

Intimacy

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Talk for BCPCA Gloucestershire, 2010

Intimacy is in many ways right at the heart of what we do as therapists. But it is also right at the dangerous edge, in the specific sense in which Arnold Mindell uses the term: an *edge* is the limit of a person's comfort zone, the aspect of our experience which challenges us to change and grow. While *achieved* intimacy is often profoundly comfortable, I suspect that to be confronted with the *possibility* of intimacy in any context tends to take us to an edge. I will say why I think this is in a moment. And Mindell suggests that when we approach an edge, we encounter threatening and critical figures, either internally or projected onto the external world.

In therapy we are constantly in situations where intimacy is at least a possibility; even once achieved it often feels fragile or intermittent. I suggest that the edge figures Mindell describes are very much present in our work, in three main forms: the dangerous therapist, the dangerous client, and what I call the Therapy Police.

The dangerous therapist is the most well known of these. Most discussions of regulation, complaints procedures and so on either start out from or very soon arrive at issues of intimacy and its abuse. Almost always this focuses on sexual abuse. I considered calling this presentation 'Intimacy Took Place' - the expression used when I was young in newspapers and law courts to signify 'they had sex'. This identification of intimacy and sex creates problems for therapy, where intimacy frequently 'takes place' but sex, hopefully, never does. It also contradicts ordinary experience, which shows us that sex often happens without intimacy and intimacy often happens without sex.

Although the phrase is no longer current, it seems to me that the counterfactual identification of intimacy with sex is still very much present in our culture. We shall be encountering this identification in one form or another all day. It is behind the identification of the therapist who offers intimacy with the dangerous therapist who offers, or even demands, sex.

Also very much present, though, is the edge figure of the dangerous client, the client who demands kinds of intimacy, up to and including sex, which are threatening to the therapist. The dangerous client has an interesting resemblance to the dangerous baby featured in a certain kind of childcare discourse: the baby who tries to have her parent 'wrapped round her little finger', who manipulates and seduces and seeks attention. With both baby and client, we might well ask 'what is so wrong with seeking attention?' The figure of the dangerous client draws forth a response of what is known as 'defensive practice' - styles of working which are shaped not by the client's needs, but by the therapist's need not to have a complaint made about them. Another sort of dangerous therapist, it seems, is the therapist who is weak, vulnerable to seduction and manipulation. We need to be tough, to offer tough love.

Defensive practice defends not only against the client, but also against the imagined criticism of one's peers, one's profession, and society – all of which can be summed up in the image of the Therapy Police. The Therapy Police monitor our practice through invisible CCTV cameras. When the dangerous therapist seems to manifest, they smash down the door and storm into the room, dragging us off to suffer in Azkaban. So our ultimate dread is the imagined dangerous client who manipulates us into 'inappropriate' intimacy, and then shops us to the Therapy Police.

What, then, is 'appropriate' intimacy? And should we try to define the term itself? Looking at the dictionary, as people usually do when writing this sort of talk, it's clear that intimacy relates to

being on the *inside* of something: a body, a group, a family, a relationship, an understanding. We offer our clients, I think, the possibility of being inside something *with us*; or at any rate, we offer them our willingness to try to be inside something with them.

The idea of being inside something together makes me think of a supervisee who found herself under the table with her client, in a little tent created by the tablecloth. I say 'found herself' because she was a little surprised, and anxious; but I don't want to give the impression that this was an impetuous move, it was thought through and talked through, and very helpful for a therapeutic relationship that had become rather stuck. It's a good example of the child-to-child transference which has been hardly talked about as a part of therapy – the two kids whispering together under the table and peering out at the adult world. I think what surprised my supervisee was that she had had the nerve to agree to something which in some ways feels as shocking and transgressive, as much in need of policing, as intimate touch.

Let's pause for a moment, and each of you find a neighbour and talk about your reaction to this image of client and therapist under the table.

I want to ask you to think about how intimate or otherwise that conversation felt?

So, we've looked briefly at two sorts of intimacy that can arise in therapy, at least in fantasy: sexual intimacy, and child to child intimacy (which can of course also be sexual, but child sexuality is radically different from adult sexuality). There is a third sort which gets a great deal more theoretical air-time than either of these, and that is parent-child intimacy. There is a very prevalent notion among therapists, sometimes explicit and sometimes not, that an experience of parent-child intimacy is the gold standard, something to be welcomed, indeed aimed for, and that it has an inherently healing and reparative function.

I feel very suspicious of all this. Certainly it's occasionally true; but we mustn't lose sight of the reality that parent-child intimacy, just like erotic or child-to-child intimacy, is a *fiction*, a fantasy; and one, I suggest, which is far more comfortable and convenient for the therapist than other fictional models of intimacy which can arise. In the role of parent, the therapist can rest safely in their identification as bigger, wiser, stronger – as the source rather than the recipient of reward and punishment. No wonder that it is our favoured model!

Ultimately *all* of these models of therapeutic intimacy are transference fictions. In fact we can think of transference in therapy precisely as a response to the offer and experience of intimacy. In order to manage the intensity of the experience, we as clients try to fit it into a previously known category - 'This is *just like* having a parent, *just like* having a lover, *just like* having a childhood friend'. Transference is thus a reaching out towards the other, making a bridge – and at the same time a *misrecognition*, a resistance to the uniqueness of what is happening by treating it as a repetition of something else. And that 'something else' may well be a negative experience rather than a positive one, or combine negative and positive elements – all of which will then be 'found' in the relationship with our therapist.

As we all know, transference is enormously helpful, because it allows early wounds to reappear in a concrete form in the therapeutic relationship – specifically, *wounds around intimacy*. And it's lucky that transference is helpful, because despite the early hopes of psychoanalysis, we have no way of getting rid of it! - And no way either to get rid of the countertransference responses of the therapist. But it is, I think, right for the therapist to hold in her awareness, at the same time as experiencing these misrecognitions in her client and in herself, that they *are* misrecognitions: to hold in

awareness that what she is really offering the client is not a parent, not a lover, not a child companion, but something quite distinct which we can call *therapeutic intimacy*.

I'm going to break again here, and ask you to go into groups of three and to each share experiences which come to mind of these three various flavours of intimacy in a therapeutic context: sexually charged, parent-child, child to child, and therapeutic. These can be either from your experience as a practitioner, or as a client. We could obviously spend a great deal of time on this, but I'm going to ask you to do what you can in about five minutes for each person – just to scan quickly through your memories and see what comes up.

Feedback

Before this exercise I suggested that therapeutic intimacy is something quite distinct from the various more familiar versions of intimacy with which we confuse it. In fact it is something new on the face of the planet: an authentic openness which is also time-limited, asymmetrical, and, usually, paid-for. All of these features can create frustration, rage and confusion: how many clients compare us with prostitutes? But the time limits and the payment, beyond the fact that they make it possible for us to do the job, also benefit the client: unlike other situations of intimacy, this one entails no further responsibility towards us than keeping appointments, paying us, and leaving in time. In a very curious way, therapy actually embodies many men's *fantasy* of what prostitution should be – without the exploitation, the danger and the brutality. Also, of course, without the sex, which is what many men seek from prostitution; but it is also well known that for many clients of prostitutes it is important to be able to imagine that the women, or man, wants to be with them, cares about them, sympathises with them, understands them.

I'm not aware that anyone has really thought deeply about the uniqueness of therapeutic intimacy – about what it is that we are and our clients are inside together. From a certain point of view, psychotherapy works by temporarily substituting its own 'impossible demands' for those which we experience in life in general. The template for this is what Freud called 'free association', taken in a very broad sense as the support and encouragement of spontaneity. One function of the request to free associate is to highlight its *impossibility*: to make us aware of our resistances and inhibitions – and, more deeply, of our lack of title, so to speak, in what is said, thought and felt: that the 'I' who is supposed to be the source and origin of our thoughts and words is in reality a fiction, an artefact. Very few therapists these days work explicitly with free association, which is perhaps a shame; but many of us certainly put a steady, implicit pressure on clients to respond spontaneously and authentically, which has the same effect.

Again, let's try a simple experiment. Turn to your neighbour, and take three minutes each to try to share everything which comes into your mind. If 'nothing comes to mind', then you are either dead; or enlightened; or censoring yourself. Censoring yourself is perfectly natural, and I'm not trying to stop you doing it; just to help you be aware of how much of it you do.

The impossibility of saying or doing 'whatever comes into your head' reveals the impossibility of accounting for oneself, the impossibility of manifesting both consistency and spontaneity. We cannot *deliberately* be spontaneous, because we can never be anything else but spontaneous. The more we *try* to be spontaneous, the more stiff and anxious we get! – which of course doesn't mean that we are no longer spontaneous, just that we don't *feel* spontaneous. Equally, we feel inconsistent, because we imagine consistency as being a state in which everything is available to consciousness and fits together seamlessly. We also confuse this with authenticity. But there is no such state. The consistent thing about us is that we are in a process of continual and uneven change, so that different parts of us are occupying different positions. We tend to struggle desperately

against this reality as we try to meet the demand for spontaneous authenticity which we experience in therapy.

What makes all this both bearable and useful, I suggest, is the fact that it happens in a context of intimacy. What therapist and client are inside together is a continuous shared struggle to relate authentically, to uncover and acknowledge the ways in which each person is defending themselves against the other and seeking to gain control of the relationship. This is far more naked than taking our clothes off!

I want to move on now to saying something about embodiment and intimacy, and something about erotic charge in therapy. These two themes are obviously linked. You may notice that I have shifted from using the word 'sexual' to using the word 'erotic': this is not a euphemism, but a way of emphasising a distinction that I think is crucial to our work.

One clear fact about human animals is that we have bodies – in fact, we *are* bodies; something that therapy has not always been eager to acknowledge. Working therapeutically in full awareness that there are two bodies in the room can be extremely challenging: those two bodies can have all sorts of powerful feelings about each other – can want to do all sorts of things to each other – and it would often be easier to keep a distance of dissociation around them. Easier, but less useful.

The slight *double entendre* of the previous paragraph was intentional: some of the things that bodies in therapy want to do to each other are indeed sexual. But the *idea* of sexual feelings is a good deal more prevalent than their actuality: in fantasy – often the fantasy of other people rather than the two participants – it can take over from all the many other impulses that will arise – to fight, to run away, to push and pull, to kick, to shake, to hold gently, to dance with, to tickle! Embodiment, sad to say, is often wholly identified with sexuality; this is one of the most stultifying aspects of our contemporary culture, and can make embodied therapy very difficult.

However it also gives therapy the task of opening out people's sense of bodily relationship to include more than sexuality: reminding them of the infinite sensuousness of embodied existence, the continuous relationship we build with the world through smell, taste, touch, sight and hearing, along with other more subtle sensory pathways like kinesthesia and proprioception. Embodied therapy invites clients to play with their bodily experience, to flirt with the sensory universe. Again with the *double entendre*! – because we can't open our bodily senses without addressing the sexual framing of bodily experience which stands in the way.

This sexualisation of the senses is equivalent to what Ferenczi (1933) called the 'confusion of tongues' between child and adult ways of being in the world. It is possible to have what we can call an erotic relationship with being alive, a constant renewal of joy and pleasure in existence, which in some ways is founded very literally on the physical act of breathing, the sensation of the breath moving down into and back up from our pelvis. Many children live wholly or partly in this state of erotic aliveness.

As we grow up in Western culture, this erotic quality tends to become increasingly restricted to sexuality, and genital sexuality at that: our genitals are a sort of indigenous reservation where the erotic charge that is taboo elsewhere in life is allowed to make its home. Therapy which supports clients in exploring their embodied experience is bound to connect both with the taboo pleasure of embodied aliveness, and with the pain of loss that attaches to it. This is particularly intense when the focus is on embodied *relationship*.

Embodied relating is by far the most interesting and challenging aspect of embodied therapy.

Useful and important as it is to help clients explore their internally-focused bodily experience, there comes a point sooner or later when the energy flows into impulses that relate to the *other* – specifically, the therapist. They begin to feel an embodied urge to do something to *us*. As soon as this urge starts to flicker into existence, I try to support it and respond to it, gently enough that I don't scare it away.

Often the first impulses are to fend me off, just as on a verbal and fantasy level the first transference feelings are often resistance: the client wants to push me away, to turn aside from me, to jostle me and tussle with me. As we physically explore these interactions, they may develop into a scenario of defiance and standing one's ground; once the client has experienced their own power to say No to me, the desire and capacity for a more interactive physicality may develop, an exploration of how our bodies can cooperate and play with each other.

Strong feelings of love or attraction in the therapy room are often experienced as scary and disruptive. In training and supervision erotic feelings are sometimes not explored, or else the emphasis is on suppressing them. Yet they are a very frequent part of therapy, and, I suggest, an inevitable accompaniment of the intimacy and intensity of the relationship and the encouragement it offers to surrender to spontaneity. More than that, erotic charge can be a powerful tool for therapeutic change. But I hope I have made clear in this talk that eros is only a *part*, though a very important part, of therapeutic intimacy. What I most want to communicate is my belief that therapeutic intimacy is something unique, which needs thinking about in its own terms and not simply translating into the more familiar languages of sexual relationship, child-child, or child-parent.

Afternoon exercise:

In threes, each take a turn to introduce a therapeutic relationship from their practice where they feel intimacy failed, Then play the client, with someone else in the role of therapist, and the third person observing. Therapist can take time out for feedback at any point., with more feedback at the end.