M. H. Stone

Turning Points in Psychotherapy

Curative Factors in Dynamic Psychotherapy

Table of Contents

Turning Points in Psychotherapy

M. H. Stone

e-Book 2015 International Psychotherapy Institute

From *Curative Factors in Dynamic Psychotherapy* Edited by Samuel Slipp. M.D.

Contributors

Michael H. Stone, M.D., Clinical Director, University of Connecticut Health Center, Farmington, Connecticut; Professor of Psychiatry, University of Connecticut, School of Medicine.

Turning Points in Psychotherapy[1]

M. H. Stone

Turning Points: The Phenomenon

Therapists often resort to the words *turning point* when describing sudden and dramatic improvement in a patient's clinical course. "Turning point" is reserved for revolutionary, not evolutionary, change. As a precondition to the experience of a turning point, the patient's presenting symptoms must deviate widely enough from the norm to lend an air of drama to their subsequent dissolution. Furthermore, the term is reserved for clinical conditions of at least moderate severity.

Patients whose conditions are predominantly characterological tend not to change via turning points. They change, instead, through small increments of improved adaptation in their interpersonal world. "Character," and by extension, "character disorder," imply habitual patterns of behavior that are highly resistant to change. One does see rapid fluctuations in the outward self during adolescence, but these occur *before* the final solidification takes place in the attitudes and behavior that we refer to, collectively as character. Character is, in a sense, *chronic*.

Many chronic schizophrenic patients undergo, at best, slow,

evolutionary change. One often speaks of chronic schizophrenics as having a disturbance in their "synthetic" or "integrative" faculty. Whatever the origins of this defect may be, the clinician recognizes that, at least in the social field, the chronic schizophrenic is a slow learner. From a diagnostic standpoint, dramatic changes seem to be confined to acute reactions (psychotic or otherwise), suicidal tendencies, phobias, and the like. Among the better integrated patients capable of classical psychoanalysis, presenting complaints usually center on matters of intimate relationships rather than on survival or separation. Hence, if an analysand comes to a turning point, it usually involves some quantum leap in the capacity to sustain and derive gratification from a love relationship. As such, the turning point will be less dramatic than that we encounter among the severer, more acute disorders.

If my understanding of the term's usage is correct, I believe its application is reserved for those treatment situations in which the therapist's verbal interventions were considered instrumental in effecting the rapid improvement. Thus, one seldom hears the swift recuperation from an acute psychosis following the administration of a neuroleptic drug spoken of as a "turning point." Whether a particular example of dramatic improvement really did derive from our psychotherapeutic, as opposed to psychopharmacologic, interventions is not the focus of the presentation. The answer to the latter depends on the solution of a complex probabilistic equation whose variables we can scarcely enumerate in their entirety, since

they depend on both the analysis of randomized studies (which thus far have almost never been carried out) and the subtraction of all those dramatic "recoveries" in persons who never even enter psychotherapy (whose numbers we can only crudely estimate). My purpose is not to elaborate a mathematics of the turning point, but merely to refine our impressions about this important clinical phenomenon. It is of interest that, despite the frequent references to turning points in discussions with one's colleagues, the term does not occur in the index of analytic writings (Grinstein, 1966) nor do there appear to be articles devoted to the subject elsewhere in the literature. Occasional reference to the phenomenon is found in papers devoted to psychotherapy (see Crewdson, 1977).

Discussion of turning points requires a careful analysis of the goals of psychotherapy. These are often characterized in such terms as the "relief of symptoms," "happiness," "maturity," or—as Freud more conservatively put it—the conversion of neurotic misery into ordinary human suffering. Apart from relief of symptoms these goals are difficult to measure. It is possible, however, to compare the number and nature of strategies both for survival and for gratification available to a patient *before* and *after* therapy. An increase in the number of adaptive strategies can serve as a reasonable measure of successful treatment. Forrest (1978) has recently introduced the concept of "play"—in the sense of increased freedom of action or movement—as a crucial ingredient of successful adaptation. A prominent feature of

neurotic behavior is that it seriously limits one's choices. The following example (taken from a psychoanalytic patient in the second year of treatment) will illustrate: A young man of twenty-five was in bed with his fiancée; it was eleven o'clock in the evening. His mother phoned him at this hour, as she had been in the habit of doing every night since he left home four years before. She spoke with him—as was also her custom—for a full hour, despite his having quite other matters on his personal agenda. During his analytic sessions he presented this situation to me as one in which he felt powerless to take a different course. Though fully aware of his fiancée's irritation, he could not bring himself to interrupt his mother and shorten their conversation. This he could only conceive as an expression of disloyalty to the woman who had brought him into this world. Besides, she would, in his opinion, become tearful and depressed if he imposed any limits on their phone time. Thus he could either endure the call and risk alienating his fiancée, *or* he could gratify his own needs and those of his fiancée and risk "destroying" his mother. He could see no alternatives.

As an outgrowth of his analysis he began to grasp that many other choices were open to him besides the two to which he had for so long remained slavishly fixed. Eventually he was able to take his mother aside and get her to see the wisdom of less frequent and briefer calls. To his amazement, she was not shattered by this confrontation. As a result, he gained respect in the eyes of his fiancée, and saw himself as a man with full entitlements rather

than as a boy. In this case the expansion through analysis of his repertoire of behavior vis-à-vis mother coincided with a turning point in his treatment. From this moment forward he took bold and rapid steps to advance his career, dealt more assertively with his superiors at work, and set a wedding date, about which he had been procrastinating for some time. This patient, a well-integrated and intelligent man with only a mild neurosis, was also able to translate the experience of finding additional alternatives into other problem areas, where, in the past, he had tended to behave in a rigid "either/or" manner.

If neurotic adaptation is characterized by limitation and ineffectiveness of strategies, borderline and psychotic adaptations show these defects in an even more blatant—at times grotesque—fashion.

Patients who are less well integrated operate as though "programmed" to issue only sharply polarized messages and to experience stimuli from the external world as though they invariably belonged to pairs of opposites.

Suicidal patients are notorious for construing life in antinomical terms. One may hear, for example, "Either my boyfriend must marry me, or I'll kill myself'; or "Either my boss gives me that promotion or I'll quit my job." Not only do suicidal patients narrow their view down to two alternatives, but one of these is incompatible with life. They live life on the brink and often make

their therapists experience their choices in a similarly narrowed way. The therapist of such a patient, especially one who is hospitalized, is confronted with such awesome quandaries as "If I allow this patient a weekend pass, he may go home and jump out the window"—but—"if I forbid any passes, he may languish forever in the hospital."

Many schizophrenic patients, even if they are not suicidal, live life on the razor's edge, so neatly divided is their ambivalence. In this state, the patient will be tilted precipitously toward one extreme or the other with only the slightest provocation. Often, the schizophrenic who harbors two diametrically opposite feelings toward important others remains cognizant only of one. Ironically, the feeling that seems to lie outside consciousness will be the one most strongly governing his outward behavior. The view that is more readily accessible to consciousness is usually the more socially respectable one, though it exerts little influence on behavior. Certain manic-depressive or schizophrenic women with "postpartum psychoses," for example, claim to love a baby whom, at least temporarily, they cannot abide. One hears only of suicidal feelings ("I am unworthy to occupy the same house with so beautiful and unsullied a creature"), when what is really preoccupying them is murder.

I am not speaking here only of "splitting," as the term is conventionally applied to the contradictory and unfused "all good" and "all bad" images of such patients. I also have in mind the unusual pairs of opposites encountered

in borderline and psychotic patients that seem completely foreign to one's work with analyzable neurotics. The success of psychotherapy may hinge on one's ability to enter the Alice in Wonderland world of the schizophrenic and to recognize dynamic factors that have no counterpart in the fantasy life of the average "well-analyzed" therapist.

For example, I have worked with a number of female patients who fancied themselves to be ugly even though they were uncommonly attractive. Each was avowedly distressed at her illusory ugliness. In two instances a surprisingly psychodynamic factor was unearthed, consisting of an intense fear of envy (experienced as "murderous" by the patient) by a (truly) unprepossessing sister. Another patient harbored the secret fear that her father would envy her beauty—that he would prefer the hopelessly (for him) unattainable comforts so readily accessible to an attractive woman to the rigors of competition with other men.

I am indebted to Harold Searles for suggesting to me the unusual mechanism at work in this last example; it was through his teaching, in fact, that I learned to suspect the *opposite*, when working with severely ill patients, no matter how far from the beaten path such suspicions might lead me. In several of these women, a turning point in therapy resulted from the exposure of the reasons behind their convictions of ugliness. Once their special and long-buried fears could be confronted, they no longer anticipated

being "struck down" if they acknowledged their personal assets. They then became assertive and grew much more comfortable in social situations.

There are a few hospitalized patients selected for long-term intensive psychotherapy who improve dramatically only on being sent, many months after admission, to a chronic-care hospital. The transfer of such patients is never effected with this hope in mind, but represents an act of desperation on the part of the hospital staff. The recovery, when it occurs, is unexpected. Every therapist and staff member seems to know of several cases of this sort, but none seems able to predict which patient will actually improve in the new setting. Some patients, for example, develop "hospitalitis" in an intensive-therapy milieu. The more attention devoted to the crisis they stir up, the more "secondary gain" they accumulate—and the less motivation they have for cooperating with the treatment program. Tension mounts; the therapist and the supporting staff reach a crisis point of their own, and, in an atmosphere of commingled relief and regret, will, with seeming suddenness, finally extrude the patient from the milieu.

One such patient, a young woman with whom I had worked for some two and a half years during my residency training, had come close to death on three or four occasions following suicide attempts around the time of my vacations. She had progressed to the point where she was able to work, and live, albeit precariously, outside the hospital. Changes in my own life—

specifically, the birth of my first child—made it impossible for me to live out the promise I once foolishly made to her of a "lifetime" of care, if that was what she "required." I no longer experienced the demandingness, the frequent midnight phone calls, etc., as "challenging"; they had become an intolerable burden.

Unable to work or to tolerate being alone in her apartment, the patient once again required hospitalization. This time she went to a large state hospital, with a very low staff/patient ratio and few amenities. After two weeks in this uncongenial setting she came to a turning point of her own. She reasoned, staring at the bare walls around her, that three paths were open to her: suicide, a miserable existence in this hospital, or a miserable existence outside the hospital. Her recent, although meager, success in managing a life outside was sufficient to render the first option less enticing than it had always seemed in the past. And there was no one in this understaffed facility who would have given her much sympathy if she swallowed pills or scratched her wrists. Of the two possibilities that remained, life in the real world now seemed preferable. She then marshaled her resources and shifted rapidly into a more assertive and much less whiningly dependent posture. Within six weeks she was back at work and living in her own apartment.

We kept in touch through letters once or twice a year, and some eight years after the second hospitalization we met for a "follow-up" session. She

had by then achieved the status of a junior executive in a large organization and had weathered several brief, rather gratifying, romantic relationships. Depressive symptoms recurred episodically but with less intensity. When I asked what, in her view, had contributed to that turning point in her recovery, she stressed that our work during the intensive phase of therapy helped her to feel more positive about life. Life became better than death, but only if I was readily available. She could not at first distinguish between wanting me and needing me. In the other hospital—where there simply was no therapist and no "environment" to manipulate, the second lesson suddenly entered consciousness: namely, that however desperately she had wanted me, it was no longer realistic to claim that she could not get through her daily chores without me. Others could help and she had capabilities of her own. It was this realization, finally brought home to her by harsh experience, that galvanized her personal resources and efforts, making possible a "turning point." The interpretive work that had gone on in the first hospital was, by itself, insufficient to catalyze such a change. Placement in the chronic-care hospital, if premature, might have had disastrous results. The two types of intervention, however, fortuitously arranged in the proper sequence and with the proper timing, led to a dramatic, and quite unanticipated, recovery.

Turning points in psychotherapy are often heralded by a dream. The dream need not be confined to the patient. It may happen, for example, that some unresolved conflict in the *therapist* constitutes the chief impediment to

therapeutic progress. But the resolution of this "countertransference" difficulty may itself be crystallized and pictorialized in a dream. After laboring for some time in obscurity, the therapist is suddenly able to grasp the essence of the patient's "complexes," or, in other instances, may suddenly be able to extricate himself from some neurotic posture (e.g., boredom, romantic overinvolvement, contempt) that has brought treatment to a stalemate. Whitman et al. (1969) have described how the analysis of therapists' dreams about patients has enhanced the therapists' comfort and effectiveness.

In the more usual situation, the patient struggles for some time without much obvious change, accumulating knowledge about his condition slowly and incrementally until he achieves—with what often seems like a quantum leap in understanding—an insight whose impact transforms his life. Events of this sort are often accompanied by a dream that is unusually vivid and storylike in its completeness. The patient will tend to attribute the insight to the dream, although it may be nearer the truth to say that work was being performed in his mind all along—only it took place outside of consciousness. As this work neared completion, the result was suddenly thrown onto the patient's mental oscilloscope in the form of a dream—in much the same way that the answer to a complex equation is all at once displayed by the crystals of a computer after some minutes of frantic but invisible calculations. The dream may indeed facilitate the translation of this otherwise imperceptible mental processing into the logical language of everyday life. To this extent it

may be fair to say the dream "caused" the insight and the gain in adaptive behavior. But beyond this, it is best to think of the "mutative" or heralding dream as a culmination, an epiphenomenon, of complex problem-solving operations already nearing completion.

In the course of psychoanalytic treatment, meticulous analysis of dreams may lead to the sequential uncovering of anxiety sources related to some major inhibition or other symptom. The symptom may persist, seemingly unaffected, throughout this process, until the final element is made conscious. What follows is an "aha experience," accompanied by a dramatic spurt in the patient's coping capacity. I have reported on a case in which a severe sexual inhibition was relieved following the exposure, through dream analysis, of over a dozen separate fears (Stone, 1977a).

How a turning point in the patient's evolution may be facilitated by a turning point in the therapist's own personal growth is illustrated in the following vignette. The rapid change in both participants was set in motion by the analysis of a countertransference dream. The patient had entered treatment because of severe depression following the departure of his homosexual partner. He functioned at the borderline level. Initially he showed little psychological sophistication and was, behind his ingratiating facade, contemptuous of both therapy and therapist. After four months of casuistical argumentation about the efficacy of "mere words" in the treatment

of depression, therapist and patient had become quite bored and discouraged with one another. At this juncture the therapist had the following dream:

> I am walking in the lobby of a hotel with this patient on one side of me, my wife on the other. The patient tells me, "I have to stop at the pharmacy for a minute to get a prescription filled; I'll meet you shortly." I walk with my wife in a different direction, and purposely "lose" the patient.

The meaning seemed clear to him at once: he had been anxious about the patient's homosexuality. In the dream he underlines his heterosexuality by the conspicuous inclusion of his wife; the two ditch the patient, leaving him to fend for himself with medications. After this "revelation" in dream form, the therapist's fears seemed exaggerated and silly. He grew more comfortable with the patient and spontaneously adopted a more compassionate and accepting attitude. The patient, sensing this change, quickly became more relaxed, candid, and positive about his therapy. The impasse was followed by a turning point: the patient's depression lifted, and he suddenly showed himself as having an excellent capacity for introspection and insight.

The following example concerns a turning point facilitated by dream analysis in a borderline patient. A single woman of twenty-two had been hospitalized because of a suicidal gesture consisting of burning her initials in her forearm with a cigarette and then taking an overdose of Valium. She had been seriously depressed on several occasions since the age of eighteen, when she graduated from high school and left home for the first time. The

second of four children, she had been raised in an outwardly Victorian household by an alternately prudish and seductive father and a shy but tender mother.

The patient was shy herself, and painfully self-conscious, but also sulky and impulsive. Exquisitely sensitive to imagined rejections as well as to even brief separations, she would make a bit of progress in treatment only to become suicidal and erratic during any of her therapist's absences. From a psychodynamic standpoint these severe separation reactions had been hard to understand, since her parents seldom left her alone and always took her along on their vacations. Following her therapist's summer vacation during the eleventh month of therapy, she went into an unusually long slump. For several weeks she was uncommunicative and restless, at times threatening to discontinue treatment, at other times reluctant to leave at the end of her session. Despite the obvious "transference" nature of her reaction, it was difficult to broach the subject, because in the past even the gentlest transference interpretations met either with intense resistance or with impulsive suicide gestures similar to the ones that had precipitated her hospitalization.

Just as the situation was becoming desperate, she opened up enough to relate the following dream:

I am sitting alone by the railroad tracks near the little station [of the small

> Connecticut town where she grew up]. No one is in sight. The train comes by and has some kind of design on the engine which at first I can't make out. As the train approaches, I see that the design was actually my mother's face. Then the train speeds past me and I am alone again.

Although there were strong allusions to loneliness, to longing for the mother, and to a sense of being bereft, suggestions that she might be in the grip of a strong reaction to having been left by someone of importance to her met only with denial. But a few days later, she reported another dream:

> Mother was in the hospital. I was trying desperately to get to see her, but as I rush along the streets leading to the hospital, several racy-looking men accost me and try to get fresh with me. I'm so delayed by their interference that when I get to the hospital, mother has already gone.

With this dream, the nature of her dilemma was spelled out unmistakably, so much so that a more forceful interpretation seemed permissible. The connection between the therapist's vacation, her overwhelming reaction of grief and devastation, and something (but what?!) to do with her mother was no longer stated to her in tentative terms but as a fact. This at first brought forth tears, then the recollection of something she had never revealed.

When she was about ten her mother had to go to the hospital for a laparotomy. Her father told her, with particular bluntness, that mother had a "bad ulcer" and might not live more than a year. All through her adolescence, the patient lived in a constant state of dread, expecting any day to come home

and hear the news of her mother's death. She became inordinately apprehensive about the most minor illness or briefest separation from her mother—who recovered completely from whatever illness she had and has been well ever since. The pattern of catastrophic reaction to separation was now firmly entrenched, however, unaltered by her mother's continuing good health. Following this sequence of dreams, however, she was able to work through much of the old separation anxiety, and within a few days, became cheerful, more self-reliant, and better able to discuss transference themes without the usual apprehensiveness. Not long afterward she was able to begin an intimate relationship with a young man—her first—and to return to graduate school.

The following example concerns a turning point catalyzed by a dramatic change in the therapist, brought about by a particularly helpful experience in supervision.

A twenty-one-year-old college student had been hospitalized because of severe agoraphobia. She had spent the previous six years in a residential setting for emotionally ill adolescents, following the breakup of her family. During the first year of hospitalization she had made little progress. On several occasions she became mute for long periods of time. The working diagnosis had been "pseudoneurotic schizophrenia," though she did not exhibit a formal thought disorder. One parent had paranoid schizophrenia

and had been incapacitated for years. The patient's anxiety was minimal so long as she remained in the hospital. She received no medication.

Her treatment consisted of analytically oriented psychotherapy, but initially she did no more than come to the office three times a week at the appointed hour, curl up in her chair, and remain silent. As the therapist assigned to her case at the beginning of the new academic year, I soon began to feel powerless in the face of her immobility. I became impatient and exasperated. These fruitless sessions continued for four months, at which time I began to receive supervision on the case from Harold Searles. After listening to my lengthy and garbled presentation of this patient's complicated history, Searles commented, "Well, I find, as happens about twenty percent of the time, that I have nothing to contribute about your patient. I have also found, whenever this happens, that there is usually something about the patient the therapist would just as soon leave unchanged. Maybe you cherish her the way she is."

Searles's comment enabled me to recognize a number of feelings this patient engendered in me, feelings I had hitherto been only dimly aware of: a genuine "paternal" affection for this, in my eyes at least, childlike and kittenish woman; at the same time, envy of her ability (through illness) to get others to provide for her needs, while I had to work hard to provide for my own. My supervisor's remarks rendered my own feelings toward her—both

the warm and the hostile ones—more acceptable. I now felt neither constrained to suppress such emotions nor reduced to making hollow and pedantic interpretations.

I told her one afternoon, "If one of us doesn't say something pretty soon, I think I'm gonna explode." To which she replied—uttering her first words of meaningful communication to me—"You too, huh!?" After this exchange, she became as verbal as she had been silent before. Almost at once we began to explore what seemed to be the central dynamic behind her mutism: namely, her apprehension that I would be like the sicker of her two parents, the one who was phobic like her, and who was unwilling to part with her or let her grow up.

It developed that she was indeed "cherished just as she was" by this parent; the similar feeling induced in me was both the transferential replica of this earlier paradigm and a stumbling block to further progress. The turning point in my own grasp of the case was brought about by Searles's comment. The patient's subsequent turning point proved to be authentic: she made rapid strides in overcoming her agoraphobia (even without the use of special behavior modification techniques), married some eight months later, and has remained well for the past fourteen years.

Emotional illness is seldom the outgrowth of a solitary major trauma,

even though patients will often assign the "cause" of their condition to some memorable event from childhood. Usually such an event is seen, in retrospect, as the symbol for a whole pattern of repeated pathogenic interactions with some important early figure. There are, however, exceptional situations where, over and above the background noise of neurotic family interaction, one pathogenic event of such magnitude occurred that it did derail in some important way the person's subsequent development. The most often cited examples of single major traumata include the suicide of a parent, adoption, or the loss of a close family member through death or divorce (Stone, 1975: Watt and Nicholi, 1978). In children who have narrowly escaped death from felonious assault, serious illness, or injury, psychiatric disturbances may also arise that for the most part, seem to hark back to the one traumatic experience. The resolution of these disturbances through psychotherapy will in some instances be accompanied by a dramatic "abreaction." The long-repressed memory, with all the attendant emotion, suddenly bursts forth during a session—followed by a tremendous sense of relief, and, in the more fortunate cases, a restored capacity to resume the normal path of development.

Such an abreaction occurred in a case reported by Kestenbaum (personal communication, 1978) concerning an adolescent suffering from depression, recurrent nightmares, listlessness, and poor concentration at school. When he was six his mother had committed suicide by hurling herself

off the ledge of a building in front of his very eyes. The truth of what had happened was vigorously denied by his whole family. By the time he was sixteen, he scarcely knew which version was correct. He had never dared broach the subject with anyone in the family. When he had been in treatment for about three months, however, he suddenly came to recognize the validity of his original impressions. As the last piece of the puzzle fell into place during one of his hours, he sobbed uncontrollably and nearly fainted in his therapist's office. Shortly thereafter several members of his family were confronted by the therapist, who obtained from them a reluctant admission of what had taken place. This sequence of events constituted the turning point in his therapy. His depression lifted, his school-work returned to its previously good level, and he was able to complete the work of mourning so long delayed by the atmosphere of taboo and denial in his family.

At times turning points in therapy may come about in strange ways that are not readily classified into any of the categories thus far outlined. For example, a schizoid man in his twenties had for years felt painfully isolated, because, unlike ordinary people, he seemed not to share in any way the ability to give vent to the usual range of human emotions. He had been in analytically oriented treatment for several years when he heard the news that one of our country's most revered leaders had been assassinated. Not only was he shaken by the tragedy, but he found himself tearful for the first time in his life. When asked what his reaction was to the events of the preceding day, he told

his therapist only that he had been "happy." Further inquiry into this seemingly repugnant response led to his revelation that he had been so moved and saddened at the news that tears had come to his eyes, which then, paradoxically, had led to a feeling of joyousness. He too, after all this time, was becoming a full-fledged member of the human family, able to love and to cry, no longer condemned to lead the freakish, robotlike existence that had for so many years alienated him from his fellow human beings.

Some Remarks on Psychotherapy in Relation to Turning Points

The chronically suicidal patient represents one of the most challenging situations in psychotherapy. The patient struggles to die; the therapist struggles to free the patient of self-destructive tendencies. We feel we have succeeded when patients no longer see life as "hopeless" but begin to view their suicidal urges as a hostile and maladaptive game that they have used to tyrannize others. When suicide no longer seems so necessary or so attractive as an "alternative," we have effected a turning point.

In the past, considerable emphasis was placed on getting suicidally depressed patients to ventilate their rage. The depression was viewed as rage turned inward; redirecting it outward must then be the curative step. There are many depressed patients who show evidence, via dreams and verbal productions, that their anger has indeed been turned inward on the self. Yet

the mere expression of this anger may not even lift the depression, let alone lead to a turning point in therapy.

It is often more meaningful to observe the sudden drying up of choices in such patients. The executive who gets fired, even if he remains consciously angry at his superior and does not lapse into self-blame, may still become seriously depressed if he reasons (correctly or incorrectly) that he has no hope of quickly finding a similar post elsewhere. If intense self-recrimination is present, expression of the underlying rage is only a first small step toward recovery. It is much more effective to help patients to find alternatives they may have overlooked and to seize opportunities of which they were unaware. This holds true for depressed patients who are reacting primarily to loss as well as for those of the particularly suicide-prone hostile-manipulative type (described by Weissman et al., 1973).

Sometimes a turning point will occur after patients have grasped and assimilated the psychological meanings attached to their suicidal behavior. But, in other cases, the dramatic turnabout will occur only after we have reeducated patients, expanded their range of options, and realistically enhanced their maneuverability. Forrest's (1978) emphasis on helping patients gain a sense of greater spatial "play" (as opposed to sense of confinement or entrapment) is an analogous concept.

Whether patients with borderline or psychotic structure (Kernberg, 1967) ever arrive at a turning point depends greatly on the therapist's ability to instill hope. But hope cannot be dispensed like pills from a vending machine. Hope arises out of a combination of many factors, some of which may, at first glance, seem highly irrational. Often, a measure of good luck must be added to good technique. The therapist should eventually (if not from the beginning) enjoy working with the patient; the therapist must see the patient as having sufficient assets to make lasting recovery possible and to tide him or her over the long period of painful exploration. Treatment may flourish only if there is a certain "chemistry" between therapist and patient (see Stone, 1971) or if the therapist feels toward his patient the kind of parental, desexualized love of which Sacha Nacht (1962) has so movingly written. Sometimes a turning point in the treatment of a severely ill, hospitalized patient will occur after the therapist has taken extraordinary measures to rescue the patient, as in the following example:

A schizophrenic women of twenty-two had been hospitalized because of a psychotic episode following the breakup of a romantic relationship. She continuously vilified her therapist for "not caring" about her, as though there were no distinction between the therapist and the departed lover. One day, in a fit of pique, the patient escaped from the hospital. The therapist, upon hearing the news, got into her car and canvassed all the bars and social clubs in Greenwich Village which her patient was known to frequent. At about

midnight, she found her patient and drove her back to the hospital. From that day forward, the patient grew calmer, less impulsive, and made rapid progress in treatment. Later, after making a substantial recovery, she told her therapist that all the interpretations during the first few weeks in the hospital meant very little to her. But after the "midnight rescue mission" it was clear, even to her, how concerned and sincere her therapist had been from the beginning.

Happily, not every borderline or psychotic patient requires this sort of vivid demonstration in order to get on with the business of recuperation. Some do, however, and it is here that the element of luck becomes so relevant. A felicitous mixture of personalities in the therapist-patient dyad may be the magic ingredient in one case; in another, it may be a matter of finding a particular therapist whose professional and life experience enable him or her to impart genuine hopefulness to an unusually great degree. I have dwelt on this matter at some length in order to make clear that, in discussing the matter of turning points, therapist factors are just as critical as patient factors.

Close attention to the phenomenon of the turning point may eventually enhance our capacity to predict which patients are most likely to experience such an event and when in the course of treatment it is most likely to occur. Something is already known about the attributes of the "good prognosis" patient, or, more specifically, about those who will go on to make a dramatic

recovery. For example, patients who show borderline structure when first evaluated and who exhibit the more favorable characterological subtypes are more prone to show dramatic improvement (often after a turning point is reached) than are patients with psychotic structure or those with the less favorable characterological subtypes (Stone, 1977b).

It is a regular feature of patients whose recovery begins with a turning point that, for some amount of time beforehand, they were absorbed in the task of learning how to improve and expand their repertoire of coping strategies. Much of psychotherapy may be construed as a tutorial program in which the patient is given individual lessons concerning hitherto problematical life situations. Ordinarily, each lesson centers on some highly specific event, often one that took place within a few days of the therapy session. The best "lessons" concentrate on an event occurring in the dyadic therapeutic relationship, i.e., on a transference phenomenon. Because the latter has been witnessed by the therapist, the lesson that evolves out of its exploration will have a freshness and reality not always present in material derived from extramural life.

Obviously, the learning that occurs during psychotherapy, especially if it has centered on the transference, is of no utility unless the patient is able to apply it to analogous real-life situations. The degree to which learning can acquire this wide applicability will vary inversely with the patient’s level of

concreteness. The concrete patient is poor at translating lessons into contexts that were not directly discussed. This may help explain why certain schizophrenic patients progress so slowly in psychotherapy. The therapist's vacation this year, for instance, is just as traumatic as the one last year and the year before; the schizophrenic patient seldom arrives at the level where "suddenly" separations are no longer anxiety-provoking. There is no turning point.

In contrast, the patient who thinks less concretely operates as though a lesson in one conceptual cell can be communicated laterally, and rather quickly, to all similar cells. If such a patient was upset during the first interruption in psychotherapy, he or she will usually take the next separation better. By the third or fourth separation, the patient will have derived enough from the therapeutic encounter and will have applied it widely enough to be able to say, "There is really nothing to be so upset about any more." It is usually a realization of this kind that underlies a turning point in therapy. Two examples, chosen from the extremes of the concreteness continuum will illustrate this point.

The first concerns a highly intelligent but chronically schizophrenic mathematician who had been in psychotherapy for many years. During the ninth year of treatment he fell into the habit of eating an apple before his session, leaving the core and some peel lying about on the anteroom table.

After quite a few tactful reminders about this from his therapist, he was finally persuaded to put the uneaten portions in the basket. Several months later, he took to eating a banana before the session and would put the banana peel on the table with the same nonchalance as before. When the therapist once more tactfully reproved him about leaving fruit on the furniture, the patient retorted, quite dumbfounded, "You never said anything about bananas."

The second example concerns a depressed professional woman in her twenties, who, when first seen, was considerably sicker than the mathematician (even though she functioned at the borderline level). She abused barbiturates, was frequently suicidal, panicked when alone, and became involved in one brief relationship after another as an antidote to her intense loneliness. The men she sought all conformed to a certain "type": they treated her poorly and predictably soon left her. The course of psychotherapy was initially stormy. At one point, before the therapist's vacation, she had to be hospitalized for several months. While in the hospital, her care was entrusted to a different therapist. Out of loyalty to the first, she assumed she would not get along with the second. But this patient showed very little of the concreteness that was so marked a characteristic of the other patient. She was able to grasp quite clearly, on resuming work with the first therapist, (1) that she *was* able to make a new attachment, (2) that the strength and quality of the first therapeutic relationship were not diminished by the separation,

and (3) that the separation itself had not been "fatal," as she had fantasized it would be.

The lesson "taught" her by her experience in the hospital was like a bolt out of the blue. Whereas before, separations of any sort had almost always led to feelings of panic, shortly after this turning point, she was able to tolerate evenings alone. Concomitant with this improvement was a sudden shift away from her old pattern of seeking instant gratification toward a healthier pattern involving sublimation. She became immersed in a wide variety of interests and hobbies and had the patience to seek out more appropriate partners. She was no longer anxious at the thought of not having a boyfriend. Her work as well as her romantic relationships continued to improve so dramatically that after two years of therapy she had become engaged to a very suitable man, had been offered a prestigious post in her profession, and was able to handle several separations—from therapist and fiancé—with a minimum of anxiety.

Turning Points: Some Theoretical Considerations

(1)Turning points in psychotherapy may be viewed as one of a large class of phenomena characterized by rapid shifts from one state to another. Living organisms are said to possess innate drives, whose expression is governed by an intricate system of reciprocal mechanisms for inhibition and

release. In addition, organisms seek an equilibrium state or "homeostasis." But in complex organisms such as human beings, homeostasis remains for the most part a hypothetical construct, approached asymptotically but never actually realized, as the person is buffeted this way and that by a host of simultaneous competing impulses. Human behavior observed at any given moment expresses the temporary balance struck between various drives relating to thirst, hunger, and sexual appetite, and such needs as warmth and freedom from pain. Appetitive drives concerning thirst, hunger, and sex are characterized by rhythmic fluctuations and thus are said to rely on feedback mechanisms that dictate the person's corresponding state of hunger or satiety.

Finally, human behavior involves more complex equations relating to such "abstract" matters as self-esteem and hierarchical position.

On the plane of emotion, one notes that the more "primitive" emotional states have in common with the stronger drives the qualities of urgency and extremeness. They are categorical and possess an "all or none" quality. Objectivity is totally abrogated, as can be seen in such expressions as "engulfed in self-pity," "enveloped by rage," and "blind with infatuation."

Among borderline and psychotic patients, emotional life swings toward the extremes—a tendency noted by psychoanalytic writers over several

generations. Rado (1956, p. 343) spoke of the "emergency emotions" (fear, rage, guilty fear, and guilty rage) operative in a less dramatic fashion in psychoneurotic persons. Kernberg (1967) has emphasized the primitivity of emotions in borderline patients; Gunderson and Singer (1975) have drawn attention to the predominance of rage in borderline patients.

Similarly in the sphere of object relations, sicker patients are noted to exhibit childlike and unassimilated views of other people, as though the world were inhabited only by bad guys and (to a far lesser extent) good guys. The higher we ascend the scale toward healthy adaptation, the more we encounter complex, integrated, flexible conceptions of self and others. The more we approach the psychotic end of the continuum, the more we encounter poor integration and widespread splitting of self- and object representations (the all-good/all-bad dichotomy), with the attendant rigidity of attitude and maladaptiveness of response.

Corresponding to the primitive, polarized attitudes and object representations in the more dysfunctional patients are primitive defense operations. Denial, for example, is a pathological on-off mechanism: some attribute or feeling regarded as "on" by those who know him, the patient vehemently asserts to be "off." This is in contrast to the relatively healthier defense of rationalization, in which the person essentially pleads guilty "with an explanation"—acknowledging ownership of the unacceptable attribute or

emotion, but dressing it up to look presentable.

At the level of interpersonal conflict, seriously dysfunctional patients have a complex system of two or more simultaneous urges of a competing or contradictory nature. The comparative strengths of these urges—some are active only momentarily, others are more persistent—will determine the patient's relative comfort or discomfort as well as his or her subsequent behavior. Consider the possibilities inherent in the courtship situation: if a woman is strongly enamored of a particular man, and if he returns her affection but is somewhat aloof or insensitive, she may decide that "the good outweighs the bad" and remain with him. (If the same woman is treated with tremendous respect and attentiveness there will, of course, be no conflict. She may even experience elation.)

But if the man should become more aloof or treat her shabbily … she will find herself caught in an intolerable state of "strain" between the two opposing emotions of love and resentment. She is now in what one might call a metastable state: tiny additions or subtractions of either emotion may suddenly precipitate a drastic change in behavior. Everyday language is full of metaphors for this unstable condition: an extra measure of shabby treatment, for instance, may be experienced as the "last straw," after which something "snaps," and the relationship is hastily broken off.

Each person works out the calculus of his or her own tolerance. But as we descend from those at the normal end of the spectrum to the distinctly neurotic and on down to the borderline and (chronically) psychotic levels, we note a progressively heightened proneness to switch suddenly to intense and highly maladaptive emotional states—often in response to progressively weaker stresses. An hour's delay in her husband's returning home will, if it is an exceptional event, be written off by a healthy woman to unusual traffic or to some urgent bit of last-minute work. A delusionally jealous woman may be frantic after only five minutes of comparable stress.

The limits of our tolerance are shaped by the intensity of any one stress or emotion as well as by the cumulative effects of concomitant stresses. The "snapping" or sudden breakdown in one's capacity to cope with a set of circumstances may occur after a solitary but major stress (the death of a loved one) or after the last of several less severe but serially occurring stresses (spouse in a bad mood, car had a flat tire, boss was critical, *and* the child brought home a poor report card) has exerted its additive effect to push the person beyond his or her limit.

(2) Recently the French mathematician Rene Thom (cited by Zeeman, 1976) developed a series of models for topological representation of sudden changes of state in physical and animate systems. These models embody what their originator has called "catastrophe theory," because of its focus on

certain common "catastrophes," such as the outbreak of war, the onset of assaultiveness in an angered animal, or, in the physical realm, the breaking point of a stressed metal beam. Within the context of Thom's theory, the word "catastrophe" is used to denote any sudden changes in state, not just negative ones.

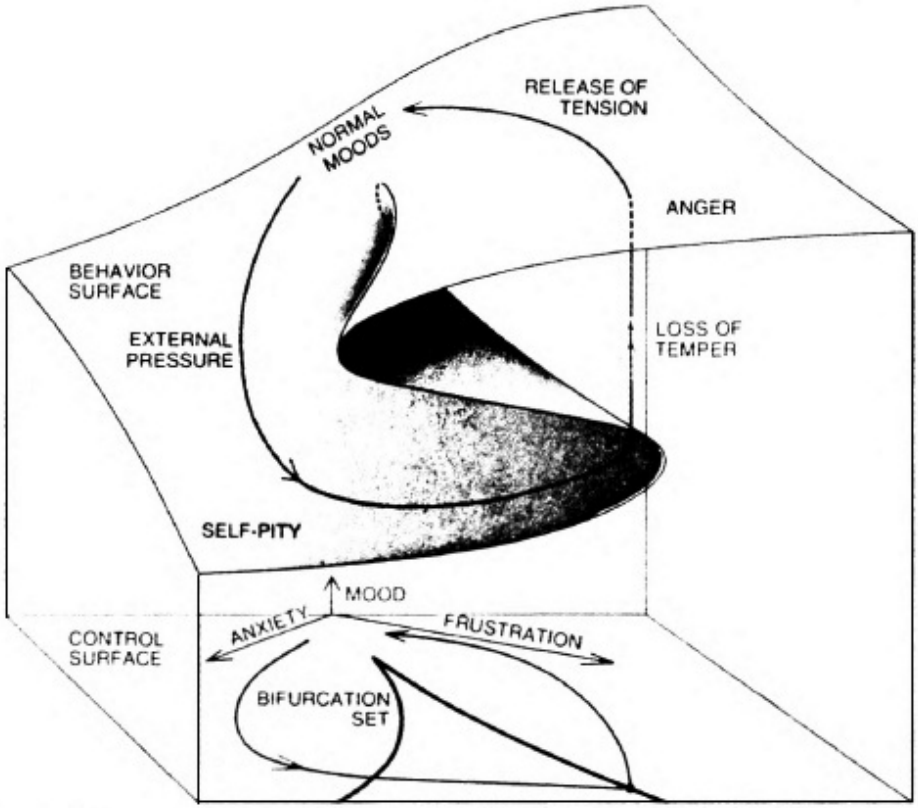
A number of typical situations in which catastrophe theory appears relevant have been discussed and illustrated by Zeeman (1976). His examples include such "negative" catastrophes as stock market crashes, wartime surrender, or, in the case of anorexia nervosa patients, fasting. There is an opposite "catastrophe" to each of the above, i.e., the bull market, the moment of attack, or an episode of gorging. Zeeman also invites us to contemplate, as an exercise in thought, the predicament of a frightened but angry dog being approached by a man. If the fear and anger are both minimal, no matter what their mix, abrupt behavior will not occur as the man comes nearer. But if these emotions are near maximal, then, depending on their delicate balance, there will be a critical distance between the two creatures such that one additional step closer on the man's part will precipitate either the dog's flight or its sudden attack.

In this relatively simple situation the catastrophe theory model could be embellished by a crude quantification, relating, say, to the maximal degree of encroachment (as a function of distance) before the dog takes action, and to

the size of the approaching man. Adherents of Thom's theory have expressed the hope that such quantification could be developed for the vastly more complicated human situations involving individual or group phenomena. The ultimate goal would be the prediction of catastrophic changes in individual and mass behavior. A number of mathematicians have criticized catastrophe theory as being quite far from achieving such quantitative, let alone predictive, goals (Kolata, 1977). It may be more reasonable, at least for now, to adopt the stance taken by Paulos (1978), who regards the theory as a useful analogy for describing a variety of events characterized by sudden change.

Thom describes a number of "elementary catastrophes" named in accordance with the shape they assumed as he attempted to represent them graphically, such as "cusp," "butterfly," "swallowtail" (see Zeeman, 1976). A salient characteristic of the catastrophe models, especially of the "cusp" diagram used to depict various psychological "catastrophes," is the existence of a sharply curvilinear region, which shades into a much gentler, nearly planar surface.

> Cathartic release from self-pity is described by a cusp catastrophe in which anxiety and frustration are conflicting factors influencing mood. Self-pity is induced by an increase in anxiety; it can relived by some event, such as a sarcastic remark, that causes an increase in frustration. As the control point crosses the cusp the mood changes catastrophically from self-pity to anger; the resulting release of tension gives access to calmer emotional states.



In Figure 1, for example, marked increases in anxiety or frustration (shown along the lower, or "control," surface) are correlated with catastrophic changes in mood (self-pity versus anger), the latter being mapped onto the sharply curved "cusp" region of the upper (or "behavior") surface. Toward the rear of the behavior surface, corresponding to low states of anxiety/frustration, is a smooth and slightly inclined region designated

"normal moods."

The catastrophe theory model is closely allied to the psychological concept of vulnerability (see Zubin and Spring, 1977). The latter may be construed as a heightened tendency of the person to break down under stresses not ordinarily associated with gross dysfunction. Borderline and psychotic patients appear to exhibit such vulnerability—we often infer it from their behavior—and we assume that in many cases genetic influences play an important role in predisposing them to this lowered tolerance for stress (Stone, 1977b). Put another way, patients require hospitalization at various points in their lives because of an acute ("catastrophic") episode, which may be conceptualized with the help of Thom's models. This is particularly true of the suicidal patient, the severe anorectic, the agoraphobe, and those who suffer from acute and crippling attacks of panic.

Well before the elaboration of catastrophe theory, the emotionally ill were described in everyday language as "edgy," "on the brink," "labile," and "walking a tightrope." These phrases capture both the affective instability so often noted in certain categories of psychiatric disturbances and the tendency toward rapid shifts of state in others. Reconsidered in the light of this theory, psychiatric patients may be visualized as perched on, or near, the most curved portion of one or another "catastrophe" diagram, where a minor change of intensity in one or more emotional states is associated with a

drastic change in ideation or behavior.

From the standpoint of available strategies, the more distressed the patient, the fewer his or her perceived options. The patient may reach the point where none of these options is at all compatible with successful adaptation. For the suicidal patient, death itself may be the only acknowledged "option." In seeking to minimize anxiety, the psychosis-prone patient may fall precipitously into delusion, where comfort is all at once reestablished—but at the price of a diminished sense of reality. Occasionally one encounters schizophrenic patients for whom psychosis is experienced quite consciously as a refuge—and the only one known to them—from intolerable anxiety. As one such patient poignantly told me, after having developed a rather enviable reputation among her hospital mates on account of the poetic manner in which she expressed her delusory ideas: "Why should I be a cipher *out there*, when *here* I can be Queen of the Crazies?!"

As therapists, we try to foster such goals as reduced vulnerability and an expanded repertoire of coping mechanisms. In the terms of the catastrophe theory model, our aims will have been accomplished when we have helped the patient move from the catastrophe-prone portion of a behavior surface to the more planar portion that corresponds to less intense degrees of the "emergency emotions" and that therefore allows greater access to nonstereotyped responses.

In this context, the turning point in psychotherapy may be viewed as a kind of reverse catastrophe, where we have facilitated the patient's rapid leap upward—*away* from the "region" of suicidal, phobic, or other grossly dysfunctional states—toward the low-anxiety "region" of normal moods and behavioral flexibility.

Summary: Guidelines for Practitioner

In psychotherapy, we use the phrase "turning point" to signify moments of sudden and dramatic improvement in a patient's clinical course, related, as far as can be determined, to our therapeutic (particularly, *verbal*) interventions. Since dramatic improvement is scarcely possible in patients whose conditions are very mild to begin with, the term is ordinarily confined to cases of at least moderate severity. Patients who are severely and chronically ill, especially certain schizophrenics whose thinking is characterized by concreteness, tend to improve in a slow, incremental fashion at best, and hence seldom experience a "turning point." One often does see a turning point, however, during the course of psychotherapy with patients showing either moderately severe affective (especially depressive) symptoms or certain dystonic and easily noticeable symptoms such as phobias.

Turning points may occur as abreactions to early traumata (including early object loss that may have been insufficiently mourned), as the sudden

conquest of a hitherto crippling phobia, or as a sudden lifting of anxiety or depression. Often the clinician cannot be sure that a particular therapeutic event constituted a turning point until enough time has passed to prove that the initial improvement was not only dramatic but sustained.

Turning points often appear to hinge on unpredictable factors, such as the "chemistry" between therapist and patient, the therapist's capacity to instill hope in an otherwise discouraged patient (who may have had several unsuccessful courses of treatment with other therapists), and the therapist's skill in confronting difficult (i.e., "borderline") patients with the proper timing and proper mix of firmness and compassion. Sometimes a turning point will be heralded by a *dream*—either in the patient or the therapist—in which the answer to a previously "insoluble" conflict is simply and obviously stated.

In many instances, turning points are characterized by the sudden transition from highly maladaptive coping styles to a more integrated state, where patterns of thought and behavior are realistic and adaptive. Examples would include the chronically suicidal patient who, having assimilated some particularly useful interpretation or confrontation, no longer resorts to suicide attempts or gestures in life situations that formerly evoked such responses. The abrupt cessation of other types of impulsive and self-destructive behavior would likewise qualify as turning points.

From the metapsychological standpoint, the "turning point" is analogous to a situation in Rene Thom's "catastrophe theory" model in which there is sudden movement away from an all-or-none (i.e., aggression versus capitulation), two-alternative behavior pattern to one in which more desirable options become available to the patient.

REFERENCES

Crewdson, F. (1977), Separation-individuation: Indicator of change for therapy of borderline patients. Paper presented at the 30th Anniversary Symposium, Society of Medical Psychoanalysis, New York, March 11.

Forrest, D. V. (1978), Spatial play. *Psychiatry*, 41:1-23.

Grinstein, A. (1966), *The Index of Psychoanalytic Writings*. Vol. 9. New York: International Universities Press.

Gunderson, J. G., & Singer, M. T. (1975), Defining the borderline syndrome: An overview. *Amer. J. Psychiat.* 132:110.

Kernberg, O. F. (1967), Borderline personality organization. *J. Amer. Psychoanal. Assn*., 15:641-685.

Kolata, G. B. (1977), Catastrophe theory: The emperor has no clothes. *Science*, 196:287.

Nacht, S. (1962), The curative factors in psychoanalysis. *Internat. J. Psycho-Anal*., 43:194-234.

Paulos, J. A. (1978), *The New York Times*, March 21st, p. 20.

Rado, S. (1956), *Psychoanalysis of Behavior*. New York: Grune & Stratton.

Stone, M. H. (1971), Therapists' personalities and unexpected success with schizophrenic

patients. *Amer. J Psychother*., 25:543-552.

____ (1975), The role of loss in borderline and psychotic conditions. *J. Thanatol*., 3:207-222.

____ (1977a), Dreams, free-association and the non-dominant hemisphere. *J. Amer. Acad. Psychoanal*., 5:255-284.

____ (1977b), The borderline syndrome: Evolution of the term, genetic aspects, and prognosis. Paper delivered at the 17th Emil Gutheil Memorial Lecture, Association for the Advancement of Psychotherapy, New York City, November 21st, 1976. *Amer. J. Psychother*., 31:345-365.

Watt, N. F., & Nicholi, A., Jr. (1978), Death of a parent as an etiological factor in schizophrenia. Unpublished paper.

Weissman. M. M., Fox, K., & Klerman, G. L. (1973), Hostility and depression associated with suicide attempts. *Amer. J. Psychiat*., 130:450-455.

Whitman, R M., Kramer, M., & Baldridge, B. J. (1969), Dreams about the patient. *J. Amer. Psychoanal. Assn*.. 17:702-727.

Zeeman, E. C. (1976), Catastrophe theory. *Sci. Amer*., 234:65-83.

Zubin. J., & Spring, B. (1977), Vulnerability: A new view of schizophrenia. *J. Abnorm. Psychol*., 86:103 126.

Notes

1 An earlier version of this chapter was presented at the Annual Meeting of the American Academy of Psychoanalysis, Atlanta, Georgia, May 1978.