

Therapist Self-Disclosure: The Illusion of the Peek-a-boo Feather Fan Dance

Part I: The Art of Becoming Real

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Abstract

This article is Part I 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 toward a deeper, more authentic therapeutic alliance, whilst advancing therapeutic change. The first section is a literature review, it presents the history and theoretical perspectives regarding this intervention. This is followed by a description of the tools and processes employed by relational body psychotherapy in regard to self-disclosure. A clinical case study illustrates the use of self-disclosure by a relational body psychotherapist and the impact on the therapeutic relationship and outcomes. The paper concludes with an exploration of the potential benefits of appropriate self-disclosure. Part II will explore the intricacies, challenges and risks of self-disclosure.

Keywords: Therapist self-disclosure, therapeutic relationship, relational body psychotherapy

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Introduction

Self-disclosure, and the Art of becoming Real.

“What is REAL?” asked the Rabbit one day, when they were lying side by side near the nursery fender, before Nana came to tidy the room. “Does it mean having things that buzz inside you and a stick-out handle?”

“Real isn’t how you are made,” said the Skin Horse. “It’s a thing that happens to you. When a child loves you for a long, long time, not just to play with, but REALLY loves you, then you become Real.”

“Does it hurt?” asked the Rabbit.

“Sometimes,” said the Skin Horse, for he was always truthful. “When you are Real you don’t mind being hurt.”

“Does it happen all at once, like being wound up,” he asked, “or bit by bit?”

“It doesn’t happen all at once,” said the Skin Horse. “You become. It takes a long time. That’s why it doesn’t happen often to people who break easily, or have sharp edges, or who have to be

carefully kept. Generally, by the time you are Real, most of your hair has been loved off, and your eyes drop out and you get loose in the joints and very shabby. But these things don't matter at all, because once you are Real you can't be ugly, except to people who don't understand."

From The Velveteen Rabbit, (or How Toys Become Real), M. Williams, 1922.

Definition of Self-disclosure

The psychotherapy room is a place where clients are expected and encouraged to confide their secrets, dreams, fantasies, suppressed memories and immediate somatic and emotional experiences. Clients come to talk about themselves, and therapy is one of those rare moments in life where talking about oneself is not only considered permissible, but necessary. The therapeutic space is also an arena where the therapist must consider what they share with their client, where there is an appropriate balance between the helpfulness of sharing a part of ourselves with another and the recognition of the danger, of perhaps sharing too much too soon. Intentional therapist self-disclosure is the self-revelation of our experiences, of our stress, our anxieties, our resilience and our coping strategies, both successful and not, in the face of human suffering (Farber, 2006). Several authors have attempted to identify deliberate/elective therapist self-disclosure. Hill and Knox (2002) created categories of self-disclosure. They included information ranging from biographical facts (i.e. professional training) to 'strategies', or ideologies that the therapist had found helpful for different life events. In addition, they included the disclosure of feelings, those evoked for a therapist through a past experience, immediate thoughts or feelings regarding the client, as well as those involved in the therapeutic relationship and process. Self-disclosure may also be a means of affirming or reassuring the client, or a way of challenging the client's thought processes or behaviour.

'All disclosures reflect decisions about the boundaries between our private self and the outer world' (Farber, 2006: 1), therefore, conscious self-disclosure and transparency should be appropriate, client-centred, clinically-driven and compassionate. It should be empathetic or 'judicious' (Rachman, 1998). An intervention such as self-disclosure requires a boundary crossing rather than a seduction or transgression (Gutheil & Gabbard, 1993; Gutheil & Brodsky, 2008; Zur, 2004).

What follows is a review of the developing ideas regarding therapist self-disclosure, and a history of the use of self-disclosure in the major schools of psychotherapeutic thought (psychoanalytical, humanistic/ client-centred, behavioural and systemic).

The Historical and Theoretical Positions Regarding Self-disclosure

'The physician should be impenetrable to the patient, and like a mirror, reflect nothing but what is shown to him.' (Freud, 1912: 331)

The theoretical orientation of classical psychoanalysis dictated therapist neutrality, abstinence and anonymity as the axis of psychoanalytical technique, and the foundation for transference analysis (Peterson, 2002, Tubert-Oklander, 2013). The resultant, dual-created, interpersonal void allows for the emergence of the client's unconscious conflicts and desires, which are projected onto the 'blank screen' analyst and the therapeutic relationship (Freud, 1915).

Therapist self-disclosure was regarded as an impediment to this process, in that the client, confronted with the reality of the therapist's self, would halt the possibility of fantasy, and

therefore the transference would be contaminated. The traditional psychoanalytical stance held that by sharing our personal self, rather than simply transitory or situational thoughts and feelings, the known could never be Unknown. It would irrevocably distort the therapeutic alliance, and compromise therapeutic effectiveness (Shill, 2004).

Whether this conservative analytic doctrine was followed in most therapeutic settings is a debatable question, and was certainly not what Freud, the author of these 'rules', tended to abide by in his actual clinical practice (Lynn and Valliant, 1998). This is exemplified by Freud's humanistic and responsive approach to his analysand, in the case of Sergei Pankejeff or The Wolf Man (Freud, 1918).

Ferenczi, Freud's contemporary, challenged this standpoint. Ferenczi (1933, 1988) departed from the paradigm of the analyst as a cold, clinical surgeon ensconced within the antiseptic environ of a clinical situation of detachment, clinical expertise, and control (Rachman, 1998). Instead, he embraced an ethos of genuine sincerity, honest self-disclosure and warm, empathic attunement. He believed this was essential to reach a traumatised individual and he challenged the nature of clinical interactions between analyst and client. He advocated self-disclosure as an active intervention, and a means to provide reparative emotional experiences, especially in cases of complex trauma (Rachman, 2007) and therapeutic mishap (Ferenczi, 1928). He felt that self-disclosure was essential in redressing power asymmetry (Gaztumbide, 2012) and that to maintain a cold, patriarchic distance was likely to re-enact original childhood traumas, and was indeed counter-effective (Ferenczi, 1933, 1988).

The idea of anonymity began to be questioned. For instance, Ferenczi (1933) noted that clients, who had repeatedly been abused and invalidated in their earlier life, often develop an exquisite perceptiveness of others' internal states - *'they show a remarkable, almost clairvoyant knowledge about the thoughts and emotions that go on in their analyst's mind. To deceive a patient in this respect seems to be hardly possible and if one tries to do so, it leads only to bad consequences'* (p.161). Therefore, he believed that not only was a stringent avoidance of self-disclosure damaging but that a certain degree of self-disclosure was inevitable.

However, the neutral stance, espoused by Freud, continued to be adopted by successors of classical psychoanalysis. Ego psychology perpetuated the axiom of anonymity (Hartmann, 1964). Object relations theory asserted that the therapist could use their countertransference as a tool for identifying unconscious object relations within a client, however, this school continued to discourage the use of non-immediate therapist self-disclosure (Ziv-Beiman, 2013). Even with the event of self-psychology, the emphasis was upon the therapist as a self-object, rather than as a joint participant (Kohut, 1971). It was only within this framework that self-disclosure could be utilised, for the therapist to elucidate their response towards the client in the transferential context.

The paradigm shifted, with the dawning of the intersubjective and relational schools of thought (Mitchell, 1988). However, as Ziv-Beiman (2013) illustrates, there are contemporary strands of psychodynamic and psychoanalytical approaches that encourage some therapist self-disclosure, unaffiliated with the intersubjective or relational movement (Farber, 2006). These proponents believe that self-disclosure should not be unsolicited, but evaluated within the setting of the therapeutic dyad. However, many scholars feel that self-disclosure is inevitable (Farber, 2006) and that change cannot happen without intentional self-disclosure from the therapist as it reveals them to be a 'real person' (Renik, 1995). Nevertheless, there is also the tacit understanding that the intervention should be assessed within the context of the relationship, and at time-appropriate moments in the process (Greenberg, 1995, Mitchell, 1997).

Relational theory and practice highlight the interpersonal aspect of the analytical situations, as well as the role of the therapist's subjectivity in the transference-countertransference dynamic (Aron,1996; Greenberg & Mitchell, 1983; Wachtel, 2008). In contrast to classical psychoanalysis, the interpersonal focus of several modern psychodynamic psychotherapies places importance on self-disclosure in relational and intersubjective perspectives (Aron,1996). The concept of intersubjectivity posits that a client must be deeply met and recognise an 'Other', to identify their commonalities and differences and, thereby, gain ownership of their subjective experience, in relation to 'Other' (Benjamin, 1988).

Along with this perspective change, there has been the development of clinical work within diverse populations, which has fostered a greater awareness of race, gender, and class in the analytical relationship (Moodley & Lijtmaer, 2007; Moodley et.al., 2013). This has led to a movement towards greater efforts for social justice within psychotherapy, and a more egalitarian approach, invested in deconstructing power hierarchies and reducing cultural mistrust within the therapeutic dyad (Aron & Starr, 2012, La Roche, 2013). For many, self-disclosure is a means to this end (, Perez-Foster et al., 1996; Thompson et al.,1994). Additionally, this openness can reduce the transference that can occur in a more analytical, anonymous therapy as it allows for a revealing of the therapist's reality. Inadvertently, it destroys the transferenceal fantasy; undercutting both idealisation and demonisation of the therapist by presenting a more human face (Waska, 1999).

Humanistic and existential practitioners suggest that therapy necessitates appropriate self-disclosure. Self-disclosure can demystify psychotherapy, challenge the power hierarchies between therapist and client and promote the tenet of therapist authenticity and genuineness (Jourard,1971). In humanistic philosophy, self-disclosure is a means to illustrate the universality of human suffering, limitations, and unresolved issues. Geller (2003), asserts that disclosure plays a role comparable to clarifications, interpretations, and questions in the repertoire of therapeutic tools. Existential therapists share similar views to the humanistic schools, as they are encouraged to share their coping strategies and beliefs in the face of existential issues of meaning and purpose, to enable their clients to find their own (Jourard, 1971; Yalom 2002).

Historically, Cognitive- Behavioural therapy (CBT), has little reference to the practice of self-disclosure, apart from Goldfried et al. in 2003, whom specifically outlines the rationale for using this intervention in CBT. However, Panagiotidou and Zervas' review (2014), acknowledges that social changes and developments in medical science, which empirically support therapists' self-disclosure, have prompted the adoption of new self-disclosure practices. Current approaches, such as Acceptance and Commitment Therapy (ACT), advocates therapist self-disclosure in instances where it enables 'normalization, validation' promotes 'self-acceptance' or enhances the therapeutic relationship (Harris, 2009:235). Nevertheless, this intervention is seen as context dependent, determined by the unique qualities of the participants as well as where they are in the course of treatment.

Other therapeutic approaches, such as social constructionist family therapy (Freedman & Combs, 1996), actively support the use of therapist self-disclosure. 'Reflecting teams' of clinicians are encouraged to make observations within a personal context (i.e. "As an African-Caribbean woman, growing up in a mining town in the East Midlands..."). In associated narrative approaches, for example, 'The Tree of Life' project, there is a radical approach to disclosure in that the facilitators are sharing their life stories (Ncube, 2006).

In feminist approaches to psychotherapy, the therapist is encouraged toward deep self-reflection and critical self-analysis. Greenspan (1995) states, "I am a great believer in the art of

therapist self-disclosure as a way of deconstructing the isolation and shame that people experience in an individualistic and emotion-fearing culture” (p. 53). Considered self-disclosure is valued for its ability to reinforce modelling and foster a more egalitarian, mutualistic relationship between therapist and client, by diminishing asymmetry and power play. Self-disclosure informs the client of the therapist personal opinions and values in political and social arenas. Thus, it enables greater agency for the client. (Greenspan, 1986, 1995; Simi & Mahalik, 1997).

The overall trend in practice shows increased interest in the subject of therapist self-disclosure both in theoretical and research literature. Nevertheless, there remain practitioners who maintain that explicit self-disclosure is unethical or exploitative. They feel that by engaging in this intervention, we are opening ourselves up to the prospect of alienating our client and causing ‘alliance ruptures’. These ruptures will then prevent the fantasy of transference and their resolution. Bernstein (1999) severely criticises therapist’s disclosure of countertransference as an ‘infatuation’; an ‘elegant disguise’ for a therapist’s ‘narcissistic gratifications’ at the expense of the client’s intrapsychic (unconscious) conflicts (p.281). Furthermore, there is the idea that intimate self-disclosure will become exploitative and lead down the slippery slope of either sexual re-enactment or regressive collusion (Gutheil and Gabbard, 1993).

However, the profession-led prohibition on self-disclosure has gradually loosened its iron hold. It is no longer the ‘dirty little secret’ of the therapeutic world and scholars have begun to expound the positive attributes of therapist self-disclosure, particularly regarding the disclosure of countertransference.

Relational Body Psychotherapy, Resonance and Self-disclosure

Over the last twenty years, relational psychoanalysis has emerged. The philosophy and clinical practice are characterised by a movement from the classical Freudian drive theory (which is impersonal and endogenous) to a developmental model approach (which includes such key concepts as attachment theory, object-relations and self-psychology) (LaPierre, 2015). Therapeutic neutrality and anonymity have been replaced by the therapeutic relationship between client and therapist, as the central locus and primary agent of change. Influenced by this movement, body psychotherapy has begun to incorporate and embrace relational psychoanalytic principles. Relational body psychotherapy (or relational somatic psychotherapy, as it is known in the United States) emerged from this union. This union has been a fertile connection and a greater integration of the two worlds of the psyche and the body (Rolef Ben-Shahar, 2014).

Relational body psychotherapy, underpinned by the humanistic movement and attachment theory, is an embodied clinical approach, which incorporates transference dynamics and therapeutic resonance within a ‘relational matrix’ (Rolef Ben-Shahar, 2014: 319). Self-disclosure has been an important issue in the world of psychotherapy, and specifically in relational body psychotherapy, where it is joining analytical discourse and contributing somatic skills to the understanding of self-disclosure.

In Davies’ (1994) seminal and controversial paper, *Love in the Afternoon*, a clinical vignette is included in which she, the relational analyst, felt it necessary to disclose the presence of her erotic countertransference. Despite Davies being a prolific writer, this piece attracted more attention than any other article she wrote. Twenty years later, in her review of her ‘enfant terrible’, she examines how it was loved and reviled within the analytical world (Davies, 2013). Davies’ original article encourages the appropriate verbalisation of transference and countertransference to untangle and demystify early relationship patterns. This now-classic

paper, further opened up collegial discussion on disclosure of countertransference and, especially erotic countertransference. However, Slavin (2013) suggests that Davis' 'real moment of truth' was 'not a self-disclosure at all', as the thought was not unknown to the client (p.145). She did not say anything that was not known. Instead, she spoke the truth of a poisoning re-enactment. Rolef Ben-Shahar (2014), a relational body psychotherapist, furthers this distinction, by suggesting that sharing resonance material with our clients is not necessarily self-disclosure but a sharing- as Slavin conceptualised - of a 'moment of truth' that 'has the potential for therapeutic transformation' (p. 304).

Going beyond emotional contagion and natural empathy, body psychotherapists develop their capacity to consciously observe and follow changes in 'gut' feelings, the breath, physical tension, heart rate and other bodily sensations, both in their clients and in themselves. In conjunction with supporting their clients' ongoing, and spoken emotions, thoughts and reactions, the relational body psychotherapist is guided by their internal bodily responses.

Relational body psychotherapist will use therapeutic resonance, a 'superb diagnostic tool' (Rolef Ben-Shahar, 2014: p. 298) to bring into awareness non-verbal and unspoken communication in the shared relational field. The body psychotherapist may consciously cultivate this skill, of using their body as an amplifier, into feeling into the intersubjective space and body (themselves and their clients). This process of resonance, of tracking changes through sensory attentiveness, and sharing resonant experiences necessitates a degree of self-disclosure.

Relational body psychotherapists, through the mechanism of resonance, can develop empathy and recognise embodied transference and countertransference. Embodied transference and countertransference refer to the way therapists and clients experience each other's physical states within their own bodies. This mutually-created, bodily (somatic) phenomena (Totton, 2014) is not 'only psychological, but also a bodily process' (Totton & Priestman, 2012: p. 39). Body-centered countertransference experiences, such as sleepiness, shakiness, muscular tension, sexual excitement, yawning, churning stomachs and nausea (Egan & Carr, 2008), can be vital clues to the intrascape of our client. This bodily conversation is the 'terrain of relational therapy' (Totton & Priestman, 2012: p. 41), a shared attempt to work backwards from transference and projections about each other, which demands an embodied experience and self-disclosure. By disclosing resonant material (or countertransference) with sensitivity, responsiveness and mutual feedback, the therapist can deepen trust, while maintaining focus on therapeutic undercurrents and providing resources to their client.

The profession-led taboo on therapist self-disclosure, orchestrated by classical psychoanalysis, may be an illusion, a misguided belief that we have complete control about what we reveal or keep hidden. In fact, our choice on what we disclose may be inhibited by metaphysical constraints. Intrapsychic and interpersonal interactions are not entirely predictable or controllable. Within the intersubjective space there can develop a rhythmic sense of oneness - like the mother-infant dyad- in which there is a mutual dialogue, and an unspoken, two-way transmission of information. As relational therapists, we should offer containment and holding for intense affective experiences for our clients, but we also recognise mutual influence and our permeability. We may not be able to stringently hold our boundaries in this 'boundless work' (Totton, 2010), and if we followed the process advocated by Gutheil and Gabbard (1993), of avoiding even the appearance of boundary violations, we could also run the risk of becoming ineffectual. The relationship between client and therapist can be a multidimensional, psycho-somatic interaction. With that in mind, we can hold boundaries as an honouring of the client, while with care and attention, and in the interest of trust, authenticity, and therapeutic

transmutation, we can dance outside of this frame.

I will present a vignette of my work with one of my clients, to illustrate self-disclosure.

Vignette

I am sitting with my client Mark, and we are discussing his alcohol addiction. Mark has slowly begun to discuss his familial and personal issues around trauma and addiction over the course of our relationship together. Today, he came into my clinic appearing disheveled, physically and emotionally exhausted and pained in his movements. His eyes are downcast, and when he suddenly and narrowly looks up at me, I notice how red-raw and bright his eyes are. He has arrived at my clinic still within the throes of a significant hangover.

“What about you? Do you drink?” He begins. I falter as I am trying to come up with an appropriate answer- the ‘right’ answer. I know that I have not, yet, met him fully in our relationship and that this degree of disclosure and intimacy feels too quick. However, there is as much ground to gain or lose, in this tenuous and precarious place, and somehow, I know that I am just not going to get it right. I am already aware that this is how he began his most important personal relationships - in a rush. Significantly, this is also how many of his relationships were quickly crushed and abandoned. I have no wish to be one of his extinguished cigarette butts.

While I am still trying to shape an answer, he is relentless with his questioning. “How much do you drink? How often? What about with a meal? A bottle of wine to finish the day? What about if a mate arrives in town, that you haven’t seen for ages, what then? You can’t say no, can you?”. My heart is racing. I can feel the heat of uncertainty on my back and a rush of adrenaline. “Why does this mean so much to me, to get this answer right?”, I ask myself. I can hear my inner critic resounding in my head, “And fools rush in ...”. I notice how desperate he is for my answer, and for it to be my truth, not a premeditated, and censored, ‘therapeutic’ version. I took a breath and chose to disclose my relationship with alcohol.

Then, for the first time, he revealed how much he had drunk the day before, and the impact it was having on his business and his relationships. He spoke of how frightened he had become of the detrimental impact alcohol was having on his body, and of how many times he had blacked out, without even the creation of a memory to attach to. Then, over many sessions, we discussed our experiences and relationship with alcohol and our strategies, successful or otherwise, for coping with trauma. He stopped drinking. He attributes it to one moment in that initial conversation, at the beginning of his self-described ‘confession’, where I had authentically disclosed my relationship with alcohol. Yet, unacknowledged by him, a catalogue of mutual, deliberated disclosures led us to this place. It was in these moments of transparency, which I felt enabled both the therapeutic alliance to strengthen and where I became - like the velveteen rabbit - ‘real’ for Mark.

His recognition of his alcoholism opened the floodgates for him, initiating his first step into recovery. He began to tell his significant others that he was engaging in the recovery process from alcohol addiction, which in turn, increased his sense of accountability. He began to reflect on unresolved material from his childhood, such as growing up with a highly functioning, alcoholic father, who was “the life and the soul, but physically trembled before any social event”, and was unable to tolerate any emotional turmoil or charge, even positive. The patriarchal model of the ‘introverted exhibitionist’ had been, unwittingly, adopted by both of his sons.

The therapeutic journey to recovery demands a resilient therapeutic relationship, based on trust, as it is long, difficult, and uncertain, with no guarantee of success. Mark continues to progress on his journey, and after four ‘dry’ years he is still progressing towards an association

of pleasure with his sobriety (“my body feels great, I can breathe, but it’s boring”). He has an ongoing struggle of embodying two world realities. At his core, he knows that he is an addict that cannot choose whether he can drink or not. On another level, he cannot reconcile this with the idea that he is just an ordinary man, who likes to celebrate with his friends and use alcohol as a social lubricant. His self-belief that he is a man of strong character and single mindedness does not sit cogently with his internal perception of a ‘weak’ addict, and yet these two aspects are both housed in this same animal body.

Later in the therapy, Mark became immersed in the world of international dating agencies and ran up subscription fees of tens of thousands. It was apparent that his addiction had become manifest in another arena. These costly relationships were mediated through emails, translators and telephones. Love letters had to be bought and translators and agencies paid. He never met, touched or sat in the presence of any of his suitors. These relationships expressed his need for connection to another, and the lengths he would go to. Yet, they stopped at the fantasy. As soon as he booked flights to China, prepared his hotel bookings, a woman that he had expressed interest in began to reciprocate his affection. Almost immediately he cancelled all connection. He stopped dead in his tracks and turned away, from China, and from this woman at his office. He reinforced his inner belief that although he had found the ‘perfect partner’, he did not have time in his busy schedule, and they would only disappoint him anyway. Although professionally successful and able to sustain long term, loyal friendships, he was protecting himself from engaging in a possible, but real intimacy. His overly jocular manner was concealing a restricted expression of emotions, and detachment.

I was aware of Mark’s conflictual self-states (Bromberg, 1996) in the transference and projections that were already evident in our relationship. He would veer from a multiplicity of states: from dissociative ‘trance’ states where he would vividly recount traumatic events in his life but then, like an amnesiac would struggle to recall them in later sessions to intense, heart-breaking, intimacy. He had often been very direct in his questioning of my professional capacity, yet it took him several months to begin asking more personal questions. He was curious about my marital status, and whether I had children, this he initiated by his revelation of how he and his last partner were about to embark upon IVF before he had decided to end their relationship. I answered him, after some consideration. I hesitated as I felt unsure as to whether I wanted to expose so much of myself to him, as well as fearing that it would have a negative impact on our relationship, or take the focus away from him. I wanted to avoid therapy becoming ‘too conversational’ and therefore cease to provide my client with a clear therapeutic model. I did not want to meander too long, whilst I appreciate that I was providing warmth and empathy, I was also concerned that there was no direction or challenge for the client, and therefore little progress was being made.

When he remarked that I did not look old enough to have three children, it was clear that he did not intend to be flattering, and that he and I are, evidently, both old enough. This self-disclosure opened up the scope for further exploration, about how he felt about his age, what he had achieved, his aims in life, and how he felt about his achievements and creations. It led us to discussions of his feelings regarding his mortality, and how much time he felt he had.

These disclosures and interpretations, then lead us into more contentious ground, one in which I began to question his attraction to younger women, and the dissatisfaction that had manifested in his previous romantic relationships. This opened an exploration of the disquieting sense he embodied; of the unravelling of his dreams and aspirations of having a family life. Upon learning that I had only met my husband after the birth of my second son,

he remarked that he felt that I had overcome significant relationship difficulties and heartbreak and eventually found a way, however unconventional to him, to have the family I had today. He felt re-affirmed by this knowledge, and that my sharing had fostered a feeling that we were “in it together.” He felt I was committed to him, his journey and to wherever it was going to lead us. By following a relational approach, and by making my inner experiences accessible, my non-immediate self-disclosures allowed for a deepening intimacy. This was verified by Mark.

His constant preoccupation with finding the ‘perfect’ romantic partner was masking his terror of a genuine connection. On reflection, he saw how he had suffered his heaviest drinking period during a relationship where he felt unable to escape his partner’s sexual advances unless he was in a bar, or too drunk to perform. I felt that his behaviour exemplified how deeply fearful of intimacy he was, and how torn he was between the conflictual needs for both dependency and autonomy. I disclosed my sense of how he, like his father, presented himself as the humorous, playful archetype, yet he sabotaged the connection he yearned, that he was unable to allow existence. Connection was prevented by his exhausting work schedule, and his solitary, often gruelling, physical activities; both precluded him from having a romantic partner.

We came to recognise that his emotional needs were complex. A fear of abandonment drove him, yet he was fiercely loyal and had the ability to hold lifelong friendships. He was not one-dimensional, but intricate, controversial and conflictual. We began a painstaking, long term examination of the factors that prevented him from engaging in a ‘real’ relationship. A real relationship which is complex, troubling and often frustrating, but can lead to a long term, dependable, reciprocal and loving relationship.

Discussion of Vignette

My disclosures and interpretations were an attempt to address behavioural, cognitive, emotional and interpersonal aspects of his therapeutic growth. At the same time, while we related to the past, present and the here and now experiences, I concurrently demonstrated my commitment to the relationship, which resulted in a deepening of trust. I believe that this active intervention of self-disclosure was a technique that encouraged insight, behavioural and cognitive change, and transformation regarding his experience of self and others.

If we consider the integrative influence of therapist self-disclosure (Ziv-Beiman, 2013), in that it can simultaneously promote different therapeutic goals, and the therapeutic relationship, while providing support and challenge to the client, we can see its powerful role. The clinical implication is that we may consider using self-disclosure when we are seeking to pursue different therapeutic goals and potentially diametric pathways. For example, when we are pursuing a course with our client, and we aim to challenge their perception, thinking or behaviour, we can concurrently strengthen the therapeutic alliance using self-disclosure. The employment of self-disclosure can potentially integrate these two approaches while maintaining homeostasis between challenging and supporting the client in the here and now. Self-disclosure has been a principal element in creating this resilient therapeutic relationship, which although still difficult, is continuing to progress and remain fruitful.

What does it mean to become Real?

As a practitioner of body psychotherapy and Integrative Mindbody Therapy (IMT), I consider my work to be both relational and embodied. In my experience, I have found self-involving disclosure, where the therapist reveals his/her experiences or personal reactions to the client, to be an effective form of communication. I have also found it to be the most challenging

as a practitioner. Self-disclosure demands resilience from the therapist. By allowing ourselves to be seen by our client, we can move from being an object, to becoming 'real'. However, as the Skin Horse explains in the opening gambit it takes time, and we may become 'loose in the joints and very shabby' as we lose the veneer of perfection. However, by instilling a sense of shared intimacy, and deepening the therapeutic relationship through authentic self-disclosure, we open possible doorways of change. Self-disclosure can also challenge the client's perceptions, and create insight into their behaviour. Together with the most fundamental element of love, and more than a little magic, we can form a real relationship with our client.

Self-disclosure creates an environment of congruency and authenticity. As a therapist, I envision my role as one of co-participant and co-creator of the therapeutic relationship. I want a lively engagement with my client, in that I enter the therapy room both with my skills set and theoretical base, at the same time as making myself emotionally and intellectually available. This positioning lends itself to a certain degree of vulnerability and intimate potential behind these closed doors, and the relational therapeutic practice amplifies the complex and nuanced issue of self-disclosure. The intimate nature of the relationship is then further complicated by the close, physical proximity of a body psychotherapist to the client, especially during touch work. Within erotic transference and countertransference, there may be even greater disclosure, as the very conformation of the transference dictates a certain, charged intimacy (Maroda, 2002).

As an advocate of human agency, I am invested in an open and egalitarian relationship which permits mutual self-disclosure. From the theoretical orientation of a relational body psychotherapist, the centre of my therapeutic work is our connection with each other. I choose to bring my subjectivity into my practice, and this, in turn, affects the degree of self-disclosure that is evident in my therapeutic sessions. However, I do not believe that this necessitates unbridled self-disclosure. There can be a 'misperception that to work relationally means to disclose relentlessly' (Watchel, 2008:245), and we should be 'attentive to the consequences' (Watchel, 2008: p.247).

When I am self-disclosing, I am taking a calculated risk. Each self-disclosure has the potential to become a powerful integrative intervention, that may effectively strengthen the therapeutic relationship, and initiate change in 'emotions, thoughts, motivation, behaviour and interpersonal relationships' (Ziv-Beivman, 2013: p.59) or risk a rupture or even a termination of the therapeutic relationship. There is a need to hold the tension between alliance and challenge.

Why Disclose?

Our self-disclosure intervention can achieve a myriad of therapeutic outcomes: encouraging the development of the therapeutic relationship, correcting misconceptions, and normalising the client's experience (Henretty & Levitt, 2010). Self-disclosure can illustrate the commonality of destructive behaviours or cognitive patterns, and can even mitigate a therapeutic impasse (Maroda, 1999) or rupture in the alliance. If we listen and disclose empathically, we can become an empowering agent.

Additionally, self-disclosure is utilised to reinforce desirable client behaviour, to offer alternative ways to think or act, or to help clients recognise boundaries between self and others (Henretty and Levitt, 2010). It can provide an authentic human-to-human interaction, and encourage client autonomy. It validates the person's perception of the world and strengthens the therapeutic relationship/ alliance by creating a deeper sense of intimacy or closeness (Jourard, 1971). Hopefully, the effect will be to form a connection and convey 'presence'

through attentiveness and responsiveness (Audet & Overall, 2010: p. 358). This is of particular importance for clients with significant, diagnosed psychopathology, such as psychotic disorder. For those who suffer from social isolation or exclusion, the value of the therapist self-disclosure is that the client can feel heard, in their unusual experiences and related to by another. Even the sharing of everyday experiences can, in itself, be inclusive and de-stigmatising (Ziv-Beiman et al., 2016).

Often self-disclosure is seen to be at the heart of relational practice. In relational theory, with the dyad-centric approach, self-disclosure can be a means to elucidate on issues such as affect regulation, defences, and transference - countertransference enactments. We can make these issues more understandable to the client, which can be both enabling and empowering. However, there is a risk that when we are challenging a client, we are entering into their unconscious internal world where there is repression and resistance. For example, if, in our disclosure, we are raising significant sexual issues, we run the risk of being profoundly misunderstood, particularly when these topics arise within an erotic transference. Erotic transference is a point at which disclosure may happen involuntarily (Maroda, 1999). As clinicians, we need to consider using more than anodyne, or remote clinical language. However, we risk causing offence, breaking the therapeutic alliance or leaving ourselves vulnerable to attack, especially when relating disclosures of countertransference.

We need to be confident that by disclosing a transference interpretation we are not engendering misunderstandings, particularly when we are challenging issues surrounding the client's acting out and malign regressions. We are not only allies but catalysts for transformation and generation. We encourage our clients to understand and own for themselves, their introjections, their identifications, and projections, which can bring about change.

Offering an alternative perspective or sharing our coping mechanisms or abilities, at the same time as attempting to gauge our client's reaction, requires a degree of sensitivity and receptiveness to how the intervention is received. By enabling an element of client agency in the self-disclosure and allowing the client to explore their self-experience, they can feel that they are a decisive agent within a mutual dyad (Aron, 1996). Thereby addressing the central theme of asymmetry, within relational work.

BIOGRAPHY

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