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Turning Points in Psychoanalysis

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In psychoanalysis as elsewhere, there are turning points in the direction of growth, development and the facing of reality; there are also moments where someone, as in organisations and groups, turns towards regression, evasion, madness, perversion or defensiveness.

One patient who had been sexually abused by her father, heard powerful persuasive voices inside her head. She would work well with her analyst for a while, opening things up. Such turning towards growth would be followed by a reaction. Thus she wrote two letters to an organisation that part-funded her analysis saying how it was crucial in enabling her to live her life, and then a third telling the funder to disregard the first two. The other voice, extremely suspicious of anyone who was apparently kind to her, had spoken. This is an example of a negative therapeutic reaction.

We make U-turns in contradictory directions, as well as partial turns in varied directions.

Some psychic changes *are* on the side of growth. These are often occasions where an interpretation has a powerful effect. We are inclined to the idea that causality is a matter of something coming in from outside, like an immigrant or a germ or an interpretation. We need to remember that for someone to change as a result of an interpretation various things have to be already in place.

I will suggest four pre-requisites for an interpretation to have traction.

First there has to be some sense of self-dissatisfaction in the patient; or at least a sense of how things could be better. Indeed a good deal of the work of analytic therapy consists in increasing patients' awareness of their own need. We analysts problematize what may have been dismissed by the

patient as ordinary, or good enough. Our job may be seen as not only 'comforting the troubled', but also as 'troubling the comfortable'.

Second there needs to be, in the patient, openness to the new, some willingness to countenance the shock of the new. An interpretation may carry conviction because the patient was already on the brink of reaching this point himself. In fact the most therapeutic approach by the analyst at such times is to allow the idea to come from the patient. These are situations described by William James, in *Varieties of Religious Experience,* as 'unconscious incubation'.

He tells a story of two brothers on an expedition. When one in his routine way gets on his knees and murmurs a prayer before going to sleep, the other says quietly, 'you don't still go in for this, do you?' At once the scales fall from the eyes of the apparently devout man. He realises that his words and thoughts no longer carry conviction for him. He is going through the motions merely. Thirty years later he is still happily agnostic. The turning point with his brother had been a kind of reverse Road to Damascus experience. James compares it to the snowflake that 'causes' a wall to collapse. The straw that broke the camel's back. The wall was already wobbly, the camel's spine on its last legs.

At other times the analyst may need, for a long time, to make analyst-centred interpretations. We say something like this: 'when I talk about your feelings towards me, you feel that I am out to humiliate you and make myself important'. We don't hammer away at a closed door by saying, for example: 'you put yourself on a pedestal and treat me like an inferior being'. If take this latter approach, then we are likely to be bluntly and furiously rejected, and the relationship risks being reduced to a mutual tennis match of insults.

I mentioned readiness to embrace the shock of the new. There is a book called: *Radical Hope*, by Jonathan Lear. It's about the Crow Indians, living on the plains of America, whose whole way of life was threatened in the second half of the nineteenth century. Lear tells the story of the dream of young Plenty Coups, later to become a Chief.

The dream begins with images of the catastrophe to come, in the form of the *replacement of buffalo with strange spotted cows and bulls*. It continues: *the dreamer was told that the Four Winds were going to cause a terrible storm in the forest, and only one tree would be left standing, the tree of the Chickadee-person. He sees an image of an old man sitting under that lone tree and is told, in the dream, that that person is himself. Finally, he is told to follow the example of the chickadee.*

The dream, then, offered a clue to survival and to the rebuilding of morale in the form of the chickadee, a bird (a small tit) noted for its wily ways and its capacity to learn from others. Lear suggests that this be understood as an

indication of a new ego ideal, a chickadee ideal - of canny openness to an unknown life. This new ideal would be necessary in their radically different context, in which the traditional values, their traditional forms of courage – courage in battle and in hunting, and all the rituals that contributed to this form of life – would no longer have a lived place. The chickadee's qualities would, at least at this point in time, have to be open-ended, unspecific. The Crow tribe already valued dreams and what they could tell them. Thus imagination was given an enhanced value for the tribe as a result of taking this dream seriously.

Lear links the Crow situation to that of the patient who is offered an interpretation by an analyst at a time when he is not yet able to know what form his new personality structure that is beginning to emerge will take.

The third thing that has to be in place for an interpretation to have traction is that there needs to be some therapeutic alliance, such that a part of the patient trusts the analyst enough to give house-room to his or her suggestions or interpretations. Such alliances can't be taken for granted; nor are they to be induced by seduction. Assuming the patient is not someone inclined to be trustful until shown that this is foolish, an alliance can be earned only by truthfulness, empathy and tact on the side of the analyst. The trusting relationship has to become strong enough to accommodate and allow mistrust and other forms of hostility. The possibilities of beneficial change will often hinge on the relative strengths of the two forces – the alliance on one side, and the touchiness on the other, a touchiness in favour of keeping things covered up.

Fourth, there needs to be the stamina and energy to follow through (what Freud called ' to work through'). The impact needs to go deep enough to outweigh the inevitable tendencies to revert or let it all drop.

Psychoanalytic theory predicts all these features. If, as we believe, the unconscious is largely constituted by what we've repressed, or disowned, there will have been persuasive reasons for the initial repression or disowning, so there is bound to be hostility and resistance to the uncovering and undoing of our unconscious ideas, emotions, orientations and dispositions.

So much (for the moment) for the patient.

What about the analyst? Again, psychoanalytic theory makes plausible what has to be in place on the side of the analyst. It holds that intellectual understanding is by itself not enough, and this leads us to expect that the analyst too has to be prepared for shocks and difficulties.

James Strachey 1934 argues that it is often the case that what we should interpret is that which we find most difficult to say. This does not mean that

we don't have to work hard to find ways of saying it that might be relatively palatable to the patient. But Strachey is right, the analyst as well as the patient needs courage, and also tolerance of uncertainty. We analysts are tempted to keep clear of saying things that will produce the greatest resistance.

Related to this is what **Neville Symington** (1983) called the analyst's 'act of freedom'. He had a patient whom he had nicknamed (to himself) 'Little Mary'. He had come to see that he, like other significant people in her life, had been pulled into being a magnanimous, grand figure who treated her with kid gloves, as if she were a child, unable to take a full part in the adult world. It took an act of freedom for him to realize what was going on, to detach himself from this imbroglio, and enable the patient to stand up for herself and begin to live up to her potential. One element in this process was his coming to think about the exceptionally low fee he was charging her. He saw that the setting of this fee was itself a move in the game played (and unknowingly orchestrated) by Little Mary, along with her fellow game-player, himself. When he increased her fee, with (we assume) appropriate comments, she was able (after her initial outrage) to accept it. She began to assert herself in her work-life, finding a more responsible job commensurate with her skills and experience. She also ditched her unsuitable boyfriend (but not, I think, her analyst).

As a result of coming to see how he had been lassoed by the patient into a particular form of relationship, the analyst was able to make a shift in his own mind, moving into a third position. This move became the occasion for the turning point - and perhaps the sine qua non for it - in the patient.

I mentioned the **analyst's uncertainty**. Often we can't be sure how such an interpretation and change in stance will affect the patient. Both our courage and our tact may well be further tested in ensuing sessions.

A patient is depressed. He walks up and down the street outside the analyst's consulting room at and after the beginning of his session time. He knows the analyst will look out and see him there. He leaves it to the analyst to do something about this. Thus he puts the analyst in a cleft stick. If the latter goes out and invites the patient in, he has broken his own rules of abstinence, and of not interfering in the life of the patient. On the other hand if he does nothing is he not being heartless towards a suffering patient?

The alternatives are usually not as stark as this makes it sound. He could leave the patient for a while, and then, if he stayed outside, invite him in. Whichever course the analyst chooses, he is likely to be able to take the whole scenario up with the patient in due course. But there is an important question: how much was the patient really unable to come in? Alternatively, or in parallel, how much was he provoking the analyst, testing him out, forcing him to make a mistake one way or another?

Acting may be a risk for the analyst. But so may the action of not-acting. My point here is that the analyst may not know in advance what the impact of either course will be. The patient may be able to take in an interpretation about his manipulation (especially if the analyst does not ignore his suffering), or he may not. He may break off treatment. It may be more important for the patient to make the analyst suffer in this way, to make the analyst feel abandoned, rather than face his own need to project his pain and be in control. Such situations can be difficult and troubling for the analyst. It may take courage to take up with the patient the range of emotions and motives involved, without any guarantee that the outcome will be a good one.

In summary

'Turning points' are closely related to the psychoanalytic notion of psychic change. They happen on large and small scales. They may be in the direction of growth, or in the direction of regression or pathological reaction. For them to happen, there needs to be a readiness in the patient, and also in the analyst. I refer to the analyst's act of freedom (Symington), and to the need at times to find ways of interpreting that which we are most reluctant to take up (Strachey). Sometimes the analyst can find in himself a third position from which he can see the situation he is in with the patient and find ways of addressing it. But even then the outcomes of his decisions to interpret in this way or that, or not to interpret, cannot be guaranteed.