Journal of Contemporary Psychotherapy (2018) 48:215–223
https://doi.org/10.1007/s10879-018-9388-9

ORIGINAL PAPER

Building and Handling Therapeutic Closeness in the Therapist-Client Relationship in Behavioral and Cognitive Psychotherapy

Luc Vandenberghe[1] · **Angelica Marden Coppede**[1] · **Marla Viegas Bittencourt**[1]

Published online: 21 March 2018

Abstract
The present study unpacks an important dimension of clinical practice from the therapists' vantage point. We interviewed 26 therapists in private practice about how the personal relationship with the client works from their perspective and conducted a grounded theory analysis. Three categories emerged. One refers to scope, aims and corollaries of the connection with the client; a second to preventing harm and managing drawbacks; and a third to taking therapeutic advantage of challenges related to closeness. Together, these categories form a model that describes how the close connection modifies therapeutic effects and generates challenges the therapist needs to deal with. The closer the dyad, the easier therapists will affect and be affected by the client. Therapists try to direct closeness to where it can nourish client process without harming the relationship, the client or themselves, and when closeness backfires, they may still try to harness uninvited effects for the benefit of therapy. This model concerning therapists' lived experience is offered to inform research on the therapist-client relationship and as a contribution to clinical competency models.

Keywords Closeness · Therapist-client relationship · The real relationship · Grounded theory

Introduction

This study is about the therapist's side of the therapeutic relationship. It was cued by the growing emphasis contemporary behavior therapy puts on the need for therapists to ground their work in experiential contact and involvement in the relationship (Wilson and Sandoz 2008; Holman et al. 2017), rather than on treatment protocol or intellectual understanding of the client's pathology. The most recent surge (the third wave) in behavior therapy emphasizes functional and contextual features of psychological suffering. This outlook supports more experiential work in session, as compared to the cognitive structures and maladaptive response patterns emphasized in the cognitive model that backs the use of cognitive restructuring and adaptive skills training as some of cognitive behavior therapy's (CBT) core methods (Fresno 2013). The contextual view gives a more central role to the interpersonal aspects of the treatment process and thus to the interactional features of the therapist as a person.

The traditional CBT literature already advocates working with the emotions expressed in the collaborative relationship (e.g., Dryden 2012; Kazantizis et al. 2013). More conspicuously, CBT for personality disorders (e.g., Linehan 2015; Young et al. 2003) stresses the clinical use of the relationship as a space where client distortions can be addressed directly as they happen. But third wave behavior therapy puts the experiential dimension of the therapist-client interaction fully in the spotlight. As an example, Tsai et al. (2013) place what happens in the personal relationship at the heart of treatment. The functional analytic psychotherapy they advocate thrives on using the intimacy in the dyad as a tool for in-vivo work on client target behavior in session. Other ways of harnessing the personal relationship for treatment were elaborated in acceptance and commitment therapy and dialectical behavior therapy, as briefly summarized in the following paragraphs.

In acceptance and commitment therapy, the therapist-client interaction is a critical enabling framework. While many daily-life interpersonal contexts support behaving according to rules and giving a wide berth to difficult feelings, the therapist is due to create a context characterized

✉ Luc Vandenberghe
luc.m.vandenberghe@gmail.com

[1] Pontifical Catholic University of Goiás, Rua 232 n. 128, 2° andar, Área V da PUC Goiás - Setor Leste Universitário, Goiânia, Goias CEP 74.605-140, Brazil

by commitment and appreciation of client pain. This helps clients actively contact issues that other social contexts cue them to avoid (Wilson and Merwin 2008). Building such a context demands going beyond conceptual understanding of client issues and bringing the therapist's values and vulnerabilities into the interaction (Wilson and Sandoz 2008). Entanglement in intellectual analysis, or avoidance of therapist sensibilities might result in modeling an unhelpfully disembodied narrative. The client may buy in to this narrative, or else, sense there is something (i.e., the therapist's theoretical concepts or avoidance) in the room without knowing what or who it is about (Pierson and Hayes 2007).

Similarly, dialectical behavior therapists are held to watch their internal experience of the client's behavior and their responses to it. Remaining in close contact, moment by moment, with how they affect the client and how the client's behavior influences them enables them to non-judgmentally focus on what happens in the moment (Swales and Heard 2007). Further, a consultation team is required to be at hand, to help the therapist reflect on his or her action and be ready to salvage therapy whenever needed, e.g., where the client evokes therapists' therapy-interfering responses or successfully reinforces ineffective therapist behavior (Linehan 2015). The inclusion of such requirement in the standard protocol shows the treatment model does not take a smooth relationship for granted. The therapist is actually expected to need help in conducting the interaction in session.

As can be gleaned from the paragraphs above, the literature on the relationship with the client has a strong normative angle to it. The present study intends to complement this approach by constructing an understanding of how using one's personal feelings and sensibilities as a professional toolbox actually works from the perspective of the clinician. This is different from research on theory-derived rules and studies that tell therapists how to relate to their clients or investigate what would be an adequate relationship. Our intention is to describe how therapists in the real-world treatment setting experience the relationship with the client. We want to know what issues they encounter in this relationship and how they deal with those. For this purpose, an inductive approach was chosen that explores personal experiences of therapists.

We opted for a grounded theory analysis (Charmaz 2017; Corbin and Strauss 2008; Glaser 2007), a method used for studying how people experience a phenomenon that is part of their daily (in this case, professional) life, and how they deal with the challenges it entails. This look at clinical practice in terms of therapists' lived experience is worthwhile because it adds another angle to an issue often approached through hypothetical-deductive and quantitative methods. Our aim is to inform research and competency models on the lived experience of the personal relationship with the client.

Method

Participants

Twenty-six psychotherapists in private practice were interviewed. Upon being queried, 19 admitted adhering to contextual (third wave) behavioral and 7 to cognitive-behavioral orientations. All were licensed psychologists and had at least one year of additional training in their respective treatment model. They had between 3 and 38 years of independent clinical experience (M = 15.2; SD = 8.0), 22 were women, 4 were men.

Type of Research

Grounded theory analysis is most often used in social research to distill mid-range theoretical concepts from interviewees' reported lived experience. Typically, the intention is to model an issue understood as relevant and problematic for the group sampled (Glaser 2007). During repeated readings of interview transcripts, codes are developed that capture what is going on in the data (i.e., open coding). Emerging provisional explanations help decide what additional data need to be found and with whom, to substantiate the insights being drafted (i.e., theoretical sampling). New participants are sought to verify emerging concepts and to further develop them. As such, theoretical sampling does not represent the population, but seeks key material for the model under construction.

Theoretical agnosticism is an attitude born out of the concern that commitment to extant theory might overly direct analysis (Henwood and Pidgeon 2006). It is not assumed e.g., that a therapist's model best explains his or her experience. As data direct the literature search (and not the other way around), notions from different origins may become relevant. As an example, ideas from relational psychoanalysis may help contextualize a cognitive therapist's feelings in relating to her clients. Instead of comparing one theory with another, elements from different models can be recruited as additional material (Glaser 2007). Our guiding idea was that therapists' lived experience at their specific location in day-to-day interaction with clients allows an epistemic advantage over researchers, so that recourse to their experience may let relevant vantage points emerge that can inform or ad up to academic work.

Research Team and Researcher Reflexive Statement

Three clinical psychologists, all of them with a third wave behavior therapy practice background served on the team. The second and third authors conducted the interviews. We

examined our expectations, agreeing that our interest in the topic stemmed from our clinical experience, which had made us aware of the role of therapist personal involvement. We believed that a grounded theory analysis of therapists' reports of the personal relationship, might allow a fresh outlook that would be recognizable and relevant to other therapists.

Throughout the project, we worked to prevent our opinions from biasing the material. Being aware that beliefs and theories we carry with us inform our study in many ways, we were concerned not to force concepts to fit (Glaser 2007). Decisions during interpretation of the data were based on what emerged in an open examination of the material including an active search for disconfirming information. Following grounded theory tenets, we used our views and theoretical notions as sensitizing concepts to detect potentially relevant aspects of the material, but also kept them in check, lest reading the data through the lens of theory or opinion would obfuscate novel or divergent issues.

Cordoba and Scott's (2001) definition of intimacy serves as an example. It describes interactions in which one person's vulnerable behavior (i.e., behavior with a high chance of being socially punished) is actually reinforced. This idea and its clinical implications (Kohlenberg et al. 2008) drew our attention to the role of vulnerability to adverse interpersonal reactions in the therapist-client relationship, a point which might not have come into focus without this cue from extant theory. Being aware we used this notion of intimacy also alerted us to not let it skew our reading of the interviews. Had we clung to this definition, it might not have become clear that the experience of the connection with the client, as reported by our participants was better understood as an enabling condition that deepens or enhances the effects therapist and client have on one another, rather than as interaction in which behavior with high probability of punishment is reinforced.

Ethical Issues

Approval was granted by the first authors' university ethics committee. The major concern was in the disclosure of therapist personal issues in the context of professional practice that might seem unsafe for participants as they could be framed as conflicting with professional neutrality and contention. Statements were included in the information sheet and stressed during consenting to assure participants understood the personal nature of the experiences they would be asked to disclose before deciding whether to consent.

Procedure

The first eight interviewees were found in managed care listings and among the faculty and supervisors of three behavior therapy courses. In the latter sample source, preference was given to the most experienced therapists. They were targeted hoping they would provide rich response sources based on their likely experience regarding case management issues. The choice for behavior therapists was due to the research question having been evoked by this approach's literature. A meeting with each psychologist was scheduled to explain the study and obtain informed consent. The actual interviews occurred in participants' offices, lasting about one hour each. In order to allow therapists to come up with issues they found important, the interviews were unstructured, focusing the general question: "How do you see your relationship with your clients?" First, participants were asked to sketch two or three experiences. Next, broad questions were asked as to what these meant to them and how they dealt with them.

Interviews were audiotaped and transcribed verbatim. Analytical codes (brief expressions that synthesize the content of each meaningful statement) were devised and written in the margin of the transcription. The authors repeatedly reviewed and discussed the codes during weekly meetings. Agreement was not sought for the sake of validity, but talking through diverging readings of the material allowed integrating perspectives and including different angles to the interpretation. Discussing disagreements about codes often produced new appraisals that none of the judges had worked out individually.

Provisional codes were grouped according to family resemblance in categories named after what connected these codes. New interviewees were recruited using a snowballing strategy, in which participants nominated colleagues they considered interested and able to contribute experiences that would counterpart or supplement theirs, so that new interviews would allow building up, verifying and refining codes and categories (theoretical sampling). Of 21 thus nominated candidates, 18 accepted participating. The assessment that the data sufficed to respond the research question was reached after 23 interviews. Three more nominated candidates were interviewed by way of saturation test, but did not contribute new perspectives.

This process rendered a set of 16 concerns, principles and practices by which therapists operate in the relationship. Table 1 gives an overview of the codes, organized in categories, with each individual capital letter representing a single participant who contributed to every specific code. The same letters identify the contributors in the write-up, where the categories are explained with the help of brief sample quotations, in as close as possible a translation from Brazilian Portuguese. The quotes were culled from the collection of text fragments that contributed to each code and thus stand for a class of statements from which the code was constructed.

Table 1 How therapists experience and handle therapeutic closeness

Codes that built each category	Participants who contributed to each code[a]
Scope, aims and corollaries of closeness	
Sources	
Disclosure produces closeness	ACVXYZ (23%)
Uses	
Boost closeness to facilitate or evoke client behavior for treatment	ACDFGHPVZ (35%)
Boost closeness to reinforce client behavior	ILNPWYZ (27%)
Boost closeness to augment the effect of therapist behavior in session	AILY (15%)
Repercussions	
Closeness is not limited to the session	ACEFPTVXY (35%)
Client sexual feelings can show up	ABCDEFGHJKMPQRSTWYZ (73%)
Therapist sexual feelings can show up	DQRX (15%)
Referral can be therapist flight from difficult feelings that originate in closeness	BEHJKMNQSU (38%)
Preventing harm and managing drawbacks	
Explain rationale for closeness	CDEFGHJKLMQUY (50%)
Select contents to disclose, filter out vulnerable edges, choose safe themes	ACEGHJQRTUVWY (50%)
Make boundaries tangible in interaction style and dress	BEJKORTUWXZ (42%)
Select contexts and forms of therapist exposure that allow managing closeness	ADJKMSUVW (35%)
Beware of avoidance in managing and preventing risks	ACFILORTU (35%)
Taking therapeutic advantage of boundary crossings	
Selectively support depending on function	CDLTVWZ (27%)
Explore for diagnostic purposes	FIPTWX (23%)
Use to offer relational interpretations	FIP (12%)

[a]Each individual capital letter represents a single participant

Results

Closeness is the term we found to label a central quality of the connection of therapists with clients in participants' reports. It describes being well positioned to touch (to affect) the other person and at the same time feeling within easy reach of that other. Closeness modifies the effect of treatment interventions on the client and of client responses on the therapist. Therapists are aware of its advantages and drawbacks. The concepts of harm prevention and risk management emerged from grouping codes concerning strategies therapists use to keep closeness from hurting them, the client or the treatment process. The category taking therapeutic advantage was built by grouping clinical uses therapists make of closeness related incidents.

Scope, Aims and Corollaries of Closeness in Therapy

Closeness is experienced as a natural, often unplanned byproduct of the interaction with the client, or as an intentionally forged condition that benefits the treatment process. Therapists incorporate it both as an element of context of the encounter with the client and as actual clinical material to work on. It alters the functions of the therapist's behavior, entailing therapeutic possibilities, but also additional risks and responsibilities.

Sources of Closeness

A disclosing therapist style may produce closeness: "I show my feelings to clients. […] Really, that is not more than being honest." (C) But a specific aimed intervention may do the same. That may be the case when a therapist discloses a personal experience to model problem solving "They can think—Ah, she has problems too, but […] she works to improve on them and so on. By this time, they know details about me" (Z) or to help normalize clients' issues: "I will tell you something about me, so you can see your experience is not that strange at all" (A). Using personal information defines the therapist as both similar and equal to the client, as opposed to different or superior.

Uses of Closeness

Sometimes, connecting more closely with the client is the actual aim of a therapist move, either as an antecedent intervention to facilitate or evoke a client response, or as a response to a client's move. Pursuing a closer connection

may help clients work through difficult issues: "I try to move toward my client. And I like to make physical contact: touching a hand, a shoulder, hugging. It varies. I come closer, metaphorically, also. All of that helps her talk to me" (Z). Or the therapist may boost closeness to evoke the behavioral repertoire a client uses to relate to others, bringing it into the relationship with the therapist: "When you're not a part of the client's life, what do you expect she will feel for you? What do you expect is going to happen between the two of you? You will not see anything of what she talks about [i.e., her daily life issues] happen in the relationship." (P)

Therapists may tighten the personal connection after an improved client target behavior occurs in the relationship. The decision depends on their understanding of the function the client move serves (e.g., social approach, in the following example): "At first I found his question too intrusive—you know—not appropriate to ask such intimate question. Then, I understood he tried to get closer to me [by means of a personal question]. If he would do that with someone else, someone may let him into her intimacy. I answered his question. I accepted his effort to connect" (Z), and on how they can affect the client: "That is why she started asking about me. She had no friends. She had spent years telling therapists about herself. Now she wanted to hear about someone else. And, by opening up to her about what I think and what I feel, I gave her exactly what she wanted." (L)

Besides facilitating talk about difficult issues and evoking or reinforcing target behavior, a tighter relationship can augment the effects of various interventions: "That he knows […] we have a real connection makes my efforts to validate his feelings much more effective." (Y) Relinquishing the protection of a distant therapist pose can help empower the client in the relationship. It makes interactions more meaningful, making the relationship into "a better tool for change." (A)

Repercussions of Closeness

A genuinely close relationship may exceed the therapy hour and intrude upon the therapist's private time. As an example, a close person's presence at client life events may be vital: "I had coached her through the entire process of courtship and engagement. It was important for her that I would be there [at the wedding], so I went. I also went to a memorial service for a patient's daughter. I found my support was important." (V) The connection makes the therapist a source of support, also in the face of treatment tasks: "I took a young man to a football game, to kick start a new behavioral repertoire. Someone he did not feel close to could not provide such stimulus." (T) When a social phobic client greets someone in public, the person's response will be the more relevant the closer the client feels to her: "It seemed vital to validate the way he coped with me in that situation [greeting the therapist in the mall]. I went over to chat." (X) When a client asked her to go see a play in which he had a part, the therapist saw this as a first step toward target behavior, and granting the request as natural reinforcement: "Asking anyone significant to him to do something was daunting […] a huge issue. The invitation was an asking. So I went [to the play] to strengthen the new behavior." (Y)

Genuine closeness defies control. It can evoke unintended responses from client or clinician. Clients not acquainted with the intricacies of the therapy relationship try to "navigate the uncharted territory" (M) according to modes drawn from other types of close interaction: "There is a high likelihood that caring behavior may be misconstrued by men, especially when they seek help for relational problems. […] You are the one who gives him attention; you are there with him and for him." (Y) Some clients, enjoying the closeness, become playful, "taking advantage of the affectionate climate." (D) Sometimes participants see boundary violations as clients' efforts to control difficult feelings evoked by interpersonal closeness: "We prompt them to disclose, but they don't want to feel vulnerable. When they sexualize the disclosure, they feel in charge." (P)

Therapists not necessarily experience client sexual attraction as aversive: "Yes, he likes my style. Maybe I feel flattered?" (Z) It may suggest the client sees the therapist as more than a service provider: "Who wouldn't want to feel desirable?" (W) Still, it often comes as a severe blow: "I felt anger, disgust and agony. I did not know what to do. I felt my face going red." (K) Some therapists feel stunned and inept to make sense of sexual signals: "I couldn't find a function in that behavior" (S) or feel the situation is "too far out of line to warrant facing this client with a functional interpretation." (J)

Half of the four male participants spontaneously reported past sexual interest in clients, while only two of the 22 women did: "Even today, I think of her. […] It never had a chance." (D) The experience is painful, even when understood in the treatment context: "It makes no difference knowing what the function is. In another context, we could have been a couple. […] For a long time, I kept telling myself that story." (R)

Almost half the participants mentioned having terminated a treatment prematurely at least once when closeness turned difficult. "When I feel something different, like physical attraction, or feelings that are too intense, […] I refer, immediately." (S) Some refuse the costs of dealing with the challenge, as expressed in seeming irony: "I would need too much therapy and supervision to help me manage my feelings." (N)

Preventing Harm and Managing Drawbacks

Therapists Explain the Rationale for Closeness

This avoids both the impression they pursue closeness for their own affective needs and ambivalence about the extension of their feelings for the client: "I explain that this personal interest I take [in the client] is the medicine: I bare my feelings, but [I do so] because I believe that will help him get better. How else would he know that my disclosure is part of the treatment?" (L). "From the start of the [first] session, I state my boundaries […]. I feel this confers a stronger image of professionalism, and avoids it [the therapist-client relationship] seeming a 'whatever' kind of relationship." (D) Clearly stating their inner experience of their connection with the client helps avoid misreading: "The other [the client] may somehow see what I feel. But speaking out is better than leaving the interpretation to him." (C) They check if the client understands their aim: "I can even ask directly—Do you know why I'm telling you about me? Do you see how this relates to your issues?" (G) This helps detect client misapprehension: "I ask for feedback. I don't just suppose he got my intentions." (F)

Therapists Select Contents to Disclose

They consider the pros and cons of each issue: "I omitted that my own obsessive and perfectionist behavior almost got me an ulcer to not undermine her reliance on me." (W) A therapist who disclosed a past depression—meaning to normalize the client's mood disorder diagnosis—was surprised to hear her client judge her unfit for the profession: "After that, I became choosy about disclosing." (V) They filter out tricky edges from relational interpretations: "When attraction is involved, I can talk about other features of what I feel for him. […] When her [the therapist's] feelings involve sexuality, she should not end up disclosing things that lead the client to misunderstand the situation as having another [non therapeutic] purpose." (T)

Therapists Make Their Boundaries Tangible in Their Interaction Style and Dress Code

An unfussy, detached, slightly formal interpersonal mode in the first sessions allows therapists to observe the client's ways of relating. This way, they collect data that help decide how, at a later moment, shifting something in their interaction with the client might be helpful in treatment. Several participants reported using a standard greeting protocol, and adapting it to the client's style. "I meet the client in the reception area and I extend my hand. Later, when a client greets me with a kiss, I do not back off. I match. The same counts for hugging. I don't hug, unless he comes up to hug me first." (W) Formal outfits should avoid evoking problems: "Even more [than on other occasions], I try to dress in discreet fashion, for fear of what could happen—I mean, a client getting interested in me. I dress discretely. I never use deep cleavages, short or sensual dresses." (B)

Therapists Select Contexts and Forms of Therapist Exposure That Allow Managing Closeness

Throughout treatment, they avoid situations in which they would lack sufficient control: "At the sessions' end, this client gave me a hug, and not an innocent hug. I noted strong physical reactions on his side. […]. From then on, I gracefully dodged [his attempts at hugging]." (C) Similar selective avoidance is applied to meetings out of session: "Off I went, to the wedding, to the church, but not to the party." (V)

Therapists Take Heed of Avoidance in Managing and Preventing Risks

Several participants emphasize that blocking unintended side effects of closeness can backfire, because it can render the therapist emotionally unavailable. Engaging fully in the interaction demands the therapist leaves his or her comfort zone. Inappropriate client efforts to connect to the therapist can be awkward first steps toward clinical improvement and may warrant support even when they unsettle the therapist: "When a client brought me roses, I understood he was trying to seduce me. […] I asked him not to do this again. That was so bad. He stopped opening up to me. And then he abandoned treatment." (A)

Taking closeness issues to peer-consultation, supervision or personal therapy helps detecting when closeness management is tainted by therapist avoidance: "I did a lot of therapy to get my affective needs out of the way." (U) "Both when we discuss our cases and when we give opinions on those of colleagues, we expose ourselves. That exposure is very constructive. And obtaining colleagues' responses helps us calibrate." (T)

Taking Therapeutic Advantage of Boundary Crossings

Therapists Selectively Support Challenges Depending on Their Function in the Context of Closeness

They may consider: "Will this [client behavior] be helpful out there [i.e., further the client's daily life goals]? What about my feelings should I share and how will that

reinforce the [client] behavior?" (L) When a client insistently asked invasive questions, a therapist pointed out the client "tried to get people's opinions on everything, to then tell them what they wanted to hear. […] I told him he could not please me that way. You need to know the function. His questions about my personal life were part of his problems." (X)

Therapists Explore Challenges for Diagnostic Purposes

Trouble in dealing with therapist-client closeness can bring the client's difficulties to life in session. Clients' behavior in session can illustrate how they deal with relationships. This information can add to the case conceptualization and help both therapist and client better understand the client's problems: "I could not have known he would respond to my disclosure in such distorted way, but it gave him a chance to deal with the fright he gave me and allowed me to learn something about how he often scares away people who care for him." (T)

Therapists Use Challenges as Opportunities to Offer Relational Interpretations

Welcoming the difficulties in a non-judgmental way allows harnessing incidents for open and illuminating discussions: "I used the moment to show him what happened here was like how he often affected people in other contexts. […] I was apprehensive, and I shared my embarrassment. He became more open and accessible in later sessions." (I). The personal nature of the material discussed can make its use more difficult for the therapist. But it can also make it particularly fit for relational interpretations: "I prefer taking the risk and fully exposing myself when it helps therapeutic change on its way." (F)

Discussion

This study highlights being close to the client as a deep feature of therapists' daily professional experience and one that deserves attention in both research and training. Closeness showed up in this study as an enabling condition that augments the effects therapists and clients have on one another. It empowers the therapist's interventions and intensifies client impact on the therapist. Our model first considers the up side of closeness. Tightening the interpersonal connection can encourage client disclosure and can help focus client process. It provides a closer feel of the other's moves, of how one impacts that other, and of how both the other and one's impacts evolve (Holman et al. 2017). This enhances the meta-awareness of noticing oneself noticing the client that helps build a flexible sense of both self and other in the dyad (Villatte et al. 2015).

As an enabling condition that modifies the effect people's actions have on one another, closeness can make what therapists do and say matter more to the client. Prior data indicate disclosure that humanizes the therapist or conveys similarity with the client better predicts positive outcome than therapist disclosure that distances or remains neutral in this aspect (Levitt et al. 2016). Central in our model is that this works in the other direction as well. Being close enough to touch a client (e.g., to evoke or reinforce effectively or to validate meaningfully) entails the client can easily impact the therapist as well. As such, the recommendation that therapists reveal their inner reactions to shape the client target behavior that evokes these reactions (e.g., Holman et al. 2017) implies they sacrifice something of their security. Going nearer to obtain a more accurate look at client experience and to improve one's chances to make effective therapeutic use of what is happening in the moment entails accepting a higher degree of personal vulnerability. Therapists are aware of the discomfort involved in the connection with the client (cf. Rabu et al. 2015) and outcome improves when therapists allow themselves the vulnerability of professional self-doubt (rather than seeking security and safety), combined with personal self-compassion (Nissen-Lie et al. 2017).

Personal closeness, even as a professional tool, still entails the vicissitudes involved in close relationships (Pope and Keith-Spiegel 2008; Zur 2007). It can make client problem behavior personally menacing. And an affective overturn in a closer relationship generally is more painful than in a more distant one. This may help explain the finding that intense involvement can jeopardize the therapist's wellbeing and efficiency (Rupert et al. 2015; Schroder et al. 2009). The hazards of a close relationship may call out therapist avoidance strategies. Clinicians disclose less to more symptomatic clients to help the latter preserve boundaries, or to maintain a safe distance for themselves (Kelly and Rodriguez 2007). For similar reasons, our participants opt not to disclose certain themes. And Gelso et al. (2014) recommend against expressing therapist sexual feelings, even though, concealment can be a burden (Jeffrey and Tweed 2015).

Some of the literature concurs with therapist experience of this safety seeking as potentially detrimental to the treatment process and, at least in need of careful monitoring. Rigid rule following that involves rejection of feelings or entanglement in treatment theory pulls away from what goes on in session (Wilson and Sandoz 2008). Being selective about what to feel does not help attune to the client and may restrict the scope of therapeutic access (e.g., Pierson and Hayes 2007). Not looking into one's difficult feelings squanders crucial data that could help correct the case formulation and better adjust interventions to what happens in the moment (Vandenberghe and Silveira 2013).

Importantly, the vagaries of closeness open up treatment opportunities. The clinical value of working through alliance ruptures has long been recognized (e.g., Safran et al. 2014). A client with closeness issues making avoidance moves when the therapist comes near or dealing badly with therapist vulnerability offers opportunities for relational interpretations and in-vivo shaping of client target behavior (Kohlenberg et al. 2008). When, at a later stage in treatment, improved client target behavior (e.g., fine-tuned social responsiveness or improved appreciation of the other person's sensibilities during conversation) tightens the connection, this increase in closeness with the therapist may act as a natural reinforcer, strengthening the very client target behavior that brought it about (Holman et al. 2017). And, even though accidental self-disclosure in unplanned encounters may cue avoidant coping or demand renegotiating the relationship (Pietkiewicz and Wlodarczyk 2014), it still can—according to our study—be productively used in the light of therapeutic goals.

As a side effect, effectively navigating closeness can promote therapist growth. Practicing a vulnerable stance in session helps to become more self-accepting and engage more positively in private relationships (Rabu et al. 2015), and dealing undefensively with one's difficulties in session offers opportunities for personal and professional development (Linehan 2015). Therapists find personal learning experiences in meaningful therapeutic relationships (e.g., Brattland et al. 2016; Hatcher et al. 2012; Stahl et al. 2009).

Scope and Limitations

This study contends closeness helps describe how the personal relationship empowers treatment. Closeness influences therapist impact, and can produce valuable raw material for treatment intervention. As such, the uses therapists can make of closeness and the strategies to handle and steer it in safe and productive directions deserve a salient place in skills curriculums. Getting the rationale for therapist vulnerability across is key to actually engaging the client as a partner in a workable close relationship. When therapeutic intention and boundaries are clear, the client can effectively locate the closeness provided, and relate to what happens in the relationship. This part of closeness work deserves more attention in training and supervision.

As a mid-level term, closeness, as described in this model, parsimoniously links together, what otherwise remain disparate theoretical and research topics including intimacy (Kohlenberg et al. 2008), alliance repair (Safran et al. 2014) and therapeutic presence (Geller and Greenberg 2012). It allows condensing much clinical wisdom generally gained through experience and or handed down informally in training and supervision.

For training purposes, an explicit model of closeness work takes an important issue out of the realm of informal supervisory transmission and may help beginning therapists avoid painful learning by trial and error. From a perspective of therapist development, showing how closeness work involves personal decisions concerning how far to venture outside one's comfort zone, how the probability of mishaps can be reduced and how, when they happen, they can be taken clinical advantage of heartens therapists to find their own style. The more seasoned therapist is urged to examine his or her sometimes time-honored interaction style, to detect where attachment to routines or general rules of conduct may become a hindrance to therapeutic closeness in specific cases, and where more attention is due to contextual variables that frame therapist disclosure.

Limitations of this study include the degree to which participants would accurately recall and articulate their experience. Another limitation is the low number of participants, all being from one geographical location. Their leaning toward cognitive or contextual behavioral orientations suggests questions concerning how similarly clinicians with other backgrounds deal with the same issues. From this sample, then, no unbridled generalizations are warranted, and we hope the present study may fuel similar research involving therapists in different cultural contexts and theoretical orientations.

Although three judges were involved in the analysis, bias remains a potential concern in grounded theory analysis. However, bracketing our beliefs and always returning to the data to resolve any questions, allowed for results to emerge other than those that would confirm our theoretical outlooks. Grounded theory analysis seeks validity through continued collection and analysis of data until concepts are fully developed and stabilized. The theory can then be empirically tested in other participants and locations. A next step may be developing a scale that measures closeness and evaluating its relation with other middle range concepts and with treatment outcome data.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Informed consent was obtained from all individual participants included in the study.

References

Brattland, H., Høiseth, J. R., Burkeland, O., Inderhaug, T. S., Binder, P. E., & Iversen, V. C. (2016). Learning from clients: A qualitative investigation of psychotherapists' reactions to negative verbal feedback. *Psychotherapy Research*. https://doi.org/10.1080/10503307.2016.1246768.

Charmaz, K. (2017). Continuities, contradictions and critical inquiry in grounded theory. *International Journal of Qualitative Methods, 16*, 1–8.

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research: Techniques and procedures for developing Grounded Theory* (3rd. edn.). London: Sage.

Cordoba, J. V., & Scott, R. L. (2001). Intimacy. A behavioral interpretation. *The Behavior Analyst, 24*, 75–86.

Dryden, W. (2012). The therapeutic relationship in CBT. In W. Dryden & R. Branch, *The CBT handbook* (pp. 83–100). London: Sage.

Fresno, D. M. (2013). Tending the garden and harvesting the fruits of behavior therapy. *Behavior Therapy, 44*, 177–179.

Geller, S. M., & Greenberg, L. S. (2012). *Therapeutic presence: A mindful approach to effective therapy*. Washington: American Psychological Association.

Gelso, C. J., Rojas, A. E. P., & Marmosh, C. (2014). Love and sexuality in the therapeutic relationship. *Journal of Clinical Psychology, 70*, 123–134.

Glaser, B. (2007). Remodeling grounded theory. *Historical Social Research, 19*, 47–68.

Hatcher, S. L., Kipper-Smith, A., Waddell, M., Uhe, M., West, J. S., et al. (2012). What therapists learn from psychotherapy clients: Effects on personal and professional lives. *The Qualitative Report, 17*(48), 1–21.

Henwood, K. L., & Pidgeon, N. (2006). Grounded theory. In G. Breakwell, S. Hammond, C. Fife-Shaw & J. Smith (Eds.), *Research methods* (pp. 342–365). London: Sage.

Holman, G., Kanter, J., Tsai, M., & Kohlenberg, R. J. (2017). *Functional analytic psychotherapy made simple: A clinician's guide to using the Awareness-Courage-Love (ACL) model in session*. Oakland: New Harbringer.

Jeffrey, M. K., & Tweed, A. E. (2015). Clinician self-disclosure or clinician self- concealment. Lesbian, gay and bisexual mental health practitioners' experiences of disclosure in therapeutic relationships. *Counselling and Psychotherapy Research, 15*, 41–49.

Kazantizis, N., Cronin, T. J., Dattilio, F. M., & Dobson, K. S. (2013). Introduction: Using techniques via the therapeutic relationship. *Cognitive and Behavioral Practice, 20*, 385–389.

Kelly, A. E., & Rodriguez, R. R. (2007). Do therapists self-disclose more to clients with greater symptomatology? *Psychotherapy, 44*, 470–475.

Kohlenberg, R. J., Kohlenberg, B. S., & Tsai, M. (2008). Intimacy. In M. Tsai, R. J. Kohlenberg, J. Kanter, B. S. Kohlenberg, W. C. Follette & G. M. Callaghan (Eds.), *A guide to functional analytic psychotherapy* (pp. 131–144). New York: Springer.

Levitt, H. M., Minami, T., Greenspan, S. B., Puckett, J. A., Henretty, J. R., Reich, C. M., & Berman, J. S. (2016). How therapist self-disclosure relates to alliance and outcomes: A naturalistic study. *Counselling Psycholgy Quarterly, 29*, 7–28.

Linehan, M. M. (2015). *Cognitive-behavioral treatment of borderline personality disorder* (2nd edn.). New York: Guilford.

Nissen-Lie, H., Rønnestad, M., Høglend, P., Havik, O., Solbakken, O., Stiles, T., & Monsen, J. (2017). Love yourself as a person, doubt yourself as a therapist? *Clinical Psychology & Psychotherapy, 24*, 48–60.

Pierson, H., & Hayes, S. C. (2007). Using acceptance and commitment therapy to empower the therapeutic relationship. In P. Gilbert & R. Leahy (Eds.), *The therapeutic relationship in cognitive behavior therapy* (pp. 205–228). London: Routledge.

Pietkiewicz, I. J., & Wlodarczyk, M. (2014). Crossing the boundaries of privacy in accidental encounters: Interpretative phenomenological analysis of therapists' experiences. *Clinical Psychology and Psychotherapy, 22*, 708–721.

Pope, K. S., & Keith-Spiegel (2008). A practical approach to boundaries in psychotherapy: Making decisions, bypassing blunders and mending fences. *Journal of Clinical Psychology, 64*, 638–652.

Råbu, M., Moltu, C., Binder, P.-E., & McLeod, J. (2015). How does practicing psychotherapy affect the personal life of the therapist? A qualitative inquiry of senior therapists' experiences. *Psychotherapy Research, 26*, 737–749.

Rupert, P. A., Miller, A. O., & Dorociak, K. E. (2015). Preventing burnout: What does the research tell us? *Professional Psychology, 46*, 168–174.

Safran, J. D., Muran, C., & Shaker, M. A. (2014). Research on therapeutic impasses and ruptures in the therapeutic alliance. *Contemporary Psychoanalysis, 50*, 211–232.

Schröder, T., Wiseman, H., H. & Orlinsky, D. (2009). "You were always on my mind": Therapists' intersession experiences in relation to their therapeutic practice, professional characteristics, and quality of life. *Psychotherapy Research, 19*, 42–53.

Stahl, J. V., Hill, C. E., Jacobs, T., Kleinman, S., Isenberg, D., & Stern, A. (2009). When the shoe is on the other foot: A qualitative study of intern-level trainees' perceived learning from clients. *Psychotherapy, 46*, 376–389.

Swales, M. A., & Heard, H. L. (2007). The therapy relationship in dialectical behavior therapy. In P. Gilbert & R. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 185–204). New York: Routledge.

Tsai, M., Callaghan, G. M., & Kohlenberg, R. J. (2013). The use of awareness, courage, therapeutic love and behavioral interpretation in functional analytic psychotherapy. *Psychotherapy, 50*, 366–370.

Vandenberghe, L., & Silveira, J. M. (2013). Therapist self-as-context and the curative relationship. *Journal of Contemporary Psychotherapy, 43*, 159–167.

Villatte, M., Villatte, J. L., & Hayes, S. (2015). *Mastering the clinical conversation: Language as intervention*. New York: Guilford.

Wilson, K. G., & Merwin, R. M. (2008). Therapeutic relationship. In M. Hersen (Ed.), *Encyclopedia of behavior modification and behavior therapy with adult clinical applications* (pp. 586–590). Thousand Oaks: Sage.

Wilson, K. G., & Sandoz, E. K. (2008). Mindfulness, values, and the therapeutic relationship in acceptance and commitment therapy. In S. F. Hick & T. Bein (Eds.), *Mindfulness and the therapeutic relationship* (pp. 89–106). New York: Guilford Press.

Young, J. E., Klosko, J. S., & Weishaar, M. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford.

Zur, O. (2007). *Boundaries in psychotherapy: Ethical and clinical explorations*. Washington: American Psychological Association.