Therapist Self-Disclosure: The Illusion of the Peek-a-boo Feather Fan Dance
Part II: A Risky Business
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Abstract

This article is Part II of a two-part exploration of therapist self-disclosure. These papers view therapist self-disclosure as an integrative concept, in that it can promote a movement towards a deeper, more authentic therapeutic alliance, whilst advancing therapeutic change. Part II continues a discussion on the role of self-disclosure in relational body psychotherapy, and explores the intricacies, challenges and risks of self-disclosure.

The paper begins with an examination of the unique challenge that the Internet poses for therapist self-disclosure and the protection of privacy. This is followed with an exploration of accidental, inevitable, unspoken, and unconscious self-disclosure. There is an account and discussion of a clinical vignette to illustrate a self-disclosure that led to a breakdown in client trust, contrasted with two clinical examples demonstrating how the deliberate use of self-disclosure can lead to positive outcomes for the client and the therapeutic alliance. Following is an enquiry as to whether we, as therapists, have full control over the boundaries of self-disclosure, particularly when engaged with relational body psychotherapy and touch. The article concludes with a discussion on how we can regulate disclosure, and ensure safety for ourselves and our client.

Keywords: Therapist self-disclosure, relational body psychotherapy.

Introduction

The notion of risks and rules are inherent within the literature on self-disclosure. The nature and the degree of self-disclosure varies with each theoretical orientation, from the classical psychoanalytical schools who view it as unequivocally counterproductive, to the humanistic schools who view therapist self-disclosure as an important tool to facilitate authentic connection (Peterson, 2002).

The discourse about self-disclosure abounds with conversations about the concept of boundaries. Defined as 'the ground rules of the professional (therapeutic) relationship' (Barnett, 2011:p. 316), boundaries are in place to provide a sense of safety for the client, and reinforce the belief that the therapist will act in the client's best interests (Pope & Keith-Spiegel, 2008). However, within relational work, therapeutic boundaries need to be permeable. As relational body psychotherapists we are in touch with clients, and our boundaries allow for mutual influence and yet should offer containment and holding for intense affective experiences.

We can honour traditional parameters of safety within an ethical frame, whilst in the interests of therapeutic transmutation encourage openness.

Therapist self-disclosure is a calculated risk, which we take. When we share our thoughts or struggles, we need to consider as to whether it is suitable and therapeutic. The practice of ethically-sound self-disclosure is far from being a simple, straight-forward, or even intuitive matter for the thoughtful clinician. Instead, it is an art form that depends on the psychotherapist's ability to integrate theory, experience, and self-awareness. Even with consideration, our self-disclosure can carry serious negative consequences, in that it can hurt or alienate the client, damage the therapeutic alliance, diminish trust in our professionalism or competency, or even cause a premature termination of therapy (Audet, 2011).

This article begins with an examination of modern day challenges, such as our diminished privacy due to the influence of the Internet, which may preclude complete anonymity for therapist and client. The challenges of being a relational body psychotherapist is then considered, where it is posited that in the formation of a 'real' or authentic relationship between therapist and client, therapist self-disclosure is an inevitable event that occurs both deliberately and unconsciously. In light of how much information is transmitted non-verbally, there is an exploration of whether the issue of 'border control' is a fantasy, and that in practice we may not be able to fully protect ourselves from exposure. As self-disclosure involves risks and vulnerability this paper concludes with an exploration of issues of safety, and the mechanisms we can employ to ensure it.

Self-disclosure in the digital age

A central area of discussion in self-disclosure regards how much anonymity we can preserve in this modern age of the Internet and algorithms (Zur et al., 2009). The pervasive nature of modern technology and in particular the Internet now dictates, to a certain degree, our disclosure. For instance, the Internet has become a primary source of information or voyeurism for the current or prospective client. Self-disclosure on social media has become an important part of many people's lives. Sharing status updates can support many positive outcomes, such as social validation, relational development and social control. However, it can also cause context collapse, increased vulnerability and a loss of privacy. Social media and changes in cultural attitudes to disclosure and perceptions of privacy are shaping both our ability to remain unseen/unknown and altering our accessibility (Johnson & Paine, 2012). A client may instigate a Web search, which could reveal personal information about their therapist which would have previously been inaccessible.

With the advent of the digital age, there have been other significant cultural shifts. Professional attitudes towards self-disclosure have evolved with cultural attitudes. The walls between doctor and patient have been breached and broken down with the societal adaptation of the ideology of 'consumer and provider' in healthcare. The client has become more empowered, more discerning and more demanding of credentials and personal information. In the media, there has been a move towards promoting more extreme and uninhibited public self-disclosure. Reality television, blogs, and social media platforms like Instagram, are leading the way in this public exposé. This is coupled with the willing compliance of members of our populace to submit their lives to comprehensive scrutiny and the uncensored voyeurism that accompanies this social climate (Andrejevic, 2002, Zur et al., 2009). If we have a media presence and act as a healthcare profession, whether we choose to or not, can we truly hide who we are? Are the feathers being plucked from our Peek-a-boo fan, or do we unwittingly shed them? There is now a very real chance we will find ourselves naked in front of our clients.

Accidental (involuntary reactions), and inevitable (expressions of self-identity) self-disclosure

Non-verbal cues or body language are not always under the therapist's full control, and it is this form of communication that clients are more attuned to than to verbal communication (Knapp and Hall, 1997). Non-verbal communication is often the means by which much of our information about the other and ourselves is transmitted (Knoblauch, 2000, Stern, 2004), and verbal communication may account for less than 7% of our communication (Mehrabian, 1972). While verbal communication is only a small part of what we do (and this is both good sense and largely accepted), we are still trying to talk our way out of trauma. Therapists are continuing to engage in dialogue alone rather than with the body. There is the question of whether we can conceal anything at all when there is the added element of relational touch in our work. Each intervention, like a burlesque dancer and her elaborate fan dance, allows another part to be seen. However, we may reveal more than we intended, as we strive to hide parts of ourselves.

In a relationship with the client, the therapist constantly reveals through their preferred theoretical model, explicit countertransference and analytical stances. Even interpretations made in the therapeutic encounter are self-disclosures; they both demonstrate opinion and the existence of a different and separate mind. Our body provides physical evidence to the 'other' of both our physical and emotional well-being. Our tiredness, the signs of a sleepless night, illness and, inevitably, our mortality are all on prominent display. We become the 'analytic object' (Murphy, 2013, Yalom, 2002).

Inadvertent self-revelation seems inevitable. We disclose aspects of ourselves - our biography, origins, values, attitudes, preferences - simply by our physical presence. The style and frequency of our intervention, all provide unspoken information to the other. The therapeutic setting, the decor of our practice, any personal artefacts, our physical appearance/ dress, accent, all provide clues (Zur, 2007). As does the way we relate to our client, the issues we attend to or not, our bodily movements, animation, and our choice of words (Knapp & Hall, 1997). Even our decision to be a therapist all disclose who we are and aspects of our life, whether we choose to or not. Our biographies and an unfolding engagement as client and therapist will further disclose who I am in context to the other. In being authentic, even if I am neither intentionally concealing nor revealing, my experience of situations will be transmitted and embodied within our dialogue.

We carry all the symbols of our production, as our socio-cultural history, race, gender and social demographic, colour our perceptions and preconceptions, and are disclosed to the other - they have only to interpret the signs. They are all part of the complexity of the therapeutic situation. What is manifest has therapeutic meaning. This manifestation is a constant, that is present throughout the analytic setting for both participants, and it is the construct in which the intersubjective relationship is founded. All of these elements require consideration if we are to offer an inclusive setting to a diverse population. This becomes even more pertinent when we work in a small, religious, or rural community setting (Knox et al., 1997), as we are more visible to our clients.

Not all disclosures are spoken.

After the Manchester bombing, many of my clients were affected by the attack, some directly. Clients were visibly shaken by this latest event in, what some of them perceived, a culmination of 'disasters'. Terrorism, natural disasters and unrest have affected my community in the last few years, from the devastating flooding of our local area which left people homeless or financially ruined, to the Orlando mass shooting in 2016, the Trump inauguration, and the local elections. How do we meet our clients if we have a shared traumatic reality? I was also struggling to navigate the same

stormy waters. My clients were bringing their shock, anguish and despair at the seeming craziness and danger of the world into the clinical space, and an authentic, yet regulated response, was being asked for. Over the last few years, fear and threat in our society have become a potent figure in my clinical practice. Traumatic events are part of our shared social reality and have shaken people's sense of security. This shared grief demanded a conscious disclosure of my authentic response; it required a therapeutic response that went beyond witnessing and processing. The changing landscape of our world is impacting on what is considered appropriate regarding self-disclosure in the therapeutic relationship (Tosone, 2011). Shared trauma alters both what clients ask and what therapists reveal.

In one such moment, I was with a lesbian client, who worked in Manchester, near to the site of the bombing. She had attended those who had been affected by the blast the day before. Aroused by the same bodily sense of horror, fear and impotence in the wake of this event, I sat in silence with her. I did not want to convey a dissonance between my bodily presence, the felt sense, and my verbal communication. I was tearful, yet connected by the same sadness, whilst regulating (by staying present, attuned, breathing and embodied). I felt that this regulated sharing provided the much-needed antidote to the senseless violence and disconnected horror.

Maroda (2009) describes how the therapist's expression of emotion towards the client, 'serves to complete the cycle of affective communication that was insufficiently developed in childhood'(p.20), in that appropriate emotional disclosure provides a 're-education' and provides a 'much needed human connection and comfort'. The self-disclosure although non-verbal, was nonetheless a powerful intervention. The key factors of embodiment and regulation allowed for a regenerative experience so that we could pull back, both from the present challenges and its resonant traumatic early relational experiences. For my client, these experiences included the terror as a child in a violent, unstable family home and the fear of being physically attacked for being 'different'.

Unconscious self-disclosure

If self-disclosure is a feature of our therapeutic approach, then whether we disclose or not with a particular client should be, as much as possible, a thoughtful choice. It should be open to reflection, by both the therapist and the client within the dyad.

However, what happens when self-disclosure occurs outside of the control of the therapist? I have found within the scope of my practice that unconscious self-disclosure can readily occur, particularly when naturalistic trance is generated. I have also found that in the moments whilst 'entranced,' that self-disclosure can be both reciprocal and unavoidable. Within the somatic and emotional experience of the transference and countertransference, there is, like emotional contagion, a transmission of emotions and information that cannot be entirely one-way.

Unconscious self-disclosures are also called 'unwitting self-disclosure' or 'self-revelations' (Gans, 2011; Jacobs, 1999; Levenson, 1996). These unintentional, unconscious self-disclosures appear to be so ubiquitous that the question of whether we can control them at all may be redundant (Aron, 1996, Renik, 1999). Suchet (2004) suggests the possibility of communication between the unconscious of the therapist and the unconscious of the client, that is outside of the control of the therapist.

In my practice, clients have known facts about me that I had not disclosed. For example, I had a client who repeatedly dreamt I was pregnant, even before I had told my mother about my actual pregnancy, or another client who felt, inexplicably, sad and noticed I was grieving when I had not mentioned the death of a friend. There may be ways that countertransference is experienced by a client, ways that go beyond words. Clients know their therapists, often through means outside of the control, and perhaps even the awareness, of their therapist.

Unconscious self-disclosure is that which is simply known by the client without been spoken. By what mechanism is this occurring, and is it an inevitable event? There is the question of whether there is a choice to transmit or receive unspoken information or to make our inner experiences accessible to the other. Can we keep ourselves hidden, when we do not wish to be seen?

There are levels of communication that we cannot always know or control. Some of what we communicate, both as a therapist and a client, may be an expression 'which cannot be put into words at all' (Reich, 1949/ 1970:361). Moreover, unconscious self-disclosure is not solely the therapists' domain. I worked with a social worker, who had an uncanny knack of enabling sexually-abused children to open up to her. Without disclosing her childhood biography of sexual trauma, her body disclosed it to all that needed to hear. The children would often respond to her, where others had failed, with the words, "well, you understand, don't you?"

Within this field, through touch and the qualities of empathic somatic resonance, permissiveness and stillness, there can be a communication which is 'subliminally conveyed and known, with clear comprehension' (Sills, 2006:211). We become true telepaths, 'transparent to each other' (Totton, 2003:202), and our clients come to know us as we know them.

In the following clinical vignette, I explore the serious implications that can arise as a result of an unsuccessful self-disclosure.

Vignette

Lisa came to see me, during the Christmas period, as she was suffering from vertigo. Unable to work, she was becoming depressed. She led a very busy life, working as a manager for the social services, as well as raising two young children. Her symptom had come on suddenly and violently.

As she spoke about her condition, a pain began in my chest and was becoming intolerable. I began to feel disorientated. Immediately, I noticed that our environment was changing, the room blurring. We were communicating in a deep cocoon of connection. I wondered how I got there. She was still talking, but I was not listening to her words. I felt sadness, a poignant, raw grief that caught my breath and hollowed out my throat, as though I had experienced a loss or death.

Stopping her mid-flow, to ask her, "have you experienced a sudden loss this Christmas?" She stared at me blankly. I continued, "a significant loss of someone that was very close, that you had a deep, intimate friendship with, that was confusing and disorientating?" She began to cry while explaining how her best friend of many years, had cut her off and ceased all communication. Her world had been rocked off its axis. I continued, "has it happened before in your relationship?" She nodded.

The communication of her body was clear and succinct. The words entered my mouth without any processing. I spoke what I felt and saw, not a visual image, but a 'knowing' that I would have difficulty explaining, other than to say that I felt the resonating words come from her to me. The pain in my chest did not subside until several hours later. After the session, she called to re-book. She returned to therapy, only on the precondition that, "we didn't do that again", and that I did not "read her mind."

In that shared space, I felt I had entered into their intimate and female friendship of long-standing. Friends who did not need to speak to be understood, and who communicate in an unspoken tongue. I had no right to be there. My sudden speaking of the unsaid broke the tension of connection. Speed had been my undoing. Our interaction created fear in her and mistrust. My disclosure had touched upon a cultural fear of the unseen and, while I could argue that intuition motivated me, she felt that is was unnatural. This disclosure created a fracture, which still has not been healed.

Discussion of vignette

Resonance and disclosure, both spoken through the body, and through verbal interactions, are a risky practice. Each relationship we form and co-create can change us both. When information is disclosed, the tension within the relational dynamic can be strengthened or broken. Through a maturation process, the relational practitioner learns the appropriateness of each disclosure (Aron, 1996). Disclosure of countertransferential material can sometimes disrupt the therapeutic relationship if shared prematurely or, as the case above illustrated, when poorly executed, partially due to the merging that occurred in the naturalistic trance. I simply spoke what I felt or 'saw,' without pausing to consider what our relationship was, or how appropriate it was for this particular client. Self-exposure has therapeutic significance only if it is related to the clinical material presented, in that it should be connected to the client's thoughts and ideas to make a difference (Zur, 2007). In this instance, my intervention was as disorientating and isolating to Lisa as the action of her friend.

This disclosure was an inner knowing (that I was aware of her grief she was experiencing and its cause). I was shaken and deeply troubled by this incident. I felt ashamed of my hasty self-disclosure, the disturbance that it caused my client and of the therapeutic rupture. I had used resonant feelings, but I had also disclosed intuitive, even spiritual aspects of the self, and my disclosure had informed my client of the existence of these parts, and of the realm in which we were also conversing. In one respect, this was not self-disclosure, but a sharing of an unspoken communication. However, without client agency, this sharing can be meaningless or create fear and asymmetry.

On reflection, I was slowly able to see how I could have altered the disclosure to make for a more productive interaction. I can imagine that had I shared my thoughts less directly and more skilfully, it would have made for a creative and dynamic interaction. With Lisa, there was an opportunity to use my own bodily resonant information as a source of curiosity, rather than a statement of fact. I could have informed Lisa of the sensations I was noticing, and the feelings ("I notice that as you are describing this sensation of vertigo I am feeling disorientated.... that I have a pain in my chest, that is intensifying...") and asking her if these sensations had anything to do with how she was feeling ("can you relate to any of these sensations in relation to how your feeling?"). This gentler and more communicative dialogue may have been more digestible, less invasive and therefore, more helpful to my client.

I am also aware that when I notice these direct 'inner knowing' within myself, that they cause me to feel uneasy and this anxiety contributes to my need to 'spill' it all out. I often feel dissociated, or panicky and fearful, when I disclose my telepathic understanding to my clients. I feel these unpleasant feelings correlates to my unwillingness to contain them within myself. I too, do not trust these messages, even though they have proved time and again to be factually accurate, and I feel shame at my experience and voicing of them, convinced by my inner critic that I am simply a 'fraud'.

I feel through this experience that I could have collapsed, however, the converse happened. I am coming to trust my 'knowing' more, and as my confidence grows in recognising them as a reliable source. I am developing my capacity for holding and containment. I have the opportunity, through recognising my own reactions to an inner knowing, that I could instead allow myself more time in the session, to process and contain the 'knowing'. By tracing my client's responses (through their body and mine) during self-disclosure, as a means of becoming more attentive, I can thereby safeguard us both.

These lines of communication which allow for subconscious disclosure are an interconnectedness. By recognising the connection between us all, we can navigate these energetic 'strings', in which we can become entangled or enmeshed, or on which we can 'glide' (Rolef Ben Shahar, 2012).

Not all mistakes are equal

One of my most painful 'mistakes' has also been the most regenerative. Claire, a transgender client, was recounting a hilarious and vivid account of an incident where she felt able to exert a powerful degree of control and superiority over someone. I remarked, "well that's the kind of man you are…" I had been joking with her, and abruptly I stopped. Mortified, I remember physically recoiling back from my words. Inflamed with embarrassment, I immediately apologised for my error. I have worked within the transgender community for several years and being culturally competent, and engaging sensitively with positive expressions of self and identity with my language, has always been paramount.

She looked at me coldly, and then in her eponymous style, she fired back, 'well…I wonder why you made that pronoun mistake?' Supported by our relationship, she chose to engage with my accidental disclosure. It had been a mistake in terms of etiquette, but together we looked deeper into why I had made it. I apologised, yet it was not stupidity that drove me to say it, but a naming of the 'elephant in the room'. (Later on, in supervision, I also recognised my part, as the outspoken child in my family of origin, who spoke out the truth, no matter how dire the consequences.) My mistake led me to a more authentic self-disclosure of an inner conflict (or ambivalence). I could make my inner dialogue transparent, in that I was able to discuss the 'I' that supported her and celebrated her, and the 'I' that felt uneasy when she displayed her power and intellectual dominance. I also disclosed the feeling that, perhaps, I had subconsciously rejected her as a female, as I held a core belief that she was different to me as she experienced privilege in her former life as a man.

This error allowed us both to speak more about gender identity, an issue that I had become complacent about. By acknowledging my hidden prejudices, she was able to explore her own doubts. It allowed us to explore how she truly felt after her 'operation', and how she had felt more of a woman before the 'endgame'. Now, with the medical complications of her surgery and the resultant infections, she felt less womanly and more asexual.

In the sharing of my 'non-understanding', I came to know my client better. I was moved to reflect if any of us are that certain of our gender identity? Transgenders can have a radical discontinuity between their sexual pleasures and actual ('real') body parts (Macdonald, 1998). Before surgery, my client's sexual expression had required an imaginary participation in an orifice that she did not actually possess. Her sexual pleasure was integral to her fantasised body. Once she was free of the appendage that she felt constrained her, she could not relate to her post-operative body as that of the body she had previously imagined. This emergent realisation was crushing and had led to her current melancholia. Her shame had prevented her from disclosing this before.

My attempt to be seen as one of her 'tribe' was a function of my insecurity and had been preventing me from being more empathically attuned. Without becoming insensitive, I let go of the mantles of self-righteousness and 'right on' ness that I had been clinging to, and I became more open to hearing about her actual experience, and more attentive to my self-experience. I also became more aware and was able to elucidate my own held sense of what I identified in her as male - the sense of privilege which I felt she must have experienced as a white, middle-class male, together with my own feelings of inadequacy/ inferiority that I had been ignoring, and the unease I had embodied. It was a difficult interaction, however this exploration was both helpful to Claire and led me to a more comprehensive understanding of my prejudices and misconceptions. In turn, this led me to a greater understanding of my client, and the transgender/ gender non-conforming community. Sadly, being perceived as a male grants privileges in this society, and I came to see that these privileges exist within a transphobic society, and are often unknown to transgender men.

This issue of privilege is a sensitive and complex one, and not without peril. This year, the author and feminist Chimamanda Ngozi Adichie, publicly suffered the hurt and wrath of the transgender community, as a consequence of entering into a dialogue on this subject. Arnold Mindell, once said that, as therapists, we must be willing to be 'shot so full of holes' that there is nothing left to hit (personal communication with N. Totton, 2017). Personally, I hope my mistakes will not be so openly executed. By engaging with disclosure, I can see that mistakes are inevitable, and often co-created. Moreover, mistakes and failures are an integral part of life, and, therefore, psychotherapy -

'In both life and therapy, mistakes are invaluable because they *bring us up against reality*- force us to recognise what is real, rather than what we imagine, fear or hope for' (Totton, 1997:317).

Within relational philosophy, there is the understanding that if the therapist experiences, and then disowns his or her negative countertransference regarding their client, there is a risk of unconsciously communicating these reactions through our behaviours. Denying these responses may, in turn, erode the patient's sense of reality, and rupture trust in the therapist, thereby repeating the original traumatic event they experienced with their significant caretakers (insincere/ neglectful parents) (Renik,1999). By owning our countertransference reactions, and appropriately disclosing them to the client, thereby supporting their reality, the therapist provides a 'corrective experience', thus increasing the client's trust in the relationship and strengthening the therapeutic alliance (Audet, 2011). Ferenczi argued (1928,1933) that it is precisely this process of rupture, reconnection, and repair that leads to the curative power of the therapeutic relationship, influencing much relational thinking on enactments (Aron, 1996; Benjamin, 2004).

A Risky Business: Intricacies and Challenges in Self-disclosure

Self-revealing disclosure brings about an emotional closeness. However, there is also a potential for engagement with the other's pre-Oedipal state, which is all the more pertinent when we are interacting with a client with early attachment issues. In this state, we are affecting a sphere of attachment and intimacy, and speaking the 'mother tongue.' Within this realm, we can enter into the dyadic nature of the mother-child relationship. Infants have had the ability, 'to engage with interpersonal communication from birth' (Stern, 2004:85) and responsive awareness towards different self-states of the other, which continues throughout life (Trevarthen & Aitken, 2001). In the concept of 'reciprocal mutual influence' (Schore, 2003), we are dealing with highly skilled, sensitive, and attuned clients, well adapted to looking past the feathers of our Peek-a-boo fan.

Our body is often the vehicle on which others' projections, and even fantasies, ride. Do we not think that, despite these projected identifications, the other may see what also lies under his own illusion? Moreover, that they may well have a keenly observant eye that sees the subtleties of unspoken communication, and of our bodily disclosures? Do we so firmly hold the belief that it is only us, the 'trained' therapist that can hold the paradoxical injunction, that is, two world-realities at the same time?

Are we not modelling behaviour to a client? The art of mirroring, empathy, active listening, resonance and, thereby, providing them with the therapeutic tools that we ourselves have developed? Therapy provides tutelage in the subtle nuances of attunement, body scanning, therapeutic touch and empathic resonance. Would it not be arrogant of us to believe that over time our client would not be as capable of learning through observation and felt experience, to match and even surpass our artful work, and see the unspoken?

With each self-disclosure, the person of the therapist comes more into view, and this can become clinically complex, especially when sensitive issues enter the therapeutic field. For example, the therapist's sexual orientation, disclosures of major personal loss and the processing of grief, or disclosures of serious illness (Cohen, 2005; Silverman, 2001).

Therefore, internal and external supervision should be imperative. Our inner supervisor (Casement,1988) can be the guiding voice in our decision on whether to disclose, and the client's own psychopathology, both medically diagnosed or not, should be taken into consideration. However, it should not be precluded on this basis. Therapists sharing unusual or 'odd' (Nelson, 1997:85), even paranormal experiences, including seeing visions, auditory hallucinations and feelings of paranoia, can create a sense of the universality of such experiences, rather than maintaining the erroneous belief that just 'mad' people have them. Simply sharing the information of the prevalence of such feelings can create relief. It does not predicate that we are agreeing or endorsing particular beliefs, but we can have a genuine empathic response to someone suffering. Also, we can impart an understanding of why someone would develop such a belief system, given his or her contextual history or situation.

Clinical work with diverse populations has increased awareness of race, culture, class, gender and social justice in the therapist relationship (Altman, 2009; Perez-Foster et al., 1996). Issues in cross-cultural treatment have become more clinically relevant regarding self-disclosure (Moodley & Lijtmaer, 2007, Moodley et al. 2013). Thus, regardless of theoretical persuasion, inflexible adherence to therapeutic boundaries without regard to the client's unique cultural circumstances may result in 'recreating shaming, oppressive experiences for racially and ethnically diverse clients, most of whom may have histories of discriminatory, shaming, and oppressive experiences' (Barnett, 2011: 407). There has also been an identification of social barriers that may be preventing culturally diverse clients from disclosing their feelings or thought processes in the transference. Research suggests that minority clients disclose more to therapists that are similar in race, culture or ethnicity (Perez-Foster et al., 1996). Conversely, it would be difficult for a therapist, especially an immigrant, to conceal their nationality, language, and accent.

Issues of power, attunement and trust (although not exclusive to working with minority client populations), are central to 'cultural competence' in practice. Therefore, the therapist needs to be more alert and responsive to these individual needs of the client. They need to be more aware of their transferential material or prejudices, and the therapist may need to disclose more (Leary, 1997). In cross-cultural dyads, the therapist must be even more vigilant in their self-disclosure. Issues of discrimination, prejudice, over-identification and even hatred could be triggered within the relationship. In this complex, relational matrix the therapist could be driven to self-disclose, to avoid the anxiety of the Unknown, or they can be unwittingly seductive in that they are deploying self-disclosure to avoid difference, by concealing their our autobiographies of class, nationality or location.

Developing mechanism of safety in disclosure

There are two issues regarding safety and disclosure. The clients' safety and the safety of the therapist, especially therapists that don't necessarily want or choose to expose themselves.

Regarding the issue of self-protection, can we intentionally hold information back? Can we truly hide our innermost thoughts or feelings? In reality, is there the possibility of concealment? When we move into altered states of consciousness or shared, naturalistic trance and resonance with our clients, can we still preserve our boundaries? As a relational body psychotherapist, so much of us is 'on show'; most of our bodily expressions are transparent to the other. I choose to enter into a shared

space, to go there with my client, and enter into their reality. How do we protect ourselves in this shared space of transparency from unwanted invasion? How can I choose what is revealed? No one is entitled to all of us, not even them.

Within the discipline of relational body psychotherapy, through attunement and somatic resonance, there can develop a shared space, where the separate subjectivities of the two participants can become indistinguishable. As a body psychotherapist, the non-dualistic integration of verbal and our intuitive, and unarticulated knowledge is a dynamic interaction. As well as paying attention to the body's explicit communication, the embodied therapist uses the 'felt sense' (Gendlin, 1996) to move towards a non-verbal, 'unnarrated' implicit knowing (Stern, 2004). Thoughts, feeling and ideas can be shared, they do not belong, to one or the other. This process can be mutual and reciprocal. The transference of the client and the countertransference of the therapist can become transmutable. In this shared, intersubjective field, unconscious communication can prevail in the here and now (Parlett, 1991). In this sense of 'jointness,' both parties experience the mutual satisfaction of surrendering to the merging within the dyadic relationship, yet, at the same time safeguarding separateness (Solan, 1991). Jointness is a regulated act, where the therapist seeks to maintain 'jointness' rather than symbiosis. This is a delicate balance of perceiving and concealing.

Increased self-awareness and attentiveness improves our ability to discern our client's material and our own empathic inferences. Mindfulness can allow for a more controlled, embodied dialogue (Kabat-Zinn, 1990, 2005). We can, like a skilled poker player, learn to physically and energetically choose to close or open the gateways of transmission. Through body awareness, I can hold back what I disclose, and develop the skill necessary to monitor and check what my body reveals to the other. By cultivating this awareness, I can form a safe therapeutic container. Mindfulness and careful observation of our internal responses may provide some self-regulation, and our self-reflection can guide us.

There can develop a shared trance of self-disclosure. As we enter into a relationship we 'open' up to a shared space or field of resonance. Within this relational process, we agree, even if the words are unspoken, to a therapeutic intimacy which can lead to a greater scope of mutual disclosure. It is on this relational edge that we, the client and the therapist, negotiate what feels safe enough and appropriate for us. We protect our client from over exposure of our subjectivity so that they may be supported in their autonomy, unbeleaguered with the sight of too much flesh, too soon.

Conclusion

Through this discussion, we have seen how self-disclosure has been perceived by many different fields of psychotherapy. Slowly, the profession's attitude to this intervention has changed and continued to evolve. There have been criticisms and concerns around its use, which continue to be debated.

Self-disclosure demands both a rigorous form of self-enquiry and self-regulation. As a relational body psychotherapist, I have come to recognise embodied markers for safe disclosure. I keep a curious watch on my somatic experience within the interaction, aware that resonance is a mode of communication, which is both reciprocal and can be honed. The relational positional stance acknowledges that there are three 'bodies' in the room. All are legitimate objects - the body of the therapist; the body of the client and the intersubjective body (Aron & Anderson, 2015). In each meeting, this is created afresh. If the disclosure is appropriate and sensitively executed, the shared body should have the capacity to tolerate the impact. In relational body psychotherapy, there is not just the psyche, but an embodied intersubjective third. This third body can be felt, and its energetic charge can be sensed by both the therapist and the client, and in this space, disclosure can occur through the body or the spoken word.

An embodied relational approach allows a body psychotherapist to distinguish between a response that is their own subjective experience and a response that is empathically driven by the other. Through external verification and a growing development of these senses we, as practitioners, can hone our ability to differentiate and clarify ownership between the emergence of our material, and those reflections of the clients' material. The relational approach invites therapists to 'move away from classical neutrality and open themselves to being vulnerable, to disclose their own experiences, and to tread common ground with their clients' (LaPierre, 2015:p. 94). However, it also demands responsibility. The therapist must know their own body, and be willing to learn from their mistakes.

A mindful self-disclosure will recognise that the interaction is a therapeutic conversation, where the therapist makes a conscious choice to share material with the aim of co-processing the emerging experience and recalibrating their view, should the need arise. The emphasis in the relational approach is on creating new relational patterns rather than offering analytical interpretations, explanations or insights on the nature of the experience.

To be authentic or 'real' does not mean that, in a relationship, we share indiscriminately. The therapist's personal voice, in a mutual dialogue, should serve the process and the client. This embodied and bodily inquiry relies on the body psychotherapist's attunement and responsibly shared sensations and associations that relate to the client's own bodily phenomena (Mitchell, 1993). Self-disclosure is also a technical decision, within our chosen modality understanding of whether or not it will be a therapeutic action. Disclosure and non-disclosure is a clinical decision, and the client will decide by staying or leaving therapy whether the technique was suitable. What we leave unsaid, what we speak about explicitly and what we allow to unfold as a natural developmental progression requires sensitivity and regulation. This regulation is informed both by technical understanding and the body.

Disclosure should be a gentle dance between risk and the deepening of a relationship. In relational body psychotherapy, we rely not solely on techniques, but on our art, the art of being with another person, and of being ourselves with another. It is an alive and dynamic art that requires commitment and loving kindness, in that, we respect our client's boundaries, and they too may be respecting ours.

Can we dare to meet the other with less rehearsal, to place ourselves to be more open to criticism? In doing so, we may seize the unique opportunity to meet the rawness of human encounter. Knowing the risks we take, we can utilise and embrace this intervention. We can step into a brave new world, one in which we can drop some of the feathers from our peek-a-boo fan, and even recognise the illusion of the fan. As the drop feathers drop, we deepen our practice in the art of becoming Real.

BIOGRAPHY
Danielle Tanner is a mother of three children, a wife, and a relational body psychotherapist. She trained with Silke Ziehl, of the Entelia Institute at The Open Centre in Deep Bodywork/ Postural Integration. She furthered her training with Dr Asaf Rolef Ben-Shahar in Integrative Mindbody therapy (IMT).
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Deepest gratitude for her teachers and to her supervisor, Nick Totton.

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