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

How does this aspect of psychology work in intimate settings between a professional and a client/patient?

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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.

Some of the first steps, even non-verbal ones, for the client to counselor relationship is the construction of trust and rapport. Robertson stated that half of the variance in therapeutic outcomes relates to the rapport in the client-counselor relationship.

Some psychologists, generally speaking, have concluded on the ways in which the school or the methodology of the counselor may, in fact, be unimportant, or, at least, not that important in the

larger scheme. Indeed, data from studies show rapport as an important factor in the positive outcomes of the patient regardless of the school of thought in counseling psychology.

Robertson stated, “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.”

But as with the artistic nature of the endeavor, there are a variety of risks and dangers. Some of those can undermine the therapeutic process in its entirety. If we take a look into the issue of the volitional self, as one can see in the research work of Robertson, this tends to form a post-behaviorist and modernist sensibility of the self. One with the ability to will something; an organism with freedom of the will, volition, or, at a minimum, the appearance of it, and the internalized self-justification of it, whether or not freedom of the will exists.

These unique volitional selves comprising human families, human communities, and human societies. Robertson talked about the possible risk in the over-emphasizing the external common traits, as this can deny some of the more self-empowering aspects or facets of the therapeutic 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,” Robertson opined, “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.”

Robertson went into another problem with the finding of common identity with the client in the possibility of a confirmation of a “dysfunctional worldview.” He noted psychotherapy is simply about the transformation from one range of mental states to another. Thus, if a patient continues onward into a dysfunctional range of mental states through the affirmation of the worldview by the counselor or the psychotherapist, and if this is happening because of the rapport built with the client or the patient, then the therapist or the counsellor may be liable and, as importantly, the client or the patient may fail in their desired ends – to become more functional in their range of mental states in the context in which they live, in contrast to their current way of life. We’re talking about a reduction in human suffering. It seems like a serious issue to me, in this light.

Robertson relayed an example stating, “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."

The key word in the quotation, truly, is the phrase "self-change," in which the client or patient, ultimately, needs to own their decisions, their tools for dealing with life, and, in turn, their tools for dealing with their decisions in life, whether happenstance trauma including abuse by a man or a woman, or life tragedies that come everyone's way.

Robertson said, "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."

A new client came to Robertson complaining about an inability to maintain long-term attention. He subsequently noted how she had difficulty focussing because of the depression. This then involved a re-negotiation of the treatment planning. He likes to project possible sessions into the future in order to develop a treatment plan, where Robertson and the client/patient can then see how many of the targeted objectives were achieved (or not). This evaluation could lead to ending the sessions, continuing on course, or trying a new one negotiated together, *und so weiter*.

Now, there is the final issue discussed in this session dealing with the possibility of a traumatic experience victim client or patient and a counselor having the transference of the trauma to themselves, or simply the problem of the reactivity of the counselor. If a counselor had similar negative life experiences, then this can create a problem for them. A man who is a professional, licensed, and respected counseling psychologist within the community of professional counseling psychologists may have witnessed the abuse of one parent by another in their youth and, in turn, hearing the recounting, by a patient or client, of their own traumatic experiences in a similar context can work them

"Hopefully the counselor has dealt with his or her related traumas before they attempt to help someone who has had a similar traumatic experience. If the counselor has not successfully dealt with that trauma then he or she should not accept such clients," Robertson explained, "On the other hand, if the counselor has successfully dealt with a similar event, that counselor 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."

Robertson narrowed in on the concern, of mine, in terms of the client or patient relationship with the counselor or therapist. In that, they may take on the emotions of the patient or client. There is a certain intimacy that develops in the sessions with the counselor or the therapist. He remarked on Karl Rogers and the stance that unconditional positive regard is important as a therapeutic stance.

Alfred Adler stated that one needs to get inside the skin of the client, to see the world as others see it – as the patient sees it. The possible danger in this instance is the possibility of facets of the worldview and trauma of the patient being taken on by the counselor.

Robertson concluded, “By maintaining this cognitive distance from the client’s emotions and behavior, the therapist is actually modeling those skills the client will need to gain control of problematic emotionally laden behaviors. Some people equate cognitive distance as a lack of empathy, but this is a misunderstanding of the concept. The therapist practicing cognitive distancing is empathetic enough to understand that the client, to gain control of his or her emotions and behaviors, must be able to sufficiently objectify them to understand them and thereby gain control.”