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"Don't call us, we'll call you" : the cell phone and the therapeutic relationship

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Cell Phones and the Therapeutic
Relationship

ABSTRACT

This qualitative study examines the impact of both clinician and client use of cell phone on the therapeutic relationship. Eighteen one-hour interviews were held with clinicians who either used cell phones as tools in their therapy practice or who had clients who used them. Different ways in which clinicians used cell phones as interventions and tools in therapy as well as the varied ways in which clients brought cell phones into therapy to discuss their own lives were examined. Open-ended questions included: affects on the real relationship, the working alliance, countertransference experience, talking on the phone, phone coaching, text messaging, emailing, social media websites, and mental health applications. The findings of this research revealed that clinicians felt that the use of cell phone strengthened the working alliance as well as the real relationship and rapport. However, they expressed many caveats. Additionally, the clinicians reported having negative, neutral and positive countertransference experiences.

"DON'T CALL US, WE'LL CALL YOU": CELL PHONES AND THE THERAPEUTIC

RELATIONSHIP

A project based upon an independent investigation,
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CHAPTER I

Introduction

The purpose of the present study is to examine and explore how both clinician and client use of cell phone technology in therapy affects the therapeutic relationship. The researcher interviewed 18 clinicians about their experiences with cell phone technology in therapy. Major themes include: how clinicians are using cell phones as therapeutic interventions, how clients are bringing cell phone technology into the therapeutic work and how these changes affect the relationship between therapist and client if at all.

April 3rd, 1973 marks the date of the first cell phone call ever made. Martin Cooper successfully completed a mobile phone call from a street corner in Manhattan. The cell phone he used weighed around two and half pounds and cost $3,900 at the time. Motorola released mobile cell phones for public consumption ten years later (Njak, Chenda, 2013).

Long before Martin Cooper and Motorola's first cell phone, people have been trying to communicate with each other using mobile devices. There are many examples of early predecessors of the cell phone. Germany toyed with mobile communication through radio technology in their train systems. Reginald Fessenden of Canada transmitted radio speech from ships to shoreline locations. World War II brought with it a surge of communication inventions. As a result, mobile phones that were attached to and operated through cars became available in

the 1940s. As mentioned above, cell phones entered the public market in the 1983. At this time they were almost as large as a brief case. In the 1990s the cell phone became smaller and more accessible to a greater number people. Additionally, with the invention of the Internet the Smartphone became possible. The first Smartphone, which combines computing technology with telephone technology, was marketed in 1993 (Lenhart, A., Ling, R., Campbell, S. & Purcell, K., April, 20, 2010).

Up until recently the mobile cell phone was a luxury invention that very few could afford. However, in the 21st century U.S., the cell phone and even the Smartphone have become integral parts of daily life. People use their cell phones for a vast array of activities: to stay in touch with friends and family, to carry out professional functions, for emergencies, to communicate, to read the news, to read their emails, to play games and to relax. Most people bring their cell phones everywhere with them and feel a very real attachment to them. In fact, studies have shown that in some cultures the cell phone is viewed as an extension of the self as well as a "transitional object" when in the absence of loved ones (Ito, Daisuke & Matuda, 2005 & Turkle, 2007).

Cell phones have changed the way we relate to one another. All of one's professional, personal and social networks are at one's fingertips at all moments of the day. The expectation that a friend will be available to one at any time has increased. Distances between people can feel much closer. Instant and constant social connection through a cell phone has become an expectation. Additionally, new information is instantaneously accessible and easily exchanged. With the Internet on our phones we can explore any new field of knowledge, check the news or stay updated on the best local restaurants. This has greatly changed how we see the world. Everything has become accessible. We are becoming used to having instant access to our best

friends, the best places to shop or eat, the best new articles, the best new videos or YouTube clips. We are becoming used to having everything and everyone being immediately reachable.

The therapeutic relationship reflects the social relationships of the current culture. As people increasingly socialize and interact over social media and technological means, the therapy relationship, too, will be influenced and shaped. As clients become accustomed to communicating using cell phones in their social and professional lives, they want cell phones to be a part of therapy too. Clients initiate much of the cell phone technology use. Many therapists feel that clients "expect" to text with their therapists for scheduling purposes and insist that the cell phone be a part of the therapy relationship. Clients are also bringing in social media cites such as Facebook as well as text conversation histories. They are using the data on their cell phones to share their lives, their experiences and their hardships with their therapists. However, the client is not the only one bringing cell phone technology into the room. Therapists have begun to integrate cell phone technology into therapy for their own scheduling convenience, to increase treatment compliance and to aid in coaching their clients between sessions. For example, therapists are prescribing cell phone applications about mental health in order for their clients to track daily symptoms and to increase implementation of life skills.

To date, very little research has been done on cell phone use and the therapeutic relationship. Some research has been done on how therapy is affected when conducted via a multitude of technological mediums. For example, it is has been verified that a therapeutic alliance can form when therapy is conducted over the phone, over text as well as via Skype and Videoconferencing. Additionally, many studies have demonstrated various ways clinicians are already using cell phones and other forms of technology in session. For example, clinicians prescribe mental health applications or text their clients about scheduling. This study aims to

give additional information about the clinician's experience of the therapeutic relationship when cell phone technology enters the work.

While there has been some research done on technology and therapy, it mainly focuses on other technologies, such as Skype and Videoconferencing, and not on cell phones. Additionally, very little research has explored how clinicians are already using cell phone technology or how their clients introduce it into the work. Finally, most of the research centers on the therapeutic alliance, which is just one aspect of the therapeutic relationship. This study aspires to fill in some of these gaps.

This research practice is relevant to social work practice because it focuses on how technology trends affect therapy. This paper will provide beginning insight as to how to use technology, specifically cell phones, in the therapy room. Additionally, it will shed initial light upon potential benefits about or cautions against how it might affect the therapeutic relationship.

This study necessitates formal definitions of the use of cell phone technology and the therapeutic relationship. The use of cell phone technology is defined as the use of a cell phone by either client or therapist as a tool for therapy both during and outside the session. The therapeutic relationship is defined as consisting of the working alliance, transference/countertransference and the real relationship, all of which are interdependent (Bordin, 1979). The working alliance is defined as the capacity of the therapist and client to negotiate and achieve agreed upon goals within the therapy relationship in order "of achieving a posttherapy state that is better than the pretherapy state" (Lui & Pope-Davis, 154). The real relationship is the literal relationship and connection between the therapist and client that is unaffected by transference and countertransference. Finally, transference is defined as the clients reactions to the therapist as well as repetitions of past relationships dynamics with the therapist within therapy.

Countertransference is defined as the therapist's reactions to the client as well as the experiences

and biases the therapist may bring with them (Lui & Pope-Davis, 2005).

CHAPTER II

Literature Review

This study explores how the use of cell phone technology in therapy affects the therapeutic relationship. This chapter discusses the literature related to trends in cell phone use, the emerging field of telemental health and how telemental health has affected the therapeutic work. In order to thoroughly address these topics the chapter is divided into the following sections. First, basic demographic facts about who uses cell phones and for what purposes are addressed. Second, the quality of social relationships conducted via cell phones and social media websites is explored. Third, telemental health's influence on the therapeutic relationship is explored followed by how the cell phone is affecting therapy in the fourth section. Fifth, current research on clinician attitudes towards technology in the therapy room is addressed. Finally, a brief summary of therapeutic theory to frame the study's findings is presented.

Therapists are increasingly using cell phones to text, to prescribe client use of mental health applications, to email, and to do in vivo skills coaching over the phone. Clients are increasingly using cell phones to get in touch with their therapists and to share what is going on in their lives through text message histories, dating websites and photos. Surely, these new additions to therapy have an impact on the relationship therapists have with their clients and vice versa. This study hopes to provide an initial investigation into this relationship.

Cell Phone Use

The Pew Internet and American Life Project have done extensive research on who uses cell phones and what for. Their research has found that 91% of adults own cell phones and 56% of cell phone owners have Smartphones (Brenner, 2013). There is very little difference in cell phone ownership in terms of gender and race or ethnicity. The largest predictor of cell phone ownership is age and socioeconomic status. Adults over 65 are less likely to own a cell phone with ownership reaching about 76% in this age group. In addition, people who have an educational level that is less than a high school degree and/or earn less than $30,000 per year are less likely to own cell phones; eighty-three to eighty-six percent of people in this group are cell phone owners (Lee Rainie, 2013).

Additionally, fewer teens own cell phones than adults. Older teens are much more likely to own cell phones with 83% of 17 year olds as owners, 58% of 12 year olds and 73% of 13 year olds. As is true for adults, gender and race or ethnicity play no significant role in likelihood of cell phone ownership. And like adults, socioeconomic status plays the most significant role in cell phone ownership; only 59% of teens from families that make $30,000 or less annually own cell phones compared with about 75% of teens from wealthier families. It is important to note that socioeconomic status and race are highly correlated. Therefore while the study does not report a significant racial difference in cell phone status there is a noticeable one; seventy-eight percent of White teens own a cell phone, while only 68% of Latino teens do (Lenhart, Ling, Campbell, & Purcell, 2010). While there are some demographic differences in cell phone ownership, there is increasing ownership in all demographic groups. In other words, there is an undeniable trend toward cell phone ownership and use in the U.S. today.

The majority of people in the United States are cell phone owners and they use their cell phones for a variety of reasons. Emanuel, R. C. (2013) surveyed 403 college students about the

ways in which they use their cell phones. Eighty-five percent of the students surveyed had a smart phone. The author notes that "college students consider the main purpose of their cell phone is for safety in an emergency followed by connecting with friends, work-related communication, entertainment, and tools/ utility" (Emanuel, 78). Additionally, college students in this survey were using their cell phones when they were bored, when they needed information immediately, to talk with family, and to use various mobile applications. Three quarters of the surveyed college students were using their cell phones during class and felt it was appropriate to use cell phones in stores and eateries, but not in church or in meetings. Due to the ubiquitous nature of cell phone use the author urges teachers to be open to integrating them into educational curriculum as a way to better engage their students. A similar discussion might apply to therapy.

In her article *Smart Phone User Survey: A Glimpse Into the Mobile Lives of College Students* (2013), Jenny Dean examined the news reading behavior of college students who have Smartphones. While this survey only looks at different types of usage on Smartphones in college students, it is still a useful glimpse into how cell phones are often used. College students reported using their Smartphones to read the news, to text, to make calls, to listen to voice mails, to spend idle time, to surf the Internet. Additionally, they reported using their Smartphones while in line, on public transit, and during class. In other words, most people in the U.S. have cell phones and they are using them all the time for a variety of personal and social purposes.

Do Cell Phones Help Us Feel Connected?

The above studies cite that one of the main purposes for cell phone use is feeling connected to others. Along the same lines, people are increasingly engaging with online communities, many of which can be accessed via the cell phone. Studies have shown that people feel they gain social benefits and human connection through these online relationships. If people

can feel connection via the cell phone and online social relationships, then one might conclude that people could feel connected to a therapist over distance or while online as well. Wang, E., & Chen, L. (2012) found that more and more people are joining online communities for many of the same reasons we participate in any community. They surveyed members of various online communities and found that people choose online communities that are in alignment with their own personal values and social norms. In addition, they found that positive online social interactions increased commitment to that online community. In other words, online communities function in very similar ways as ones that are face-to-face.

Cheung, Chui & Lee (2011) explored the motivation to be part of an online community by looking at one specific online, social community. They asked the question: "Why do students use Facebook?" Using quantitative surveys from 182 university students, the authors concluded that they use Facebook to feel like they are participating in joint group action, because it implies human contact, because it is a way to be socially present and to get instant contact with peers and friends. Furthermore, Chung (2013) found that people prefer support from online groups if their offline relationships are not perceived as supportive. In other words, online groups can be a resource for support if support is lacking in a person's face-to-face relationships.

These studies are important to note as many regard these types of communicating as representing the current trend towards disconnection. However, these studies firmly posit that online communities do provide social and emotional support for their members. These communities are a vital way for some to connect. Furthermore, if individuals are able to connect to social communities virtually, they could connect to a therapist this way as well.

In fact, many people turn to online support groups for their mental health issues in addition to general social support. Mo, P. H., & Coulson, N. S. (2013) found that people who are

living with HIV/AIDS and who participated in online support groups had higher levels of optimism and feelings of self-empowerment. They also felt less socially isolated and depressed. These studies are important because they highlight that our social relationships are increasingly being conducted via online mediums. Additionally, they demonstrate that people feel that they are gaining real social, emotional and even mental health support from relationships that are not face-to-face. The cell phone can facilitate the creation and maintenance of these relationships.

There is contradicting evidence as to how helpful online support groups actually are for mental health issues. Ellis, L. A., Campbell, A. J., Sethi, S., & O'Dea, B. M. (2011) compared a group of 39 university students who participated in an online Cognitive Behavioral Therapy program for symptoms of anxiety and depression with those who participated in an online support group for symptoms of anxiety and depression. Results showed symptoms decreased in both groups and that feelings of social support increased for those in the online support group. Even so, the authors insist that more research is needed before the efficacy of online support groups for mental health is confirmed. Griffiths et. al (2012) found that an online support group for depression alone did nothing to alleviate depressive symptoms after a three-month period. In other words, online social-support groups may do much in helping people feel connected and supported, but they may do little therapeutic work or symptom reduction.

Technology in the Therapy Room

As social relationships are increasingly being conducted using technology, it is no surprise that technology is popping up in therapy relationships. Mishna, Bogo, Root, Sawyer & Khoury-Kassabri (2012) argue that technology has "crept into" the therapy room. They note the increasing client trend to contact their therapists via email rather than the traditional phone call. The authors interviewed 15 clinical social workers about their experience with digital

communication with clients. The clinicians identified that email creates more permeable boundaries to treatment as well as presents ethical issues around mandated reporting. In addition, the clinicians noted that email seemed to be a more comfortable medium for some clients to process difficult emotions.

Therapeutic relationships reflect the types of social relationships we have. As our social relationships become progressively online or through the cell phone, the therapy relationship may follow this trend. However, many professionals within the mental health field are skeptical as to whether a therapeutic relationship can form if the client and therapist are not face-to-face. A growing area of research is developing to explore this very question. Much of this research centers on whether a therapeutic alliance can form when using e-therapy or telemental health.

Sucala et. al. (2012) conducted a meta-analysis of studies that look at the therapeutic alliance with e-therapy. In their study and in the present one e-therapy is defined as "a licensed mental health care professional providing mental health services via e-mail, video conferencing, virtual reality technology, chat technology, or any combination of these" (Manhal-Baugus M., 2001). In the 840 studies they reviewed, only 11% examined the impact on the therapeutic relationship. According to client report, the studies showed no significant difference in the quality of therapeutic relationship when e-therapy was conducted instead of face-to-face therapy.

Moreover, many studies have found that a therapeutic alliance can occur in a variety of types of e-therapies and with a variety of mental health issues. For example, Wrzesien, M., et al. (2013) compared the quality of the therapeutic alliance for clients who were treated using In-Vivo Exposure Therapy with clients who were treated using technology-mediated Augmented Reality Exposure Therapy for cockroach and spider phobias. The study found no significant difference in the quality of the therapeutic alliance between the two groups.

Similarly, Chu et. al. (2004) examined various types of technological therapeutic interventions and their effect on both treatment outcomes as well as the therapeutic alliance for with children with anxiety disorders. The study looked at the use of Virtual Reality Exposure, in which the client is exposed to the fear-provoking stimuli via 3-D software instead of in-vivo exposure. Using this technology, clients had positive treatment outcomes and a therapeutic alliance comparable to that of in-vivo therapy. In addition, clients appreciated the increased control during their exposure as well as the intervention's similarity to familiar technologies in their everyday life. Finally, this study also surveyed the effectiveness of computer-based self-help programs and CDs in dealing with child anxiety. Family and client reports attested to the effectiveness of these interventions, neither of which necessitates the involvement of a therapist at all.

Not only are therapists using computer programs in therapy, but they are using Skype and Videoconferencing technology also. Germain, Marchand, Bouchard, Guay, & Drouin (2010) compared the perceived strength of the working alliance in one group given face-to-face therapy with one group given therapy via videoconference for PTSD. The study found that a therapeutic alliance was able to develop in both situations according to both client and therapist report. Thus, many studies confirm that a therapeutic alliance can exist over Videoconferencing or using e-therapy.

In fact, it has been established that an alliance can form even when there is no therapist there at all. Barazzone, N., Cavanagh, K., & Richards, D. (2012) measured the strength of the therapeutic alliance in three different computerized Cognitive Behavioral self-help programs for depression. The authors found that a therapeutic alliance was established, but that there was little

development or maintenance of the alliance or relationship beyond its establishment. This may represent a potential limitation to therapies that are fully computer-based.

As Mishna, Bogo, Root, Sawyer & Khoury-Kassabri (2012) cite, technology seems to be "creeping into" therapy because clients are bringing it in with them in addition to clinicians. Gordon, Zaccario, Sachs, Ufberg & Carlson (2009) provide a helpful case example of how a computer can be used to build rapport, the real relationship and to gather assessment data. These authors present a case study of a physically disabled, adolescent, girl, who used her MySpace, instant messages online and websites of interest to feel comfortable in therapy and to show her therapist about her life. The therapist reported initial hesitation in allowing the client to use the computer in session, but concluded that it increased the client's trust and feelings of closeness to the therapist as well as provided the therapist with important assessment information. This case has limited generalizability because it is a case study, but provides us with a useful example of how clients are bringing technology into therapy and using it as a tool for the work.

Gensler (2011) provides another case study about a client who requested that they conduct therapy via instant message while sitting in the same room. His client, who had come into therapy for dissociative behavior, mood swings and anger, requested that they try sitting across from each other and instant messaging on computers instead of talking. The therapist acknowledges many benefits of using instant messages for her and their relationship. For example, she was more comfortable expressing herself and it allowed her to choose her words more intentionally. The therapist acknowledges that "I had learned her thoughts and that we had done something fun together" (p. 406).

At the same time, the therapist worries that he was "missing the rest of her" i.e. nonverbal cues and her physical presence (p. 407). Regardless of what he have missed, he concludes that it

was this mode of communication that allowed his client to fully use therapy by "invoking feelings while also keeping them at bay in a ways that feel protective of some genuine or authentic experience" (p. 409). In other words, this teen-ager's use of instant messaging enabled her to explore difficult emotions while maintaining her own emotional safety. This may not have been possible in traditional talk therapy and it was this type of communicating that permitted the growth of rapport and alliance between the two parties.

Cell Phones in the Therapy Room

In addition to computer and video based interventions, therapists are already using cell phones in treatment. Many studies confirm that a therapeutic alliance can exist over the phone. Stiles-Shields, C., Kwasny, M. J., Cai, X., & Mohr, D. C. (2014) compared face-to-face Cognitive Behavioral Therapy to Telephone Cognitive Behavioral Therapy and found no difference in client report of the alliance. Additionally, they point out that while the phone takes away visual nonverbal cues, others such as tone of voice are preserved. Therapeutic alliance over phone counseling has been found to exist for child clients as well (Lingely-Pottie & McGarth, 2006; 2008).

Vogel et al. (2012) conducted therapy for OCD using teleconferencing for six sessions and cell phones for nine sessions. The majority of the six participants had about a 50% reduction in their symptoms, which is comparable to the results of face-to-face therapy. Additionally, all of the participants had a reduction in depressive symptoms. This is particularly significant since the management of depressive symptoms has been a source of push back in the discussion of using this technology.

The cell phone has become a central part of our lives. Unsurprisingly, it is increasingly being used in therapy as a way to literally "meet the client where they are at". Burda, C., Haack,

M., Duarte, A. C., & Alemi, F. (2012) provided cell phones to ten homeless people with both substance abuse issues as well as mental health diagnoses. The participants received daily phone calls on a cell phone that was provided for them for 30 days to remind them to take their medication. The study found that they were able to reach their subjects 93% of the time and that medication compliance was reported 100% of the time. Participants also reported that the calls made them feel cared for and allowed for increased social connectedness with their families.

Talking on the phone is not the only way clinicians are using cell phones in therapy they are texting too. Aguilera & Munoz (2011) examined the effect of text messages from therapists to clients during the week. Clients reported that they felt closer to their therapists and their therapeutic group, as well as increased completion of therapy homework and increased completion of goals due to the reminder texts. This study reflects the ability of technology to improve feelings of client closeness (rapport) and the working alliance due to text communication throughout the week.

Cook & Doyle (2002) evaluated the strength of the therapeutic alliance for groups who received therapy via text or online communication. They used the *Working Alliance Inventory,* a questionnaire designed to measure the strength of the working alliance, in order to determine strength of the therapeutic alliance. They found that a strong and effective alliance was able to occur through online mediums and in some cases was more desirable to clients. Some clients found that communicating online or via text removed feelings of shame and perceived judgment that sitting in a room with a therapist might cause.

Another popular utilization of cell phones for both therapists and clients alike are the many new mental health applications. Kiume (2013) compiled a list of the top 10 most popular mental health cell phone applications currently. The top application is called "Bellybio". This is

a free application that helps guide in deep breathing exercises and is targeted toward people who struggle with anxiety. Other examples from the list include: Operation Reach Out, an application to aid those having suicidal thoughts to redirect their thinking and get support, and iSleepEasy, an application with a soothing female voice, music and more to help people sleep. Specific treatment modalities such as CBT and DBT have their own applications as well.

Morris, M. E., & Aguilera, A. (2012) list the increasing types of mobile phone applications that target improved mental health. They point out "Of the 9,000 consumer health apps that are currently available, approximately 6% are categorized as relating to mental health, 11% to stress management, 4% to sleep and 2%, to smoking cessation" (p. 622). In other words, consumers are using their phones in order to track various aspects of their mental health. The authors argue that it would behoove therapists to become familiar with these applications and use them as complimentary interventions. However, the authors point out that there are some practical risks. Clients cannot be guaranteed that their data will be private nor can the tracking of one's mood guarantee the on-call intervention of a therapist when mood is dangerously low.

The authors urge the therapist community to embrace mental health call phone applications. They argue that in our current culture, the cell phone has become an extension of the self. Therefore it is imperative to use the mental health capabilities of the modern cell phone. For them benefits include, reduced stigma surrounding the treatment of mental health issues, increased access to mental health treatment, real-time tracking of mood, which reduce biases of retrospective report, and the potential for mental health applications to act as a partner in the therapy process. They also emphasize the precaution that mental health applications are not private and can create a false sense of intimacy. Nevertheless, it is highlighted that mental health applications should be integrated into therapy for assessment, tracking and treatment outcomes.

Lastly, many clinicians are using emails to communicate with their clients (Cook & Doyle, 2002). Email can be accessed on Smartphones, which most adult U.S. Americans own. In fact, in their study of internet-based self-help treatment of insomnia, Lancee, J., van den Bout, J., Sorbi, M. J., & van Straten, A. (2013) found that sending one supportive email to clients between weekly sessions increased treatment compliance, treatment effectiveness. The effects of this additional support were maintained for six months after treatment.

Zur (2011) complicates the concerns and benefits surrounding email. He notes the convenience of scheduling via email as it eliminates the need for phone tag or long drawn-out messages. At the same time, he notes that clients use email to extend the session by emailing their reactions to the content of the session or to inform their clinician of a dream or event throughout the week. The author notes that these emails can be very long and time-consuming to read. This can complicate matters for the therapist in terms of billing, how to spend their time outside of session and how frequently to check their email.

Even with its complexities, it is becoming clear that the phone may be a preferred tool for counseling over online communication. King, R., Bambling, M., Reid, W., & Thomas, I. (2006) found that phone sessions had higher impact and outcomes than online counseling. They point to time as a major factor as to why phone counseling may be more effective than online. Vocal exchanges are more rapid and efficient than text exchanges, which have lag times as well as extra time needed to write out a response.

Although cell phones are already being used in therapy, their use remains complicated and complex. Benefits include increased access especially for people who cannot drive to a clinic due to distance or disability, lowered cost of therapy, and cell phones allows for people to have sessions while at work or more convenient times. These gains are better for people of lower SES

or older adults who may not have access to transportation. Additionally, the ease and convenience of therapy via the cell phone has been found to have comparable reduction in symptoms to face-to-face therapy.

However, there are many challenges. For example, the clinician has less control over the environment in which therapy is conducted. Clear boundaries and rules should be set around how to conduct phone sessions. Additionally, it is still unclear as to whether the therapeutic relationship would be negatively impacted due to the lack of nonverbal cues. This may make it difficult for the therapist to feel empathy or to convey empathy over the phone. Finally, some clients may need to have face-to-face treatment due to their particular mental health issue. For example, people dealing with interpersonal or relational issues may do better in face-to-face treatment (Brenes, G. A., Ingram, C. W., & Danhauer, S. C. 2011).

It is important to note that not all studies report success when technology is used in therapy. Johansen, A. B., Lumley, M., & Cano, A. (2011) examined how technology in the form of a preparatory video might affect the therapeutic alliance as well as mood when beginning therapy. The researchers showed a group of 105 people one of three videos before their first therapy session. One video focused on the Working Alliance, one on Experiential Acceptance and one was a control video. The study found that people, who watched the video on the therapeutic alliance, actually reported higher negative affect after viewing. In addition, their therapists reported them lower on the *Working Alliance Inventory*. This study represents an example of when the use of technology as an intervention can hinder the alliance.

Clinician Attitudes about Technology in Therapy

Many clinicians do not welcome the addition of technology to therapy. Rees & Stone (2005) studied therapist's views of the therapeutic relationship when using technology as a

treatment modality. This study used Videoconferencing in order to conduct therapy over long distances. Thirty therapists reported that the alliance seemed to suffer as a result of using video in place of face-to-face treatment. This study may represent clinician resistance or it may represent the reality that the therapy relationship might suffer due to the addition of e-therapy.

While many studies cite the trend of clinician negative bias around the use of technology in therapy, Byrnes, E., & Johnson, J. H. (1981) posit that resistance is a natural part of the change process. They assert that current clinician resistance to the integration of technology into therapy is a natural part of any type of systemic change. These authors do not view clinicians' current negative attitudes toward the efficacy of technology as an indicator that technology has no place in therapy. It is currently unclear as to what causes clinicians' negative views about technology.

Moreover, many researchers are able to provide a more balanced view about the use of technological intervention in mental health work. Litvin et. al (2013) explores both benefits and risks associated with different Technology Based Interventions (TBI). The authors define "a TBI as content intended to promote change in substance use behavior or antecedents to behavior that is transmitted or communicated in the absence of direct human contact or facilitation via an interface between the intervention recipient(s) and a technological device (stationary computer or mobile device)" (p. 1748). Examples include online counseling, support group blogs, real time communication between therapist and client such as texting or emailing, and self-guided computer interventions, among others. The authors point out that these interventions have many benefits. For example, they are cost effective, easy to access, they feel familiar to clients, are portable and they require less clinical training. On the other hand, TBIs seem to appeal to a certain age group. Additionally, few have been empirically tested for their efficacy. Finally,

some clients may require face-to-face work. One example is people who are dealing substance abuse issues and need assistance in detoxing and continuing to stay sober.

Dehra Glueck (2013) also considers the complexity of employing e-therapy. She examined how Videoconferencing can affect rapport in the therapy relationship. The author defines rapport as "the spontaneous, conscious feeling of harmonious responsiveness that promotes the development of a constructive therapeutic alliance" (Sadock, Sadock, Ruiz, &Kaplan, 2009). They argue that rapport can be built and maintained using Videoconferencing in order to do therapy. Using video technology with high bandwidth, nuances in changes in body posture, vocal pacing and tone as well as shifts in affect can be easily picked up upon in real time. Moreover, due to the physical distance between therapist and client, Videoconferencing encourages regular check-ins about therapist empathic attunement throughout the session. In addition, Videoconferencing emphasizes mirroring. Clinicians are able to see both their clients and themselves during the session. Being able to see their own faces can provide important information about what is going on in the session and how to appropriately respond.

At the same time, she cautions about some difficulties with telemental health. Internet connections can go out and abruptly end a session. For this reason, she suggests always having a backup method of communication, such as a telephone, in order to end the session. Furthermore, the clinician is not in the room with the patient in order to ensure their safety. This is particularly important to consider when working with suicidal clients or elderly clients who may become disoriented among others.

It is interesting to note that technology is not just impacting the therapeutic relationship as an intervention, technology might be the reason a client is coming into therapy in the first place. Brunborg et. al (2013) explore the effects of gaming addiction on mental health. Gaming

addiction is defined as ''the persistent inability to control excessive gaming habits despite associated social or emotional problems'' (Lemmens, Valkenburg, & Peter, 2011, p. 38). People who suffered from gaming addictions also suffered from irritability, sadness, increased levels of fear, exhaustion and increased anxiety symptoms. Additionally, Perri Klass (2011) explains that screen time may actually cause attention problems in children. The constant changing and fast pacing of computer games and online social networks might cause some children to be "underwhelmed and under stimulated" by the external world. To further support his point, he cites that many children with A.D.H.D. engage in increased amounts of screen time compared to children who do not have attention challenges. In other words, increased screen time in children may be related to symptoms that children come into therapy for.

Oravec (2000) explores the many ways in which computers are changing family systems and how this in turn is changing the topics in therapy. She points out issues such as caregivers navigating how to control the amount of time family members spend on the computer, how to keep their children safe while online as well as how to increase family closeness and communication by using online mediums. All of these emerging issues affect the content within therapy and the interventions used by the therapist.

Summary of Theory

It is important to understand how cell phone use fits into therapy within the context of therapeutic theory. In other words, different theories, psychodynamic and otherwise, make room for the use of cell phones in different ways and for different reasons. The reasons often have to do with how the cell phone use will affect the therapeutic work and relationship. In the psychodynamic field, there are many existing theories as to how the therapeutic relationship forms and how it can be used in treatment.

The therapeutic relationship is defined as consisting of three elements: the working alliance, the transference and countertransference dynamics and the real relationship. All of these parts work together to enhance treatment outcomes and all of them are interdependent (Bordin, 1979). As defined previously, the working alliance is the capacity of the therapist and client to together negotiate and achieve agreed upon goals within the therapy relationship. Its job is to accomplish "a posttherapy state that is better than the pretherapy state" (Lui & Pope-Davis, 154). The real relationship is the literal relationship and connection between the therapist and client that is unaffected by transference and countertransference. Finally, transference is defined as the client's general reactions to the therapist as well as the clients reenactment of past relationships patterns within the therapy relationship with the therapist. Countertransference is defined as the therapist's general reactions to the client as well as the personal material the therapist brings with them (Lui & Pope-Davis, 2005). These three components together make up the therapeutic relationship.

It is widely agreed upon that the therapeutic alliance is the single strongest predictor of treatment outcomes. Different psychological camps hold varying views about how the alliance and greater therapeutic relationship function. The following three articles represent three different theoretical approaches to the therapeutic relationship. This paper will use these three therapeutic approaches to discuss how the use of cell phones affects the relationship. These approaches are Relational Theory, Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT).

Coutinho, Ribeiro & Safran (2009) write from a Relational perspective. According to the authors, the therapeutic relationship itself is the vehicle of change. These authors assert that the therapeutic relationship should be seen as both a technique and therapeutic intervention in and of

itself. From this perspective, it is the process of forming and maintaining the therapeutic relationship- of coming to moments of rupture and then recovering from them- that creates healing and personal change. In this approach the therapeutic relationship represents a model that demonstrates to the client that two people, with two different subjective experiences, can relate to each other and can survive disagreements. Additionally, the therapeutic relationship is seen as co-created by both client and therapist as the lens through which the two examine the client's internal experience together. Relational Theory stems from a psychodynamic approach and is based on a set of beliefs about the therapeutic relationship that complicates the use of cell phones in therapy.

On the other hand, Cognitive Behavioral Therapy (CBT) represents a treatment approach that seems to welcome the addition of technology. CBT posits that our thoughts, behaviors and feelings influence each other. Furthermore, it is our disordered thoughts that are the cause of mental health issues. Therefore, negative or maladaptive thoughts are targeted for change in order to create behavioral and emotional change. The therapeutic relationship is not emphasized in this approach, but it is worth noting that CBT's treatment interventions can easily be adapted to cell phone technology (Lind, C., Boschen, M. J., & Morrissey, S., 2013).

Similarly to CBT, Dialectical Behavior Therapy (DBT) welcomes the addition of cell phone use. DBT focuses on symptom management and distress tolerance by teaching clients a concrete skill set. The therapist is seen as a coach, who helps their clients learn skills in session and apply them outside of session as well. In true DBT, the therapist is available by phone to their clients at all times to help coach them through crises. In this case, cell phone use has been welcomed.

The above research studies have many limitations. First and foremost, most of the studies have relatively small sample sizes, which limit the generalizability of their findings. Moreover, the clients in these studies are members of demographic groups that are comfortable with technology. The efficacy of using text messages might look very different in an elderly population, for example. Along the same lines, the studies often focus on the use of technology when treating one specific mental health diagnosis, which limits the therapy's applicability to other types of mental health issues or to dual diagnosis patients. These are important limitations to note because it implies that the use of technology in therapy may work best for clients, who are at a higher level of daily functioning and not for more severe or acute cases. In addition, many of the studies focus on whether a therapeutic alliance can form at all, but pay little attention to whether that alliance is maintained and built upon throughout treatment. Finally, the majority focuses on the alliance and ignores other dynamics within the treatment relationship, namely the real relationship and transference and countertransference issues.

These studies serve as a platform for the present study in many ways. First, this study hopes to create a fuller picture of how cell phone use in therapy affects the whole therapy relationship, not just the alliance. Second, this study focuses on cell phones. Many of the existing studies are on computer-based therapeutic intervention and this research may assist in expanding the literature to other types of technological interventions. Because so few studies discuss the therapists' use of the cell phone, this study can act as an initial exploration of how clinicians are already using cell phone technology as well as how they introduce it in session. At the same time, this research hopes to provide beginning insight as to how clients are bringing their cell phones into session as well. Further, it makes room for the exploration of which clients respond well to the use of cell phones and which ones do not.

Much of the literature presents a field that is divided about the integration of technology into the profession of psychology. The present study aims to explore the validity of this and perhaps provide a more balanced view on the matter. It aims to provide beginning information on why some clinicians welcome the use of technology and others do not. This particular topic allows for initial exploration of the limitations of cell phone use with clients with more severe diagnoses as well as the advantages and disadvantages of using cell phones with clients, who have many different types of diagnoses. In sum, the present research hopes to begin to paint a more detailed picture of what the therapeutic relationship looks like when cell phone technology is used.

CHATPER III

Methodology

This study investigates how the use of cell phone technology in therapy affects the therapeutic relationship. A qualitative, exploratory method was conducted. Semi-structured interviews with a set of open-ended questions were used to facilitate dialogue and encourage responses about the clinician's experiences with cell phones in therapy.

Sample

After obtaining approval from the Human Subjects Review Committee, recruitment was obtained through various online mental health list serves that exist in the Bay Area as well as Northern California. This researcher sent an email to colleagues and mental health workers in the area requesting that they post the study's recruitment statement on online list-serves that they were members of. Individuals who were interested contacted this researcher via email or by phone. This recruitment method allowed access a wider pool of people than those who are in this researcher's direct professional circle. This was a nonprobability sample with reliance on convenience and snowball methods.

The recruitment statement asked for participants who met the following criteria: clinicians who used cell phone technology or who had clients who used cell phone technology in their therapeutic work. Inclusion criteria included in the informed consent paperwork as well. Deliberate effort was made to obtain a diverse sample in terms of age, race and ethnicity and gender as well as the setting in which participants work.

Qualitative interviews were chosen for this study in order to allow for richer and more detailed initial exploration into this topic. Due to the paucity of research on the subject, qualitative interviews permit a fuller beginning discussion of how new cell phone technologies are impacting the therapeutic field.

Data Collection

In the interview, quantitative demographic data was collected including participant age, racial and ethnic identity, gender identity, work setting, theoretical orientation and type of clinical degree. Participants were given informed consent as well as provided consent to have the interview recorded. Participants understood that they would not be compensated for participating in the study.

Data was gathered in person or over the phone when necessary. Interviews were recorded using a hand-held audio-recorder. Interviews lasted from 50-110 minutes. Interview locations included local coffee shops and cafes, participants' homes and participants' offices. Location was determined by participant request and convenience.

Interviews were semi-structured with predetermined questions as well as themes that were to be touched upon in each interview. Questions were open-ended in order to stimulate responses about the clinician's experiences. The interview was broken up into three themed areas: the clinician use of cell phone, the client use of cell phone and the impact of cell phone use on the therapeutic relationship. Questions asked included: "Do you use cell phones in therapy and if so how?" "How does texting your client throughout the week affect the therapeutic alliance?" "How does texting your client affect rapport?". (See Appendix A)

Personal identity of participants was protected in many ways. Audio-recordings did not include names of the participants. Additionally, they were stored and transcribed using a

deidentified number system on a locked computer. This researcher was the primary handler of all confidential information. Four people were hired to help with transcription of the interviews. All transcribers signed confidentiality forms and had access only to interview recordings that were already deidentified. Interviews and their transcriptions will be kept in a locked and secure location for three years and then destroyed.

Data Analysis

Interviews were recorded by a digital recorder. All interviews were then transcribed by this researcher and four transcriber assistants. Once transcribed, interviews were coded for thematic and content similarities. This was done by categorizing and coding content for similarities, differences, and other important topics. In order to do this, this researcher read through each interview and coded each line for a particular theme using color-coding. Once all interviews were coded this researcher compared how many times each theme was discussed, in what ways as well as differences of opinion and experience. Although this study's small sample size and limited population diversity do not lead to broader generalizability, this research represents a step in that direction.

The findings and major themes of this study will be discussed in the following chapter.

CHAPTER IV

Findings

Introduction

The purpose of this study is to explore how the use of cell phone technology affects therapy. This chapter contains findings that are based on eighteen (n=18) interviews with clinicians who use cell phone technology in their work or who have clients who bring cell phones into session. Interview questions were designed to gain initial insight about how clinicians and clients are using cell phones in session and how these various uses influence the therapeutic relationship. Interviews began with demographic questions including race and/or ethnicity, gender, age, agency stetting, type of degree, and theoretical orientation. Qualitative questions began with a section on clinician use of cell phone technology followed by sections on client use and then how these impacted the therapeutic relationship.

Demographics

Eighteen (n=18) clinicians were interviewed using semi-structured interviews throughout Northern California's Bay Area. The interview included an initial quantitative section in order to obtain demographic information. Eleven participants identified as female and seven identified as male. Participants ranged in age from 31 to 69. Racial and ethnic breakdown was as follows: one Chinese-American person, eight Caucasian only, seven Jewish and Caucasian, one Mixed Middle Eastern, and one Latino.

Participants had varying clinical degrees with two MSWs, five PsyDs, five MFTs and six Clinical PhDs. Of the eighteen participants six work in private practice, four in school settings,

two in medical settings, three in community mental health agencies, one clinical researcher in a public university, and two in a combination of settings. Participants had diverse theoretical orientations with three identifying as Cognitive Behavioral only clinicians, one as Dialectical Behavioral only, four as psychodynamic, one as Relational and Control Mastery, one uses Sprinson's Unconditional Care, and eight as some combination. While this researcher realized there were few MSWs as she finished the interviews, it was deemed more consistent and beneficial to the research to continue to use snowball and convenience methods than to reach out to MSWs specifically.

The client populations discussed in the interviews represented almost every client population in mental health possible. Client ages varied in age from young children to adolescents to adults. Client populations represented varying racial and ethnic groups including undocumented, Mexican immigrants, African-Americans, Caucasians, Latinos, Asian Americans and Middle Eastern communities. Clients identified with diverse sexual orientations, varying socioeconomic status and presented with a diverse array of mental health issues including substance abuse, victims of crime, trauma, mood disorders, anxiety disorders, characteristics of personality dysfunction, and ADHD. Clients were varying degrees of functionality and severity ranging from high functioning professional adults to middle school students with emotional and behavioral issues.

All 18 participants identified with either using cell phone technology with their clients or having clients who used cell phones in therapy. Of the 18 interviews, 17 were conducted face-to-face and one was conducted over the telephone.

Therapist Use

Of the eighteen clinicians participating in this study, only five did not give their clients their cell phone number at all. At the same time, only four clinicians gave their clients their cell phone number while simultaneously telling their clients that it was their personal cell phone number. Each of these four clinicians gave their clients specific instructions as to what appropriate contact should be. One clinician did not give his cellphone number to any of his current clients, but chose to give his cell phone number to three adolescents who had been group therapy with him previously. He gave his cell phone number with specific instructions as well. Four participants had professional cell phones provided by their agencies. Six clinicians provide an office number that is forwarded to their personal cell phone. Five of these six clinicians use Google Voice.

Three clinicians reported that they do not provide their cell phone number directly, but that a few of their clients got their cell phone number when they had to contact them using it for one reason or another. Of these three, two participants reported that they provided specific instructions about when to use the number, but do not explain that it is their personal cell phone. One did not explain what the number was nor provide instructions around use.

Thirteen of the eighteen participating clinicians reported that they used their cell phones to talk to clients. Three clinicians used their cell phones to do initial intake sessions before meeting for the first in person session. Five reported that they do therapy sessions over the cell phone. Nine reported doing check-ins and collateral work over the cell phone. Three therapists reported using their cell phones to do in vivo skills coaching with clients. Four use their cell phones to schedule. One clinician reported that he used his cellphone to conduct sessions over FaceTime.

Sixteen of the eighteen participants were using their personal cell phone or a work cellphone in their work with clients. Thirteen participants used their cell phones to access their email and email with their clients. Two participants had secure email messaging systems that were part of their agency system that they used instead. Seven of the thirteen participants were using their emails to schedule with clients, two used their email for billing, two for reminding their clients about session times or homework, three to send resources to their clients, one to conduct brief check-ins, one to do case management, and one to get in touch with collateral contacts and parents of their clients. Three participants did not identify how they used email but verified that they did. All clinicians reported that they used a professional or business email for communicating with clients.

Thirteen participants endorsed that they text messaged with their clients. In other words, 100% of the clinicians who used their personal cell phones in therapy also used them to text with their clients. Ten of the participants reported that they used text messaging to schedule with their clients. Five reported that they used texting for brief check-ins with their clients or their clients' parents, four for reminders of session times or of homework, one used texting for coaching and communicating issues around safety and crisis, one therapist had facilitated a therapy session over text and one clinician used text to get into clients' homes when doing home visits. One clinician reported using text messages and emails in order to do psychological research.

Five clinicians reported prescribing mental health application to their clients. The primary goals for mental health applications included tracking mood, identifying triggers, journaling, and using the diary cards of DBT.

Table 1: Clinician Use

Type of Use	Number Of Clinicians
Personal Cell Phones as Telephones	13 (72%)
Work Cell Phones as Telephones	3 (17%)
Cell Phones to Email	13 (72%)
Secure Messaging Email System Provided by Work Setting	2 (11%)
Cell Phones to Text Message	13 (72%)
Cell Phone Applications	5 (28%)

Other cellphone uses included: two therapists reported using games on their cell phones during therapy. Two clinicians reported using their cell phones to play music during session. One clinician reported using their cell phone to bill using Square. One clinician reported using the GPS on their cell phone to find clients' homes. One therapist reported using his cell phone to take photos of psychoeducational material generated during session. He would then email that photo to the client as well as add it to their electronic medial record. One clinician reported using his cell phone to video record his clients and then have them watch themselves as an intervention. Two clinicians reported using their cell phones to look up resources and information on the Internet. Finally, four clinicians reported using their cell phones to access videos for psychoeducational purposes. Websites accessed included YouTube.

Clinicians were using the cell phone itself as an intervention. Seven clinicians reported using the reminder and alarm functions on their clients cell phones as interventions for ADHD, ADD and to help their clients increase their homework completion.

Lastly, clinicians were using their cell phones to help themselves. Five clinicians reported storing their clients in their personal cell phones using either client initial, first names or full names. Four clinicians reported storing their work schedule in their cell phone. One clinician

responded that she uses her own cell phone reminders to ensure she brings the correct items to her sessions.

Client Use

The clinician participants in this study replied that all of their clients have cell phones. The exceptions to this included two clinicians who work with children in elementary school. Each of them reported that some of these younger children do not have cell phones. One was able to point to children under nine as the cut off age for cell phone ownership. Additionally, one therapist who works in a high school reported that one of her clients does not have a cell phone because s/he is illiterate. Lastly, one clinician said that sometimes her teen clients loose their cellphone privileges and therefore do not have access to their cell phones.

Additionally, some of the participants were able to highlight particular demographic groups that are more prone to using cell phones in session. Six clinicians noticed that younger clients were more likely to use cell phone in therapy. Two of these six felt that their younger clients "expected" that cell phone use would be a part of the therapeutic relationship. In this case, "younger" described teens, young adults and adults into their 40s. Three clinicians felt that older clients were less likely to want to use cell phones in therapy. One of these three pointed to people over sixty as less likely to want to use cell phones and another said that more tech savvy adults were less likely to want to use cell phones due to their level of knowledge of the product.

The participants pointed to many ways that their clients are using cell phone technology in sessions with them. All eighteen clinicians reported that their clients or their clients' parents would call them using a cell phone. The purpose of these calls included scheduling, check-ins, updates, and phone coaching. Thirteen (72%) clinicians reported that their clients were using text messages in therapy for various purposes. Of these thirteen, six clinicians reported that their

clients would text them outside of session in order to schedule. Additionally, they reported that their clients would text them to let them know if they were going to be late to a session. Nine clinicians reported that their clients show them their text message conversations with other people and want to discuss them in session. Four clinicians reported that their clients text them outside of session in order to request phone coaching or a check in. One clinician reported that his teen-age clients will text him just to check-in.

Twelve (67%) clinicians reported that their clients use email with them both in the therapy room and outside of the session. Email was included as type of cell phone use as email is increasingly being accessed via the cell phone. Of these twelve, four clinicians reported that their clients use email to schedule sessions. Eight clinicians reported that their clients would use emailing as a way to debrief and extend the session outside of the therapy room. Two therapists responded that their clients would send them updates via email. Five clinicians felt that their clients used email to vent to their clinicians. Two clinicians reported that their clients would ask them for advice over email. One reported that her client writing samples over email. Finally, six clinicians have clients who bring in their own email histories into session to discuss. Overall, the participants felt that their clients used email as a way to maintain connection with them as well as to extend the session throughout the week.

Eleven clinicians replied that their clients would show them social media sites on their cell phones during session. Eight had been shown and had discussions about Facebook. Facebook was used to show photos of important people in client's lives as well as inspired discussions around interpersonal conflicts. Three clinicians reported seeing clients' Instagrams. One reported viewing her client's blogs. Two reported seeing their clients' dating websites and one reported that their clients brought in YouTube videos to show.

There were multitudes of other ways that clients were using their cell phones in therapy. Eleven clinicians have clients who use their cell phones to show them photos. Photo subjects include: important people, family members, pets, and important events. Only three clinicians reported that their clients were using mental health applications without the suggestion of a therapist first. Three clinicians reported that their clients brought music into session on their cell phones. Nine clinicians have clients who schedule on their phones and four have clients who would put therapy related reminders in their phones during the session. Four clinicians have clients who bring games on their phones into session. One therapist had her client use his phone to check his grades in session to discuss with her. One therapist helped her client get in touch with her parent using Facebook on a client's cell phone. Finally, one therapist has clients who have looked up things using Google on their cell phones during session.

Table 2: Client Use

Type of Use	Number of Clinicians Who have Clients Who Use
Cell Phones as Telephones	18 (100%)
Cell Phones to Email	12 (67%)
Cell Phones to Text	13 (72%)
Text Message Histories	9 (50%)
Social Media Sites	11 (61%)
Photos	11 (61%)
Scheduling and Reminders For Therapy	9 (50%)
Cell Phone Applications	5 (28%)

The Cell Phone and Confidentiality

Confidentiality is one of the primary concerns about cell phone use in the field of therapy. The clinicians in this study handled these issues in various ways. Seven of the

participants address the lack of privacy and confidentiality of cell phones in their initial

paperwork and consent forms. Six more clinicians did not have formal paperwork for their

clients to sign, but did have discussions with their clients about the lack of security when using

cell phones for communication. Four of the clinicians did not say anything about the security

issues around using cell phones in therapy.

This variability represents the lack of professional standards around cell phone use.

Because cell phones have been introduced recently into the therapeutic context, the profession as

a whole has yet to come up with official guidelines around its use. In fact, many clinicians cited

the lack of professional standards and guidelines as one of their greatest concerns about cell

phone use in therapy. As a result, more and more agencies and private practitioners are including

privacy issues in their consent forms.

Ironically, this study's participants reported that their clients do not care that cell phones

are not confidential. One clinician even reported that her clients "laughed" when she mentioned

it. At the same time, one clinician said that his older and more tech savvy clients have refused to

communicate over cell phones apparently "due to their knowledge about cell phones".

Additionally, another clinician reported that her more "paranoid" clients have not wanted to

communicate using cell phones.

The Cell Phone and the Therapy Relationship

Overall, all eighteen participants felt that the cell phone and its capabilities represented a

helpful "aid" or "tool" for the therapeutic relationship. All the clinicians in this study were able

to think of examples when the cell phone benefitted or at the very least helped the therapeutic

relationship in someway. Few were able to come up with examples of when it hindered the

relationship. The cell phone's impact on the therapy relationship will be discussed in a general manner in this section and explored in more depth in the following sections.

There was consensus among the participants that the cell phone acted as a "tool" for therapy. For example, clinicians mentioned that the cell phone provides multiple mediums through which to reach one's clients. It allows for easy and instant access to psychoeducational videos on the Internet. It permits for in vivo mood tracking using mental health applications. It creates space for "booster sessions" between face-to-face sessions when necessary. It provides access to greater amounts of data about one's clients on social media sites. It is a way to engage young clients by playing games and music they are familiar with.

As a result, all the clinicians answered positively that cell phones have a place in therapy though to varying degrees. One clinician explained how he felt cell phones fit into therapy:

> "I think the industry term like joining and alliance building is part of it because it opens up an additional mode of communication and there's abstract ways that can be helpful, like the patient venting to you with the understanding that you're gonna read it, but you might not reply. That's different than them saving it up or not acknowledging it because they don't have a meeting for another four weeks or whatever the model is. I think it's good for pscyhoed. in terms of, like, you have insomnia and you'd like to change that. Guess what? There's an intervention for that and it's on your phone…here is that extension of the therapist, you know, 'What would my therapist think?' The interventions that my therapist would do, like tracking or perspective taking, now I'm gonna be doing that."

Another echoes similar themes:

> "To solve certain problems in terms of people not being able to get into the office. I think the emails for some people are really helpful, a little extra session contact that makes them feel like she can express things to me between sessions that we might not get to. And I think that can be valuable. Even the little stuff that feels gray area-ish, it is part of the fabric of society. We can't totally live in another century."

These clinicians point out many of the reasons that other clinicians feel that the cell phone is important to therapy. First, it makes having a session possible when a client cannot come to the office. Second, it facilitates psychoeducation during the session. Third, it creates support

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between sessions and as the first quotation implies it increases the likelihood that the client will

internalize the interventions of the therapist. Finally, it is the reality of our times.

In fact, many therapists felt that cell phones are part of our culture now and as such are

impossible to ignore:

> "It's the way of the world. Um, it's like anything. If it's used well and
> thoughtfully and integrated with some discussion and process, it can benefit. To
> shut it out entirely, is not realistic, not healthy, limits possibilities and it's just not
> where we are culturally."

While all of the participants could discuss the potential benefits of cell phone use in

therapy, some also talked about their drawbacks as well. One clinician talked about both the

benefits and the potential drawbacks of cell phone use:

> "I think some people will not be able to communicate in any other way and if you
> want to have a connection that might be the only way. And I think that also it can
> provide a quick and easy way to keep in touch on a regular basis. Just to know the
> lines of communication are open. I think some of the cautions are if you just let
> the kid go off on his own. You have to have some limits around that and question
> it. You know, 'Do you do this with everybody? Is there anyone you can trust?'".

In other words, while the cell phone can open up communication, it also has the potential to shut

it down. A client could use a cell phone to avoid interaction with the therapist.

Another clinician wondered:

> "The other stuff that goes with it, you know the social media stuff, I think of as
> kind of separate and that's not clear to me that has an overall place in therapy- So
> does their online networking, but I think it's quite specific to a population group. I
> don't really see the place of social networking in my adult, with my adults."

This clinician is unsure of how social media fits into therapy if at all. Further, it is seems to her to

be relevant to younger groups, but not for older groups.

Finally, a clinician expressed:

> "Sometimes I am not sure if it's the best thing all the time and that there is some
> kind of question in my mind: how much responsibility do I have to make the best

use of our time? And sometimes it is just a distraction element, like somebody hasn't put away their phone…it is hard to create that feeling that this is a sacred place and we are doing something important and special. There is some boundaries that they renounce. Something is lost and something is gained."

While all of these clinicians, like all the study's participants, agreed that cell phones have a place in therapy, they do bring up concerns about the manner in which cell phones can be used in therapy.

Examples of how the cell phone affected the therapy relationship are in the following sections. Sections are divided into sub-categories each representing one of the three aspects of the therapeutic relationship: the real relationship, the working alliance and countertransference.

Talking on the Phone and the Therapy Relationship

All eighteen clinicians reported using the phone to talk with their clients though not all of them used cell phones. All of the clinicians who used cell phones to talk with their clients reported that this was beneficial to the therapeutic relationship and only one was able to provide an example of when this hurt their relationship with a client. Due to the fact that therapists and clients have been able to communicate by phones for a long time, it is not surprising that the use of a cell phone as a phone had less varied responses.

Rapport and the Real Relationship

All participants replied that the use of a cell phone as a phone increased rapport, trust and closeness between clinician and client. These elements are part of the real relationship. One clinician explained how both the cell phone itself as well as its ability to make a phone session possible increases rapport:

> "In a way it feels like they are bringing their home into the session. It is a part of themselves. They are really opening up to even allow me to hold the cell phone, for people that can be possessive or have a hard time with trust or don't want to hand over this part of themselves, a thing they rely on so much, to show me this inner part of their world. I feel like it can really build something and the fact that

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we can do phone sessions really helps…It gives me more chances to reach them or reach out to them."

Phone sessions are another way that the client and clinician can connect. Additionally, for this clinician, just the sharing of a cell phone in session is an intimate experience. He highlights a common theme: that the cell phone is an extension of the client's self. Simply bringing it into session to share is a moment of closeness.

Another clinician explains that phone sessions and phone coaching is precisely what draws people into DBT. She says:

"Oh they love it. They love it. I think that's part of what they're looking for in DBT. I mean, they've heard that we give good phone contact and we'll be able to help with crisis, so it's one of the selling points, really, is the phone access. So people are very excited to be getting it."

The availability by cell phone is what hooks people into this type of treatment in the first place. This allows for the relationship to occur as well as engages clients in the treatment.

While all participants agreed that talking on the phone helps with rapport, one clinician felt that it was not as effective as developing rapport and the real relationship as being face-to-face:

"You can't see the nonverbal communication and you can't develop the same rapport…There's more opportunities for distraction than when you're face-to-face in a one-on-one therapy session."

She reminds us of concerns about conducting clinical work over the phone. It is easier for both therapist and patient to be distracted. It can be harder for the clinician to feel empathic without a face to look at and this could affect the rapport.

While the majority of clinicians could not think of times when the cell phone negatively impacted the therapeutic relationship, one did have a story to tell:

"There was one client where, if he didn't get to the most intimate and painful part of his story or the session and I would forget to have my phone off and my phone would go. It happened like three times. It was almost comical. And, I just had to

work with it…and the first time he was angry, and I stopped, and we talked about it. And then the second time he was kind of, like, befuddled and then, like, the third time we were laughing about it."

In this example it is the clinician's cell phone that disrupts the session and breaks up the therapeutic work. As with most of the examples in which the therapy relationship is negatively impacted by a cell phone, the therapist and patient are able to work through it and recover.

The Working Alliance

All the clinicians felt the ability to talk on the phone helped most with the working alliance, particularly the clinicians who use CBT or DBT. For them, using the cell phone for talking on the phone provided the tools for in vivo phone coaching. Phone coaching is when a client calls their clinician outside of session for assistance in a difficult situation. The therapist then helps them to use the emotional and behavioral skills that they learned in session. This intervention is considered essential to therapeutic change. As one CBT clinician discussed:

> "I think we get a lot of things done outside of the session. It actually helps people make progress…My sense is that it actually helps people make more progress and it probably does help the alliance to know that I'm actually available to them and that I'm thinking about them outside of session, that I'm invested in them doing well. All of those things, I think, just help people move through therapy in a better way."

This clinician confirms that phone coaching is helpful to alliance building. Not only that, but she asserts that them knowing that they can call her is an essential part of the alliance building process. Finally, she points out that a lot of work happens outside of the session when on the phone, making it an integral part of the therapeutic work.

Another clinician explores the effect a phone session can have on the work:

> "Clients, as I say, they love the phone. They love that they're not getting the non-verbal information especially if they're not very good at processing that information. And often times, I mean, I have a client who can tell me things on the phone. We actually ended up scheduling every fourth session on the phone on purpose…because she could tell me things when she didn't have to look at me

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that she couldn't tell me in person, and once we figured that out, it made sense to allow us to communicate by phone on a semi-regular basis, just as a way to deal with her issues."

In her experience, clients benefitted from talking on the phone. In fact it was not being face-to-face allowed this client to share more. Using the cell phone in therapy become an essential part of maintain the working alliance and continuing to meet the goals that they had set.

Other clinicians discussed how the ability to talk on the phone was essential for scheduling, check-ins and phone sessions, all of which contribute to the working alliance.

Countertransference

It is interesting to note that while all the clinicians felt the use of cell phone, as a telephone was helpful to alliance building and rapport, they had mixed countertransference experiences. The three clinicians who provided phone coaching felt positively about their experiences. Phone coaching lasts 10-15 minutes, is highly goal-oriented and is not a therapy session.

Clinicians felt mixed about phone therapy sessions. Only one clinician reported that he did not worry about getting distracted when doing phone sessions. He even was able to do them while driving on his commute to and from work.

One clinician discussed her countertransference around phone sessions:

> "I think for me it is much better if I am in my office. I have tried to have phone sessions not in my office and it really doesn't feel right. It feels like much of the setting is broken. I remember when there was a time where I was in a situation where I had a phone session where I was actually in a park. I found a private spot, but still it just felt crazy. It felt not right. It felt like I was exposed, you know, somebody could walk by and I didn't feel enough professional space somehow."

Another explains:

"I'm hesitant around actually providing the therapeutic service through a telephone, um, just because I feel like so much can be missed, um and, it's hard to read cues in the same way and it's hard to know if someone is on speaker phone and someone else is listening and what you're really providing and those kinds of things. Um, and even, like, I was on the phone driving home and I was like 'I'm wondering who else is around you'. Because, you know, if there's going to be some husband or, you know, you never know who else is in the picture, um, that could be within earshot."

These two quotations illuminate many of the participants' experiences with phone sessions. As the first speaker points out, one can conduct a phone session anywhere. For her, and others in this study, this creates the feeling that the professional frame has been broken. For her, it feels "crazy" and she worries about the lack of general privacy. The second speaker highlights the concern for the privacy of the client. Since they cannot see one another, the therapist cannot be sure who else is around and who might be listening. Additionally, nonverbal communication is lost when on the phone. For the therapist as well as others, this can make delivering good therapy more difficult.

Lastly, one clinician explained that she is able to use her difficulty reaching a parent as a means to understanding her client better:

"I think when you notice how hard it is to get ahold of parents, um, you're able to pick up on, like, what the kids experience might be. In terms of, if mom's so unavailable to me, what is she like to this kid."

She is able to use her experience of calling a mother on a cell phone to relate better to the young client.

For the participants in this study the cell phone is an important tool that affects the rapport and real relationship in a positive way. This is because it is a way for therapists to provide additional support and contact outside of the therapy room. Additionally, it facilitates the working alliance by providing phone coaching, phone sessions and additional support. Finally, clinicians have mixed experiences and reactions to using the phone in therapy. While they are

able to recognize its usefulness especially to clients, it can allow the therapy session to spill

outside of the therapy room and cause distractions during the therapy session itself.

Table 3: The Cell Phone and The Therapy Relationship

Aspect of Therapeutic Relationship	Benefitted	Neutral	Hindered
The Real Relationship	18 (100%)	0	1 (6%)
Working Alliance	18 (100%)	0	0
Countertransference	"Increased ability to understand client experience" "Convenience"		"Distracted"; "Disruptive"; "Crazy"; "Privacy"

Text Messaging and the Therapy Relationship

Rapport and the Real Relationship

While all the participants used phones to talk to their clients, not all of them

communicated with them using text messaging. Those who did reported that they felt texting

represented a moment of connection even if it was just about scheduling. These clinicians stated

that the text acted as a quick reminder that the therapist was available to their clients and that

they cared for them. This in turn increased feelings of closeness for the clients and built rapport

between client and therapist. In other words, text messages when used for check-ins and

logistical matters strengthened the real relationship more than not. For example, one therapist

explains that check-in texts are a culturally and generationally appropriate way to have a brief

connection outside of session. She describes:

> "This is their language. This is their modality. So for me it's kind of bridging entering their world and having some very sweet- I mean, actually feeling empathic connection through a sweet text, you know? And going 'Aw' or like, you know, 'Thanks so much, that really helped' and then write back- I send back a 'Smiley face, anytime', you know? It's like a bookend and there is connection there."

This clinician argues that she is able to create empathic connection through a quick check-in with

a client. This reinforces the real relationship.

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Another clinician discussed the effect of reminder texts on her relationship with her clients:

>"The texting feels like…I think it feels kind of safe to the clients; like they can rely on me letting them know when I'm gonna come, reminding them when I'm coming, um, I think that they know what to expect from me. So, I think that's helpful to our relationship."

It is important to note that these text exchanges are one or two text messages in length. The participants in this study were not reporting long, drawn-out text exchanges with their clients that took up a lot of their time. As reported earlier, the clinicians in this study did not report boundary violations due to their clients having access to their cell phone numbers. This is significant because it provides a solid, initial example that texting with clients mostly acts to increase closeness in the relationship and does not burden the clinician as many in the field fear.

While the majority of the clinicians reported positively about their experiences with text messaging their clients, one school-based therapist upset her client when she texted his parent with a behavior update that was less than flattering. She explains:

>"He doesn't want the mom to know what's going on at school…And if course there were some repercussions at home…I think that the kids don't want their parents to know what they're doing and I don't want to be a tattle tail, that's not my role. But, it's also important that the parents know so that they can respond."

As she clarifies, he got mad at her when she revealed to his mother what he had been doing at school. While this is an example of when text messaging was the form of communication, this therapist would have had to communicate with the mother regardless of the modality.

The Working Alliance

Text messages contributed most strongly to the working alliance when clients showed their therapists text message histories from their own lives. For the therapists, text message histories are a concrete and objective written record of something that happened. This eliminates the biases of subjective reporting after the fact. As many of the clinicians explained, seeing a text

message history allows them to do reality testing with their clients as well as to help them see the conversation from different viewpoints when they get stuck. One therapist elucidates:

> "Like, you know, a husband is verbally abusive and she is just telling me that versus she shows me the verbally abusive text I get more information and I know she needs help stopping that…There is something about that reality bit that is the same thing when you have couples therapy when you are actually in the room with two people. The fact that it is not all subjective I think can speed things along a little bit…when you get this piece of reality, you get more information that helps you see where they are stuck or where they are distorting or what they can't do in a relationship or what they can do…Also sometimes people just showing you pieces of their own texting or writing, I can learn something about them through how they decide to express themselves."

Like this clinician, many other interviewees explained that text message histories from abusive partners were extremely helpful for them in understanding the severity of a situation. Actually seeing the words from a client's partner or boss enabled therapists to empathize better and to intervene according to the level of severity. Additionally, this clinician points out that viewing a non-subjective written record can sped up the therapy process because the clinician observes how a client writes to how they view verbal and emotional input from others in their lives.

Additionally, text messages can provide important assessment information as well and help shape treatment goals:

> "If they're a poor communicator, having a conversation about the best way to navigate conflict…Text message is probably not the best to talk about how they were late to this really important event that you had, you know, this past week and how upset you are about that over text, probably not the best format. So you know, having a conversation about that use of technology can be helpful."

In this case the clinician uses how a client communicates using text message to then discuss ineffective ways the client communicates in general. The text message history itself led to an intervention around general communication.

One point of controversy did come up when discussing client text message histories. Many clinicians were concerned about the other party who was in the text message conversation but not in the therapy room to defend themselves. They were concerned about their privacy and the fact that they had probably spoken assuming no one else would read the conversation let alone someone's therapist. Because of this a minority of clinicians preferred that their clients do not show them the text message history, but instead paraphrase it themselves. For these therapist, it both protected the third party as well as drove right into the client's emotional process around the text messages:

> "Just saying 'I'd rather that you just tell me in your own words. If you want to quote it, fine.' And people have quoted what the other has said. Bit it's more so not about the content, it's about what's the impact of the content…Even if I don't really know what the content was, I believe the impact on them."

The majority of clinicians wanted to see both the text history itself as well as discuss it with their clients. One therapist put it succinctly:

> "I want the content and I want the process. Content is the text message and how it made them feel is the process. I think you'd loose a lot of important information if you didn't have a sense of both."

Lastly, the majority of clinicians felt that text messaging with their clients did help to build the alliance. In almost every case, clinicians did not initiate text conversations with their clients, but responded when clients texted them. Most text conversations were short and about logistical issues or check-ins. Only one clinician was not convinced that texting with her clients in and of itself would increase the alliance. She talked about check-in texts with clients:

> "Sure, I mean, but more in the sense of getting the face-to-face. Um, but I think a client does appreciate if I text her just to see how she's doing even though she doesn't always respond…Yeah so maybe not so much alliance building but leading to the next step to build the alliance."

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Countertransference

Clinicians had both very positive and negative countertransference reactions about text messages and their clients. The text message exchanges with clients, such as a reminder text or a check-in text, were generally reported as positive. One clinician described them as "sweet" and another as "nice". Clinicians felt differently when it came to clients showing them text message histories from the clients' lives. Some therapists felt it was very helpful, interesting and aided in treatment. At other instances, many clinicians reported feeling "overwhelmed", "uncomfortable", and pressured to validate their clients when they did not want to. The majority of clinicians described feeling that a client would bring in a highly emotionally charged text conversation because they wanted to be vindicated in their belief that they are right and the other person was wrong. One clinician explained:

> "They've been carrying it in their phone is kind of like them trying got hold on to whatever thing or whatever emotion it is and it's not necessary. So you feel like they're sort of bringing in this, this ignition or it's more like 'I'm not crazy look! Look!' But I never said you were crazy."

Like this therapist, a few others described an upsetting text conversation as "fuel for the fire" which the client would bring in to "vent" or "unload on" the therapist. This could be hard and "uncomfortable" for the therapist to navigate. Another popular concern was the privacy of the other person involved in the text message conversation who was not the client:

> "I feel, like and, very aware that also of the other person's privacy might be violated. They didn't know that person was going to show this thing so I am aware of that it is bringing me inside in the sense that we wanna be sometimes. We want to think of ourselves as more of an observer on the outside, but you are actually reading a text from two people. You are, like, inside in a different way."

Another clinician was a bit more playful in her experience:

"I am interested which then I feel guilty about so it is a combination. I don't want to be rejecting some uncertainty if it is the best way to use our time. A little voyeurism, curiosity, there is an intimacy in that too; them handing you their phone, have you read something. Sometimes people will have me listen to a voicemail. How interesting! So it's a combination of curiosity and anxiety about setting boundaries."

One clinician in the study reported facilitating a text message therapy session. She described her experience:

"It was weird...It is a form that lends itself to not feeling fully present because you can be doing other things practically, not that I was. My computer was there and the rest of the room was there and it is just this little thing on my phone. It is not like you are fully engaged as either if you are having a conversation with your voice or if you're in the room...There is more a sense of I could be distracted...I was aware that I was doing something unusual and that I should be thinking about it. It was interesting too because I think even ending the session was different, like, the time was up. I told her on text but then she texted me something else and said 'Oh I guess it's too late' and I didn't answer. She was able to keep texting and it feels weird because she has my cell phone number to text. I was feeling like boundaries were a little less solidly professional."

This clinicians experience with distractibility and the shifting of the professional frame is representative of other clinicians' experiences with texting and cell phones in general as well. In sum, text messages for the purpose of check-ins and scheduling do help the real relationship as well as have mostly positive effects on countertransference. Their effect on alliance building was more minimal. Clients showing their text message histories helped with alliance and treatment goals, but had more negative and mixed countertransferential experiences.

E-mailing and the Therapy Relationship

Rapport and the Real Relationship

Because we are increasingly accessing our email via Smartphones, email has been included as one further capability of the cell phone. Clinician opinions about email on the cell phone functioned much like that of the text message. Like with text messages, the participants viewed email as a way to join, connect and check-in outside of the session. One clinician stated:

> "I would say that is a joining and alliance building proposition that 'You can email me'. A more tech savvy patient will feel more confident sending an email back. And even if the reply is just 'Thank you' we might have had one more point of joining there that they actually responded and replied with a note of appreciation."

In fact, one clinician provided an example of when her emailing with a patient provided him the support he needed to continue with therapy at all:

> "A couple of weeks ago I had a session with a client and at the end of the session he was kind of not so sure he wanted to make another appointment because it was very anxiety provoking. The whole thing was just emblematic of how he operates in the world, very avoidant. So, then I emailed him a few days after the session and just said that I hoped I would see him and that he was doing OK. I was thinking of him and he wrote me back and said that he really appreciated it. So I think that that definitely helped him know that I was accepting and thinking about him and that I really cared about him. That was important."

Like the text message, no clinicians reported that their clients were emailing them too much. Mostly, email between therapist and client acted as a reminder to clients that their therapists were there for them and cared. However, there were instances when email did negatively impact the therapeutic relationship. This clinician provided one of the two examples in this study:

> "I had this client who, uh, it was an adolescent and one of the parents- Sometimes you get these relationships between the adolescents and the parents where the adolescent's independence is terrifying and threatening to the parent… So I was constantly getting this barrage of anxiety filled emails saying basically how horrible the client was. And what happened then was that created an experience in me where I started to view the mother as all bad and aligned with the teenager. And ultimately that ended in a therapeutic failure because it got to be too scary for the mom because I started to push her away and didn't engage with her because she was so annoying on email. I mean, it gave me a great experience of what life was like for the adolescent, but on the other hand if I had only experienced the mom maybe every now and then in session, I wouldn't' have succumbed to that negative view of her and so that's an example of how it hindered a treatment. And ultimately I got so judgmental of mom and she felt that, that she pulled her child out of therapy."

In this case, email with the mother of a client impacted the therapist's ability to be unbiased with her and hindered the therapy relationship so much so that it ended.

The Working Alliance

Overall, the majority of clinicians felt that email with clients was alliance building. For example:

> "Email with certain patients was a little, like, surrogate booster session that could have taken place over the phone but was actually less practical to take place over the phone because of my time and the patient's own schedule. One patient in particular would email me as sort of like a vent."

Additionally, seven clinicians reported that they got important information about their clients through email:

> "There are times when I get very important collateral information through email like such and such was arrested, such and such had a DUI, you know."

In fact, one therapist reported that she had a client that was better able to express himself when using email:

> "I had another patient who, we were having a really hard time and he had a lot of ideas about the therapy and what the goals were and our approach that he, I think, was better able to express to me by email then he was in session because he would get really activated and had a lot of emotions and then by email he had a little more time to really think though what he wanted to say and say it more effectively and there I think it was extremely helpful in helping our alliance and we could use the session time more effectively."

Thus, email between the therapist and patient for check-ins, updates and to some extent venting, was reported as helpful to the alliance. Clinicians felt it helped clients to be able to update their clinicians via email in between sessions so that they did not have to carry difficult emotions with them without an outlet. Additionally, it provided the participants with important collateral information for assessment.

Moreover, the majority of clinicians felt that clients bringing in their own email exchanges to discuss in therapy was helpful to the alliance as well:

> "It definitely helps with alliance forming because most of the stuff that they bring in, if I think about it, is around relational conflict, relational problems and it definitely helps me understand what's going on better. So if they read me an

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email from someone they're dating then it allows me to understand what lens they're using to receive that data versus if they just describe it. I may be able to hear that lens less…This client I was talking about with the divorce would read me these absurd emails from her ex-husband. This guy was just a master at emotional manipulation, taking pieces of truth and spinning it into a story. And she had trouble, you know, kinda, not buying into that. So seeing that email-because she had been hypnotized- but seeing the email helped me ground in the reality of what was really going on."

Much like text messages, client email exchanges enhance the therapist's ability to reality test, get objective data, empathize and to understand the client's process.

Countertransference

Interestingly, clinicians reported more positive countertransference with client's email histories then with text message histories. This might be because, as one clinician explained, email does not require a response as well as most clinicians set clear rules with their clients about what types of emails they would read and how long they will take to reply. One clinician felt that client's emailing her felt completely natural:

"I feel like it's sort of seamless in the same thing with me that it's, you know, like the longer emails get included with the writer, you know, in the old days...then she brought me stuff, because she, I guess, had a printer at home. And I'd read it. And it just seems nice that I can read it in the modern age, you know. And so that feels like it's part of how we interact."

Another clinician felt that actually seeing a written record of the client's experiences helped him with his own countertransference:

"I fall into the trap of resisting what the client's saying. And sometimes this has helped me get out of that trap. I either overestimate or underestimate the level of distress that the communication is causing the client and sometimes I fall into the trap of self-blame like 'It's your fault client that you're acting this way'. And it has helped me get out of that judgementalness because I see the actual data. I see what the client is saying. It's important. Both sides right? Sometimes I get hypnotized by one's suffering and I get drawn into the drama and then if I see an email, you know, what are the facts?"

While many of the clinicians felt positively about email with their patients, it is important to note that there were diverse opinions about it. Many clinicians felt "overwhelmed" by the

length of emails they received. In addition, many felt unsure that reading pages of email outside

of session was a fair use of their time. Lastly, as this clinicians points out in the quotation below,

email allows a client to send a written history of a communication exchange without processing

it at all. One can thrust it into the arms of one's therapist for them to grapple with as a way to

avoid its content:

> "To me, the problem that can come up is just not knowing how much is the patient communicating to me. If she is just dumping thousands of words, I am not going to read it all and I feel like I have been put in this uncomfortable position of not knowing how much I really should know or not know in terms of what has been dumped my way…Huge dumps of text and email does not feel relational. It feels like a confessional where you're just not expecting a real dialogue but 'I'm just going to dump all of this on you and you sort through and get back to me'."

In sum, email is a very useful way to collect collateral information and contributes

positively to the working alliance most of the time, although it can damage it as well. Generally,

it increases rapport and the real relationship. Countertransference is mixed ranging from

"overwhelmed" and confused to "natural".

Social Media Sites, Photos and the Therapy Relationship

Rapport and the Real Relationship

Every participant who had clients bring in social media on their cell phones also felt that

these experiences increased rapport, closeness and the real relationship. As many of the

following quotations will demonstrate, social media such, as blogs and photos on Instagram and

Facebook, permit the client to share important aspects of their lives and themselves with their

clinician. Of particular importance is that these social media sites provide the therapist with a

fuller, richer and often more positive picture of who their clients are. The therapists in this study

gave many examples of how seeing a clients' blog or Facebook showed their clients strengths,

which gave an invaluable contrast to the problem-focused nature of many therapy sessions. One

clinician highlights this way that photos on a cell phone built the real relationship:

> "When this woman brought in her pictures. She is someone who struggles with anxiety and dissociation and trauma and I saw a different side of her because she showed me this wonderfully artistic, very impressive- We spend so much time talking about what's not working, it helped me appreciated the real strengths that she had. And so it gave me a different lens, a different experience actually of her. An experience of someone who's competent, who has a- something to add to the world, you know, a skill. And that was great for our relationship. It gave me a different perspective on it…I think it is actually helpful for rapport because they want to share a part of their life with me. There may be a sense of pride there and love and so I want to support that. So looking at the pictures and just making a nice comment about that…you know, in general, I think it does add to the warmth of the relationship."

One clinician explained that allowing a client to use games on their cell phone helped to

create initial rapport and establish a relationship:

> "Because it's a game and it's something that's familiar to them. And here's this grown up doing it with them and enjoying doing this with them and it doesn't feel like therapy. It just feels like, you know, we're having a good time over here. Then it totally eases up things between the both of us…Kids are generally very aware of therapists asking a lot of questions. Oaky, they're very weary of adults because, you know, what is this adult going to do with this information that I do, that I'm going to provide, okay? But if you get at their level and you play at their level and you are comfortable at their level, they'll go along with you. They'll be totally fine with you."

Another therapist commented on websites like Facebook and Instagram and their effect

on the real relationship in general terms:

> "It is more intimate. They are bringing me right into their world, which is good and bad. It's good because it makes them feel connected to me and I can have a better chance of understanding and reassure them that, you know, I am available to receive the communication that they want to give me, but it takes away from sort of the opportunity to filter everything through their own consciousness, which is potentially extremely formative in a different way."

But, not all the clinicians in the study were convinced that social media and blogs

affected the therapeutic relationship at all beyond creating more closeness. This clinician agreed

that seeing a client's blog helped them get closer, but maintains that it did not do much beyond

that:

> "I think being able to see the window of someone's writing through a blog was something that brought that relationship closer. You know, beyond that, you know, the closeness I wouldn't say has been a driving factor with the use of technology. It is more just easier access to more data that we are sharing collaboratively together. I haven't seen it deepen the therapeutic relationship."

Furthermore, one clinician, who also provided examples of how gaming can build rapport,

cautioned against ways in which the use of gaming can actually separate the client from clinician

instead of increasing closeness. She comments:

> "Well I think it depends on the kid and sometimes it's a diversion. And sometimes if- I'm thinking of a kid who was mad at me, and so went over to the computer and I said, 'Oh I see that! You're maybe mad at me right now so you don't want to have anything to do with me. Go ahead. That's all right. You can be mad at me'".

In this case, her client uses games on her work cell phone in order to avoid interacting with her.

As this clinician warns us, it will be important for clinicians to be aware of when clients use cell

phones to connect with their clinicians and when they use them to avoid something painful.

The Working Alliance

As with the real relationship, social media websites bolster the working alliance because

they provide additional and often essential information for the therapist. The therapists explained

that this is useful because it can help them to literally see a person or a situation that is discussed

in therapy. For example:

> "Like if it's a pet or a spouse, on a superficial level, just to put a face to the story can be helpful. But, if it's something more along the line of- I had a patient who was a special ed. teacher and her classroom was completely destroyed by a kid who had a tantrum. And the see that, that's traumatizing; to see the condition of the classroom after all that. It really helps put me in their experience. And so to that end, that's helpful."

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In this example, being able to see the state of his client's classroom allowed this therapist to empathize better with his client and to deliver more effective and appropriate interventions.

In addition, clinicians have been able to use information from client's sharing social media websites to inform their treatment goals as well as to check in about treatment goals. This clinician provides an example:

> "I had one client who is an older, gay, male, middle aged, gay, male, who a part of his own treatment goal was to stop chasing after 21 year old guys and he was showing me the guys that he wanted to go on a date with on OKCupid and Grinder and all of them were 21 year olds and I was like this doesn't match with your treatment goals, but it is cool if that's what you want and I brought it up and it fostered this good conversation about self-doubt, shame and societal pressure. It was pretty cool."

Here, a client sharing dating websites opened up a conversation around how his behavior was not matching the very treatment goals he had put forth for himself. This was important information for the therapist and allowed them to work on the alliance together.

There are many more examples of when the sharing of a social media site has deepened a therapists understanding of their client and moved treatment forward. For example, one clinician examines instances in which important information about risk behaviors have been revealed and assessed using Tumbler and text messages:

> "They've been very focused on some of their self-harm behavior on their Tumblers and seeing that has been very diagnostic and informative and helpful and having the kid be able to share that with us when they're hiding it from parents has been pretty critical, really, to their treatment. And we do have kids- and the other scenario, as I've mentioned, is around sexting, being online with guys and what they're saying and what the guys are saying and if they'll let you into that it can be really helpful to get a sense of functional level and risk."

Another clinician depicts a similar example:

"She had a lot of issues with her dad. And when I saw the picture that she showed me, the pictures on Instagram, or whatever the heck it was, there was a lot of death. There was a lot of death and a lot of blood. And that kind of, like, opened up doors to: 'Have you ever wanted to hurt yourself?' And then we were able to tie it in with how her relationship or lack of relationship with a parent had prompted her at times to think of hurting herself."

In both of these examples, social media sites accessed on cell phone offered essential diagnostic and assessment information that shaped treatment and the working alliance. Both of these clinicians agreed that this information probably would have surfaced without the social media, but also that it did bring it up much faster, which is important when safety is involved.

Fortunately, clinicians also reported that social media websites expanded their understanding of the strengths of their clients as well. One clinician illustrated her experience:

"It was really helpful seeing some of her Christian-based beliefs coming through that are a huge source of strength for her that I think she filters sometimes just to interact with non-Christian people and mainstream, secular culture. I was very much aware that she was Christian and that this was important to her but I hadn't seen her genuinely and uninhibitedly talking about it except for this blog. And seeing how she is using prayer and her relationship with G-d to help her manage her emotions and manage her relationships through her words unfiltered was really helpful data…I think showing me her best sides that come out through her blog was really validating for her…I think that was some data we were missing when we were so problem focused. It was a bit myopic and neglecting the other rich aspects of her life."

For the clinicians in this study having access to their clients social media websites, blogs, dating sites and photos on their clients' cell phones had an important impact on the working alliance. The level of risk or trauma becomes clearer with a photo attached. The mismatch between a client's treatment goals and their behavior can be illuminated. Clients become fuller, more complex individuals as their strengths can be explored on these websites. All of this contributes to the therapist understanding of their client and how to deliver them the most appropriate treatment.

Countertransference

As with many of the cell phone technologies, the participants reported varied feelings in their countertransference. Some clinicians felt that the cell phone provided access to things clients have always brought. One clinician commented that before email her clients would bring in letters and before photos on a cell phone they would bring in hard copies. Another therapist echoes the same sentiment:

> "I kind of like it. Like I would any kind of production that they would bring in. I mean, I've almost always had clients bring in pieces of their lives in one way or another, especially if they, you know, they bring in poetry, they bring in journals, they bring in art they've made and I always feel that that's a window into another aspect of a person. So I feel like the photography is the Facebook…There's hardly anything that's more central to their lives these days than their social networking so I kind of enjoy it."

For these clinicians, they "like it" and it is not so different than things clients shared in the past.

For others, it can feel a bit uncomfortable or awkward:

> "It is interesting because it breaks the frame. They're either wanting me to come over to the couch to sit beside them or they are coming over to hand me a phone and say 'look at this'. Physically it shifts the scenario, which is something I have to think about.... It is a little awkward I think. I think it is because of the psychical boundary that changes. There is something containing to me as the therapist, to stay a comfortable distance away because there is a lot of energy going on. I like that boundary. That's what's hard for me; when clients break that physical boundary and they want to come over and give me their phones and hangout right there and tell me about these really personal things. I think to some degree it makes me feel closer to them but sometimes it feels a little uncomfortable for me."

And for some clinicians, there is a point when enough is enough:

> "Well I think one client that I was telling you was kind of, like, shoving these photos in my face, um, I just put the boundary down. I'm like this is exceeding the boundary. It's indulging her and gratifying her in a way that clinically is not appropriate. And beyond that, in a countertransferential way, it's creeping me out."

Table 4: Social Media Sites

Aspect of the Therapeutic Relationship	Benefitted	Neutral	Hindered
The Real Relationship-Closeness	11 (100%)	0	
The Real Relationship-Disrupts Closeness	2 (11%)	0	
Working Alliance-Assessment	11 (100%)	0	0
Working Alliance-Client Strengths	11 (100%)	0	0
Working Alliance-Treatment Goals	4 (22%)	0	0
Countertransference	"Increased ability to understand client experience"; "Understanding of client strength"; "Fuller picture of the client"	"Same as always"	"Uncomfortable"; "Awkward"; "Crosses boundary"

Mental Health Applications and the Therapy Relationship

Rapport and the Real Relationship

Of all the technology on a cell phone, mental health applications seemed to have the least

effect on the therapeutic relationship. Only two clinicians were able to comment on their effect

on rapport and even then the following comments indicate an indirect relationship between the

cell phone application and the real relationship. The first quotation discusses how rapport can be

increased by the client's excitement while using the application in their treatment. The second

highlights how mental health applications are proof that the therapy is working and therein instill

a sense of trust in the therapy relationship that increases rapport. The first therapist describes

how he sees rapport being affected in a group setting:

> "I think that when I periodically will mention in a group therapy context that there
> is an app that allows you to track your days sober…They are happy to bust out
> their phone and you kinda see that sense of appreciation and a little bit of

inspiration…You might see them pull out their phone everyday for five weeks to track their days and for me that's like, 'Yes! Mission successful'".

The second clinician discusses how the real relationship can be influenced by mental health applications in an individual therapy context:

> "The effects of hope on trust. You know, if a patient feels hopefully that therapy's going to be affective the underlying feeling is that they trust you. You're giving them the sense that their life could be different. And to that end that they sense that they could trust me, I feel the natural consequence is that they relationship is closer in someway. And the app is a proxy for that."

Although only two clinicians felt mental health applications positively affected the real relationship, none of the clinicians reported a negative impact.

The Working Alliance

While clinicians reported little affect on rapport, they did see mental health applications as very helpful in alliance building. All the clinicians reported that the mental health applications were used in accordance with treatment goals. For example, one clinician describes how she uses alarms on cell phones to help with treatment goals:

> "I'll actually ask patients, since I'm coming from a CBT approach, I'll actually ask them to set their cell phone alarms at noon to check in on their mood or an alarm at 10pm to start winding down for bedtime. Basically to try to really implement their homework assignment because people will forget and move on to their daily life so we'll use external reminders to help them."

In this case, this therapist uses the alarms and reminder functions to increase treatment compliance and homework completion both of which are directly related to treatment goals and the working alliance.

One clinician explained how she used a mood tracking application for assessment, another aspect of the working alliance:

> "The mood tracker was very helpful for him because on the one he would kind of constantly have a high level of symptoms but the mood tracker would show his mood as actually pretty good. So, just having that contrast, that was useful information for assessment and we would discuss what was going on and why this was high and that one was not so high."

Here, the client reported one mood state verbally and another using the mood tracking application. The use of mental health applications revealed an inconsistency between how badly this client perceived his mood versus how bad it actually was. This was essential information for both client and clinician for treatment that was gained through a mental health application on a cell phone.

As with rapport, one clinician discussed the mental health applications affect on the working alliance in terms of a tool for creating hope within the client:

> "Only in the sense that it gives them a sense of hope. That they can have an idea that there's something that they can do about their lives and that app is a tool. And to that end the hope instills a sense of trust in the relationship in that therapy can be effective and to that end I think that it can be helpful to the alliance."

This therapist views cell phone applications as means through which clients can see themselves improve. Using this tool, patients are able to believe in their own ability to change as well as in the power of therapy as treatment. This positively impacts the working alliance between client and clinician. Another clinician added when asked if she feels mental health applications benefit the working alliance:

> " I do. I do. I think it is just- I mean I can absolutely relate to if I don't have an external reminder that's saying 'Wake up today!' then I will not wake up on time. And so I think it can certainly be an aid and particularly with the population that I am working with which is high anxiety, overwhelmed with many tasks and organizationally overwhelmed, having this way to keep them in check and grounded can help."

For her, mental health applications can provide needed supports to clients in their daily lives and therapists can help them in this process. She also points out that this type of intervention can be particularly helpful with populations who have issues with anxiety.

While most clinicians using mental health applications felt they helped the therapeutic alliance, one did not. For him, mental health applications such as symptom tracking and mood tracking provide no new data that any "good" clinician would not know anyway. In his opinion, these applications do not provide any new information for the therapy. As he puts it:

> "I just don't know how interesting just symptom tracking data is when I can just ask someone how they're doing…It's like, 'Did you not know that? Did you not know that from working with them?'"

For this clinician they are essentially useless.

Countertransference

Of all the cell phone technologies therapists were using, the mental health applications draw forth the fewest countertransference experiences. This is likely because clinicians are not using them much in the treatment itself. Mostly clinicians refer their clients to an application and then let them make use of it on their own. Clinicians reported that they either never used them in treatment, and therefore had no experiences with them in session, or they would check in around symptom tracking, but the application itself played a small role in the relationship.

One clinician did mention that she felt pressure to respond when one client showed her the applications her client had found; it was an uncomfortable experience for her. As states:

> "I feel pressure when somebody shows a phone, or even the client that was showing me apps that she was going to use, to say 'Good job' I don't know that it's helpful. That feels like that is more social; I am your friend and not as conscious a kind of communication."

Another clinician mentioned one concern he had about referring people to applications that facilitate social contact:

> "And then there's always a possibility something like MeetUp.com, which I truthfully know nothing about. Like, this guy could go on some kayak event where everybody was drinking and it could have been a disaster for him…and those issues become outside of my control."

In sum, mental health applications had the least amount of impact on the therapy relationship. Usually, a clinician would refer a client to an application and then only sometimes the data collected on that application would be discussed. Because of this process, the real relationship as well as countertransference was not influenced much. However, the clinicians agreed that mental health applications did help with the therapeutic alliance including addressing treatment goals and assessment.

How Personal Cell Phone Use Affects Therapist Use of Cell Phone in Work

Due the participant responses, the following question was added to the interview in order to reflect the emerging theme: Does your personal use of cell phone affect how you use it in your professional work? Because the question was added later into the interview process, six people were not asked this question. Of those who were, ten clinicians felt that their personal use of cell phone directly impacted how they used the cell phone in their therapeutic work. Of these ten, three felt it helped them to organize both their personal and professional lives. One of the three felt it improved his customer service capabilities.

One participant explained that her comfort with cell phone technology allowed her to be more open to its integration in session. She speaks about cell phone games in particular:

> "I'm just more comfortable with it. And I ask the kids about it. And I've been able to translate to the parents what it means. Like I was thinking it was a cold medium and all the time they spend on there they're not interacting with other people. But then as I talk to them, I found out...they are actually interacting through all these games. They play games together and against each other. They are making judgments about each other about who's fair and who's not. It matches some of their values."

Another clinician considered how simply owning a Smartphone increased her cell phone use in therapy:

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> "I think that just having a Smartphone for example, I got the email and the text and all that is very easily accessible to me. I think it makes me more likely to use it as opposed to if I didn't have a Smartphone. I just had my home computer, then I might discourage people from using that because I would get it much less frequently."

Similarly, clinicians who do not use their cell phones very much in their personal life also did not use it very much in their professional work:

> "I could probably be more cell phone savvy. Um, and I know there are apps. Now out there. I just recently got and I Phone for work and it's pretty new to me and I'm learning it since I don't have a Smartphone, I don't have a personal Smartphone.... I haven't explored that yet.... If anything, I just could probably utilize it more, but I am just not quite of that generation and I'm not always tied.... to the cell phone."

While the cell phone's affect on therapy from the therapist side is clear in this study, two therapists denied that their personal cell phone use affected their professional work. In fact, one therapist argued the opposite:

> "Once we started using cell phones in our professional lives and I had to have it on me and be available, I started using it for more things because I was, like, glued to it. Before it was part of my practice, I actually had more distance from my cell phone than I do now. So I feel like it's actually become more a part of my personal life because it was in my professional life than the other way around."

This might be due to the fact that this person is a DBT clinician. As part of the practice, DBT encourages clients to call their clinicians anytime for in vivo skills coaching. This requires that the clinician be by their cell phone and available at most hours of the day.

The fact that the majority of the clinicians affirmed that their personal use of cell phone affects how they use it in their therapeutic work attests to the fact that cell phones truly are shaping the ways we interact with each other. They are affecting how therapists interact in their professional work. They are informing treatment interventions. One's personal use of cell phone helps one's understanding of how one's clients are using their cell phones. It helps therapists organize.

How Agency Setting Affects Therapist Use of Cell Phone

Every therapeutic setting comes complete with its own rules, policies and regulations. As such, the varying practice settings that the participants worked in influenced how they were able to use cell phones in the work. This section answers the question: How does the setting in which you work affect how you are able to use cell phones? This question was added later in the interview series as it became clear that the professional setting played a large role in cell phone use. Because of this and time constraints, not all participants were asked this question.

Nine clinicians answered in the affirmative that their practice setting directly affected how they were able to use cell phones in their work. One clinician responded that it "kind of" affected her use. However, this clinician worked in a school where the students were not allowed to have cell phones out at school at all. As such, she reported very low levels of cell phone use on the part of her clients. In addition, she was using her work cell phone mostly to communicate with parents of the students. This was true of the other clinicians who worked in schools. In other words, the rules of the school highly impacted how much clients were able to use their cell phones as a tool in session as well as who the clinicians used their cell phones to contact. Four of the five schools discussed in this study block certain websites so social media was also not accessible to be used during therapy. Lastly, three of the five school clinicians were provided with work cell phones.

In fact, one clinician in a school setting described how the anti-cellphone school policies affected how he viewed cell phones in therapy:

> "I get the frustration because they are always on cellphones but there is a lot of yelling, a lot of aggressive anti-cellphone in school systems when I feel like there can be a happy medium. If there is some way we can incorporate cellphones...and figure out a way to use it because the adults are yelling at the kids about cellphones."

This clinician is wondering if there might be a way to create an alternative experience in therapy with an adult who is open to participating in using a cellphone with an adolescent client. This may prove to be an important corrective experience to the constant yelling about cell phones that occurs in schools.

In contrast, clinicians in private practice have full control over how much they choose to use their cellphones in their work. As one private practice therapist explained:

> "It's completely up to me...This way I get to make my own policies as long as my colleagues, who all, I would say, use their cell phones in the same way I do. We're kind of on the same page, so as long as that's happening, I can do whatever I want."

Working in a medical system affects the use of cell phone as well. Clinicians are not allowed to provide their personal cellphone number. The two clinicians who worked in medical HMOs did not communicate with their clients using a cellphone. However, they were able to prescribe mental health application as well as have their clients tell them about their lives using their cellphones. One of these clinicians explained why he does not need a cellphone in his work:

> "We have secure messaging through our website in our system. I have my own office line that they can call. There's a crisis line if there's a problem."

For them, there is a system in place that takes away the need for the therapist to be reachable by cellphone.

The culture of community mental health clinics also influenced cellphone use. Clinicians were provided with office lines as well as professional emails. Most importantly, the clients are

generally more severe and in crisis more often than clients in private practice. One clinician explored how the client population shaped her cellphone use:

> "Agency clients tend to be a little more needy, in some ways. As a generalization, the general population of clients are more social-service consumers and they are more used to relying on care-provides, case managers, etc."

This clinician explained that since this client population sometimes needs more extended support, and for good reason, she is less likely to give her personal cell phone to these clients right away. Instead she waits to see if that would be clinically indicated.

At the same time, there are instances in which working in the community necessitates the use of a cell phone. Another clinician working at a community mental health agency uses her cell phone often to find her clients homes for home visits, to call or text her clients to let them know she is at their home, and to keep track of her gas mileage in order to be reimbursed by her agency.

The agency in which the participants worked played a large role in determining the ways in which they could use their cell phones. Those in private practice had the most freedom and were able to use their personal cellphones as much as they wanted to. The clinicians who worked in school settings used cellphones to contact parents, but did not contact their direct clients very much. Those in medical HMOs did not use their personal cellphones at all although their clients still could. This is important to note because the use of a cellphone might be appropriate in some therapeutic contexts while not in others. On the other hand, some therapeutic services may be underutilizing the cellphone.

Increased Access to Therapist

The cell phone represents the possibility of access to increased contact and communication with one's therapist. The study's participants were of two minds about this; some

clinicians worried that communication outside the session might create increased dependency on the therapist within the client. Other clinicians argued that increased contact would facilitate the implementation of skills outside of the therapy room. Half of the clinicians felt that increased access would have a negative outcome for the client. One therapist explained why:

> "I don't want to encourage multiple modes of communication that seem like they could be instantaneous. I also think it is very counter to the ideas that you are trying to develop in therapy about waiting gaps and times...There is a lot about learning to live with wait, gaps, pauses, a rhythm, that the sessions come in a rhythm. You know that we are not about instant gratification in our work. We are about trying to create space for thoughts and feelings to kind of emerge and bubble up over time...I actually think it is not growthful to get things instantaneously. It is like the mother who cannot wait a second to give the milk...It gives the message to the patient you think they can't wait. It creates a certain dependency that I think goes beyond what our roles intended to be. We are trying to help someone internalize reflective function."

The above quotation touches upon many of the concerns the other eight therapists also had. The first is that increased access to and therefore increased communication with one's therapist is actually counter indicated to the goals of therapy. If the goals of therapy are to help one's clients believe that they can survive difficulty on their own, then the ability to access their therapist all the time will impede the growth of that belief. Because the client can turn to her therapist at any time, she will not believe that she can survive on her own and therefore she will not believe in her own capacities to tolerate distress. This therapist argues that it is in the moments where a client has to wait to see her therapist that the client begins to believe in and depend on herself. Secondly, it communicates to the client that the therapist does not believe that the client is capable of making it on her own. This is a powerful message for the client to receive and could increase dependency on the therapy relationship.

Along the same lines, another clinician explained that access to one's therapist outside of session could decrease one's sense of self-efficacy:

> "You want the person to learn that they can tolerate the thing that they think is not tolerable. These issues of self-efficacy and agency come into play when you want them to feel and to perceive that they made the choice themselves. And that they were the one who ended up being capable of dealing with it."

This therapist echoes the importance of the client tolerating difficulty on his own so that he knows that he is capable of doing it. If the therapist were always there to save the day, the client would not learn that he could save himself. Additionally, a third therapist highlighted that less access increases the responsibility on the part of the client:

> "They've been victimized so many times that it's easy to be a victim in this circumstance too and if you kind of force them out of that comfort zone and to look at the resources and to, you know, see what's available in their community, and to connect with other people that have been through similar things, they're empowered out of that roll of the victim...They need to bring their part to the table."

In other words, containing access to the therapist to mostly within the session can empower the client to look for resources in her own community and to build more long-term support systems in her daily life. In addition, it teaches her that she is not a "victim" but has control over her life. Lastly, this therapist reminds us that the client has a job in therapy just as the therapist does. Their job is to work on creating a support system for themselves that exists outside of the therapy room. While the therapist certainly assists in this process, too much support could hinder the client from turning to other resources.

Two of the nine therapists spoke to how the ability to access one's therapist might actually overwhelm the client too much. For example,

> "I think it is a little overwhelming for them to think that they can just call their therapist directly. I think it is important to keep the boundary because we are not friends. It is not a personal relationship and I don't want there to be any confusion about that. It is a professional relationship and I think by holding that boundary it gives permission to really bring their stress in."

Maintaining clear boundaries around the therapy relationship itself as a contained, professional relationship are the conditions that allow clients to be vulnerable with their therapists. And,

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boundaries are important for therapists too. One clinician worried that he would not be able to leave work at work if his clients had the capability to access him on his personal cell phone. Finally, five of the nine clinicians explicitly stated that increased access to one's therapist would blur the definition of what the role of therapy was. Some private practice clinicians worried that they would be treated as a crisis line and one clinician wondered how much of his personal time would be consumed by this.

While half of the clinicians were able to articulately explain why increased access to clinicians would negatively impact the therapeutic work, 28% of the clinicians believed that increased access to the therapist was integral to their work. Of these five participants, three identified as CBT or DBT therapists, who use cell phone coaching outside of the session as part of standard treatment. For them, it is impossible to transfer the skills discussed in therapy to daily life without some temporary help. One CBT clinician explained:

> "I think a lot of things happen outside of session that are relevant to the work. And then when they get triggered by something or they're having a really hard day mood-wise or whatever it is, they can tell me about that. We can work on it right there and have them use their skills as opposed to, we talk about it in retrospect, a week later. Actually, a lot of really good work gets done by texting sometimes."

This clinician points out the practical limitations of having access to one's therapist only once a week. A lot happens outside of the session and there are really benefits to the client to be able to process it right then and there.

Contrary to the views of the participants who were concerned about increased access, one clinician discussed how reaching out to one's therapist is in alignment with the goals of therapy:

> "I have a client that idealizes independence as the linchpin of masculinity and that can be a true barrier to reach out to anyone including his therapist."

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In other words, part of therapy is helping clients increase healthy help-seeking behavior. Allowing access to one's therapist via personal cell phone might foster those very behaviors. Not only that but also this clinician felt access to her benefited her relationship with her clients:

> "I think that is does deepen the relationship that I'm not just there for one hour a week in this very defined and compartmentalized way."

A DBT therapist elucidated how phone coaching works and way it is helpful to the client:

> "The reason that is encouraged is if they are in crisis and need to apply DBT skills to the crisis. So that's what we encourage them to contact us for. So the idea is generalization of skills in the moment, outside of the office, sort of in vivo behavioral work...you kind of have to train clients how to use you appropriately to get help."

Just as in CBT, DBT also believes that access to one's therapist on a personal cell phone is an essential part of therapeutic learning for the client. And, as this clinician points out, there are specific ways to use this that are taught to the clients.

Lastly one clinician provided an important example of how access to clinicians on their personal cell phone can truly benefit the client and the work. This clinician works at a school and has a work cell phone that she carries with her always. One evening she got a text from an adolescent client that he was having thoughts of suicide. She urged him to talk to his parents about it as they "were in the next room", but he would not. She recounts:

> "So I ended up calling the police and a policeman came and checked on him. That was kind of a wake up call for him that I was taking him seriously. And if I hadn't gotten that text, I wouldn't have known that."

In this example, the cell phone became a crisis line through which a client could reach out to his therapist in a time of need and therein receive the appropriate intervention.

The participants provide us with real benefits to and cautions about client access to clinicians on cell phones. Some clinicians feel that this interferes with the therapeutic work by creating dependency, by decreasing the clients' belief in their own self-efficacy and by blurring

the role of the therapist in their lives. Others feel that contact in between sessions is the means through which clients learn and heal.

It is important to note that while the majority of the clinicians expressed some concern about their clients having access to them, only one person reported ever feeling that a boundary had been crossed. Seventeen of the eighteen clinicians reported no clients ever abusing their access to their therapists' cell phones or work lines. Two of the seven-teen reported two occasions when people in their clients lives over-stepped, but these instances were not the client. Finally, one clinician reported being "stocked" on Facebook by an ex-client. However, this client had not been given the clinician's cell phone number.

Therapist Concerns About/Resistance to Cell Phone Use

As alluded to above, the participants had a multitude of concerns about cell phones entering the therapeutic work. One major concern therapists had was that once clients had their cell phone numbers, they would be able to find out other things about them. One clinician related:

> "Finding me on the Internet, you know, like my personal life because everything is so interconnected. For example, Facebook, I don't know how many times I've been getting from Facebook, um emails saying update your cell phone, update your cell phone because they link your cell phone with your account...You know, the therapeutic relationship is very one-sided. It's not about me. It's about them. Okay, and I don't want any type of projections about what my life is, is about. This is about their projections of their life onto me, not them being able to project based about how I live, or whom I with, or how I do things."

The other clinicians echoed this sentiment as well. The idea that the client might use their cell phone number in order to find out other personal information about their therapist feels both uncomfortable for the therapist but also might get in the way of the therapeutic work itself. According to psychodynamic theory, the client will inevitably project onto their therapist past

relationship dynamics, fantasies and even parts of themselves. As this therapist points out, if the client knows too much about the therapist, it could get in the way of this process.

Another primary concern for the participants was boundaries. This included both appropriate boundaries with clients as well as the ability to maintain healthy personal and professional boundaries for themselves. Eight clinicians worried that they would have difficulty creating a healthy and happy work/life balance if their clients had their cell phone numbers. They worried they might want to respond to text messages that are received late at night or that they would have difficulty compartmentalizing work from their personal life. One clinician called this boundary her "self-protection". Ten clinicians were concerned that a client having their personal cell phone number would blur the boundary of the therapy relationship. One clinician detailed the reasons she would hesitate to give out her cell phone number:

> "It really gives the idea, and especially with like, I think, a young clinician, um, it really names that this is a professional relationship rather than a personal relationship. Um, and getting a phone call on my personal phone, from, like accepting a phone call, like, on the weekend, like a chatty phone call from a client's family, or you know, on the weekend blurs my own boundaries and so it makes it harder for me to say, you know, 'This is my weekend.'...And so just having the separation of a different number, um, I think gives me permission to, to say no if I need to."

This clinician explains how giving a professional contact her personal cell phone number might complicate the boundaries of the relationship both for her as well as for her clients.

A third concern for the participants was the fact that communicating via a cell phone is neither confidential nor secure. As a result, clinicians become more vulnerable to issues of liability. Three clinicians worried specifically about the security of cell phones and six were worried about how cell phones might increase liability. Related to this, two clinicians mentioned their concern that text messages and email provide a written record of what was said. Additionally, three clinicians pointed out that currently there is no professional standard around

cell phone use, which increases clinician vulnerability. One clinician spoke to many of these

issues:

> "I don't know the technology well enough to trust that it really is secure. Um, I don't necessarily want somebody being able to, um, mistakenly or intentionally forward something that is shorthand, intended for someone, that could be misunderstood, even by that person much less somebody else. Similarly, you take the risk with email, you know, that someone could easily forward an email that you send. So, I'm very cautious...If you go too far down that path, hopefully you know your clients and trust them, but you never know what someone's going through or how they'll interpret something or if you piss them off and there's a natural break in the relationship...But then, professionally, I don't want something to get misconstrued or misguided that I'm gonna have to try to defend or try to come out on when there's confidentiality issues and there's my own professional standards."

This quotation represents many of the concerns other participants shared. She highlights that cell

phones are not secure, that there is a written record, that there are liability and legal issues at

stake. Furthermore, she adds another concern: that communicating over email or text message

with a client can easily be misinterpreted. This could lead to small disagreements and even to

disruptions in the relationship.

Issues of client dependency resurfaced here. Four clinicians worried that having the

personal cell phone of one's therapist would increase the dependency of the client. One therapist

said:

> "You really want them to terminate and move on to somebody else. It broke my heart with that kid. I hope he has transferred that connection to the next therapist and fortunately he did. Because really what you're trying to do make them self-sufficient and not be dependent on the therapist for the rest of their life and help them build skills for themselves and the family. So you don't ant them to think that they can always call you."

As explored in the previous section, some of the participants worried that being able to contact

one's therapist via their personal cell phone might create a relationship of dependency that is

ineffective in the long-term.

Other concerns included lack of clarity as to how to bill for time spent responding to emails or text messages. Similarly, two clinicians wondered how much of their time would be taken up by various emails and phone calls from clients and how to handle that. Two clinicians felt that younger clients have too much screen time in their daily lives and therefore did not want to increase it in therapy. Others described how the cell phone breaks the frame of the work and can be disruptive to the session.

It is important to note that while fourteen of the eighteen participants discussed concerns that they had about including the cell phone in therapy, four clinicians had no concerns at all about it.

Benefits for Therapist

While the participants had many concerns about the entrance of cell phones into therapy, they also felt it provided many benefits. Seven clinicians mentioned the convenience of the cell phone. For example, one clinician explained that texting and/or emailing decreased the time spent playing phone tag with a client. Five clinicians reported that the cell phone increased their own efficiency and organization as well as the clients. One participant described:

> "It can also help people, you know, with, you know, being organized, or with skills, or keeping up with homework, or things like that. And also with the communication and convenience, you know, to do Skype sessions or phone sessions or things like that. Because people's schedules are busy and changed and so on and so we need to be flexible to meet their needs."

As this clinician elucidates, the cell phone aids the therapist in meeting the everyday needs of their clients. Additionally, it helps the clients increase treatment adherence and homework completion. Two therapists including this clinician felt that cell phones helped with homework completion. In addition, one other therapist agreed that the use of cell phone facilitates in "customer service".

Nine clinicians explained that using a cell phone in therapy is in alignment with the cultural norms of today, especially when working with youth. Many of these clinicians argued that the cell phone was one way to "meet the client where they were at" as well as a means to enter into the client's world. Others described the cell phone as an "extension of the client's self." For example,

> "I think it brings a part of the clients self into the session that wouldn't be...I think there is something so rich with how they choose to present themselves in the office and that can be really cool for them and it can be this whole other world that they can create and play around with."

The cell phone makes room for clients to show various parts of who they are and explore them in therapy.

Many clinicians discussed how the cell phone often makes communication possible. Two clinicians felt that using the cell phone for therapeutic work was better than having no session at all. Additionally, three participants saw the cell phone as representing a more diverse array of means to get in touch with their clients and their clients' parents. In fact, one clinician reported that it comforted her to know that her clients had her cell number and could reach her if needed.

Many clinicians recounted the ways the cell phone could be used as a tool and intervention in therapy. As mentioned earlier, five clinicians used their cell phones to access videos with the purpose of psychoeducation and validating and normalizing their clients experiences. Cell phone applications are used to track moods, to journal, to identify triggers and to find resources in the community. Alarms and reminder functions on phones are used to increased homework compliance as well as in the treatment of ADHD. One clinician explained how he sees it:

"It's a tool. Just as much as discovering fire transformed our lives, I feel like integrating apps and technology into our lives opens up a wholes host of opportunity. I mean before we were eating vegetables and raw meat and all of a sudden we can cook and we don't have to work as hard because we can digest our calories much easier and we can sharpen blades with fire. And with (cell phone) technology, you know, I mean you can reach out to online communities. And you can message your therapist with your thought on the fly. You don't have to wait a week or a month or whenever it is the next time you see them. It just gives them more freedom and opportunity in their lives. That's why I think it is so powerful."

As this clinician likens the addition of cell phones into therapy to the discovery of fire, he illuminates how they have the capacity to change therapeutic work for the better. For him, the cell phone is a tool that allows the client greater access to support both from community and from their therapist. It represents a new way for clients to access mental health and help themselves get healthy.

Limitations of Cell Phone Use

Although it is clear that therapists are increasingly using cellphones in their therapeutic work, it is important to note that its use has limitations. Certain populations may not benefit from the use of cellphones in therapy. Clinicians pointed out individuals who are severely mentally ill, who are in substance abuse treatment, who are suicidal, or who have social anxiety and/or interpersonal issues as examples of populations who would not benefit from cellphone use. For example, it would be more difficult to tell if a person had been abusing a substance if the therapy were conducted over text message or even just over the phone. In addition, it would be more difficult to work to decrease cravings and releases using a cellphone. Second, one clinician said that it is more difficult to accurately assess for risk factors, such as if a weapon is accessible, when not in the same room as someone.

The same clinician explained that mental health applications are to be used only as an addition to therapy. They are not meant to replace one's therapist and should be used with the

guidance of a professional. One clinician summarized the above points when discussing cell phone apps:

> "I think for people who are particularly high functioning and technologically savvy and well motivated then that's a better fit for them. But, for people who are in greater distress specifically with severe depression, I think that having an actual person help them through it- there's no substitute for that. So I support the technology with caveats, with conditions. It has to be specific to the person's need and their ability to use the technology effectively."

Additionally, one clinician pointed out that he has stopped facilitating certain types of treatment over the phone as well as over Skype because he feels that they do not work when not conducted face-to-face. He identified EMDR and exposure therapy as two treatment modalities that must be done in person.

Summary

This chapter represents the findings of eighteen interviews with clinicians who have experience with cell phone technology as part of therapy. Participants were asked questions about their use of cell phone technology, their clients' use of cell phone technology and how this affected the therapeutic relationship. Nine clinicians felt that cell phone use helped to increase rapport and benefitted the real relationship. Three felt that cell phones could both help and hurt rapport and four felt it had no effect. Ten participants agreed that cell phone technologies aid in alliance building. Six felt it helped somewhat. On a related note, all clinicians except for one felt that cell phones are helpful in assessment data collection as well as aid in increasing insight about their clients. Eleven reported that cell phone use could assist in the formation of treatment goals, while five did not. Finally, the clinicians had varying countertransference experiences with their use of cell phones in session from "sweet" and "fun" to "annoying" and "uncomfortable".

Overall, the participants agreed that the cell phone is an unstoppable force in therapy. It has become a staple part of our culture and how we interact and therefore it has become a part of

what is discussed in therapy. Therapists are using it in different ways and view it as fitting into therapy differently, but it is undeniable that clinicians are using it in therapy and that for the most part it is helping the therapeutic relationship.

The following chapter includes a discussion of these findings as they apply to therapeutic theory as well as the previously reviewed literature. In addition, further discussion of the strengths and limitations of this study and implications for future research will be addressed.

CHAPTER V

Discussion and Conclusion

Introduction

This study explored clinicians' experiences with cell phone use in therapy. The study hoped to answer the question of: how does cell phone use affect the therapeutic relationship? Clinicians were interviewed about both their use as well as their clients' use.

The following chapter examines the major patterns and trends from this study's findings followed by an examination of this study's findings in relation to the existing literature. Next, how clinicians conceptualize cell phone use will be applied to therapeutic theory. Finally, the study's strengths, limitations and implications for future research will be discussed.

Major Patterns and Trends in Findings

Many interesting themes emerged throughout the interview process. As discussed in the findings section, participants agreed that the cell phone is most beneficial to the creation and maintenance of the working alliance. Additionally, clinicians found that cell phones aided in the establishment as well as maintenance of rapport and the real relationship. This was particularly true for clinicians who used games as a way to connect with younger clients as well as the use of photos of social media. However, a few clinicians worried that cell phones were also used in session to avoid difficult content or interaction with the therapist. Conversely, participants reported mixed feelings when it came to their countertransference experiences. Here participants had negative, neutral, and positive experiences.

Every single participant agreed that the cell phone has a place in therapy. The clinicians in this study felt that the cell phone is an undeniable force that has become so expected in the daily lives of clients that it would be silly to deny its use in therapy. In other words, the cell phone has become a staple of our culture today so much so that many clinicians described the cell phone as representing "an extension of the self". For example, the cell phone functions as our memory when we store numbers or to-do lists in it. It acts as our executive functioning with its alarms and reminders. It is our connection to those we care about both for communication as well as in the photos it stores. It represents our creativity in the blogs and social media sites cell phones allow us access to. All of these examples are essential parts of who we are and we use our cell phones to hold these pieces of us. As such, clinicians insisted that it is important to welcome clients to share on their cell phone. The cell phone has become part of the client and holds integral data about who they are and what they do.

While there was an overarching agreement that the cell phone has an important place in therapy in terms of clients sharing about their lives, there were more mixed feelings about its use as a communication device with clients. On the one hand, all the participants acknowledged that the cell phone makes communication with clients very convenient. In addition, it was understood that the use of cell phones in therapy was most likely a trend that would only increase and that it would be remiss to ignore or deny it. At the same time, there were many ways in which the participants felt strong ambivalence about the integration of cell phones into therapy. For them, there are significant pros and cons when it comes to cell phone use.

For the participants in this study, cell phones have considerable benefits. For example, they are an endless source of data about the client. From text message histories to social media sites the cell phone holds rich records about the client. In addition, the cell phone can be

therapeutic intervention in and of itself. The reminder and alarm functions are seen as an

essential tool in treatment of ADD and ADHD as well as other types of treatment. Mental health

applications are aids to therapy for a vast array of treatments. Thus the treatment itself is eased

and aided by cell phone use.

In addition to the treatment, the comfort of the client is increased with the use of cell

phone. Many participants in this study pointed out that their clients were able to share more or in

different ways over technological mediums. For example, clients were able to be more

vulnerable when using email or over the phone. This is a huge benefit for therapy. It allows

therapy to move along faster as well as increases the relationships between client and therapist.

This particular point is extremely important when considering how to best match treatment to the

clients needs.

While the benefits of cell phone use are significant and must be considered, there are

equally important cautions. As the participants in this study explained the cell phone is neither

confidential nor secure and there are currently no professional standards of use. As such,

clinicians become vulnerable to issues of liability and legal action. Additionally, the lack of

professional standards present confusion around how to bill for time spent on email or texting

with a client.

Lastly, while the cell phone enhances the therapeutic interaction in multiple ways, it has

the potential to hinder it as well. The participants in this study offered examples of when clients

used the cell phone in order to avoid interaction with their therapist. This was done by texting

with friends or checking emails during session as well as playing a game on the cell phone.

While this may be important behavioral data in general, it certainly interferes with therapeutic

connection and progress. It is important for each individual clinician to weigh the pros and cons

of cell phone use for themselves and their own practice and to decide how much cell phone integration feels appropriate to them.

Study Findings In Relation to Existing Literature

There is very little literature written on the subject of cell phones and the therapeutic relationship. The vast majority of the literature pertaining to this specific topic concerns the cell phone's affect on the working alliance. Additionally, the majority of empirical studies about cell phone use in therapy center around therapist use of text message or phone calls to remind their clients to take medication or to complete therapy homework. This study is consistent with the literature's conclusions that cell phone functions increase the strength of the working alliance. Like studies found in the literature, reminder text messages as well as phone calls positively influence the working alliance. Furthermore, this study found that the use of text messages, emails and cell phones for check-ins as well as in vivo coaching benefitted the quality of the working alliance.

It is of particular importance that this study is based upon clinician opinion. Most of the literature about technology use in therapy as well as cell phone use is based upon client report. Furthermore, the few studies that include clinician experience found that clinicians reported a weaker working alliance when technology or cell phones mediated the therapy experience. Conversely, this study found that clinicians actually felt that cell phone use had a positive impact on the working alliance. Moreover, clinicians considered cell phones to be most helpful for the maintenance and strength of the working alliance.

Very few existing studies examine the effect of cell phones on the real relationship. The two studies mentioned in this study's literature review explore the impact of different computer functions on rapport, closeness and the ability of the client to trust their clinician. One study

looked at online messaging instead of talk therapy and the other at the impact of a client's sharing of websites with her clinician. In each case the clinicians report that this process helped their client to trust them, to open up and become more vulnerable and brought the relationship closer. These two studies match closely with the results of this one. In both, the use of technology to match the daily habits and culture of a client functioned to increase the client's trust, openness and closeness, in other words the real relationship.

There is even less literature about clinician countertransference in response to the use of cell phones in therapy. This study cites three articles in which the therapists' experiences are discussed. These articles include the two mentioned above as well as one article in which the author discusses his concerns about email. The concerns mentioned in this article match those of the participants in this study. Issues such as the amount of time that is appropriate to dedicate to reading client emails, the length of client emails, the use of client emails to extend the session as well as how to bill for this time are mentioned both in the literature as well as by the participants in this study. Additionally, the first two articles echo the worry as to whether computers (or cell phones) are the best use of therapy time.

Similarly to these articles, this study's participants expressed much more mixed feelings in their countertransference than for the real relationship and working alliance. Responses ranged from "uncomfortable" and "awkward" to "sweet" and "nice" to "natural" to "annoying" and "irritating". While the participants were all able to recognize the usefulness of cell phones, actually having them in the therapy room during a session drew out differing experiences personally. This ambivalence corresponds with the ambivalent status of cell phones in the field of therapy today.

Application of Theory

It is important to understand cell phone use in the context of therapeutic theory because each theoretical camp conceptualizes cell phone use differently. This paper uses Psychodynamic Theory with a specific concentration on Relational Theory, Cognitive Behavioral Therapy, and Dialectical Behavioral Therapy in order to further understand clinician views about the use of cell phone. These theories were selected because Psychodynamic theories are often represented in the literature as the most resistant to any type of technology use. CBT and DBT were selected as examples of clinical approaches that are already integrating cell phones.

Traditional psychodynamic approaches value what is called the therapeutic frame. The frame is considered to be a defined, contained set of expected standards that the therapy session adheres to. These norms include that the therapy session will last for one hour, that it will be weekly and that contact with one's therapist is minimal in between each session, among other things. These things are important so that the therapy session is consistent for the client. As such, clients in distress know that they can expect their therapist to be reliable, steady and constant. This pattern and structure are considered an important aspect of healing for clients.

The cell phone symbolizes a major departure from the therapy frame. With text messages and emails, a client (or clinician) can easily break the frame of the weekly, one-hour session. Contact between sessions becomes literally at one's fingertips. While this may have its benefits, it represents a threat to traditional psychodynamic theory. Therapy has been conceptualized as a compartmentalized, weekly event. The cell phone has the potential to disrupt this pattern and therein jeopardize the way therapy has been conducted for many years.

Some welcome this change, while many in the psychodynamic camp argue that the frame serves vital purposes for therapeutic change. As discussed in the findings section, many

clinicians contend that the therapy frame enables the client to tolerate distress. As they learn that they can survive from one session to the next, they learn how to tolerate difficult emotions and situations and begin to believe in themselves. They become self-supporting and independent. These clinicians worry that the cell phone allows for the therapist to be used as a crutch and would block the growth of distress tolerance and self-efficacy.

As discussed in Chapter Two, Relational theory, one of the many psychodynamic theories, locates therapeutic change in the therapy relationship itself. According to this theory, it is the process of forming and maintaining a relationship that causes change within the client. For those who adhere to this therapeutic approach, the cell phone presents many complications. On the one hand, it denotes more opportunities to have a relationship. For example, texting and emailing permit check-ins and the "moments of connection" that the participants spoke of. Additionally, sharing personal contact information communicates to one's clients that one cares for them and is committed to their wellness. On the other hand, cell phones signify many potential hindrances to the therapy relationship. As many of the clinicians commented, access to a therapist's cell phone number can blur the boundaries of what the therapy relationship is; whether it is professional or social. It is paramount to Relational Theory that the therapy relationship be clearly defined so that the client can use it to the fullest extent.

The majority of the clinicians in this study self-identified as psychodynamic. Many of them articulated many of the theoretical complexities just discussed, however none of them rejected the idea that the cell phone could be used in therapy. While their concerns mirror the tenants of the theories to which they subscribe, all of them understood how cell phones might be beneficial to therapy and many psychodynamic clinicians were already using them in their work. This is important to note because the psychodynamic camps of the therapeutic world are depicted

in the literature as resistant to the use of cell phones in therapy. This is not true of this study's respondents. The majority of the psychodynamic clinicians in this study were already using cell phones in their practice and those who were not still confirmed that cell phones have a place in therapy.

The field of Cognitive Behavioral Therapy (CBT) holds a different view. For them, behavior change is the ultimate goal. The cell phones is another tool through which this goal can be achieved. Clients learn and practice many behavioral skills in session. These skills include literal behavior modifications like relaxation exercises, mediation and breathing exercises to thought modifications through mood tracking and journaling. CBT therapists believe that all of this is too much to learn, internalize, perfect and then implement with just one-hour session a week. In order to master thought and behavioral change outside of the therapy session, the client needs support from his/her therapist outside of the therapy session. Thus, the client is encouraged to call his clinician's personal cell phone in order for in vivo coaching to occur in between sessions. For CBT, the cell phone is an integral way for a client to receive needed support from their therapist. Phone coaching and texting are essential in the treatment process.

It is noteworthy that the therapy relationship is not valued in the same way in this approach. Unlike Relational Theory, the therapy relationship is never examined or discussed by client and therapist and it is not considered a vehicle of change. Therefore few CBT clinicians would worry about the therapy relationship at all let alone whether or not a cell phone would affect it. This is just not a focus of this approach.

Dialectical Behavioral Therapy uses the cell phone in the same way CBT does. In fact, DBT was the first treatment to include in vivo skills coaching via cell phone in therapy treatment ever. DBT was designed for clients who have high levels of distress. As such, DBT assumes that

their clients need support in between sessions. For them, it is too much to ask that a client make it through the next week without some help. Additionally, DBT heavily makes use of psychoeducation and behavioral skills. The phone coaching is integral in the implementation of these skills in real life. For DBT as well as CBT, the cell phone is an essential tool for crisis management and the therapeutic work.

Unlike CBT, DBT holds value in the therapy relationship. In this way, it is more like Relational Theory. For both, the therapeutic relationship is a place of healing and change for the client. And in both approaches the therapist is allowed to discuss their experiences of the client with the client when appropriate. Thus, if the client uses phone coaching too much or violates the clinician's boundary in someway, the clinician can discuss it with their client. They can even tell them how that experience was for them. This is important because it reminds us that clinicians have the power to let a client know if their cell phone use is inappropriate in some way. Clinicians do not need to fear being berated with text messages because usually a simple conversation will fix it up. And the simple conversation will suffice because a solid relationship will have been built between patient and therapist.

Thus we see that the way in which a clinician is able to use the cell phone in therapy depends greatly on the theoretical approach from which they work. The cell phone is conceptualized as having different positive therapeutic functions or negative relational complications depending on which theoretical camp one sits in. It is imperative to hold these differing views in mind when considering whether the cell phone has a place in therapy at all. Each type of therapy looks very differently and has a different set of goals in mind. In other words, it might make sense to include the cell phone in one type of therapy and to exclude it completely from another. Or, as was the case in this study, it was fitting to use the cell phone for

the purpose of coaching in CBT and DBT but not in psychodynamic practice. However, it was appropriate to text message with clients for other reasons for psychodynamic clinicians. In general this paper argues as the participants in this study felt: that the cell phone has a place in therapy but that it must be used with a clear purpose on the part of the therapist and with constant thought about who its use is benefitting.

Implications for Clinical Social Work

This study's findings provide potentially important information for the field of clinical Social Work. Before discussing these in depth, it is important to note that few of this study's participants are MSWs. As mentioned earlier, this was due to the use of convenience and snowball sampling methods. However, this fact does not diminish this research's importance to the clinical social work field. Like MFTs, PhDs and PsyDs, MSWs practice clinical therapy; their clinical practice is almost identical and their use of cell phones in this study were indistinguishable. Furthermore, because clinical social workers are out in the community more often than other fields of mental health, cell phones are particularly important tools for them in terms of navigation, reimbursement, home-visits and case management.

There are many ways in which the cell phone could be used as an integral tool for social workers. As mentioned above, social work is a mental health service that focuses on the community as well as the individual. Therefore, many social workers spend their time driving from location to location in order to best serve the needs of their clients. The cell phone could be an essential instrument in helping social workers get from place to place as well as coordinate with a multitude of other service agencies and individuals. For social workers, the cell phone represents a vital tool for community fieldwork, direct service and case management.

In addition, this study offers clinicians many therapeutic interventions that they can use a cell phone for. For example, the utilization of mental health applications is discussed. Secondly, many clinicians shared that their clients were able to share more intimately over the phone or email. Clinicians are encouraged to consider whether it would behoove their practice to include more frequent phone sessions or email communication. Additionally, clinicians can use the cell phone of their clients, with consent of course, to open up rich and meaningful discussions about the clients' lives.

More globally, the present study highlights the reality of the current US culture. Cell phone ownership and use is rising in our daily lives. This study illustrates many ways in which clinicians and clients can be using cell phones for logistical purposes as well as meaningful connection. The therapeutic field must mirror the current culture in order to "meet their clients where they are at".

Finally, this study seeks to assuage some of the resistance in the therapeutic field. Not one clinician reported a boundary violation as a result of a client having their cell phone number. Additionally, the clinicians felt that they were able to provide clear instructions around cell phone use as well as discuss any missteps with their clients. While the addition of cell phone use is not without some precautions, it has not resulted badly for the participants in this study and therefore should be a welcome option for the therapeutic field.

Strengths of This Study

This study's strengths include that it was a qualitative and exploratory study. This research design allowed for in depth exploration of and discussion about the experiences of the study's participants. Additionally, semi-structured interviews permitted that they made room for the emergence of various themes and experiences. Finally, due to the lack of research on this

subject, this study provides initial insight around how cell phone use in therapy affects the therapeutic work, therapist experience and the therapeutic relationship.

Ironically, this researcher's personal bias was a strength of this study. This researcher is not particularly technology savvy and knows very little about technology in general. As such, this researcher did not write this thesis in order to convince the therapeutic community to increase their cell phone use. On the contrary, this researcher became interested in this topic as a result of her surprise at how ubiquitous they were becoming in the field. Thus, this researchers marginally negative bias about technology had little to no effect on how positively the cell phone is impacting therapeutic work.

Limitations of This Study

This study also had some limitations. First, the study has a small sample size (n=18). Secondly, while particular effort was put forth for a diverse sample, the participant population is mostly White, middle-class as well as English speaking. In addition, they all live in Northern California's Bay Area. This limits the generalizability of this study's findings.

The clinicians in this study all worked with clients that were functioning in their daily lives and only one clinician mentioned that she worked with a few people with Personality Disorders. Therefore, the participants interviewed in this study did not work with individuals with psychosis or Personality Disorders. This is important to note because individuals with these diagnoses are often ones who need the most support and would be most likely to push boundaries of cell phone use. The client populations discussed here represent the majority of mental health clients, but do not represent more severe or acute client populations, who may use cell phones in different ways.

Lastly, while the semi-structured interview allowed for deep examination of the participants' experiences, it also meant that some themes were explored in depth while others were less so or completely left out of some of the interviews.

Implications for Future Research

While this study was able to discuss and explore many aspects of client and clinician cell phone use in therapy, many themes were left untouched. Future research could include interviews with clients in order to gain their perspective, further examination of how clinicians understand what is gained and lost by each modality of communication, interviews with larger groups of clinical social workers, a longitudinal examination of clinician experience with cell phone use overtime, deeper exploration of each modality individually as well as how the cell phone might be used in clinical research.

Summary

This study examined the impact of cell phone use on the therapeutic relationship. Participants in this study described the ways in which both clinician and client used the cell phone in therapy. The participants in this study felt that the cell phone most benefitted the working alliance when it could be used as a therapeutic intervention or therapeutic aid. Additionally, the clinicians agreed that the use of cell phone generally increases rapport and the real relationship. However, they reported negative, neutral and positive countertransference experiences.

Much of the literature depicts the field of therapy as hesitant to use of cell phones as well as technology in general. While this reflects some truth in terms of different theoretical approaches, this study demonstrates that clinicians are much more open to cell phone use than the literature describes. This is important because the use of cell phones as well as technology in

general will only increase from here on out. In many populations, the use of cell phones increasingly means culturally and age-appropriate care and what our clients want and need matters. While there may be some major concerns for therapists, the use of cell phone or other technologies is increasingly matching client expectations, wants and needs. It is imperative that the therapeutic world follows such cultural trends and this study represents a willingness to do so. The use of cell phone, when appropriate, represents an opportunity for Social Work to be on the front end of therapeutic change as opposed to playing catch up later.

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Appendix A

Interview Questions

Questions about the client side:
"How many of your clients have cell phones? Who are the people who do have cell phones and who are those who do not?"
"What percentage of your clients use their cell phones as a therapeutic tool in session?"
"What are the most common ways your clients use their cell phones in session in general? Can you give me some examples of these?"
"How have you noticed clients using their cell phones to help them describe their lives in session? For example, do you have clients that show you their text message conversations? Do you have clients that show you photos on their phone? Do you have clients that show you their FaceBook, Instagram or Tweeter accounts? What purpose do these actions seem to serve for them? Does it help you to understand their lives? Why or why not?"
"What applications or social media sites are clients bringing into session? Can you tell me about a particular example?"
"Do clients use their cell phones for scheduling? In what ways?"
"Do your clients use their cell phones for therapy homework if you assign it? And how?"
"What therapeutic cell phone applications have your clients found helpful? Which ones have they not liked as much?"
"What types of clients bring cell phone technology into session? Are they generally from a certain demographic group?"
"Do they seem to have certain personality types or certain diagnoses?"
"Why might some clients want to use cell phones in order to tell you about their lives? How do you think it may be helpful to them?"
"Do you feel this gives an accurate picture of the client? Why or why not? Can you give an example?"
"Do these cell phone technologies seem to work as tools to gather assessment data? How so?"
"Do you like when clients use cell phones in therapy? Why or why not?"

Questions about the clinician side:
"Do you ever use cell phones as part of an intervention? For example, do you use them to schedule? Do you text your clients? Or do you prescribe mental health applications to your clients?"
"If yes, what types of cell phone interventions do you use? Please describe each one to me."
"How have you integrated cell phone technology into your therapeutic practice? What are some examples of this?"
"When you do use cell phones in therapy, how do you introduce it to your client? Could you tell me about a particular example about how you have introduced cell phone technology?"
"Do you discuss whether these modalities are secure and/or private with your clients?"
"What types of reactions have you gotten from your clients when you do introduce cell phones into the session? Describe a few."
"Which clients are open to this and which ones are not?"
"Why do you think some clients are open to it and some are not? Do they fall into certain demographic groups?"

"Do you give your personal cell phone number to your clients? Why or why not?"
"Why would it be important to you to have personal contact information that is separate from your professional contact information?"
"What cell phone interventions have you found most helpful? Please give me some examples."
"Do you feel cell phones should be in the therapy room? Why or why not?"
"Do you notice that certain types of clinicians are more open to using cell phone technology in the therapy room? Who is open and who is not? And why?"
 "What potential benefits do you see to the use of cell phones in therapy? What potential hindrances?"
"Do you feel that the setting you work in may affect how you use cell phones in therapy? Is your agency or private practice (etc) open to the use of cell phones? Do they encourage it? How might this affect the way you integrate cell phones into your practice?"
"Does your personal use of cell phone affect how you use it in your work?"

Questions about the Therapeutic Relationship:
"How does the inclusion of cell phones in therapy affect data collection or assessment? And in what ways?"
"Have you ever been able to get information from a cell phone that you could have not gotten any other way?"
"How might the use of cell phones affect the working alliance? Can you tell me about some examples?"
"How might the use of cell phones affect the rapport with your client? How has this looked in your practice?"
"How does this affect your feelings of closeness with the client? Please give examples."
"How has this affected your reactions to or feelings about your client? Sometimes people refer to this as countertransference. Can you give me an example?"
"Has it affected your client's reactions to or feelings about you to your knowledge? Some schools of thought call this transference. Do you have any examples?"
"Do you find yourself having to check any internal biases about technology in session- whether those biases are positive or negative?"
"Do you feel cell phone technology has a place in therapy? Why or why not?"

Appendix B

Participant Consent Form

Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA

………………………………………………………………………….

Title of Study: Client and Clinician Use of Technology and Its Effect on the Therapeutic Relationship

Investigator(s): Rachel C. Gordon, Social Work, XXX-XXXX-XXXX

………………………………………………………………………….

Introduction
You are being asked to be in a research study of the effect of the use of cell phones on the therapeutic relationship.
You were selected as a possible participant because you are a practicing clinician who has clients who use cell phones and/or social media applications in session or with whom you use cell phones and/or social media applications in session.
We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study
The purpose of the study is to explore the effect of the use of cell phones on the therapeutic relationship.
This study is being conducted as a thesis requirement for my master's in social work degree.
Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures
If you agree to be in this study, you will be asked to do the following things: to participate in a one hour long face-to-face interview on the topic and as well as to participate in a follow up phone call if needed.

Risks/Discomforts of Being in this Study
There are no reasonable foreseeable (or expected) risks.

Benefits of Being in the Study
The benefits of participation are the ability to gain insight on professional work, opportunity to process clinical work with a master's level student, to have an opportunity to discuss issues that are interesting and important to you, and an opportunity to learn more about how technology is being used in therapy.

Confidentiality
The records of this study will be kept strictly confidential. Research records will be kept in a locked file, and all electronic information will be coded and secured using a password protected file. Only this

researcher will have access to audiorecordings of the interview. They will be erased once this researcher's thesis has been turned in in June of 2014. We will not include any information in any report we may publish that would make it possible to identify you.

Payments
You will not receive any financial payment for your participation.

Right to Refuse or Withdraw
The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely at any point during the study. If you choose to withdraw, the researcher will not use any of your information collected for this study. You must notify the researcher of your decision to withdraw by email or phone by March of 2014. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns
You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Rachel Gordon at xxxx@smith.edu or by telephone at XXX-XXX-XXXXX. If you like, a summary of the results of the study will be sent to you. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent
Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep, along with any other printed materials deemed necessary by the study researcher.

……………………………………………………………………………..

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

……………………………………………………………………………..

[if using audio or video recording, use next section for signatures:]

1. I agree to be [audio or video] **taped for this interview:**

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

Form updated 9/25/13

HSR Approval Letter

SMITH COLLEGE

School for Social Work

Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

November 22, 2013

Rachel Gordon

Dear Rachel,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form. **Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D. Co-Chair, Human Subjects Review Committee

CC: John Erlich, Research Advisor