CHAPTER 3

The “Intimate Edge”

ATTENDING TO THE MOST SUBTLE aspects of what goes on interactively in the analytic relationship, in an almost microanalytic way, increases the dimensions of the immediate experience and actually transforms it, generating a unique trajectory of evolving experience at what in effect becomes the “intimate edge” of the relationship (Ehrenberg, 1974).

Focusing on the interface of the analyst-patient interaction is not the same as focusing on the patient or the analyst. Rather, it is the nature of the integration, the quality of contact, what goes on between, including what is enacted and what is communicated affectively and/or unconsciously, that is addressed.

The “intimate edge” ideally becomes the point of maximum and acknowledged contact at any given moment in a relationship without fusion, without violation of the separateness and integrity of each participant. Attempting to relate at this point requires ceaseless sensitivity to inner changes in oneself and in the other, as well as to changes at the interface of the interaction as these occur in the context of the spiral of reciprocal impact. This kind of effort, in itself, tends to have reflexive impact on both participants, and this
in turn influences what then goes on between them in a dialectical way.

The "intimate edge" thus is never static but becomes the trace of a constantly moving locus. Each time this is identified it is also changed, and as it is reidentified it changes again. The analytic expanse is enlarged significantly as aspects of the relationship that are generally not explicitly acknowledged or addressed, as well as their vicissitudes over time, are identified and explored in an analytic way. The emphasis is on process, on engaging live experience, and on generating a new kind of live experience by so doing, in an ever expanding way.

In some ways the focus is on what Winnicott (1971) refers to as the "continuity-contiguity moment" in relatedness. What distinguishes my conceptualization is the necessity for acknowledgment and explicitness, since I believe the process of acknowledgment increases the moment's dimensions and changes the nature of one's experiences of it. What is achieved is not simply greater insight into what is or was, but a new kind of experience.

Working at the "intimate edge" creates a unique context of safety and allows for maximum closeness precisely because it protects against the threat of intrusion or violation. Attending to the most elusive interactive subtleties and "opening the moment" actually becomes a way to detoxify the field, as dangers of mystification, seduction, coercion, manipulation, or collusion are minimized (Levenson, 1972, 1983; Ehrenberg 1974, 1982a; Feiner, 1979, 1983; Gill, 1982b, 1983; Hoffman, 1983). In some instances this makes it possible for both participants to engage aspects of experience and pathology that otherwise might be threatening, even dangerous.

The protection of the kind of analytic rigor that attending to interactive subtleties provides allows for more intense levels of affective engagement without the kind of risk this might otherwise entail.

In effect, the "intimate edge" is not simply at the boundary between self and other, the point of developing interpersonal intimacy and awareness of interpersonal possibility in the relationship; it is also at the boundary of self-awareness. It is a point of expanding self-discovery, at which one can become more "intimate" with one's own experience through the evolving relationship with the other, and then more intimate with the other as one becomes more attuned to oneself. Because of this kind of dialectical interplay, the "intimate edge" becomes the "growing edge" of the relationship.

As moment-by-moment shifts in the quality of relatedness and experience between analyst and patient are studied, individual patterns of reaction and particular sensitivities can be identified and explored. This allows for awareness of choices, as decisions to become increasingly involved, or to withdraw, as well as the influences on this may be responsive to, can be studied in process, and the feelings surrounding these can be examined. The patient's spontaneous associations to the immediate experience often not only become an avenue to affectively charged memories of past experiences that might not have been previously accessible but also allow for the metaphoric articulation of unconscious hopes, fears, and expectations.

Even when the "intimate edge" is missed and there is some kind of intrusion or some failure to meet due to overcautiousness, the process of aiming for it, the mutual focus on the difficulties involved, can facilitate its achievement. The effort to study the qualities of mutual experience in a relationship, the interlocking of both participants, including a mutual focus on the failure to connect or on inauthenticity or collusion, can thus become the bridge to a more intimate encounter.

The "intimate edge" is, therefore, not a given, but an interactive creation. It is always unique to the moment and to the sensibilities of the specific participants in relation to each other and reflects the participants' subjective sense of what is most crucial or compelling about their interaction at that moment.

Focusing on the interactive nuances in this way often requires a shift in perspective as to what is figure and what is ground. For example, where a patient drifts into a fantasy that figuratively takes him or her out of the room, the interactive meaning is as important as the actual content (if not more so). Exploring what triggered the fantasy, and what its immediate interactive function might be, may help the patient grasp some of the subtler patterns of his or her own experience. While the content of the fantasy can provide useful
clues to its function, staying with content may be a way for both patient and analyst to collude in avoiding engaging the anxieties of the moment.

Where some form of collusion does occur, as at times it inevitably will, demystifying the collusion has internal repercussions as well. The clarification of patterns of self-mystification (Laing, 1965) that this makes possible is often liberating. It can facilitate a shift on the part of the patient from feeling victimized or helpless, stuck without any options, to freshly experiencing his or her own power and responsibility in relation to multiple choices.

For example, one patient who had difficulty defining where she ended and the other began was invariably in a constant state of anger with others for what she perceived as their not allowing her her feelings. As we explored how this operated between us, she realized that no one could control her feelings and that it was her own inordinate need for the approval of others that was controlling her. It was her need to control the other, to control the other's reaction to her, that was defining her experience. The result was that she began to feel less threatened and paranoid. She also was able to begin to deal analytically with the unconscious dynamics of her needs for approval and for control, and to focus on her anxieties in a way not possible earlier.

Particularly where a patient might become “aware” so as to comply with what he or she believes the analyst considers necessary or desirable, the demystification of the interactive subtleties can be pivotal. It can evoke emotionally charged associations to the past and the recovery of important memories.

Aiming for the “intimate edge” requires that the analyst be acutely sensitive to inner changes, as well as to changes at the interface of the interaction, as these occur in the context of the spiral of reciprocal impact. Because of this the analyst must be able at times to work from within the countertransference. Even if we ourselves don’t know why we are responding at a given moment, we can still use our reaction as a clue to the fact that something in the interaction may need to be clarified and addressed. (I will elaborate on this in later chapters.) The analyst’s affective sensitivity is particularly key where the patient may not be fully in touch with this dimension of his or her own experience. If the analyst can use his or her own experience when the patient cannot, this can help to locate the affective center of experience in the immediate moment. When this occurs, it can be like opening a mine shaft leading into the depths of an emotional core.

On the other hand, where there may be a countertransference problem, aiming for the intimate edge may help to locate it even if the analyst is not aware. For example, a supervisee related that a patient he had recently begun to see was reporting self-destructive behavior outside of treatment. The patient had never engaged in such behavior before. The analytic candidate was eager to arrive at some theoretical formulation based on this information and on historical data he had gathered, so that he could make some interpretative intervention. I suggested that the student consider that the patient’s report might have as much to do with the patient’s relationship to the analyst and to the treatment as to anything else, and that he try to address what might be going on between them.

The following week the supervisee reported with excitement that when he tried to explore the patient’s feelings about the treatment and about himself, the patient became extremely responsive and commented that he felt like crying. The patient was then able to articulate specific anxieties about the kind of attachment he believed he might want with the analyst. His fear was that the analyst would find this repellent, a fear he backed up with evidence based on the analyst’s responses to him. He elaborated relevant reactions to experiences of partings and greetings with the analyst and of seeing the analyst with other patients who came before or after him. The analytic candidate had not been aware of these as having affected the patient.

In this instance, aiming for the intimate edge not only set the work back in motion but also enabled the patient to alert the supervisee to the fact that he (the supervisee) did have anxieties about a more intimate kind of engagement and about what this might portend given the intensity of the patient’s feelings for him and the patient’s evident neediness. The analytic field was significantly expanded as a result. (This kind of intervention, of course, often derives some of its power from the fact that it conveys to the patient
The analyst is no longer afraid to try to engage the moment, even if it is difficult.

A similar shift in figure and ground is often useful where focusing on old concerns can be a way of avoiding engaging the present (by either or both participants). Attending to why something from the past is activated at particular moments, and how its use may be in response to what is going on in the immediate interaction, can become a way to move into present reality. This enlivens the experience and generates a new perspective and a new set of analytic and experiential possibilities. Ironically, clarifying either person’s defensive use of the past may trigger an associative process that then opens onto the past with a new kind of emotional meaning.

Attending to the interactive subtleties in this way also helps sensitise us to the impact of how we position ourselves in relation to our patients. If we think we are being “collaborative” and find that the patient experiences our participation as authoritarian, or even patronising, or interprets our behavior in other ways that we never would have been able to anticipate, this can help illuminate transference-countertransference issues that might otherwise elude us.

This kind of engagement also can help to clarify the analyst’s limitations, thereby providing an opportunity for the patient to work through fears, fantasies, patterns of idealization, illusions and reactions to disillusion, even extreme degrees of punitiveness and intolerance, in an ongoing way. The confrontation with the complexities of reactions to disappointment can at times open the way to working through patterns of self-mystification. In some instances it leaves the door open for the patient’s own creative gestures and for the development and recognition of resources of which he or she may have been unaware.

In aiming for the “intimate edge,” the goal is not to transcend distance but to identify the distancing tendencies and to help illuminate how they affect what occurs. In this regard, Guntrip (1969, p. 105) described the “sense of a gulf which the patient cannot cross but which perhaps the therapist can and does if he shows the patient that he knows about it.” He saw this as being of the highest importance in treatment. What I am emphasizing is the necessity to focus on this very gulf between. If the analyst tries to bridge such gulfs to form a more vital connection, an important analytic opportunity may be foreclosed, as the anxieties and distancing patterns themselves may be obscured rather than engaged.

In this vein Winnicott; (1965) has noted that there are healthy uses of noncommunication in the developing child. The development of the self many involve “a sophisticated game of hide and seek in which it is a joy to be hidden but a disaster not to be found” (p. 186). What I am stressing is that, to the extent this may be operative in the treatment context, working at the “intimate edge” requires clarifying that one makes choices about what to hide and what to seek. The ways in which these choices are made may be responsive to interactive subtleties, often out of awareness.

Paradoxically, engaging in the kind of exploration I am suggesting, which involves respecting personal boundaries and attempting to illuminate their significance and function, tends to open the way to greater intimacy. This is precisely how we turn a boundary into an “intimate edge.” The opportunity this creates for the patient to experience in the immediate situation that a constructive kind of intimacy is indeed possible can be a revelation. On the other hand, an effort to press past boundaries most likely would preclude intimacy and might be experienced as a form of symbolic rape or violation.

The goal is to make it possible for anxieties, feelings, and fears about contact to be identified and addressed, rather than smoothed over and obscured. Where there is a pathological lack of boundaries, the same applies. We must help clarify that this is so, and in what ways. Staying clear and assuming a protective role so as to avoid intrusion without addressing the boundary issues does not allow the difficulties and vulnerabilities to be identified and engaged. In effect, an authentic encounter can be facilitated by acknowledging the limits of what may be possible at any given moment, where ignoring these or pretending these do not exist precludes a more genuine and penetrating kind of engagement (see Farber, 1966, and Maldonado, 1987, among others).

My emphasis on the importance of this kind of engagement is consistent with Buber’s view that profound growth and change in the treatment situation occur in the context what he labeled an “I-Thou” relation, in contrast to an “I-It” relation. He called its unfolding the “dialogical” (1957b, p. 106). I believe the emphasis, as
Buber notes, is on dialogue. The dilemma, however, is how to facilitate this kind of dialogue. Aiming for the intimate edge seems to be uniquely effective where this may be problematic.

In a similar vein, Guntrip (1969) states that

what is therapeutic when it is achieved is 'the moment of real meeting' of two persons as a new transforming experience for one of them, which is, as Laing said (1965), 'Not what happened before [i.e. transference] but what has never happened before [i.e. a new experience of relationship].'(p. 353, bracketed additions in original)

He stresses that what is key is that analyst and patient meet "mentally face to face" and come to "know each other as two human beings."

I believe that at best such moments are transforming for analyst as well as patient (see Buber's views 1957a, 1957b, 1958), and that the opportunity to realize this can be influential in itself. Furthermore, my view is that Guntrip's "moment of real meeting" is not an end, but is itself an important starting point that may have continuing leverage in the analytic process.

Analytic work does not stop when contact is made or when each is truly touched in some profound way by the other and by their interaction; rather, it takes on new dimensions as the affective complexity of what gets activated in the moments of meeting can be clarified and explored in an endless progression.

When positive feelings develop, much is to be gained from an exploration of how the patient understands why he or she feels better, how he or she understands shifts between states of feeling better and worse in general, and how he or she experiences the impact of the analyst's participation. It can serve to clarify the patient's awareness of or fantasies about these nuances of experience.

As reactions to intimacy and distance, as well as fears and fantasies about moments of emotional contact (or lack of emotional contact), are clarified, they can also be worked through in the immediate interaction. For some patients, the opportunity to discover that neither participant need be damaged or diminished by the experience or expression of positive feelings and closeness is as crucial as discovering that it is possible to survive negative ones. The discovery that it is possible to talk about such feelings with the person with whom one is experiencing them can also be significant.

At times this kind of exploration at the intimate edge will expose a collusive need to maintain an idealized view of the analyst. This opens the way to dealing not only with feelings of disappointment and disillusionment, but also with tendencies toward compliance or even submission, among a multitude of possibilities. This process affirms the need for the patient to take an active role in the work, while providing an opportunity for the patient to discover that he or she has something to offer (Singer, 1971; Wolstein, 1959, 1971).

Of course, the unique kind of intimacy this process structures has effects and consequences of its own and can itself become problematic. At times it can be experienced as seductive. This too can be grist for the mill. The point is that avoiding this kind of intimacy can preclude an analytic possibility altogether.

The perspective implicit in this orientation is different from those that have emphasized the importance of the "real relationship" between analyst and patient as a facilitating condition for successful analysis but do not see it as the actual medium of the analytic work. Analytic work actually takes place within, and is a function of, the two-person interaction and of the new experience that is generated within it. Aiming for the "intimate edge" is a way of extending the reach of psychoanalytic interaction.

Some clinical examples follow.

EDWARD

At one point in the course of his treatment, Edward spoke at length about how miserable he felt and how hopeless he believed he was. Despite the pain this might imply, it sounded to me like some kind of recording. It felt as though he were trying to put me off rather than communicating his feelings to me. I shared my reaction. He reflected on it and came up with the realization that he preferred to keep a distance between us. He formulated that what he had been involved in with me was actually a "pretense" of a relationship. I asked for his associations and he produced memories of experiences