Ask Dr. Robertson 4—Just You and Me, One-on-One Counselling

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Image Credit: Dr. Lloyd Hawkeye Robertson.

By Scott Douglas Jacobsen

Dr. Lloyd Hawkeye Robertson is a Registered Doctoral Psychologist with expertise in Counselling Psychology, Educational Psychology, and Human Resource Development. He earned qualifications in Social Work too.

His research interests include memes as applied to self-knowledge, the evolution of religion and spirituality, the Aboriginal self's structure, residential school syndrome, prior learning recognition and assessment, and the treatment of attention deficit disorder and suicide ideation.

In addition, he works in anxiety and trauma, addictions, and psycho-educational assessment, and relationship, family, and group counseling. Here we talk about the clientele.

Scott Douglas Jacobsen: When working with clients or patients one-on-one, how do you build rapport and trust with them? I imagine, on a one-on-one basis, difficulty in working with them without rapport or, especially, trust.

Dr. Lloyd Hawkeye Robertson: Numerous studies have found that client-counsellor rapport accounts for up to 50% of the variance in therapeutic outcomes, and this has led some psychologists to conclude that the methodological school of psychology one practises is not important. What the data actually shows is that without rapport the client is less likely to experience positive outcomes regardless of methods used, but that still allows for the possibility that some practices are more efficacious than others for particular issues.

Probably the easiest way to build rapport is to identify commonalities between therapist and client. This could include gender, race, ethnicity, religion, social status, and so on. Once the client has revealed the problem or issue that has brought him or her to therapy, the therapist may share that he has faced a similar issue, and this too has the effect of establishing rapport, but there are risks associated with this approach.

The first such danger is that it can undermine the therapeutic process. As discussed in an earlier conversation, psychotherapy is predicated on the notion that each of us is a unique self-determining individuals. By over emphasizing our external commonalities, we run the risk of denying that self-empowering process. The clearest example I can think of occurred when I was Director of Mental Health for Northern Saskatchewan. Concerned with the lack of effectiveness of its alcohol and drug addiction program, the province brought its addiction program under the authority of the mental health program. I discovered that addictions workers had been hired, not on the basis of their competence in psychotherapy, but on the basis of their status as “recovered” alcoholics. These workers had maintained sobriety for years, and they thought they could use their own experience as a template for others. They gave advice based on their own experiences and they thought they were doing therapy. Such an approach denies the individual experiences and cognitions of the client.

A second danger of establishing rapport through the development of a common identity is that it could confirm a dysfunctional worldview. Psychotherapy is about change. If a man comes to me having been abused by women, and I reveal to him that I also have been abused by women, then we could commiserate and blame while avoiding dealing with the changes the man will need to make to have healthy transsexual relationships. Similarly, Feminist Psychotherapy adds an ideological perspective to the field and that perspective could keep female clients from undergoing beneficial self-change.

I am not discounting using therapist and client commonalities in building rapport, I am just cognisant of some of the risks that need to be monitored while taking such an approach. There is another way of building the therapeutic alliance. Adler viewed the client or patient as an expert in himself and therapy as a collaboration between two experts. Another way of picturing this approach is to view the therapist as a kind of consultant. The client identifies the issues he or she wishes to tackle, and I offer alternative therapies the client may use to reach agreed upon goals. We then co-construct a treatment plan. Treatment then is in part experimentation to see which

approaches are most effective in this situation given the unique attributes the client possesses. In the process, the client learns self-monitoring and self-assessment skills that can be applicable in other situations.

Jacobsen: What are you bearing in mind in this working environment, in one-on-one counseling? How do you gauge individual needs and project possible timelines of the patients?

Robertson: In most cases, the client comes to me with an issue or issues on which they wish to work. We don't necessarily stay with the same issue. In one example, the client came to me with the complaint that she was too sensitive to criticism. Following a couple of sessions, it became apparent that she was the recipient of emotional abuse, so this shifted the strategies we used. In another case, the client came to me with problems maintaining attention, but it became apparent that the reason she had difficulty focussing was depression. Such changes in focus involve a re-negotiation of treatment planning. I like to project a certain number of sessions in which to incorporate a treatment plan with the idea that at the end of those sessions we, that is the client and I, evaluate the achievements obtained. This could result in terminating our sessions, continuing with the present treatment plan, or negotiating a new plan.

Jacobsen: How do you work to prevent the possible transference of trauma to the counsellor or reactivity of the counselor, in case they or you may have had prior similar negative life experiences? For example, a male counselor who witnessed abuse of one parent by another in youth, and then hears a recounting of a client's experience with this. This may work them up.

Robertson: Hopefully the counsellor has dealt with his or her related traumas before they attempt to help someone who has had a similar traumatic experience. If the counsellor has not successfully dealt with that trauma then he or she should not accept such clients. On the other hand, if the counsellor has successfully dealt with a similar event, that counsellor may be able to offer unique helpful insights. The person who experiences a trauma is not necessarily forever wounded by it.

The issue of transference was first noted by Freud who viewed the client or patient's attribution of emotions and motivations to the therapist as an opportunity to generate positive insight. I think what you might be concerned with is the issue of countertransference where the therapist takes on the emotions of the client. The counsellor or therapist has a special relationship with the client involving a kind of intimacy. Karl Rogers called this therapeutic stance unconditional positive regard. Alfred Adler said you have to get into the client's skin to see the world through his eyes. The danger here is that the therapist may so identify with the client that he takes on aspects of their worldview and trauma. This, of course, does not do anyone any good. The therapist is conducting a cognitive exercise in monitoring the client's cognitions, emotions and behaviour. By maintaining this cognitive distance from the client's emotions and behaviour, the therapist is actually modelling those skills the client will need to gain control of problematic emotionally laden behaviours. Some people equate cognitive distance as a lack of empathy, but this is a misunderstanding of the concept. The therapist practising cognitive distancing is empathetic

enough to understand that the client, to gain control of his or her emotions and behaviours, must be able to sufficiently objectify them to understand them and thereby gain control.

Jacobsen: Thank you for the opportunity and your time, Dr. Robertson.