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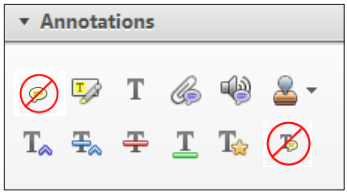

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Response

group analysis

On Intimacy and its Defences in the Consulting Room. A Response to Elisabeth Rohr's 38th Foulkes Lecture

Farhad Dalal

In this response I am going to pick up on one of the central themes in Elisabeth Rohr's Foulkes Lecture, that of intimacy, and ruminate on that. But rather than pick up this theme in the context of a globalized world, I want to think about intimacy and its defences in the consulting room—not only the patient's ways of defending against intimacy, but also the therapist's.

But in putting the question in this way, I have run ahead of myself, because implicit in the way that I have framed my intention is the assumption that intimacy in the consulting room is a good thing.

Not everyone will agree that it is a good thing, nor is there likely to be agreement as what intimacy is.

To frame the upcoming discussion, let me ask two questions:

- Is intimacy a necessary ingredient to a therapy, for the therapy to be therapeutic?
- Or is the presence of intimacy a corruption to the work of therapy, the presence of which stops the therapy being therapeutic?

But first, what is intimacy?

It has to do with closeness, proximity, connection, union and touch.

It has to do with openness, vulnerability, with being utterly exposed, with intensity and with depth.

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It is a state in which the barriers of shame come down and perhaps disappear entirely.

If shame is the barrier between the public and the private, then in the state of intimacy there is no holding back, the private is made visible. In the state of intimacy one lets oneself be truly seen. As such, intimacy has to do with deep acceptance.

Intimacy then, has more to do with a state of Being rather than Doing.

Sexual union is perhaps the epitome of intimacy. But often enough, sexual union is anything but intimate.

In contrast to the intensity of sexual union, there is another version of intimacy, which is akin to Winnicott's 'infant playing alone in the presence of mother'. Two people sitting together, but each absorbed in their own tasks be it reading, musing or knitting. My associations to this sort of picture are those of warmth, of ease, of peace and comfort.

The look between mother and child is another sort of epitome, but here too one has to say, not always. Sometimes the mother looks at the child with 'dead eyes' to use the phrase alluded to by Elisabeth Rohr.

Then there is a kind of lived intimacy between say, mother and child, which arises through the processes of attunement. At times they are so much a part of each other, that the child thinks nothing of taking food from the mother's plate or spitting something back into it, and the mother does not bat an eyelid.

So intimacy is a being together, sometimes dissolving into a oneness. It has to with a deep familiarity and ease. There is a bodily intimacy, and there is emotional intimacy.

In sum, intimacy is a deep meeting or coming together. Key to the experience of this kind of intimacy must be some kind of reciprocity and mutuality.

But we should not leave out the other, more fractious side of intimacy—wherein one feels no inhibition in expressions of irritation and annoyance. With the shame barrier down, the inhibitor, the censor is largely absent and one speaks one's mind. We regularly witness these aspects of intimacy within couples and siblings, and also friendship groups.

The repercussions of expressions of irritations and so on, create distance, and can provoke irritations in turn. So if this too is intimacy, then it is the opposite of the usual connotations that intimacy usually conjures up. Given that in this sort of experience there is no mutuality

or reciprocity (as it is usually understood), should this sort of phenomenon still be called intimacy?

There are other sorts of situations, say when the master feels free to expresses his irritation with the servant, we would be in no doubt that there is no mutuality or reciprocity here. So another question: is intimacy is possible in a context where there are large power differentials?

I will put these important complications aside for the moment, and return to them a little later.

The aspect of intimacy that I have been fleshing out is a deep form of involvement. I also notice that I have been drawn to use the word 'deep' repeatedly in trying to capture something about the notion of intimacy.

Psycho-analysis, Group Analysis, as Research

What does our Foulkes lecturer, Elisabeth Rohr, have to say on these matters?

On the one hand she mentions Freud approvingly to say that,

> psychoanalysis is primarily a psychological theory and research method and only in second place a therapeutic practice…this of course is true for Group Analysis as well. (Rohr, 2014 **[page to be inserted]**)

If it is indeed the case that group analysis is primarily a theory and research method, then it does not sound like group analysis would be a very promising environment for the fostering of intimacy.

Yet our Foulkes lecturer concluded her presentation with the rousing words:

> I am convinced that Group Analysis is capable to offer what is increasingly missing in society: a place to experience *intimacy*, coherence and cohesion, to overcome isolation and narcissistic defence,…to offer inclusion and recognition. . . (Rohr, 2014: **page no. to be inserted)**

Here then is a tension, which arises out of the perennial questions that we return to time and time again: just what is group analysis, just what is psychotherapy? Are they even the same thing?

On these matters as a profession, we are profoundly divided. The fundamental division for some is the division between analysis and psychotherapy. There are many psychoanalysts and also group analysts, who would say that the profession of the *analyst* is distinct from

the profession of the *therapist*. The work of analysis, they would claim, is a search for truth. In this sense it is research, a research into the psyche of the patient. The project is one of understanding—not one of alleviating suffering which is delegated to therapists. Analysts who hold this sort of view tend to look down on the lesser beings called therapists.

Let us for a moment grant that intimacy is not only possible in a group therapy setting, but that it is a good thing and ought to be fostered. Now, we are likely to find ourselves divided yet again when it comes to the question of whether or not intimacy is to be fostered between therapist and group of patients, or therapist and patient in a group of patients, or therapist and patient in the one to one setting.

Perhaps you will have registered that having just alluded to the divide between analyst and therapist, I am using the term therapist. In doing so I have declared which side of the divide I stand.

In speaking to you, of necessity I have to make assumptions about which side of the divide you might be standing. No doubt there will be a range of views and opinions, none falling neatly onto one or other side of the polarization analyst/therapist. In part this is because there is no agreement about how the terms analyst and therapist are to be understood in the first place.

All this makes my task in how to speak more complicated—on the one hand I do not want to inflict on you the tedium of resuscitating old saws and of rehearsing ancient arguments; but nor do I want to inflict on you the arrogant presumption that all right thinking people must of course think like me. So as I speak I need to make *assumptions*, which at times might come across as *unwarranted presumptions* about what you think or where you stand. Sorry.

Back to the task:

Our Foulkes lecturer tells us a number of things about where she stands and where she thinks that the group analyst stands—on the edge. She calls on the authority of Foulkes who has said of the group analyst:

> To be at the same time inside and outside of the group . . . to be a 'participant observer'. . . (Rohr, 2014 **[page number to be inserted]**

She goes onto say that

> This is in fact quite a unique role description. It means to be involved emotionally, but not in action and to maintain at the same time the capacity to be an adamant

> observer . . . [it is] a position 'in between', it does not allow purity or objectivity or absolute truth . . . It is a privileged position I think, because it allows us to take part and at the same time to stay an observer. (Rohr, 2014 **[page number to be inserted]**

This kind of research methodology, which privileges subjectivity over subjectivity, is very different from Freud's view of psychoanalyst-as-researcher and psychoanalysis-as-research-methodology. His version was grounded the 19th-century version of science, which presumed that the researcher's relation to the researched was an unproblematic one: a straightforward separation between the observer and the observed. Crucially, this view presumes that the analyst could be and ought to be *the detached observer* and commentator of psychic phenomena emanating from the patient. Central to this position is the notion of value-free neutrality, of non-interference, of reason purged of emotion. This gives rise to the iconic image of the impassive, blank screen psychoanalyst-as-scientist.

The distinction is important. Because although Elisabeth Rohr relies on the authority of Freud to legitimate the *principle* of research, she *practises* a form of research that is very different from the one envisaged by Freud, and perhaps would even be anathema to Freud.

The distinction is also important for the following reason: The removed stance of the classical psychoanalyst is predicated on the belief (derived from Freud) that the driver of social life is to be found entirely in the internal workings of the psyches of monadic pre-social *individuals*.

Consequently, it is claimed, the patient's experiences of the external world are consistently distorted by their projections from their internal world. The scientist–analyst reads backwards from the manifest—what the patient says and does—to make inferences about the dynamics within the patient's internal world. The analyst keeps themselves out of the picture in order not to contaminate the data emanating from the internal world. And if the analyst does engage more directly with the conversation about the reported external world, then they are thought to have capitulated, or been seduced, or acted out and lost the plot in some way.

Many contemporary psychoanalysts continue to embody this stance in relation to the patient and the work. In my experience, this is also the belief system of many fellow group analysts who might speak the rhetoric of the social, but whose practice deifies the internal

psychological, and whose stance and attitude is that of the detached observer of clinical events.

When I say this kind of thing, mostly I meet protest. I am told that we do not believe that sort of thing anymore. I am also sometimes told that that is how it might be in psychoanalysis, but it certainly is not so in group analysis, if only because the analyst is more visible and exposed to group members. I beg to differ.

Just recently, I was in a group experience during which the conductor of the group looked steadfastly at the floor for the entire 90 minutes, and said nothing apart from one interpretation towards the end of the session. I (like you) have had many experiences of the group conductor doing their utmost not to enter into a dialogue with participants, choosing rather to make the odd stilted pronouncement into the ether, sometimes of extraordinary opacity. All this is very far from the stance that Foulkes advocates for the therapist, which is that he ought to 'have the courage to be his natural self' (Foulkes, 1984: 142).

In contrast to the idea of the detached researcher Elisabeth Rohr tells us (and here I agree with her) that

> there is no way to observe a human being, without being involved and . . . there is no valid description of any situation, without describing the interaction between the observed and the observer . . . (Rohr, 2014 **[page number to be inserted]**

But despite promoting the view that the researcher is necessarily embedded in the research, Rohr thinks (and this is something that I do not agree with) that it is possible to inhabit 'the edge' in such a way that one ought 'to be involved emotionally, *but not in action* and to maintain at the same time the capacity to be an adamant observer'.

How is it possible to be involved and 'not act'? It seems to me that this stance is made to appear possible by creating a split between mind/body and thought/action, a split that does not exist in lived reality. This belief is commonplace in our profession, even though some classical psychoanalysts are clearly aware of the effects of their presence. For example, the psychoanalyst Etchegoyen (who declares himself a Kleinian) tells us of an experiment in which

> the subjects of the experiment were asked to pronounce freely all the words that came into their minds, with the experimenter listening and offering a grunt of approval every time the subject pronounced . . . a word in plural form. This stimulus was sufficient to increase significantly the number of plural words. We can imagine then how much our implicit or explicit interest will influence the interviewees' choice of topics. (Etchygoyen, 1991: 48)

He uses this to make a point about the initial assessment interview. He is against the practice of some psychoanalysts, who conduct the interview in almost total silence. To them he is saying that the prospective patient is picking up the smallest of clues from the analyst, and so the analyst cannot help but influence the direction of the interview. Etchegoyen advises them to be more active in this initial session.

But when it comes to the process of the analysis proper, Etchegoyen says that the

> The analyst . . . must be a serene and impartial observer and at the same time be committed. The analyst participates in the analytic situation (the field), but he must do it in such a way that the data of observation come from the analysand. (Etchygoyen, 1991: 514)

The same question as we asked of Rohr must be asked of him: how can the analyst participate and yet keep himself out of the picture given what he has just told us—that the slightest of gestures influences the direction and content of the proceedings. The usual kind of answer given is that the art of the analyst is to be present as a 'receiver', but not a 'transmitter'. I do not think this to be possible. The way that it is made to seem possible will become clear in the next section.

Transference and Countertransference

Rather importantly, Elisabeth Rohr describes the interactions that take place during the research (whether it be in the field or the clinic) as transferences and countertransferences.

This raises for me the interesting question:

> Are *all* the interactions and experiences that take place between the protagonists in a therapy to be construed as versions of transference and countertransference?

I find myself asking this, because in the way that transference and countertransferences are usually talked about, they are 'counterfeit' experiences. I use the term counterfeit, to point to the belief that a transference experience is one which in a sense, is not real. The sources of the transference are not in the here and now, but from another time and place. The sources of the analyst's feelings are called countertransference, which being a response to the transference, are tarred by the same brush.

It is not that the experience is imagined or false; rather the experience although tangible and 'real', is a distortion of how things really are.

It is a commonplace phenomenon that is familiar to us all. Here is an ordinary enough illustration. Last week in a once weekly group, during a silence that had gone on for a minute or two, John says to Jane: 'why have you stopped speaking?'. She had not noticed that she had drifted off and the question brings her back into the group. She says that as she was speaking she noticed me put my hands to my head, and this she took to mean that I was bored, and she stopped speaking. I was not bored, but stirred by what she was saying.

The notion of counterfeit throws up its opposite, authentic. And the notion of distorted, throws up its opposite, accurate. This tells us that one of the counterpoints of the transference is an idea of objectivity, of reality. Here then is another question:

> If all the experiences taking place in the clinic are manifestations of transference and countertransference, then can they ever be said to be authentic?

We must think so, or else we would not be doing this work.

This tells us that we have made too sharp a distinction between transference and objectivity. This also tells us that the classical psychoanalytic position is immersed in a version of positivism, in which external reality is an apolitical unproblematic given. In this viewpoint the course of the analysis can be thought of as the patient's journey from the transference to reality, helped by the guiding lights of the analyst's interpretations.

It is also the case that because the transference and countertransference are construed of as 'not real', then it is used to mean that feelings said to be transferential, not only need not be acted on, they ought *not to be*. For example, during a casual conversation over a cup of tea with the Foulkes lecturer, Elisabeth said that she had developed such strong feelings for Daqui that she wanted to adopt him and bring him back to Germany. But then she realized that her feelings were just countertransference.[1] I refer to this not in order to suggest that Elisabeth ought to have brought Daqui to Germany (which I do not), rather to open up some of our curious but taken for granted understandings about the transference.

I know for myself that when in India (and increasingly in the streets of Europe), I avoid looking at the suffering street-urchin or the deformed destitute beggar in the eye; I hold back from the impulse to

pet a stray friendly dog. I have learnt to harden myself. I do this because I know that if I do look, then I will become emotionally involved. I will recognize their sentient natures, through which my sense of responsibility will be stirred up, as will a burgeoning attachment. With growing involvement, I will find it hard to turn my back on their need in order to get back unscathed to my cushioned and comfortable life. And if I did open myself up to one beggar/dog, then how would I stop the tidal wave of feeling for the multitude of other needy beggar/dogs?

I do not want to throw the baby with the bathwater. I do think that the ideas behind notions of transference and projection are valuable. But I also think that in many circumstances, notions of the transference are used as the *means* of detaching from very real feelings in situations of intimacy and entanglement, and as a means of *legitimating that detachment*.

If intimacy has to do with mutuality and reciprocity, then in these kinds of detached analytic situations, not only will intimacy not be possible, it will also be construed of as a *corruption* of the analyst's objectivity as well as the analyst's allegiance to truth.

The tactic can also be employed by the patient. Familiar to us all is the kind of experience in a group in which a patient X says that they find Y irritating, but then immediately say that they know it is because Y reminds them of their father, and so on. X has used an idea of 'the transference' to detach from the immediacy and intensity of their emotions and experience, and in so doing sanitise the moment.

To my mind, these sorts of moments (feelings for Daqui, beggars, other group members) are value laden ethical predicaments; therefore, the way we deal with them will reveal much about ourselves, our integrity, our values, and so on. It seems to me, that at times we (and I include myself in this 'we') defend ourselves against this value-laden ethical moment by using the notion of transference to transmute the value-laden ethical predicament into a value-free fact; in so doing, we detach ourselves not only from the situation, but also ourselves. In turning away from a destitute beggar, in walking away from Daqui, we feel guilt. And why should we not? What's wrong with that? Similarly, I think we can use the technical notion of 'boundaries' to legitimate calling time at the end of a session whilst the patient is in the midst of something, in order to defend against the ensuing guilt.

In contrast, I think that most of us might agree with Elisabeth Rohr that as humans, we are always mired in subjectivity, we are always in

the thick of things, we are always interconnected and entangled. If we recast '*the* transference' as experience as it is being patterned by one's history, then one cannot make the sharp distinction between reality and transference, either in the clinic, or 'out there' in the ordinary world. All this is as true of the analyst as much as it is the patient.

Although most would concur with this viewpoint in principle, in practice things are often very different. We can catch glimpses of just how different by observing how our training institutions engage with their trainees, the way that various panels treat their interviewees and so on. Often enough, the stance is authoritarian, between the ones-who-*know* and the ones-who-have-to-*show*. And if there is a dispute between the ones-who-*know* and the ones-who-have-to-*show*, then the problem is firmly located by the ones-who-are-certain-that-they-already-*know*, in the ones-who-have-to-*show*. All this suggests that not only is intimacy not going to flourish in strongly hierarchical authoritarian contexts, nor will reciprocity, mutuality and relationality.

Well, it is not fair to say our 'institutions', it is more accurate to say some individuals within our institutions. But the protocols and procedures within our institutions are set up in ways that tend to bolster and back the individuals that they invests their authority in, and are not inclined to question these individuals regarding their ways of doing things once they have invested their authority in them.

But if were to follow the relational, the narrativist, the inter-subjectivist, the social-constructionist, the hermeneutic and the ethno-methodological turns (as I do), then we would whole heartedly agree with the Foulkes lecturer that

> there is no way to observe a human being, without being involved and . . . there is no valid description of any situation, without describing the interaction between the observed and the observer . . . (Rohr, 2014 **[page number to be inserted]**

But if this is indeed the case that the observer and observed are entangled, then it is a bit of a fantasy to imagine that the therapist can 'be involved emotionally, but not in action'. After all Elisabeth bought food for those she was researching; obviously, Elisabeth was active, and momentarily something therapeutic occurred because of the activity. I think that our profession is inclined to sustain the fantasy of non-action because of its aspiration to be viewed in the same light as the natural sciences.

I would say that this kind of detached stance is the analyst's way of defending against the experience of intimacy. And how could they

not? All the connotations of intimacy—reciprocity, transparency and exposure—are undermining of the very idea of detachment that the analyst holds so dear.

Foulkes

Foulkes himself was well on the road in these matters. He said:

> It is important for the therapist to admit that his personal influence is inevitably strong in spite of all his precautions to minimise this . . . [therefore he] should use it consciously rather than haphazardly or unconsciously. (Foulkes, 1986: 129)

In my Foulkes lecture (Dalal, 2012), I argued for something similar: for the virtues of a responsive therapist rather than a removed one. In my view, within this kind of framework, not only is intimacy possible between therapist and patient, but that it is necessary to the therapy for it to be therapeutic. But I put it too strongly. Better to say that therapy is the journey towards a growing intimacy.

Foulkes provided us with two terms, each of which speaks to the analyst/therapist divide—group analyst and group conductor. The task of the analyst is to interpret and the task of the conductor is to facilitate.

About the conductor he says

> Interpretations are important . . . but they are only one kind of intervention, which fall to the lot of the conductor. He may sometimes have to select the topic of discussion, to draw attention to what the group is trying to gloss over, he may have to confront people, he may have to explain links which are not recognized . . . He may address individuals or the group. He may ask questions, ask for information and so forth . . . [he decides] when to be silent and when to speak, what to take up, how, when . . . (Foulkes, 1986: 110)

When I began supervising training groups at the IGA many years ago, in my report on one of the trainees I said that whilst she did a lot of facilitating, she did not interpret much. This was a criticism. I now think the opposite. I think facilitation to be more important than interpretation. Why? Because the task is to deepen the communication. Of course interpretations too deepen communication, but not when they are obscure, enigmatic and delivered by an opaque analyst from a great height; on these occasions mostly the effect is to silence and bewilder—effects which are then pathologized.

But the two positions are not as distinct as they are mostly made out to be. I think with these two terms Foulkes is struggling with the paradox (as does Elias) that we are both, detached and involved *at the same time*.

When I think about what the activity of conducting means to me in my day to day practice, I would say that:

At its most straightforward I take conducting to mean 'drawing attention to'.

At its simplest I take conducting to mean 'noticing'.

At its most practical, I take conducting to be the act of speaking in order to draw attention to.

One can see then that the act of conducting is not particularly mysterious, esoteric or arcane.

Now let me turn to analysis and its main instrument, the interpretation.

The most potent instrument in the analyst's repertoire is the interpretation. Much has been written on it. But in the main there is agreement that the interpretation is a different kind of communication from all the other sorts of contributions made by the analyst. Most texts on classical psychoanalytic technique caution against the therapist making suggestions, advising, reassuring the patient, taking on the role of a teacher, and so on. Real change is said to come from insight—and specifically insight born of the mutative interpretation.

Here then is an interpretation utilized by Foulkes, which incidentally Foulkes cites as the kind of interpretation he *would not make*. A patient admitted that she masturbated. She came to the next session with red fingernails and expressed revulsion at the thought of having been breast fed. The analyst said:

> I interpreted to her how she felt the breast was revolting because she felt she had torn it to bits with her nails which were stained with blood. She asked me not to say things like that as they terrified her and I interpreted that she felt terrified of this torn breast, which she felt as an internal persecutor of which I was the representative when I made these interpretations to her. (Foulkes, 1986: 125)

Now, leaving aside questions of accuracy or effectiveness of the interpretation, the issue that I want to flag up is, in what sense is this (or any other) interpretation not an explanation? In what sense is it not educative? In what sense is it not simply telling the patient how things stand, and why that is so? In seeking to distinguish the interpretation from information and education, it has been made a mysterious and mythic form of communication—an incantation.

The incantation called interpretation has magical properties in that what is apparently potent about it is not what we actually see—its informational and educative content—but apparently some other mutative quality. Often, the interpretation is made to appear objective by being spoken in the third person. In the original German term used by Freud for 'interpretation' was Deutung.

About this Foulkes says, tongue in cheek:

> Deutung has an underlying meaning of a quite specifically created act of the 'Deuter' (interpreter) based on specific knowledge on his part, almost of a supernatural kind, by no means open to everyone, but only the select few who have been initiated on the strength of a quite peculiar ability. (Foulkes, 1986: 114)

The distinction between conducting and analysing, between facilitation and interpretation is further undermined by Foulkes reminding us that in German, all 'deuten' means is 'to point to'.

Foulkes says that the

> broader meaning of interpretation is . . . to draw a person's attention to another meaning of the line of thought or action he is just pursuing. (Foulkes, 1986: 114)

But this is exactly how I described the activity of 'conducting' earlier.

In other words both, interpretation and facilitation are simply ways of drawing attention to something. (And necessarily, drawing attention away from something else).

It is for these reasons, that rather than speak of therapy in terms of facilitation or analysis, like many others, I prefer to think of therapy as *conversation*, a conversation that is emergent, and is being co-created by all the participants—including the therapist.

Returning to Intimacy

The conversation in the final large group at the conclusion of a two day workshop was warm and appreciative. Participants expressed gratitude to each other as well as the convenors. After while one of the convenors said something about this being the honeymoon period, and if we carried on meeting then we were sure to have more difficult feelings towards each other. He asks: where are the critical, disappointed experiences?

The group is being told that by focussing on the positive it is being avoidant. Further, that the feelings aroused during the honeymoon phase are not real but born of projection and fantasy—honeymoons

are states in which the idealization of the other prevails. Whilst there is no doubt some truth in this viewpoint, it is not all true and there is more going on than meets this convenor's eye.

I think that the convenor is uncomfortable precisely because of the feelings of intimacy prevailing in the room, and in speaking in this way at this moment, he spoils something.

This sort of moment is not unfamiliar of course; Humour is regularly interpreted as manic avoidance and so forth.

Another moment: during a workshop on ethics at the IGA, we were shown a fragment from a TV drama on therapy. The therapist is in supervision, talking about a very difficult situation he finds himself in. The excerpt we were shown ends with emotional intensity, with the supervisor saying to the therapist something like—I will stay with you whatever happens.

What was interesting to me was the reaction in the room during the discussion that followed.

There was a consensus between the people that spoke up: the supervisor had collapsed and capitulated. The tone of the comments were somewhat superior, scornful and pitying of the supervisor.

I do not doubt that there are avoidances and so on in play in all these scenarios. What I object to is the formulaic way in which moments of burgeoning intimacy are continually and relentlessly interpreted as pathological, as pairing, as a manic flight into positivity, etc.

I think this kind of ritualistic assault on good feelings is in many cases born of envy in the therapist. I think that on these occasions the therapist cannot bear the invitation to intimacy, perhaps (and here I speculate) because it threatens their allegiance to the stance of the detached therapist. And as we know, the function of envy is to spoil and destroy.

The rationale behind this way of going about things is the belief that deep within each human being is an endogenous malevolence and destructivity born of the death instinct or some version thereof.

To end, I want to go back to the group session I mentioned briefly earlier. Harry had visited his ageing parents. He said that his relationship with them was much closer, he was sure that they loved him. Martha asks him: 'how do you know?' He ponders and says, 'I don't think they have ever said to me—I love you. Even as a child. But I *infer* from the way that they are that they do'. Others resonate with the theme and elaborate with their own associations and stories.

During this conversation it occurs to me that an awful lot of inferring goes on this group. There is very little direct communication between persons about how they experience and feel towards each other. I say this because it evokes a sense of panic mixed with excitement. There is hardly any direct engagement between members. Although this group is caring, thoughtful and reflective, and consequently can feel quite safe and cosy—there is almost no intimacy between them. They attend to each other, they help each other, but do not dare to *respond* to each other. In this way to some degree, their communications, being so sanitised, are made barren; they dare not have intercourse with each other—particularly in public. They do not dare to express directly their fondness and warmth for each other, and nor do they dare to express their irritations and frustrations. It is as though the tap is turned off at the mains, and so neither hot nor cold water is able to flow.

Their conversation then segues into the themes of the fear of exposure, of being judged, of being wrong, of potential shame if they were to dare to let themselves be seen; of humiliation and reprimand if they would dare to let any of their responses—negative or positive—become known.

To my mind this kind of struggle is what group psychotherapy is all about. In this work I see my task as helping bring down the threshold of shame, in order that intimacy might start to flourish. One of the ways I do this, is to allow myself to be transparent to some degree, to let some of my responses be visible—not thoughtlessly but circumspectly. In one place Foulkes calls this 'controlled instinct' which he describes as 'The group conductor] must act first, but think about it afterwards' (Foulkes, 1984: 141). In another place he calls it 'discriminating *activity'* (Foulkes, 1984: 137). In allowing myself to be transparent in this sort of way, I risk getting egg on my face, and often enough do so. In proceeding in this way, I aspire to be like the psychoanalyst Harold Searles who wrote after 30 years of practice:

> As I have become more and more deeply convinced that I, in keeping with my fellow human beings, am a basically loving and constructively orientated person rather than a basically malevolent and destructive one, I feel increasingly free to interact, whether in subjectively loving or subjectively malevolent, manner with my patients. I would no longer find it necessary to inveigh quite so strongly against love-replacement therapy as I did in [1955] . . . and would no longer . . . caution . . . that 'It is well for the therapist to maintain . . . a degree of emotional distance between himself and that patient . . .

> Now . . . I find a generous place in psychotherapy for all the sadism I can muster—for example to needle and infuriate the apathetic or 'out-of-contact' patient into more overt relatedness, or to pay him back for the hurts he has been inflicting upon me. With an abundance of this kind of interaction between us, he has good reason to know that I am in no wise a saint, and we can deal with his own problems about sadism in a person-to-person fashion. (Searles, 1986: 25)

It seems to me that this is quite a good description of what intimacy in the consulting room might look like, and one, that as a profession we might dare to aspire to. And if we did, then we would be more likely to fulfil Elisabeth Rohr's hope that

> Group Analysis is capable to offer what is increasingly missing in society: a place to experience *intimacy* (Rohr, 2014: **[page number to be inserted]**)

Note

1. Cited with Elisabeth Rohr's permission.

References

Dalal, F. (2012) 'Specialists without Spirit, Sensualists without Heart: Psychotherapy as a Moral Endeavour', *Group Analysis* 45(4): 405–29.

Etchygoyen, R.H. (1991) *The Fundamentals of Psychoanalytic Technique*. London: Karnac.

Foulkes, S.H. (1984) *Introduction to Group-Analytic Psychotherapy* London: Karnac.

Foulkes, S.H. (1986) *Group Analytic Psychotherapy, Methods and Principles*. London: Karnac.

Searles, H.F. (1986) *Collected Papers on Schizophrenia and Related Subjects*. London: Karnac.

Rohr, E. (2014) 'Intimacy and Social Suffering in a Globalized World', *Group Analysis*

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