control over the counseling relationship and is more vulnerable to unreasonable demands on his time. (Miller noted that in some circumstances it might be appropriate to charge patients for telephone contacts.)

The temporal property appeals to impulsive patients who cannot tolerate anxiety. The psychotherapist often experiences anger with these patients, and Miller suggested that he set firm limits on how much use of the telephone he will accept.

The single-channel property appeals to patients who want anonymity to protect themselves from the psychotherapist. They do not distrust the psychotherapist; they may be merely exploring the possibility of psychotherapy, or they may find it less embarrassing, anxiety provoking, or shameful to discuss problems over the telephone. The lack of visual cues may distress psychotherapists who utilize nonverbal communication. It may impede effective patient evaluation or induce misleading fantasies on the part of the psychotherapist.

The mechanical property of the telephone may appeal to obsessive neurotics and schizophrenics. On the other hand, Miller felt that counselors dislike its impersonal quality. He felt that the dyadic property appealed to those wishing to exclude others from communication with a psychotherapist, but face-to-face psychotherapy is no different in this respect.

Miller noted that the psychotherapist can make active use of the telephone. He can use it to support insecure and unstable patients between regular psychotherapy sessions. He can instruct impulsive patients to call whenever they feel that they might act upon their impulses, and he can instruct patients who block in psychotherapy to call when they recall a blocked thought. He can utilize the telephone for patients who have difficulty talking about particular issues face-to-face. He can also use the telephone to contact significant others to bring them

into the treatment process or to evaluate the patient more accurately.

PROBLEMS ASSOCIATED WITH TELEPHONE COUNSELING

Along with the advantages of telephone counseling, several disadvantages and dangers exist. Although it may be useful for the client to be able to fantasize about the counselor, the reverse is never useful. There are, however, eventual dangers in the client's fantasies about the counselor. At some point during the counseling process, these fantasies must be brought out, examined, and adjusted to reality.

Brockopp (1970) noted that counselors can easily slip into conversation with clients rather than remain in a psychotherapeutic mode. The telephone is strongly associated with conversation, and the counselor may revert to old habits when using it. The telephone also allows greater distance between client and counselor (such as anonymity) but encourages intimacy. The counselor may be relaxed in a comfortable chair, and the client's voice is close to his ear. This intimacy can facilitate or induce a conversational mode.

This tendency toward conversation is a problem for counselors in clinics that maintain twenty-four-hour counseling services. Occasionally a counselor will work alone at night. (It is a poor practice to sleep between calls, for the counselor may resent being awakened by a client in crisis.) A counselor who is awake and alone can come to welcome calls from clients, since such calls help to pass the time. Under these conditions a counselor may seek to prolong conversations with clients because he has nothing else to do, and counseling will often degenerate into "conversation."

If "conversation" develops, the psychotherapeutic process is minimized, distorted, or eliminated, the counselor's objectivity is reduced, confrontation is less likely, the client's anxiety may be reduced to such an extent that he no longer feels a need to work on his problem, and it develops the false assumption that psychotherapy is taking place.

PROBLEMS WITH TELEPHONE COUNSELING SERVICES

Not all telephone counseling problems can be blamed on the medium. Many agencies providing telephone counseling use nonprofessionals: college students, preprofessionals, housewives, persons who have personally been through crises. It is the personnel rather than the telephone that cause problems. Lamb (1970) has discussed some typical problems nonprofessionals have in counseling, such as the common fantasy of omnipotence and its variants: "But all I'm doing is listening!", "If I talk about it, it may happen" (the "power of positive thinking" error), and "But he's manipulating me" (the "who's in charge here?" error).

Although volunteers and nonprofessionals have long been used in mental health (Gruver, 1971), the growth of telephone counseling services has increased their use. A counseling service needs sixty to eighty volunteers to maintain a seven-day twenty-four-hour service in a major city. Usually, most of these counselors are nonprofessionals who have received at most twenty-four hours of training and perhaps an hour of supervision weekly.

This use of nonprofessionals has raised the issue of whether they perform worse, the same, or better than professionals. McGee and Jennings (1973) argue that nonprofessional counselors have higher levels of empathy than professionals, but McCoiskey (1973) argues that if we believe clinical training has any value, it is absurd to believe untrained people perform better than trained people. With rigorous selection, adequate training, and good supervision, some nonprofessionals can do a good job with most clients, but can they handle all kinds of crises and be trusted to behave professionally? The first answer is clearly no, since most services find that they must employ professionals as twenty-four-hour back-up consultants. The second answer is also probably no.

The American Association of Suicidology recently debated the ethics of recording calls without the clients' knowledge; the majority of centers considered it unethical. At a center where I worked, we recorded calls for supervision of the counselor and for research purposes. I have heard a call where the counselor fell asleep while a client was talking and one where a counselor

began a call by laughing at a client who said she felt like killing herself. (Our counselors recorded their own calls, and surprisingly neither of those erased their performances.)

Most centers argue that their counselors do not make these errors, yet most centers do not monitor their counselors by day or night. The regular staff have no idea of what their counselors are up to. Further, nonprofessional telephone counselors, lacking a concept of professional behavior, may easily become emotionally and intimately involved with clients. Sometimes when counselors leave a service, they contact clients who formerly called them at the service, in order to maintain a relationship with the client. The mental health professions have enough problems today with therapists' unethical behavior. The problems with nonprofessionals are much greater.

As a result of such problems, I have advocated that nonprofessional telephone counselors be closely supervised, more closely than other groups of mental health workers (Lester, 1973). Further, I have advocated replacing the hordes of part-time volunteer nonprofessionals by a few full-time, well-paid, highly trained paraprofessionals whose performance can be accurately monitored.

Since telephone counseling services are limited in the service they can provide, it is important to recognize that telephone counseling by itself is not sufficient to provide assistance. Hoff (1973) has discussed the importance of adequate follow-up, including subsequent medical and psychiatric help personally or by telephone and contact with the significant others of the client. Richard and McGee (1973) described the development of an outreach team that has the training and mobility to make home visits. Such a service is a most useful addition to a telephone crisis intervention service.

Crisis intervention can also be traumatic for the counselor. He may well need support, advice, and the opportunity to share responsibility for the client.

PROBLEM CALLERS

Telephone counseling services attract clients who present certain problems less common in face-to-face counseling. The most noteworthy example of "problem callers" is the obscene caller.

Telephone counseling services receive calls from males who wish to talk to a female while masturbating. Particular problems are also raised by the silent caller (who calls but refuses to speak), and the nuisance or prank caller. The management of such problems was discussed by Lester and Brockopp (1973).

I have discussed a caller experienced by most telephone counseling services—the chronic caller (Lester, 1971). These clients call regularly—some call five times a day and spend as much as thirty-five hours a week talking to counselors. Since typical services employ large numbers of counselors, a chronic caller may talk to a different counselor each time. It is difficult for each counselor to report to other counselors on problems and progress with the caller and difficult for full-time staff to design an effective treatment plan. Further, it is difficult to enforce a treatment plan, once it is formulated, if counselors are not supervised. (An excellent and respected counselor at one center refused to limit calls from a chronic caller in the way that the treatment plan recommended. He said to do so was inhumane.)

Clients often gratify counselors' needs that are not necessarily relevant to their function. For example, one female caller to the teen hotline in Buffalo became a chronic caller partly because the male counselors at the center liked talking to this attractive-sounding girl. The sexual gratification for both client and counselors was apparent. The professional staff tried limiting her calls to one counselor and inviting her to the center so that she and the counselors could meet and remove fantasy from the involvement. Several months later, however, the problem had not been solved and the girl was still a chronic caller.

I have focused upon chronic callers because the telephone counseling service itself creates this problem, and the psychological condition of the chronic caller may deteriorate because of dependency upon the service. Perhaps the dependencies were more appropriately distributed prior to involvement with the center, and they are certainly not usefully distributed *after* the development of chronic dependency upon the center. Centers often justify continued involvement with chronic callers by hoping that telephone contact reduces the client's chance of hospitalization in a psychiatric facility. The center sees itself as helping the client to continue to exist in the community, but there is usually no supporting evidence for this. Innovations in

any field, perhaps especially in mental health, often create new problems that we deal with by creating additional services. Providing easily available mental health services may reinforce behavior that is not advantageous to mental health; it may reinforce obsessive preoccupation with our psychological moods and behavioral symptoms, encourage lack of responsibility for unhappy relatives and friends who have problems in living, and label people as "psychiatrically disturbed" and thereby facilitate their introduction into the career of psychiatric patient (Scheff, 1966). Whether mental health services increase the level of mental health or happiness in the community is an open question.

The "chronic caller," therefore, is the kind of problem that should make telephone counseling services examine the rationale for their continued existence and the effectiveness of their treatment programs.

CONTINUED EXISTENCE OF AGENCIES

Brockopp (1973) noted that often agencies become less concerned with their function than with their continued existence. They draw their funds from many sources: state and local government, colleges, churches, hospitals, and voluntary associations. They lose sight of the client and focus on procuring furniture and a larger budget for the next fiscal year. Brockopp urged that all innovative agencies should be set up with the understanding that they will be disbanded in five years, transferring successful experimental programs to other agencies. In this way, the agency would focus on its function rather than its continued existence.

This point is an important consideration for all kinds of agencies, but telephone counseling services merit special attention. Telephone counseling services established in response to temporary community needs face identity crises as community needs change. Should the service continue or disband? Baizerman (1975) discussed this issue for teen hotlines which now handle problems different from those they were forced to deal with. Ten years ago, teenage crises concerned drug highs, runaways, a place to bed down for the night, arrest, military draft counseling, etc. These were "real crises" to the counselors. Today, calls concern loneliness, family conflict, and dating problems. The

"crisis" has gone out of the crisis call. Teen counselors now wonder why they are counseling, whom they should serve, what they should do. The services seem to have lost their purpose. Some argue that the services should close their doors and disconnect their telephones; others are searching for new purposes.

THE RESEARCH STIMULUS OF TELEPHONE COUNSELING SERVICES

The development of telephone counseling services has stimulated a good deal of research in a variety of areas.

The suicide prevention movement in the 1950s saw the need for a decision model for counselors to estimate the probability that a client would kill himself. Simple scales were developed to predict suicidal risk (Lester, 1970). There are a number of other behaviors for which simple prediction scales would be useful. For example, perhaps we could predict whether an individual was likely to assault or murder others. Without the stimulus of counseling agencies to deal specifically with assaultive behavior, however, the construction of such predictive scales has been slow.

A number of reports have appeared concerning the selection of telephone counselors (Lester and Williams, 1971; Tapp and Spanier, 1973) and the particular personality traits that characterize such volunteers. A good deal of work has also been done on evaluating the effectiveness of telephone counseling services and their counselors (Lester, 1972; McDonough, 1975).

Telephone services provide a convenient setting for research on the effectiveness of counseling, but the formulation of objective criteria determining whether clients have been helped has proved difficult. How can we measure psychological improvement? In telephone counseling services, we can often find objective but limited criteria—for example, whether the client accepted the suggested referral for a face-to-face psychotherapy session (Slaikeu et al., 1973; Buchta et al., 1973).

Because telephone calls can be recorded, it is easy to simulate calls with an actor playing a patient with a particular problem. The call is recorded and later examined to see whether the telephone counselor functioned adequately (e.g., Bleach and Clai-

born, 1974). Most telephone counseling services use a crisis counseling model, so it is easy to listen to calls and rate counselors for technical effectiveness in following guidelines for handling crises (Fowler and McGee, 1973). Judges can also rate the empathy and genuineness that telephone counselors are supposed to show (Carothers and Inslee, 1974).

It is probably true that telephone counseling services have been more aware of the importance of evaluating their effectiveness than have other mental health agencies.

CONCLUSION

The telephone provides an important tool for the counselor in helping his clients. Because of the telephone's qualities, some clients use it exclusively, and many other clients use it at some point in their counseling. It poses problems for the counselor, but adequate training and experience should enable the counselor to employ the telephone effectively.

Telephone counseling services have been an important influence in the treatment of psychological problems. The services fulfilled community needs and have stimulated much discussion about the role and purpose of mental health agencies. The services have also stimulated a good deal of research on the selection, training, and evaluation of counselors. In many respects, therefore, telephone counseling services have had a welcome catalytic effect on the thinking of mental health professionals.

REFERENCES

Baizerman, L. 1975. Changing crises. *Crisis intervention* 6 (2), 45–51.

Beebe, J. 1968. Allowing the patient to call home. *Psychotherapy* 5, 18–20.

Bleach, G., and Claiborn, W. 1974. Initial evaluation of hot-line telephone crisis centers. *Community Mental Health journal* 10, 387–394.

Brockopp, G. 1970. The telephone call. *Crisis intervention* 2, 73–75.

_____. 1973. An emergency telephone service. In D. Lester and G. Brockopp (eds.), *Crisis intervention and counseling by telephone*. Springfield, Ill.: Thomas, pp. 9–23.

Buchta, R., Wetzel, R., Reich, T., Butler, F., and Fuller, D. 1973. The effect of direct contact with referred crisis center clients on outcome success rates. *Journal of Community Psychology* 1, 395–396.

Carothers, J., and Inslee, L. 1974. Level of empathic understanding offered by volunteer telephone services. *Journal of Counseling Psychology* 21, 274–276.

Catanzaro, R., and Green, W. 1970. WATS Telephone therapy. *American journal of Psychiatry* 126, 1024–1030.

Chiles, J. 1974. A practical therapeutic use of the telephone. *American journal of Psychiatry* 131, 1030–1031.

Fowler, D., and McGee, R. 1973. Assessing the performance of telephone crisis workers. In D. Lester and G. Brockopp (eds.), *Crisis intervention and counseling by telephone*. Springfield, Ill.: Thomas, pp. 287–297.

Greist, J., Gustafson, D., Strauss, F., Rowse, G., Laughren, T., and Chiles, J. 1973. A computer interview for suicide risk prediction. American Association of Suicidology, Houston.

Gruver, G. 1971. College students as therapeutic agents. *Psychological Bulletin* 76, 111–127.

Hoff, L. 1973. Beyond the telephone contact. In D. Lester and G. Brockopp (eds.), *Crisis intervention and counseling by telephone*. Springfield, Ill.: Thomas, pp. 132–148.

Lamb, C. Telephone therapy. 1970. *Voices* 5 (4), 42–46.

Lester, D. 1970. Attempts to predict suicidal risk using psychological tests. *Psychological Bulletin* 74, 1–17.

_____. 1971. The chronic caller to a crisis hotline. *Crisis intervention* 3, 62–65.

_____. 1972. The evaluation of telephone counseling services. *Crisis Intervention* 4, 53–60.

_____. 1973. Psychologists/community crisis services. *Newsletter, Division 31*, 5 (2), 3.

_____. 1974a. The unique qualities of telephone therapy. *Psychotherapy* 11, 219–221.

_____. 1974b. Recent trends in telephone counseling. *Crisis intervention* 5 (2), 8–15. (b)

Lester, D., and Brockopp, G. (eds.). 1973. *Crisis intervention and counseling by telephone*. Springfield, Ill.: Thomas.

Lester, D., and Williams, T. 1971. The volunteer in suicide prevention. *Crisis Intervention* 3, 87–91.

MacKinnon, R., and Michels, R. 1970. The role of the telephone in the psychiatric interview. *Psychiatry* 33, 82–93.

McColskey, A. 1973. The use of the professional in telephone counseling. In D. Lester and G. Brockopp (eds.), *Crisis intervention and counseling by telephone*. Springfield, Ill.: Thomas, pp. 238–251.

McDonough, J. 1975. The evaluation of hotlines and crisis phone centers. *Crisis Intervention* 6 (2), 2–19.

McGee, R., and Jennings, B. 1973. Ascending to "lower levels." In D. Lester and G. Brockopp (eds.), *Crisis intervention and counseling by telephone*. Springfield, Ill.: Thomas, pp. 223–237.

Miller, J. 1973. The telephone in outpatient psychotherapy. *American Journal of Psychotherapy* 27, 15–26.

Nathan, P., Smith, S., and Rossi, A. 1968. Experimental analysis of a brief psychotherapeutic encounter. *American Journal of Orthopsychiatry* 38, 482–492.

Owens, H. 1970. Hypnosis by phone. *American Journal of Clinical Hypnosis* 13, 57–60.

Richard, W., and McGee, R. 1973. Care team. In D. Lester and G. Brockopp (eds.), *Crisis intervention and counseling by telephone*. Springfield, Ill.: Thomas, pp. 149–154.

Robertiello, R. 1973. Telephone sessions. *Psychoanalytic Review* 59, 633–634.

Scheff, T. 1966. *Being mentally ill*. Chicago: Aldine.

Slaikeu, K., Lester, D., and Tulkin, S. 1973. Show versus no-show. *Journal of Consulting and Clinical Psychology* 40, 481–486.

Tapp, J., and Spanier, D. 1973. Personal characteristics of volunteer phone counselors. *Journal of Consulting and Clinical Psychology* 41, 245–250.

Williams, T. 1971. Telephone therapy. *Crisis Intervention* 3, 39–42.

Williams, T., and Douds, J. 1973. The unique contribution of telephone therapy. In D. Lester and G. Brockopp (eds.), *Crisis intervention and counseling by telephone*. Springfield, Ill.: Thomas, pp. 80–88.

Wolf, A., Schwartz, E., McCarty, G., and Goldberg, I. 1969. Training in psychoanalysis in groups without face-to-face contact. *American Journal of Psychotherapy* 23, 488–494.