Chapter 20
Reflections on the Impact of Remote Counseling: Friendship in a New Therapeutic Space

Meredith Hemphill Ruden

Introduction

During a global crisis where unexpected death looms and occurs, I find it apropos to consider existentialist Irvin Yalom’s viewpoint on therapy’s gifts. Yalom (2003) considered the fear of death as ever-present and commanding in every patient’s distress and the “deathbed scene” as a potential moment of openness and honesty as that fear is realized and released at last.

As I have counseled individuals throughout the coronavirus pandemic, I do not believe that it is coincidental that my thoughts have turned to my past work in hospitals with people who are critically or chronically ill. I find myself drawing upon hospital social work terminology in conceptualizing my private practice clients’ problems – terms and phrases like “uncertainty” and “struggle to wait” – as new COVID-19-related issues overlay old ones and bring new clients to my “door.” We (both therapists and clients) are being presented with daily life-threatening/deathbed scenes. We are at that bedside as we watch the news and hear stories of serious illness through our extended networks. And, of course, if we contract COVID-19, we are in that bed and manage its symptoms without knowing if we will survive or return to good health.
Case Vignette

Counseling Through Illness

My counseling of Richard\(^1\) through his illness with COVID-19 demonstrates how a serious illness positioned me as a bedside witness.

*I had worked with Richard on depression, underemployment, and procrastination for 1 year prior to quarantine with weekly in-person sessions. In early spring 2020, he had contracted COVID-19. I counseled him as he sat in his bed, being unable to move from it for several weeks, and as I sat in my home office, I felt trepidation prior to our remote sessions (“was he feeling better?”). I was nervous about how little seemed predictable about the illness’s course, according to the news. People who were low risk for serious complications were getting them; people who seemed to be minimally symptomatic one day were critically ill the next. In awareness of this, I checked on Richard’s health, inquired about his strategies for care, and offered suggestions for additional support, in each session. He was understandably anxious, saying that he was unsure of how to interpret current symptoms and what to expect. As well as thinking of ways to minimize “unknowns,” we discussed coping with uncertainty. These coping strategies were directed toward him but served as useful reminders for myself, as I coped with limited data on his health and welfare. To lessen my own worry, I occasionally texted Richard between sessions during this time to see how he felt physically.*

Prior to COVID-19, I was less curious about a client’s health and details of his day-to-day routine, preferring those lines of inquiry that appeared more directly linked to his presenting problem and therapeutic goals. This purview was not developed out of an uncaring, prescriptive, and hierarchical approach. On the contrary, it was derived out of a profound respect for my client’s agency and capacity and willingness to have them guide me. Like Tosone (2006) prior to the traumatic impact of 9/11, I prided myself on my warmth and caring but these feelings as existing within the confines of the therapeutic space. During Richard’s illness, I noticed that my caring extended beyond the parameters of therapy.

*What changed in therapy and the therapeutic relationship, and what caused this change?*

Had the therapeutic relationship simply become *less formal*?

If yes, then, this would explain why I thought less about how what I asked and was told related to Richard’s therapeutic challenges and why I thought about his welfare in a more personal way. It made sense to me that my interactions with Richard during his illness should resemble my past counseling work in hospitals. Like my relationship with those patients, my relationship with Richard was starting to resemble an amalgam of many types of relationships, including personal ones. And, similar to my approach to my hospital work and its heightened sense of

---

\(^1\)The client’s name and other personal identifiers have been changed to protect privacy and confidentiality.
intimacy with patients, I saw the shift in therapeutic dynamics as a positive one, full of therapeutic potential. It did not qualify as an overstepping of client boundaries, of the sort that concerns Reamer (2002) in *Eye on Ethics*. Rather, this shift struck me as an ethically and therapeutically good fit for the client and situation (i.e., illness at home) in which it occurred. But, did *less formal* adequately capture what *more* I gained through this relational change? *Was I “lending ego”?*

Psychoanalytic tradition theorizes that the client can borrow cognitive abilities and emotional capacities from the therapist’s own mind (Misch, 2000). Although possible to do so, I think my earlier, pre-pandemic work with Richard in assisting him to plan ahead and problem-solve to combat procrastination better fits this concept. I think that my work during his illness involved less of his borrowing of a faculty missed or undeveloped than of my supporting him as a friend might. Like a friend, my motivation for supporting him was simple: to support him so that he did not have to manage his illness and its accompanying stress alone. I will say more on this later in this chapter.

*Had the relationship shifted toward a more sensitized and compassionate form, as a result of a shared trauma?*

During the time that Richard was ill, our therapeutic exchanges were typical of that seen in a shared trauma reality. In such a reality, a therapist can develop an altered perspective, wherein the line between professional concern and personal caring is seen as superfluous (Tosone 2006). And, indeed, my caring for Richard took on a different hue. This is illustrated by the fact that I felt compelled to text him, so that I could be assured that he was improving. Drawing on research in vicarious post-traumatic growth and vicarious resilience, Nuttman-Shwartz (2014) describes how shared trauma leads to numerous positive outcomes (i.e., greater self-confidence, sensitivity, compassion, and hope) that impact the therapist’s outlook and therapeutic work. Combined, these outcomes suggest that the therapist attempts to understand a client’s problem more and increases her part in the effort to overcome it. This delineation aptly describes my purview and intense effort to help and support Richard during his illness when his “problem” was, first and foremost, his poor health.

**Counseling Following Illness**

As Richard recovered from his illness and was able to leave his bed during our sessions, he sat in his living room which faced an outdoor patio. He invited me to look at what he saw.

*Richard – “I’ve been working on my garden. Do you want to see it?”*
Me – “Yes, I’d love to. I’ve heard so much about it...Wow, you’ve put a lot of work into it. You really like gardening, don’t you?”
Richard – “I do. I think it really might be my thing. It makes me happy.”

I felt interested in what he had to share. My interest did not feel necessary or the result of an altered perspective brought on by existential questioning (what matters most?), as can occur when the impact of trauma continues to be felt. It was the result of being invited into more parts of my client’s life, and it was the result of my decision to explore that new terrain without any preconceived notions of therapeutic value. A voluntary aspect of relationship formation is a precondition for friendship. Moyer and Hajjat (2017) describe friendship as a “negotiated attachment” (p. ix) that is separate from group affiliation or categorization; it is a chosen relationship entered into voluntarily when one gravitates toward some aspect of another’s personhood. It is an “affective bond” (Moyer and Hajjat 2017; p. x) that one may or may not have with, say, a sister – or, say, a client. And, indeed, in the warmth that I felt as Richard shared his garden project with me, I noticed affection, affection for a person who had taken a risk to share with me an interest and part of himself that he had not, until now. Our relationship shifted toward professionally based friendship. Without extending the bounds of professionalism, I expressed more interest in all aspects of Richard’s life. I did not guide my assessment and inquiry by what seemed relevant to therapy; and, Richard shared more openly, apparently also ridding himself of such strictures.

Richard’s case, and others like it, suggests to me why Yalom (2003) considers friendship in the “a necessary condition in the process of therapy” (p. 181). If fear of death is the source of our psychological distress and causes a sense of loneliness as Yalom supposes, it makes sense that confrontation with our own mortality should need companionship to tolerate and survive psychologically. COVID-19 is confronting us with our own mortality. We can no longer be certain that death is in the distant future (in fact, we never could). And, as the pandemic confronts us with a threat to our well-being, we are aware that we are alone. It makes sense that in such moments, moments of profound loneliness, we benefit most from a metaphorical hand to hold. Such a “hand” does not deny the aloneness we feel but challenges our sense of its totality (recognized in such self-statements like “I am completely alone”) and, thus, helps better tolerate it. Again, I argue that holding a metaphorical or literal hand outreached in such a situation is ethical.

But, while Yalom’s link between friendship and mortality coheres with part of the story of Richard’s therapy during this pandemic, it does not wholly explain how therapeutic intimacy developed. Richard recovered quickly from the virus without any long-term change in his emotional well-being, outlook, and self-concept, or me to mine. When the bedside was left, it became a nontraumatic memory. We continued therapy remotely as virus rates surged, and our therapeutic intimacy, that personal, contextual, and “evolving” (Tosone 2006, p. 89) phenomenon that is commonly considered part of effective therapy, grew. It did not grow out of a processing of a life-threatening experience, and it was formed as a result of a shared
reality in that it was remote because pandemic precautions meant that we could not meet in-person.

How could professionally based friendship and therapeutic develop remotely? It seems unlikely given the lack of curated therapeutic space and the physical distance between client and therapist in remote counseling, which arguably disrupts the intimacy of a shared therapeutic space. Research and literature abound with concern about the limiting qualities of remote counseling. In Morin’s (2019) article “Does Online Therapy Work?,” the author expresses common worry that the absence of face-to-face therapeutic exchange limits therapist’s observations and, thus, their ability to make informed interpretations and interventions. Research on the impact of the therapy office environment on client perception also suggests that, without it, we, therapists, are at a disadvantage. Pressly and Heesacker (2001) cite studies that link art, furniture selection and positioning, and other environmental cues in therapists’ offices with a client’s feelings of comfort, degree of self-disclosure, and view of their therapist’s competence. It is also striking that, in a group of seven clinical social workers whom I interviewed recently for a qualitative study underway, all expressed loss connected with transitioning to remote counseling and all described efforts to maintain the quality of their therapeutic work. They worry that the quality of their therapeutic work will suffer when it is remote.

Today, I no longer have access to that designated space in which I use the positioning of my chair, certain décor, and the way I sit and hold myself within it to communicate my therapeutic approach and expertise; and, my clients no longer benefit from going to a designated space that often supports the therapeutic relationship in orienting her/him/them toward therapy.

Yet, despite this space’s absence, I have experienced more intimacy with Richard and other clients. In the removal of the specialness of a curated therapy space, there is room for the ordinariness of my clients’ lives. I see and hear things that may not have been mentioned, deemed unworthy for, or irrelevant to therapy. I also shared more of me as a person, as Richard and others saw my un-curated, personal space. This had a two-part therapeutic benefit: (1) it revealed interests and motivation unknown beforehand. Richard’s real interest in his garden work was not emphasized in therapy previously, and it was uncharacteristic. By meeting him in his home, we found a possible path toward a brighter future for him; and (2) it worked toward greater equality between me and my clients. The dynamic wherein my clients self-reveal necessarily and I self-disclose in a controlled, minimal manner has changed. Now, they learned and could assess things about me, just as I them. This calls upon me to have greater humility in my work. To use the consensus drawn from Rowden, Harris, and Wickel’s (2014) study on humility in relational therapy, I define it as “an attitude of openness,” “recognition…. (and) comfort with one’s limitation(s) or problems,” and “recognition of one’s own contribution to relational problems” (p. 385). My lack of awareness of Richard’s garden prior to the pandemic illustrates a problematic, blinkered approach. I looked for motivation to get a job; I looked for interests that had strong potential to develop into employment opportunities. I did not ask more broadly: “tell me about your interests.” The new, co-created therapeutic space primes me through environment to more deeply understand that
my catalyst for change lies in greater openness – openness to know them and them (within the reasonable limits of the computer screenshot) me.

**Remote Counseling’s Potential**

There is hesitancy to accept remote video counseling as a viable long-term alternative to in-person therapeutic sessions within the community of social workers and therapists. Yet, in this chapter, I chose to focus on its therapeutic possibilities, partially for pragmatic reasons. We must consider the possibility that video counseling may be the only viable alternative to in-person counseling for some time and work with it in order to best support our clients. I also focus on these possibilities because I am seeing them realized with some of my clients and believe more is possible. While the therapeutic relationship is not all that therapy rests on, it is a significant mechanism for change. In that regard, I think that remote counseling has something to offer: the potential for a greater sense of friendship between therapist and client.

**References**

Misch, D. A. (2000). Basic strategies of dynamic supportive therapy. *The Journal of Psychotherapy Practice and Research, 9*(4), 173–189.

Morin, A. (2019, July 17). *Does online therapy work? Here’s what science says.* Inc. Retrieved from [https://www.inc.com/amy-morin/does-online-therapy-work-heres-what-science-says.html](https://www.inc.com/amy-morin/does-online-therapy-work-heres-what-science-says.html)

Moyer, A., & Hajjat, M. (2017). *The psychology of friendship.* Oxford: Oxford University Press.

Nuttman-Shwartz, O. (2014, November). Shared resilience in a traumatic reality: A new concept for trauma workers exposed personally and professionally to collective disaster. *Trauma, Violence and Abuse.*

Pressly, P. K., & Heesacker, M. (2001). The physical environment and counseling: A review of theory and research. *Journal of Counseling & Development, 79*(2), 148–160.

Reamer, F. (2002). Eye on ethics. *Social work today.* Retrieved from [https://www.socialworktoday.com/news/eoe_030402.shtml](https://www.socialworktoday.com/news/eoe_030402.shtml)

Rowden, T. J., Harris, S. M., & Wickel, K. (2014). Understanding humility and its role in relational therapy. *Contemporary Family Therapy, 36*, 380–391.

Tosone, C. (2006). Therapeutic intimacy: A post-9/11 perspective. *Smith College Studies in Social Work, 76*(4), 89.

Yalom, I. (2003). *The gift of therapy: An open letter to a new generation of therapists and their patients.* New York: Harper Perennial.