Elements of Change and Cure in Psychoanalysis

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Many elements are involved in the process of change and cure in psychoanalysis, some of which are seen as facilitative and others as definitive. I attempted to establish and illustrate the role of the interpersonal interactions between analysand and analyst. As a result of the traditional analytic process, the patient relives at a regressive level some of the unresolved developmental conflicts and crises in the relationship with the analyst. Thus, he has an opportunity to find, through the current experience, a more satisfactory and appropriate developmental resolution of previous psychopathology.

(Arch Gen Psychiatry 1963;40:99-96)

In attempting to describe or define the processes of change and cure in psychoanalysis, one should keep in mind the fable of the six blind men and the elephant. Dealing with such a highly complicated multivariable situation carries a risk that attention to some of the elements of the curative process may seem to de-emphasize other aspects, unwittingly producing a distorted or incomplete picture. But failure to observe some elements in depth and detail leaves the process obscured in vagueness and generalities.

In this article I show that a successful psychoanalytic therapeutic process involves a simultaneous interaction among many therapeutic forces and experiences; that specific interventions that the analyst makes (or does not make) may have multiple effects at various levels; that elements of change and cure include interpersonal as well as intrapsychic experiences; and that these issues demonstrably are present even when the analyst maintains a "classic" psychoanalytic position and technique.

GENERAL CONCEPTS

Change in psychoanalysis is not an "all or nothing" phenomenon, nor does it occur only after a particular elapsed time or phase of the analytic process, nor suddenly or dramatically. Change is more likely to occur in a continuing, at times barely perceptible, spiraling fashion, in which one element of the process influences another, sometimes sequentially and sometimes simultaneously, leading to the unfolding of an ever-deepening and expanding process.

The changes that occur as the successful psychoanalysis proceeds can be conceptualized as facilitative and definitive. By facilitative I am referring to those components in the psychoanalytic process that must necessarily occur to provide the frame and field, as well as the vehicles and tools, for patient and analyst to eventually initiate and sustain the processes that lead to definitive cure.

As illustrative of facilitative change I would include such elements in the psychoanalytic process as the establishment of the psychoanalytic situation; the unfolding of a therapeutic alliance and a regressive transference neurosis; the intensification of the transference experience through the maintenance of appropriate transference identifications by the analyst; the offering by the analyst to the patient of appropriately timed interventions and interpretations; the recognition and reduction of the patient's use of various tactical resistances; the patient's increasingly direct exposure to and tolerance of affects, drives, and previously unconscious fantasies; and the acquisition by the patient of deeper and progressively more personalised understanding and insight.

All of these issues are crucial aspects of the overall psychoanalytic process. Each of them occupies a considerable amount of the time, technique, and energy that both patient and analyst devote to the work of the analysis. Their importance as necessary precursors to the process of cure cannot be minimized.

Accepted for publication July 21, 1962.
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These elements provide the field, the framework, and the tools of the analytic process, out of which then emerge and occur the more definitive elements in the analysis that lead to lasting change and ultimately to cure. As illustrations of definitive change I would include such process elements as internalization and identification; the reliving and ultimate improved mastery of important developmental crises and arrests; the increase in psychic continuity (both longitudinally and cross-sectionally); the application by the patient of insights gained; and the eventual renunciation of inappropriate infantile and childhood wishes (the strategic resistances).

Facilitative changes occur gradually and in a spiraling fashion, progressively from the beginning of the analysis. However, the rate of change tends to accord with a geometric rather than linear progression; the major thrust of definitive change often occurs only in the late middle and termination phases of the work.

The elements responsible for cure in psychoanalysis have been discussed for many years, but the introduction by Alexander et al. of the "corrective emotional experience" and their technical recommendations on how to evoke it served to polarize the issues. Eissler's description of ideal analytic technique and process involving interpretation and the asking of questions by the analyst further narrowed the concept of "the basic model technique."

A detailed review of the literature on curative effects is beyond the scope of this presentation. But the controversy has continued to the present, illustrated by the contributions of analysts such as Blum, Brenner, and Valenstein, who emphasize the imparting of understanding and insight by the analyst's interpretations. Kohut and his followers emphasize the role of "transmuting internalization" as the major therapeutic element, and Gillen stresses the centrality of the importance of the transference in the "here and now" of the analytic situation. Greenon and Wachler emphasize the importance of the real and human elements in the therapeutic relationship, while Loewald calls attention to the idea of the analyst as a new object for the patient to internalize. Kernberg points out the importance of the analyst's interactions, attitudes, and behaviors, particularly when dealing with borderline patients.

For the analytically sophisticated reader, this discussion primarily will involve issues of emphasis, rather than new discoveries. Even those who stress the centrality of insight acknowledge that the elements I will describe are part of the analytic background, but they minimize their therapeutic importance.

For the analytically unsophisticated reader it is my hope that this discussion will provide an illustrative context within which can be encompassed the multiple elements of change leading to cure.

I intend to focus more on some of the major interpersonal elements, partly because of their importance and partly because some of them seldom receive explicit attention in writings about technique or analytic process.

In doing so I will illustrate the concepts by material from the analysis of a patient I will refer to as Mr. G. This analysis was not particularly unique or unusual, and the clinical data to be presented will be common and familiar. The various vignettes I have chosen easily could be replaced by others from this case, or from the analysis of other patients.

CASE HISTORY

Mr. G was a middle-aged lawyer who entered analysis because of anxiety, guilt, a feeling of being out of control, and having been clinic in love with a woman whom he knew to be inappropriate-

ate. He was drinking heavily, feared he might become alcoholic, suffered an inhibition in his work, and found himself increasingly estranged from his family.

He felt his sister, seven years his senior, was preferred deeply by the father. Apparently, after the birth of their first child the parents could not conceive a second child, which the mother had wanted desperately, and she became profoundly depressed to the point of receiving electroshock therapy. The patient was adopted shortly after his birth, partly to aid in the mother's recovery. When the patient was 4 years old, the mother gave birth to a son toward whom the patient showed great envy, feeling that the brother had replaced him and had been the parents' favorite. The father was a deeply religious businessman with straightlaced personal habits who demanded perfect performance and obedience from the patient. Until the birth of the brother, the mother was suffering from serious chronic depression, and the patient's earliest memories involved having to be concerned about the mother and playing quietly lest he awaken her from her nap.

The patient was bright and talented as a child, and did well academically and athletically, but from age 13 through 20 years he was involved in the use of alcohol and drugs, defiantly against the father's preaching and pronouncements, but never became involved in an open showdown with the father. He was frightened of girls and sexuality and suffered intermittent impotence. Having left home to go to college, he was less defiant in the use of alcohol and drugs, was academically successful, and met and married his wife shortly after entering law school. At the beginning of the analysis they had one daughter aged 7 years. The marriage was essentially stable, although the patient occasionally experienced intense jealousy of his wife and also found himself preoccupied with sadomasochistic fantasies during sexual relations.

Outwardly successful in his professional life and able to meet and make friends, the patient had always thought himself to be under pressure to perform. He had thought that all caring for him had been conditional, that he had never been loved genuinely by anyone, and that in spite of his capacities for function and living, he derived little genuine enjoyment or pleasure from his life.

THE INTERPERSONAL RELATIONSHIP

There are a variety of elements in the interpersonal interactions between patient and analyst by which the analysis comes to represent a new and unique type of object relationship in the life of the patient. These include the following: the constancy of the analyst's interest and acceptance, regardless of the type of material that the patient presents; a high degree of reliability in the analyst in regard to keeping appointments, duration of the sessions, and structure of the situation; the analyst's systematic attempt to put the patient's welfare foremost in the situation between them and not to use the patient for his own personal needs; the analyst's suspension of moral value judgments and willingness not to require that the patient conform to any particular standard of behavior determined by the analyst; the analyst's demonstration via the interventions he makes of the capacity for empathy, insight, understanding, and acceptance, thus relieving the patient of a previous sense of isolation and alienation in regard to his own thoughts, wishes, fantasies, and earlier feelings; the patient's opportunity now openly and directly "to speak the unspeakable" to someone who not only tolerates its being spoken, but shows an active interest and desire to under-
stand the meaning of that which was previously unthinkable and unseparable; and the analyst's maintenance of a holding environment through his interventions, which protect the patient from disruptive levels of displeasure or disorganization.

Mr G had been terrified to be aware of oral homosexual yearnings in dreams and had manifested a variety of typical character defenses against such wishes. Toward the end of the second year of analysis such yearnings were increasingly, directly, and consciously experienced toward me, accompanied by intense anxiety and shame. As he expressed the deep yearnings to suck my penis, swallow my semen to gain my strength, be impregnated and carry my baby, and be warm and fused with me as one, he repeatedly expected me to attack him, punish his transgressions, show contempt for his lack of manliness, interrupt the analysis and get rid of him, be frightened by his sexual overtures, or react in some other nonanalytic way.

When I maintained my analytic position and interest in these regressive transference experiences, he was convinced that "sooner or later [I would] spring the trap." He began to employ provocative maneuvers designed to elicit anger, rejection, and active control of my behavior by me. When these too were responded to by abstinence and analytic interpretation of their defensive meaning, he said, "For the first time in my life I feel that I can show myself to someone exactly like I am and not feel like I'm some crazy weirdo." On another occasion he commented, "I don't understand how it's possible for you to understand and accept me and these feelings. It's a whole new experience for me to feel you do."

In all of these forms of appropriate analytic behavior, the analyst provides a type of early parent-child relationship and experience. Greenacre has commented on the difficulties for patients caused by the "tilt" in the analytic relationship. I would point out that by maintaining the appropriate classic psychosanalytic position, stance, and activity, and by permitting himself to be used by the patient as a transference object, the analyst contributes to a unique kind of new relationship, "tilted" heavily in favor of the patient's ultimate well-being.

In the second year Mr G told me that he would be canceling four sessions to take a trip with his wife and daughter. I had said nothing at the time, but in my consistently structured way I told him one week in advance that I would be canceling two sessions that overlapped with the patient's vacation. The next day he told me,

I had the problem of deciding not to let people in as a little boy because I needed the protection. If they came into me emotionally, I couldn't be myself. I would be the extension of someone else and I would have to be a slave. You've let me be myself here and that has been a new experience, but maybe it's a trick and maybe you are really reducing me. But yesterday when you canceled the sessions anyway, it told me that you wouldn't trick me or take advantage of my ignorance.

After repeatedly experiencing and expressing his intrapsychic fantasies and drive systems, he described his experience:

You can understand these awful things that I've lived with, and for the first time in my life I can really begin to live. But I'm still afraid it's a mirage and not real, and that you'll spring something awful on me and tell me something horrible that I don't know. I don't know which is the real world. There are two of you. One is Dr Dewald, the analyst, who listens and doesn't say much, but the other is the sadistic, critical, angry bastard that I expect and that I've felt for so long. For the first time in my life, someone has been kind and I don't expect that reaction. Maybe the basic idea that I'm just a bad seed and that I did something wrong is not true. That gives me a glimmer of hope, and that's the experience of Dr Dewald. I've finally made emotional contact with another human being, and that's you.

During any analysis there may be prolonged periods of bitter transference, frustration and resultant hostility, negativism, withdrawal, contempt, or criticism of the analyst by the patient. The fact that these responses and behaviors do not cause the analyst to retaliate, reject, or otherwise move out of his analytic position offers the patient more evidence of a unique form of acceptance.

INTERNALIZATION AND IDENTIFICATION

Such experiences result in progressive internalization and identification with the analyst by the patient in the following forms: the patient's development of self-analyzing functions; the shift in the patient's ego-ideal toward a more active willingness for introspection and the acceptance of psychic truth; a greater tolerance in consciousness of primary process thinking and affects; and a model of interpersonal activity involving empathy, altruism, and constancy. Although some elements of identification with the analyst are defensive and eventually need to be analyzed and given up by the patient, some of these characteristics are permanent and tend to persist after the analysis is over.

On one occasion after I had made an appropriately effective and empathic interpretation, Mr G burst into a flood of tears and sobbed heavily for several minutes. "I feel like a turtle that just came out of its shell, and didn't get its head cut off. It's so sad to be afraid to love people because I'm always protecting myself."

Repeatedly, Mr G insisted that I see him as "the bad seed" and to confront him with the "fact" that he could never love anyone or anything. When such accusations were not forthcoming, he reacted with surprise, mistrust, and finally rage. He demanded "the showdown" with me to put him out of his doubts and suspense about when it was coming. "Tell me now and get it over with, or shut up forever!" Slowly he began to consolidate a genuine sense that, "If you really don't see me as basically so evil, and if you can tolerate me coming here day after day, and I guess I'm really not hurting you... so maybe I don't have to go on thinking of myself as the bad seed."

REGRESSIVE RELIVING OF DEVELOPMENTAL CRISIS

In the clinical situation the distinction between the intrapsychic transference and the interpersonal interactional elements of the relationship may not always be clear and sharp. Transference phenomena influence the selection of perceptions in the situation as well as the emotional importance those perceptions have for the patient. Reality experiences in the interpersonal sphere also may activate a variety of transference responses. However, in spite of such overlapping, there is a schematic advantage in separating these two elements in the total relationship.

Much of what is considered the hallmark of an analysis is the unfolding conscious recognition and affective participation by the patient in the emergence of a regressive transference neurosis. In this paradigm and with the technical help of the analyst, the patient ultimately experiences in consciousness many of the regressive infantile and early childhood core fantasies, wishes, object choices, defenses, adaptive organizations, and expectations. While these phenomena are not the same as the original developmental processes, they probably represent an approximation of the patient's infantile and childhood developmental psychic experiences, now reported and modified as actual "here and now" phenomena by a verbal adult.
Simultaneously or in oscillation, the adult patient is also aware of the "as if" aspects of this situation and set of experiences, and is willing and able to tolerate the displeasure, "danger," and distortions induced by the transference regression in hopes of ultimately being cured of the neurotic symptoms. These aspects are described and defined as parts of the therapeutic alliance.

Whatever the intensity and level of the regression during the transference neurosis and the vivid immediacy of experience of the infantile and early childhood phenomena, the analyst seeks to maintain his analytic posture in the face of the patient's multiple transference-inspired attempts to elicit a gratifying, seductive, punitive, rejecting, sadomasochistic, or other inappropriate reaction. In spite of the patient's transference expectations, the analyst maintains abstinence for the transference wishes; continues the empathic interpretation of the meaning, importance, and relatedness of the patient's material; shows continued acceptance and tolerance of the patient without judgment or prejudice; and continues in his primary concern for the patient and the patient's perceptions of the earlier childhood relationships, fantasies, wishes, traumas, and methods of adaptation.

This maintenance of transference and countertransference abstinence by the analyst is perceived by the patient at the level of transference regression as a new and unexpected interpersonal relationship and set of affectively meaningful experiences. It serves several important functions in the analytic process. The dynamic effect of frustration of derivative wishes tends to promote further regressive awareness and intensify the pressures for wish fulfillment. Such abstinence makes the situation "safe" for the patient to give full verbal and affective expression to previously repressed wishes, without having to be immediately responsible for action or reaction. It also sets a model for the patient in regard to the solid distinction between feelings and fantasies vacuums.

At the level of the regression occurring in the transference neurosis, the analyst now represents a new and different object. While the patient's transference-induced expectations of the analyst persist, the patient's current regressive experience of the analyst in the anticipated dangerous relationship is not in keeping with the expectations.

In that sense, the patient now has an opportunity partly to relive some of his early developmental crises and conflicts with a person who is responding differently than did the original objects, either in reality or in the patient's fantasy. In this way the current regressive experience of the analyst represents a fresh or new reality for the patient occurring at the level of the transference-induced regression. In reliving such conflicts and crises the patient now has the new insights achieved by the analytic process. Additionally, in spite of the regression, the patient now also has available an adult capacity for reality testing and for options in regard to the resolution of the previous developmental crises, alternatives that were not available to the child at the time of his original development.

These two sets of perceptions in the patient's regressive transference experiences (the repetitive transference expectations and wishes, and the new experiences with the analyst at that level of regression) provide a differential set of phenomena that must be reconciled by the more mature, self-observing, integrative, and synthetic functions that are part of the patient's activities in the therapeutic alliance. The process of reconciling the differences between these two forms of experience at the level of regression that the analysis has induced is an important definitive component in the production of change, and represents one of the ways by which the patient applies newly acquired insights.

For example, early in the analysis Mr. G. responded with anger, depression, and a sense of suspension of functioning in response to any separation from me such as a canceled appointment or a vacation. He described a state in which he felt cut off from me, and unsure whether I would ever return. He felt that without my presence, he was unable to carry out functions that he could accomplish when I was there. He described himself as living in a state of isolated and suspended animation, unable to function and fearing that the relationship had been terminated totally, and having to wait until my return before he could feel like himself again.

In the later stages of the analysis, Mr. G. could tolerate and express directly the experiences of sadness, yearning, and missing me at the times of such separations, but he thought that the relationship between us still persisted and that it was all probability I would return and that he could not continue to function even when I was not physically present. Whereas early in the analysis he had difficulty retaining a dynamically active image of or affect about me during the separations, he now was able to retain a clear visual and affective memory during the separation and consciously experience and recognize that he was sad and that he missed me. In this repeated experience in the analytic situation and relationship the patient now was able to relive and achieve a more advanced and solid level of object constancy than he had been able to experience in his childhood.

On another occasion I canceled two sessions, and Mr. G. was convinced that I was ill and depressed, that he had gone too far, and that I was going to have to go to the hospital "for something that [he had] done and that [he] didn't mean to do." Feeling in this regressive state that his increasing enjoyment and successes in life had led to his distress, depression, and illness (since he had not fulfilled his obligations of taking care of me first), he verbalized many of the bitter complaints that he had experienced but never expressed as a child.

Die if you must! I'm sick of hearing about it! Every day I hear about it, on and on, poor you, and it's all I ever hear around here! You martyr! There's no Dr. Dewald around here today. It's only you and your preoccupation with your depression. You can't be a mother because you have no energy for it! You don't give me a second thought! All you think about is yourself and you expect me to put what I feel second and take care of you!

He experienced genuine surprise that his bitterness did not cause me to cry, withdraw from him, feel depressed, or be angry. He also found it startling in the father-transference that I did not accuse him: "Look what you've done to your mother!"

On other occasions he would experience intense competitive fantasies toward me in a typical triadic oedipal father transference. He was convinced that I wanted all the women to myself, that I would attack and punish him for his sexual fantasies about my wife, and that sooner or later we would become embroiled in a hand-to-hand "fight to the death."

On one occasion late in the middle phase, Mr. G. canceled an analytic session in favor of attending a purely pleasurable function. He expected me to be either angry and critical, or hurt and depressed by his "unfaithfulness to mother." When I was neither one, he suddenly at a regressive level experienced me as "the perfect father" he had always wanted. In association to that experience he directly got in touch with feelings about both his mother and father "from the time when they were perfect," and had a sense of deep love.
I...isa...tion, and closeness. "I have an image of myself lying in bed between them, and I'm their baby, and I crawl on their laps, and they love me. And then suddenly I'm excluded, three is a crowd, I'm out, and I feel terrible. The girl you love just chose another boyfriend." He recognized a sense of "falling from grace," feeling excluded and also feeling subsequently replaced by his younger brother. He recognized his own defensive withdrawal, anger, and determination to get revenge through not allowing them ever to know his true feelings. Although apparently smoothed over on the surface during childhood, this sequence was repeated again and again through his characteristic defensive pseudo-independence, avoidance of the experience or expression of love, and defiance of his parents' wishes for him. As he reflected on this entire sequence from an adult perspective, he began to accept his own active part in the emergence and establishment of the characteristic behavior patterns that had caused him so much pain and distress during his development and adult life.

Following the completion of this experience during the analytic session, the patient described a sense of heightened feeling and awareness, greater clarity regarding his own difficulties, and a sense of feeling happier and more secure within himself. These effects were not lasting, but other versions or editions of these experiences occurred again and again, ultimately contributing to substantial and lasting positive change.

This vignette illustrates the common analytic experience whereby a transference-induced process is activated during which the patient simultaneously experiences a pleasurable and/or painful childhood organization; regressively relives it with an object who does not respond in accordance with the patient's transference expectations; observes himself at the same time from a more mature adult perspective; introduces that more mature perspective into the simultaneous reliving of the old trauma at the regressive level; and then begins to achieve a new and different pattern of resolution.

These phenomena also allow us to understand more clearly why countertransference interferences with the function of the analyst are so disruptive of analytic progress. When the patient with the regressive transference neurosis can provoke in the analyst a response that is in keeping with the patient's childhood or infantile expectations and is a repetition of the fantasies or actual ways in which other persons responded to the patient's neurotic processes in the past, the differential between those expectations and the current regressive experience is not wide enough to permit change to occur. The present experience with the analyst then becomes another repetition of the past, and the patient's original neurotic expectations, perceptions, and distortions are again confirmed and strengthened.

ACCESS TO AFFECTS, DRIVES, AND FANTASIES

An important element of change, which is initially facilitative but eventually is also definitive, occurs as the patient progressively achieves access to deeper, more direct and basic awareness of affects, drives, and the previously unconscious fantasies by which they are experienced and expressed. This change results from repeated exposure to initially "dangerous" psychic experiences that for the patient are threatening and against which multiple automatic and unconscious adaptive and defensive functions have been directed. The patient repeatedly recognizes such mental contents and finds through his own experience that he can allow such feelings and fantasies into consciousness and yet retain control access to action. He consolidates confidence in the difference between expression in verbal form and destructive or dangerous activity, and progressively the awareness and experience of affects and drives become less dangerous and threatening.

An important element in this process is the patient's observation of the analyst and his comfort with such phenomena, his willingness to discuss and try to understand them in verbal form, his implied faith in the patient's capacities for control, and his suspension of moralizing judgment and punishment for such impulses and fantasies. Thus, once again by maintaining an analytic position, the analyst also serves as an important model for identification by the patient in regard to ego and superego functions related to such psychic processes.

Repeatedly at times of intense hostile or sadistic transference fantasies, Mr. G would remark with amazement at the "strange" situation that I was not attacking him or did not seem afraid of his aggression. "If you are not afraid of it, then I guess I don't have to be either."

Prior to the fourth summer vacation, the patient elaborated on his anger, bitterness, and anxiety that I was leaving him, but in spite of my interpretations he manifested multiple denials and other defenses against the experience of sadness. Finally, just prior to the separation, he was able to experience the genuine depth of his sadness, indicating, "This analysis means more to me than anything I have ever done. My whole future is invested in this. But even if you don't care about me I want you to know that I love you and I'm not afraid of saying it or feeling it anymore. I really will miss you!" In the transference regression the patient was finally able again to get in touch with previously denied feelings of love, warmth, and attachment; and in the new experience at the regressive level he could now feel and express them directly without needing his previously rigidly used character defenses.

Early in the analysis when affective experiences would occur, Mr. G responded with intense anxiety, fears of being dangerously overwhelmed, and fantasies of running amok and being the destructive and impulse-ridden "bad seed" whom his family had always accused him of being. This entire sequence was condensed in his expression that, "Something from deep within me is coming out, and it feels like a shark." Toward the end of the analysis when the same phenomena would occur, he would experience it with curiosity and comfort, saying, "What once was a shark has now become a dolphin."

In this repeated spiraling process the patient experiences the "dangerous situation" in fantasy, accompanied by signal or neurotic anxiety or other affects, and leading initially to characteristic, unconscious, adaptive, or defensive operations. The analyst and analytic process encourage him to suspend these defensive operations, to undergo further intensification and direct experience of the earlier danger situations and fantasies, and to tolerate for progressively longer intervals the anxiety that accompanies them. This leads to an improved capacity for mastery of the anxiety and also simultaneously for better perception of the difference between thought and action. The final effect is an enhanced confidence for and control of those stimuli that still evoke the signal of anxiety, a decrease in the number of such stimuli and situations, and a substitution of conscious for previously unconscious adaptive mechanisms and functions. These changes in ego functions also are accompanied by reeducation of the superego and the ego-ideal, inasmuch as the person is now capable of tolerating, without undue guilt or shame and as part of his own image of himself, elements that were previously threatening, unacceptable, or intolerable.
THE USES OF INSIGHT

One of the results of the analytic process is that the patient achieves a new level of personal insight and understanding in regard to himself, his history and traumatic experiences, and his repetition in the present of now outmoded and no longer age-appropriate fantasies and interactions with earlier key people. A discussion of the pathogenic importance of primitive, unconscious, and intrapsychic fantasy systems is beyond the scope of this presentation (see Arlow*), but the insight that is acquired includes the detailed elaboration of the origins and varying forms of the pathogenic fantasies, their organization, and their effects.

Insight by itself, however, does not produce change. It is how the patient applies and uses that insight to modify and resolve preexisting conflicts that determines whether change will occur. But the acquisition of insight now permits the patient, from the standpoint of adult reality testing, to expose the details of the specifically pathogenic unconscious fantasy systems to the corrective influence of adult reality testing, thereby gradually changing the preexisting fantasy to a relatively harmless memory and removing its pathogenic effects.

For example, the G recovered a series of exquisitely painful and humiliating memories of primal scene experiences that had occurred during his first three years when he slept in his parents' bedroom. The typical fantasy systems evoked by these experiences included sadomasochistic interpretations of sexuality; narcissistic humiliation of himself as inadequate to gratify the mother; her preference of the father on the basis of the boy's phallic inadequacy; the image of the father pleasurably proclaiming his superiority and threatening to castrate the son for his sexual arousal, curiosity, and desires to participate; and wishes for revenge on both parents.

As the patient gained insight into the nature of these fantasies and the situation that had evoked them he could subject his regressive experience of them to current reality testing. He could now more appropriately understand the meanings of the experiences he had been unable to objectify as a young child, thus reducing their pathogenic impact and allowing belated reexperience and mastery of a previously unintegrated and unresolved developmental crisis.

Even his move from the parental bedroom at the time of the birth of his younger brother, which previously had been to him another sign of his being "the bad seed whom nobody wants," could now be perceived and integrated in a new and less narcissistically damaging way.

Throughout this process, the fantasies that had contributed to the pathogenic organization were dissolved so that the experiences eventually were looked at from a more objective perspective as serious and at one time traumatic memories, but which now no longer need influence him in his perceptions of himself or of his relationships with men and with women. In this way, insight eventually led to a dissolution of the pathogenic fantasy systems, allowing the experience ultimately to be retained as a conscious memory but one that no longer evoked pathologic affective or drive elements.

These vignettes illustrate how in the psychoanalytic situation the patient has an opportunity regressedly to relive some of the developmental crises that he was unable to resolve successfully as a child. In doing so this time he now has available various adult mental functions that have developed since the original crisis. He has insight and awareness regarding his previously unconscious pathogenic mental processes. He also has the empathic support, guid-

ANCE, control, constancy, and attitude of the analyst and does not have to cope with the perceived danger situations alone. In spite of transference expectations of conflict, this time the environment (analytic situation and analyst) is an understanding participant in the achievement of resolution and mastery.

TERMINATION AND RENUNCIATION

One of the major definitive processes leading to cure is the resolution of the transference neurosis that occurs during the termination phase of the analysis. The analytic process deliberately has activated a set of experiences within the patient, leading to the investment in the analyst and the analytic situation of the regressive infantile and early childhood wishes, yearnings, object choices, hopes and fantasies of fulfillment, as well as the various reactions of pain, disappointment, and aggression at the frustrations involved. Before analysis and during the earlier phases of the treatment, these wishes, fantasies, and yearnings as well as the frustrations were accompanied by conflict, anxiety, guilt, shame, inhibition, and defense. In the termination phase resistances against experiencing the transference reactions have been reduced substantially, and the patient is more fully aware of their naked intensity.

In the termination phase of the transference neurosis the analyst now simultaneously represents the original infantile and early childhood objects and the yearnings for satisfaction in those relationships; the objects of transference frustration as well as aggressive and destructive wishes and impulses; the newly experienced regressive object in relationship to whom the patient has more successfully relived some of the major developmental conflicts and phases; the professional therapist with whom the mature elements of the patient's personality have cooperated in the therapeutic venture; and the newly internalized object with whom both the regressive and mature components of the patient's personality have undergone a variety of new and unique experiences.

All of these elements of the relationship must be voluntarily modified and/or renounced by the patient if a final cure of the underlying neurosis is to occur. In the typical process of grief, mourning, and renunciation that occurs in regard to the analyst and the analytic relationship during termination, the patient simultaneously is renouncing claims on the original objects and the relationships that they represented.

By giving up claims to and yearning for the fulfillment of libidinal and aggressive infantile and childhood strivings and the objects to which they are attached, the patient undergoes a major psychic maturation. The impulses and yearnings then may be modified in keeping with the patient's developing adult status and currently available age-appropriate objects and activities, now enabling him to express drives and affects in realistically satisfying and conflict-free forms.

While the original infantile and early childhood fantasies, yearnings, and wishes are never fully renounced and persist in even the healthiest persons, their intensity and peremptoriness are reduced substantially. A controlled access to the basic core of the person's psychic life now can occur, enabling freer, less conflicted, and ultimately more realistically fulfilling forms of satisfaction of basic human needs. It is these processes of maturation that represent the ultimate definitive phenomena of change and cure in psychoanalysis. These maturational processes of renunciation and reorganization, which reach their greatest intensity during the termination phase, are the final common expression and effect of all the earlier facilitative and definitive

94 Arch Gen Psychiatry—Vol 40, Jan 1983

Psychoanalysis—DeWald
The perseverative elements of the psychoanalytic process.

Early in the termination phase Mr G recovered a series of memories as a young boy when he had taken naps with his depressed mother who permitted him to touch her everywhere "except in her vagina." The mother had apparently paid little attention while the patient had enjoyed the sensual quality of the experience. "I loved it and hated it, but I'm part of it and it's in me." Increasingly he realized that he had to make a choice between keeping the sensual intimacy with his mother and the partial symbiosis it entailed, or giving it up to establish a sense of excellence, performance, and pride in himself with others. His experience with me in the transference was that, "day after day I try and put in effort to cure you, but it just isn't working and I can't understand why." For a long time he thought that if he tried harder and in a more sustained way he might reverse the disease, but gradually in the newly experienced relationship he felt a new sense of independence, and that my well-being or my difficulties were not his fault. He could see himself as all right without being responsible for me as the depressed woman, and that it would not help for him to dictate a response from me of being grateful and aware of his sacrifices.

In the process of grief and mourning of the termination phase, he became increasingly aware of the intensity of his yearnings to experience fulfillment of his core fantasies, and to be rewarded for the sacrifices he had made in his life. His behavior typically oscillated between progressive function, pleasure and awareness, and regressive yearnings "not to grow up." He recognized that, "Tommy has to die in order that Tom can begin to live."

Realization that there would be no apology, no reversal of the original "family verdict," thus no revenge for past humiliations and sacrifices, and that no matter what happened his childhood and adolescence were over, led to intense experiences of bitter rage. Renunciation of the wishes for revenge at my not having satisfied his childhood fantasies or having made him into a "perfect person" was painful and disappointing to him, and yet occurred gradually, accompanied by increasing freedom from his neurotic patterns.

INTEGRATION OF THE PROCESS ELEMENTS

My thesis has been that an evolving process of interaction occurs between patient and analyst in which each is responsive to input from the other. Some of the analyst's input is expressed in the handling and structuring of the analytic situation in regard to such variables as time, money, absences, vacations, and office furnishings; some input is related to observable personal idiosyncrasies and personality characteristics of the analyst.

Even more importantly, however, there are also major interpersonal processes that occur as the result of the analyst's therapeutically appropriate responses to the patient's experience and expression of the regressive transference neurosis. What are transferred and experienced toward the analyst are the multiple fantasies, drives, superego expectations, regressive ego perceptions, and adaptive or defensive ego functions, all reflecting intrapsychic processes originating in the patient's infancy and early childhood. At the regressive level what is new and real and experienced interpersonally by the patient (and hence is not a transference) are the analyst's responses to the patient's transferences, as described in the body of this report.

Such interpersonal experiences must be included as important foreground phenomena if our understanding of the processes of change in psychoanalysis is to be enhanced.

One may wonder why some of the elements in this report have not been emphasized more extensively previously in discussions of the analytic process and the process of cure. Phenomena similar to the ones I have described are repeated in every analysis.

It is my speculation that because psychoanalysis has been criticized so pervasively for so long as "nonscientific," and because many of its practitioners have remained defensive in this regard, anything that involves humanistic and interpersonal influences may seem contrary to measurable concepts of "hard science." Thus the previous emphasis on insight, interpretation, and the cognitive components of the analytic process may have seemed more "scientific."

C. Settage, MD, (oral communication, May 8, 1961) also has suggested that there may be a fear among analysts that the elements I have emphasized could be interpreted by colleagues as "transference gratification," and thus as "nonanalytic." My point is that precisely because the analyst maintains an analytic posture, which includes optimal transference abstinence, the process of cure as I described it is initiated. Maintaining transference abstinence is necessary to sustain that curative process, and the type of interpersonal experiences I have described result from the analyst's abstinence, interpretative, and nonjudgmental stance. Transference gratification, manipulation, or affective self-exposure by the analyst serve to delay or interfere with the ultimate renunciation and reorganization that constitute cure.

SUMMARY

Gill has indicated that "the very existence of the analytic situation provides the patient with innumerable cues which inevitably become his rationale for his transference responses. In other words, the current situation cannot be made to disappear—that is, the analytic situation is real."

That reality inevitably adds an interpersonal relationship and series of responses as part of the analytic process, along with the more purely intrapsychic and transference-countertransference components.

REFERENCES