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The Existential Dimension to Termination

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In this essay I set out to examine Freud's views on termination, which he summarized in his lengthiest paper on technique, "Analysis Terminable and Interminable." Freud's thoughts about the termination of analysis were both ambiguous and complex. He was less concerned with the practical problems that are entailed in bringing analysis to an end than he was with the inherent dilemma that termination, by its nature, introduces into the treatment situation. By the time this seminal paper was written (two years before his death) Freud believed that interminable analyses are invariably the product of the patient's death drive, a concept that then held center stage in Freud's thoughts about the nature of the patient's resistance to therapy. Indeed, the greatest single obstacle to successful termination is the patient's resistance to life itself. This aspect of Freud's thinking suggests an inherently existential dimension to his understanding of the analytic experience, a dimension that says as much about the human condition as it does the limitations of treatment. Though many psychoanalysts are

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uncomfortable with this development in Freud's later work—indeed, most have rejected it outright—I argue that it is implied from the beginning of Freud's conception of psychoanalysis and informs a central feature of its curative power.

Psychoanalysis, Terminable—or Impossible?

Freud's "Analysis Terminable and Interminable" **(1937a)** was his final effort to review the efficacy of analytic treatment and its limitations. Though it is frequently characterized as his last paper on the subject of *technique*, it is essentially a theoretical effort. (It was actually his next to last paper; "Constructions in Analysis" **[1937b]** was published a few months later.) Those who turn to this paper seeking practical advice on the art of termination are invariably disappointed. Freud says very little about termination itself. Instead, he seeks to review the aims of psychoanalysis and the obstacles that lie in their path. In choosing this manner of addressing such a pivotal question, the paper is surely one of his most subtle, and consequently, difficult to understand. Freud's command of the subject is even more remarkable when we recall that he was in his eighties when he wrote it, suffering miserably from the cancer that was consuming his body and finally killed him two years later. His powers of perception and communication appear to have suffered not in the slightest, in spite of his condition and advanced age.

It was in this paper that Freud offered his notorious allusion to psychoanalysis, along with politics and education, as one of those "impossible professions." In fact, the degree to which psychoanalysis is at all possible is the principal question that concerned Freud throughout this paper. He acknowledged that analysis is a lengthy affair. Consequently, considerable effort has gone into finding ways of limiting its duration. Many of these efforts, however—such as Rank's attempt to reduce analysis to a simple form of "trauma therapy" (Freud, **1937a**, p.

216)—have only succeeded in rendering versions of psychoanalysis that are less effective in the long run. Freud attributed the seemingly needless prolongation of analytic treatment to the patients' own resistances to change, resistances which are frequently confused with the pathological suffering they occasion. If only they could be made to abandon their resistances the duration of treatment might be shortened accordingly. Freud actually offered a device for especially intractable cases, which he used in his analysis of the Wolf Man. Simply announce a termination date—perhaps one year in the future—and thereby compel the patient to accept that he has a limited amount of time in order to resolve his neurosis. Whatever momentary gratification he may enjoy from his relationship with the analyst will become threatened, and the reality of his situation will be brought home to him. Though this stratagem appeared to have succeeded at the time, Freud admits that ultimately it failed. Some years later his former patient suffered a relapse and resumed treatment. The Wolf Man became the most famous of psychoanalysis' "interminable" patients, never having achieved the hoped-for gains from his analyses with Freud and his subsequent analyst, Ruth Mack Brunswick.

Attachment to one's analyst is only one type of resistance that may complicate the termination of treatment. Many of these obstacles seem impossible to influence. Freud even asks: "Is there such a thing as a natural end to an analysis—is there any possibility at all of bringing an analysis to such an end?" (p. 219). What does it mean to bring an analysis to an end? What do we expect to have happened because of it? Practically speaking, analysis has ended when the two participants cease meeting. Freud proposes, however, that two conditions should have been met before agreeing to terminate:

> *[F]irst, that the patient shall no longer be suffering from his symptoms and shall have overcome his anxieties and his inhibitions; and secondly, that the analyst shall judge that so much repressed mterial has been made conscious,*

so much that was unintelligible has been explained, and so much internal resistance conquered, that there is no need to fear a repetition of the pathological processes concerned [p. 219].

Freud's characterization of the optimally completed analysis, though ambitious, includes qualifications. He limits its criteria to the specific symptoms that patients happen to possess at the time of treatment, and the specific anxieties they know they are suffering. Further, he limits the amount of unconscious material that should be made conscious—the quota of truths that are disclosed during analysis—to the specific pathological processes that happen to arise during treatment. This apparently ambitious characterization of a "completed" analysis (note that the word *cure* wasn't invoked), sounds somewhat less ambitious when contrasted with Freud's description of an even more ambitious one:

[One in which] the analyst has had such a far-reaching influence on the patient that no further change could be expected to take place in him if his analysis were continued. It is as though it were possible by means of analysis to attain to a level of absolute psychical normality—a level, moreover, which we could feel confident would be able to remain stable [pp. 219-220].

Do such achievements ever actually occur? Freud believed that they do. Since they are rare, however, they can hardly serve as the standard that one may apply to every treatment. In fact, even the more modest standard for termination is difficult to realize. Why? Freud suggests that in the (relatively) successful treatments, a number of conditions need to be met, which are determined by the etiology of the neurosis that is being treated. The etiology of every neurosis rests on three factors: (1) the strength of the instincts; (2) the effects of early trauma; and (3) the relative strength of the patient's ego. The

implications of Freud's triadic formula run through the entirety of this paper—just as their effects are felt throughout the length of treatment, and, in significant ways, determine its outcome.

If the child's instincts are too strong (which is to say, if the force of his need to obtain gratification exceeds his grasp), then his ego (his ability to bear frustration) will be overwhelmed. He will erect defenses against his anxieties which may inhibit the development of his personality and compromise his ability to both perceive and accommodate reality. On the other hand, the child's instincts may not be the problem. Instead, a traumatic event in his or her environment—in relationships with parents, for example—may overwhelm the child's ability to accommodate the frustrations encountered. Consequently, that child will erect defenses to ward off the anxieties brought about by reality. Significantly, the traumatic etiology of neurosis is, in Freud's opinion, infinitely more treatable than the constitutional (i.e., instinctual) ones.

Freud's reasoning isn't hard to fathom. If one's patients are dealing with the effects of their environment and the ways they customarily cope with it, psychoanalysis can help them discover the traumatic (i.e., disappointing) events in their history that they have never learned to accept. The patients' ego (which in this context entails the capacity to accommodate reality) should be capable of investigating the nature of their suffering, and they should be able to learn to value the eventual benefits of this new understanding. But if their neurotic conflicts derive from excessive demands for gratification, all that they are bound to discover as a consequence of being analyzed is that they are excessively demanding. This is a hard pill to swallow, and a truth that many patients may be no more prepared to accept about themselves as adults than they were as children. In effect, they still are children, coping with the same problems and the same complaints. It is this type of etiological history that was bound to further compromise and alter the patient's ego as a child, prompting him or her to develop a

habitual pattern of defensiveness whose purpose was, and still is, to reject those realities that arouse uncomfortable levels of frustration. While the so-called traumatic forms of neurosis are more suited to a successful termination of treatment, those which derive from a predominantly constitutional etiology—and all neuroses, as we know, contain elements of both—are more likely to prove "interminable." This isn't to say, however, that an "altered ego"—whose perception of reality is excessively compromised due to the prevalence of his or her defenses against it—is always due to the strength of that person's "instincts" (i.e., the desire for gratification). There is a predilection in some to defend themselves against reality irrespective of etiological factors. Perhaps this factor, too, has an etiology of its own. It may be a question of personality or even conditioning. We do not know. But this question prompts Freud to introduce an element of ambiguity into every analysis that I am inclined to call "existential." It is an element that cannot be foretold or easily explained. It seems that some patients are simply more amenable to the effects of analytic treatment. Freud offers two examples of how this constellation of forces conspires to determine the outcome of treatment and its aftermath.

The first example pertains to Freud's analysis of Ferenczi (Freud, **1937a**, p. 221*n*). The treatment was rather brief yet ended successfully. Ferenczi resolved some previously chronic issues concerning his rivalry with men and he subsequently married and went on to maintain a close collegial relationship with Freud. But years later, for no apparent reason, he developed feelings of aggression for his former mentor and even accused Freud of not having given him a thorough analysis. He charged that Freud failed to analyze his negative transference which, Ferenczi believed, was only now emerging (Freud, **1937a**, pp. 221-222).

But Freud refused to accept his former patient's argument, for two reasons. First of all, the negative transference hadn't emerged of its own accord during the treatment, so how was

he to analyze something that didn't exist? Should he have contrived to force his patient's negative feelings to the surface, and how was he to presume that they existed in the first place? Anyhow, now that they had arisen, why did Ferenczi not analyze them himself? Why blame Freud for not having unearthed them sooner? After all, he was now claiming that these feelings were *transferential* so, by definition, he was proposing that they didn't concern Freud at all but a figure in his childhood.

His second reason for rejecting Ferenczi's argument derives from the insinuation that his former patient's feelings for his analyst during the treatment were exclusively transferential. We know that Ferenczi went on to develop a conception of countertransference that was significantly at odds with Freud's; one in which the analyst assumes enormous responsibility for the outcome of treatment. Ferenczi suggested that Freud's countertransference feelings prevented him from exploring his (Ferenczi's) latent hostility. But Freud rejected this argument—a pivotal one in terms of contemporary analytic practice—by reminding us that every analysis also occasions real feelings that the participants experience for each other, as well as the transferential. His affection for Ferenczi had been genuine, as had been his former patient's for him. It would seem that Ferenczi's belated conviction that his analysis had failed to free him of sentiments he was now experiencing was due to his being predisposed to them, rather than being the fault of his former analyst, or even of the analysis itself. There was no way of predicting this would happen and, now that it had, there was apparently no reasoning with Ferenczi to view it differently. This is an example of an "alteration in one's ego" that now assumes a life of its own prompted, perhaps, by latent instinctual urges. This "conviction" became a central feature of Ferenczi's analytic theories, and his personality as well.

Freud contrasts this example with another, one which would seem to be its opposite, but similar to the first. He treated a woman who had suffered from hysterical symptoms since puberty, making it difficult for her to walk. After nine months

of treatment her symptoms disappeared and this woman, “an excellent and worthy person,” resumed her life. But she was subsequently beset with a number of disastrous difficulties over which she had no direct control. Financial losses and family misfortunes prevented her from achieving the happiness she had hoped for. Unmarried, she grew older realizing that her chances at love were slipping away. Years later, she required a hysterectomy and, desperate, fell in love with her surgeon. Frustrated, she withdrew into neurotic, masochistic fantasies but was unable to resume her analysis. She died a broken woman. Freud had no way of knowing if her subsequent neurosis was somehow related to the original one or independent of it. But he was convinced that had it not been for the innumerable traumas she suffered in the years that followed her analysis, it is doubtful that her second neurosis would have ever developed.

In the first example, there was no hint of subsequent traumas that might have explained Ferenczi's change in personality. His hostility was due to an inherent feature of his personality rather than the circumstances in his life. He was eventually overwhelmed by latent constitutional factors which his ego was unable to accommodate or understand. In the second case, Freud's former patient had been subjected to one trauma after another that, collectively, were simply more than her ego could be expected to endure.

Freud conjectured that the skeptic, the optimist, and the ambitious person would each derive a different lesson from these two examples. The skeptic will conclude that no matter how successfully an analysis is conducted, nothing can insure against subsequent outbreaks of symptoms. The optimistic and ambitious analysts look forward to the day when psychoanalysis will evolve into a more effective form of treatment that will guard against the kinds of subsequent recurrences that Freud outlined above. Freud questions the optimist's ambition—a sign of therapeutic ambition?—and challenges the presumption that neurosis, like medical illness, can be isolated and treated in such

a way that it can be eradicated. After all, if neuroses—in fact, all forms of psychopathology—are the consequence of self-deception, prompted by our unwillingness to accommodate harsh truths, then how could any form of treatment possibly inoculate us from future tragedies that we are helpless to prevent? If each of us has our limit to what we can bear before defending ourselves from pain, how can we determine what those limits are until we encounter them? Unlike military training, psychoanalysis does not contrive to create miserable conditions in order to strengthen our resolve against artificially imposed frustrations. It can only give us the opportunity to examine the life we are already living.

This prompted Strachey to infer that Freud's views about the potential effectiveness of psychoanalysis changed over the years. Strachey suggests that, "according to the earlier view the analytic process seems to have been considered as capable of altering the ego in a more *general* sense and one which would persist after the end of the analysis" (see Strachey's Introduction, in Freud, **1937a**, p. 214); whereas now Freud seems to be saying that analysis is incapable "of dealing with a conflict that is not 'current' and of … converting a 'latent' conflict into a 'current' one" (p. 214). While this is probably true, this maturing of Freud's position does not necessarily comprise a shift or alteration in his views. It is consistent with his thoughts about the nature of analytic truth and our resistances to it. While our capacity to become truthful generally bolsters our efforts to remain truthful, our resolve to be truthful depends on the circumstances—in reality as well as in ourselves—each of us comes to encounter in the course of our lives. Fate plays as decisive a role in our capacities as our inclinations.

This is the point, perhaps, where the conception and terminology of Freud's recently imposed structural model begin to challenge the subtlety of his thinking. In a recent study Arlow chastises Freud for still referring to the abandoned topographical model while speaking from a frame of reference in which it has been replaced with the structural, so that "the two frames

of reference are used side by side, sometimes in a contradictory fashion" (Arlow, **1991**, p. 44). Indeed, discussing his views in terms of a newer model of the mind begs the question of whether Freud's views have changed or merely the terms that describe them. Freud raises the notion of an antithesis between the individual's instinctual urges and his ego—between the so-called primary and secondary processes—repeatedly throughout this paper. Each time he addresses this issue the question of constitutional (i.e., congenital) factors in the etiology of neuroses arises. We customarily depict the constitutional factor as that which we are born with, but Freud corrects this common misunderstanding:

> *However true it may be that the constitutional factor is of decisive importance from the very beginning, it is nevertheless conceivable that a reinforcement of instinct coming later in life might produce the same effects. If so, we should have to modify our formula and say "the strength of the instincts at the time" instead of "the constitutional strength of the instincts" [**1937a**, p. 224].*

What are the implications of this qualification? For one thing, it replaces the notion of constitutional factors as those that are exclusively historical or developmental in nature with one that is specifically dynamic, even ontological. All of us struggle with our instincts—our emotions, our passion, our fears, our will to live, our resolve—at all times, at each moment of our lives. The outcome of our conflicts and the struggles they occasion aren't predetermined for us. We come to favor certain affects over others. The strength of those instincts (our desire) works for us and against us, depending on the situation. The structural model was intended to show how a "strengthened ego" is capable of surmounting the demands of passions whose satisfaction has become impossible. This newer understanding was supposed to help us conceptualize the ambiguous nature of the ego whose strength lies in its ability to accept

reality, whereas its weakness is its resolve to deny it. When we say that the aim of analysis is to "strengthen the ego," we are talking about a person's willingness to face an unwelcome truth about the aims his instincts compel him to placate. That is because the neurotic's weakened ego is incapable of listening to reason. He is unable to reflect on what's causing his frustrations or understand the interpretations being offered. Freud even suggested that this quantitative factor in psychoanalysis—the brute *force* of one's quest for gratification—was being neglected by his followers. This (sometimes immovable) force often explains the insurmountable obstacles to a successful termination. It may compromise one's capacity for accepting a disappointing reality and even for maintaining an honest relationship (an analytic attitude) with one's analyst. This form of analytic failure, however, isn't a failure of technique or even of analysis. It is simply the arbitrary limit of a given individual's capacity to accept the anguished nature of that person's existence.

Why are analysts nowadays more likely to attribute analytic failures to erroneous technique than to the limitations of the patient being analyzed? Why, in turn, are Freud's remarks and his rather sober tone in this paper commonly rejected as pessimistic? Has psychoanalysis really advanced that much? Or are we still struggling with the same questions and the same limitations? The call for more effective and ambitious efforts to succeed with analytic patients where others have failed isn't new. Freud questioned these sentiments and argued against them in this paper. In a tone that is evocative of the technical papers he wrote between 1911 and 1915, Freud still pleads against the therapeutic ambition he believed to be so detrimental to the efficacy of the treatment. The call to interpret more cleverly, to analyze resistances more astutely, and even to prolong the duration of analysis more interminably are all rejected by Freud because, "however much our therapeutic ambition may be tempted to undertake such tasks, experience flatly rejects the notion" (p. 231). Much later, Winnicott concurred that the overzealous analysis of resistances, while often technically correct,

was generally ineffectual because "the patient's False Self can collaborate indefinitely with the analyst in the analysis of defenses, being so to speak on the analyst's side in the game" (**1960**, p. 152). This is why efforts to force latent issues to the surface only succeed in turning one's patients against the analysis. Besides, why arouse a crisis in the treatment when we know that analysis is not at its best when confronted with acute, contrived or otherwise, expressions of erotism, fear, or hostility? Efforts to lance a boil that hasn't come to the surface only succeed in releasing some blood—and creating a newer injury for which the analyst himself is responsible.

If we are helpless to provoke or in any way manipulate what we are convinced (perhaps erroneously) are latent issues that haven't surfaced, then where should our efforts be inclined? We should reconcile ourselves to the surface—what each patient actually experiences in the course of his or her analysis. Perhaps, for this reason, Freud spends a lot of time exploring that factor we do have some influence over, the one concerning the "alteration in one's ego." Freud's increased reliance on the structural model inevitably compels us to find some thread that links the old model with the new. Remember how the "alteration of the ego" comprises one of the three etiological factors that accounts for neurotic conflict. Every onset of neurosis is due either to, (1) the strength of instincts having overwhelmed one's ego; (2) the factors in one's environment; or (3) the ego itself having been "weakened" so early in its development that it couldn't withstand the constitutional or traumatic forces which, under normal circumstances, it would have. Consequently, the aim of analysis is to, (1) establish a rapport with the patient's ego in order to analyze the crippling effects of his excessive instincts and traumatic injuries; and (2) strengthen the patient's ego in order to further his collaboration with his analyst's efforts to understand him. Yet, we mustn't forget that one's ego, due to its history of having combated these congenital and traumatic forces, has probably been "altered" and thus compromised in its development.

What, exactly, does the notion of a weakened ego depict? What does it mean to strengthen one's ego? What part do defenses play: do they strengthen or weaken? Finally, how is Freud's preoccupation with the nature of truth addressed in this newer, more structural, terminology? Does it vanish altogether in favor of adaptational concerns, or does it persist, but in metapsychological clothing? A weakened, or altered, ego is the consequence of a time when children, unable to accept their frustration, opt to repress the wish that caused their frustration in the first place. Because of repression, they are able to accommodate reality but do not, strictly speaking, *accept* it since, in order to live with what they cannot have, they have to pretend it no longer matters to them. In turn, the circumstances that elicited repression need to be altered too, in order not to notice that something was repressed (pp. 236-237). These alterations—actually, obfuscations—of the child's perception of reality compromise his or her capacity to perceive the real situation and accept it. This is because, in order to comply with something, even when we have no choice, we must see it for what it is. The tendency to compromise one's perception of a frustrating reality is how Freud defines an "alteration of the ego."

Thus the ego is inherently ambiguous and serves a complex purpose. It has to perceive reality in order to understand the context that may or may not complement its aims. But if the reality it perceives is unbearable, the ego is able to lie to itself while concealing the desires that were frustrated. This compromises the ego even more. It becomes paralyzed. It can neither service its desires nor abandon them, and so instead it resorts to phantasy. In its weakened state, it becomes defensive. It is less able to tolerate reality. (Freud believed that the neurotic is more prone to repressing the wishes that are in conflict with reality, whereas the psychotic is more liable to distort reality itself. All neuroses and psychoses, of course, are a combination of the two.)

Novel as it first appeared, Freud's structural characterization of the ego wasn't entirely new. It conforms in significant

ways to the picture of mental functioning he proposed earlier in "Formulations on the Two Principles of Mental Functioning" **(1911)**. In that paper, as well as later in *The Ego and the Id* **(1923)**, he depicted the ego as not completely in "command" of itself. The ego, whether we like it or not, is in the service of forces it can never resolve. It is nothing more than a "submissive slave" which now tries to serve its desires, and later the realities they oppose. The ego is sometimes less concerned with determining the truth than with occupying a position somewhere "midway between the id and reality" (**1923**, p. 56), where it serves both masters, equally. Yet, by trying to please everybody, "it only too often yields to the temptation to become sycophantic, opportunistic and lying, like a politician who sees the truth but wants to keep his place in popular favor" (p. 56).

If this inherent ambivalence characterizes the fundamental nature of the ego, which feels compelled to serve truths but just as easily conceals them, then what are analysts supposed to do when they encounter these tendencies in their patients' neuroses? They need to reintroduce their patients' ego to the truths it has been hiding, and help them to recognize the distortions that subvert this process. Analysts can only hope to accomplish their task by helping their patients to, (1) see what the truth is, and (2) discover the reasons they have chosen to distort it (Freud, **1937a**, pp. 237-239). The patients' resistances to this process is conceived in terms of their incapacity to tell the truth, which corresponds to the initial "alteration of ego" when they were unable (as children) to accept the truth. A weakened ego is only weakened in proportion to one's fear of the truth, while a strengthened ego has no need to erect defenses against the truth. Eventually, however, one has to acknowledge how unwieldy Freud's structural model becomes in actual practice. The patient's ego—the *person* with whom we are engaged in this struggle—*is* the desiring subject whom his ego is attempting to serve. We would never come to terms with our truths in the first place if our egos weren't at one with our instincts. The

structural model's failure to fully explain the nature of unresolvable resistances finally prevented Freud from equating resistance with defense. Why do some analyses succeed while others fail? Can this quandry be explained by defense alone? Freud thought not. If the aim of analysis is to be less secretive by becoming more truthful, then the resistance we employ against this effort is inevitably intended to protect ourselves from realizing that aim. If we escape the treatment with our conflicts intact, we will likely face the same impasses later, perhaps long after the analysis is over. When he attributed a portion of one's resistance to the ego specifically, Freud was pointing to that aspect of ourselves that is prone to lying. We defy reality as long as we are able to get away with it. The ego's capacity to discover truths is equaled by its ability to distort them, through the defenses that serve to protect us from a reality we are fundamentally opposed to.

But there is another form of resistance that does not entirely conform to the one I have just described. In fact, it crops up in those treatments that are frequently the most interminable. Referring to them as "id resistances," Freud hoped to draw our attention to those patients who seem innately drawn to their suffering, who are so protective of their impulses and so determined to serve them, that the truth about the conflicts they are embroiled in are of secondary importance to them. In his paper on working through **(1914)**, Freud attributed the deepest layers of resistance to the strength of one's instinctual urges, to one's need for pleasure at any cost. It is as though some people are so committed to repeating their infantile dramas that all the frustration in the world will not prompt them to change, or even to question, their behavior. The resistance to change is so deeply entrenched they are resigned to it. Some analysts mistakenly depict these resistances as ego defenses. Freud, however, reminds us that we should "not overlook the fact that id and ego are originally one" (**1937a**, p. 240). In other words, the more we become acquainted with our patients' resistances the more we begin to realize that we are witnessing

their resistance to the movement and revelation of their own existence, no matter how much their defensiveness costs them. The so-called id resistance does not refer to repression of instinct so much as a willfulness at the depths of one's being, seemingly employed to act against one's self-interest.

Some resistances are derived from innate, deep-seated aims instead of the circumstances in the environment that may occasion traumatic injury. Many patients find change particularly difficult because their libido (desire) is "adhesive" and resistant to any change whatsoever. Others change—displace their libido—rather easily, but so easily there is no stability to their lives. Positive cathexes evaporate as easily as problematic ones. None of these forms of resistance is adequately explained by the term *defense mechanism*. They seem to have a life of their own. These considerations prompted Freud to hypothesize the existence of a negative therapeutic reaction which he originally outlined in *The Ego and the Id* (**1923**, p. 49) and, later, in "The Economic Problem of Masochism" **(1924)**. In fact, Freud's skepticism about the possibility of change with "interminable" patients can be laid at the doorstep of this descriptive term. In *The Ego and the Id*, Freud describes such patients thus:

> *There are certain people who behave in a quite peculiar fashion during the work of analysis.... they show signs of discontent and their condition invariably becomes worse. One begins by regarding this as defiance ... but later one comes to take a deeper and juster view.... Every partial solution that ought to result ... in an improvement ... produces in them for the time being an exacerbation of their illness; they get worse during the treatment instead of getting better [**1923**, p. 49].*

Paradoxically, such patients appear to get worse, not because of the treatment itself but due to their attachment to their suffering. Freud was at a loss to explain why this is so, but his view that such patients exist, and that lack of progress was their

responsibility, not the analyst's, is consistent with a conception of the human condition that is more existential than medical. This partly accounts for the argument between Freud's detractors, who characterize his clinical views as primitive or outdated, and Freud himself who accuses his critics of falling prey to therapeutic ambition. Why should so many patients stay chained to their suffering when a means is available to get rid of it? Freud turned to his theories on guilt and moral masochism as a possible explanation. In "The Economic Problem of Masochism," Freud suggested that

> *The satisfaction of this unconscious sense of guilt is perhaps the most powerful bastion of the subject's (usually composite) gain from illness—in the sum of forces which struggle against his recovery and refuse to surrender his state of illness. The suffering entailed by neuroses is precisely the factor that makes them valuable to the masochistic trend [**1924**, p. 166; emphasis added].*

Freud became increasingly dubious, however, about the proposition that masochism and unconscious guilt could be justified in terms of *pleasurable* gain. His hypothesis of a death drive—which he returns to in this paper—suggests a parallel drive, in addition to erotism, which competes with pleasure for relief from anxiety. One of the features of Freud's hypothesis—wedded, to some extent, to a biological foundation—is the *anticipation* of a pleasurable gain. Some of the most intractable forms of phantasy, for example, which arise in the erotic transference, include the anticipation of the analyst's capitulation. Some patients receive so much gratification from their wish that the analysis fails to resolve the resistance. Guilt may also offer a deep-seated form of satisfaction that is derived from self-punishment. It may be sufficiently powerful to undermine the potential gains from treatment. The notion of self-punishment, moreover, doesn't necessarily mean that these alternative

gains are entirely devoid of pleasure. Perhaps Freud's hypothesis of a death drive simply depicts a kind of pleasure, wedded to a release of aggression, that is directed against life itself. What sweeter victory of narcissistic omnipotence than one which might finally overcome life's exasperating toll of defeat and capitulation? The notion of a negative therapeutic reaction might explain the ostensibly incomprehensible behavior of those patients who seem to derive more comfort from resisting the treatment than submitting to it.

Freud's conception of a death drive is still controversial. It stands out amongst his later theories as having been almost universally rejected. The idea that each of us contains an innate impulse toward self-destructiveness is antithetical to the sensibilities of those analysts—the vast majority of them—who prefer to see human nature in terms that imply a fundamental resolve to perpetuate one's existence. But the commonplace rejection of the death instinct can also be attributed to the increasing loss of favor with Freud's instinctual theory. In Britain virtually all the object relations theorists have either rejected Freud's drive model outright (**Fairbairn, 1952**; **Guntrip, 1968**) or altered it so drastically that its original impetus barely survives **(Winnicott, 1960)**. Even Melanie Klein, alone in her adoption of Freud's death drive model, came to favor the language of object relations and primitive defenses in her late work **(1957)**. In America, those analysts who defend Freud's drive model, following Hartmann **(1958)**, have replaced Freud's notion of a primary self-destructive instinct with an aggressive one which is directed at an object outside oneself. The idea that humans engage in self-destructive behavior, simply for the sake of their destruction, is summarily rejected. Instead, they retain a version of Freud's earlier theory where he attributed masochistic behavior to a secondary aim which was principally directed against someone else. Many aspects of spiteful and suicidal behavior can be attributed to a form of aggression which is turned inwards as a roundabout means of attacking an external object.

Freud eventually became convinced, however, that the pleasure principle could not explain all forms of self-destructiveness. One example of what he was driving at is the negative therapeutic reaction. How could psychopathology—presumably a form of suffering—be rooted in the same pursuit of pleasure that serves as the model for psychic health? If the concept of pathology is going to make any sense, shouldn't it be rooted in suffering itself? Prior to introducing the death drive Freud had attributed moral masochism to the effects of unconscious guilt. Self-punishment appeases the guilt we feel for hating the person we love. A principal feature of the Rat Man's obsessional neurosis was his guilt for hating his father. Once the source of his guilt was acknowledged, it disappeared. This explanation, however, eventually lost favor on theoretical grounds. The persistence of resistances to treatment persuaded Freud that a revision in his drive theory was inevitable. Others began to question even the validity of the drive model **(Fairbairn, 1952)**. Freud acknowledged that self-destructiveness could not always be explained by the term *gain from illness*. Yet, something appeared to drive some patients to prolong their suffering inexorably, something that cannot simply be reduced to defenses against anxiety.

Alongside our innate lust for life and its consequent pursuit of gratification, Freud conjectured a parallel drive which strives to actually eliminate suffering entirely. This idea was vaguely hinted at earlier in Freud's conception of a pleasure principle whose goal is to satisfy desire. Theoretically, the satisfaction of a desire would virtually eliminate it, but in practice, this is only partial and temporary. Because of this paradox, Freud reluctantly revised his pleasure model. Now pleasure is no longer juxtaposed with reality. Instead, life (Eros)—which now includes the sexual function—is juxtaposed with death (Thanatos), whose aim is avoiding strife. The consequences of this reformulation are remarkable. For one thing, Freud's conception of sexuality—long criticized by other schools of analysis for being too narrow—becomes subsumed under the life drive,

which alters his earlier conception of love. Sexuality now serves love instead of the other way around. Freud's conception of pleasure is also altered. It is no longer preoccupied with eliminating the frustrations caused by desire, but with accommodating them instead. Healthy individuals—pleasure-seeking and life-affirming—bear frustrations in the service of their aims. They no longer seek to vanquish them altogether. In fact, the optimal state of pleasure—of life—includes frustration and hardship. There's no better example of this than the higher forms of love which involve the pleasure of sacrifice and the capacity to bear suffering in deference to the person one loves. This is the kind of love, epitomized by Christian *agape*, which Freud characterized as genuine in his paper on transference love **(1915)**. The need to eradicate suffering once and for all by deadening one's experience of it is now attributed to the death drive. Hence it becomes a factor not only in pathological forms of suffering but also plays a part in our everyday preoccupation with avoiding the kind of hardships that are inherent in living.

On closer examination, is the death instinct really a drive toward death? Is it even an instinct in the sense that we usually understand this term? The answer to both of these questions is no. The common tendency to take Freud's terms too literally probably accounts for some of the opposition he encountered with this revision of the drive theory. In the first place, Freud didn't use the term *instinct* in the sense of *animal* instinct. He even referred to instincts in the *New Introductory Lectures on Psychoanalysis* as "our mythology" (**1933**, p. 95). In a recent review of Freud's instinct theory, Andre Green **(1991)** suggests that Freud's conception of drive is predominantly metaphysical. It isn't specifically rooted in conventional notions of biology (p. 136). Freud's so-called drive model, which he tried to justify with biological theories of organicity, serves to account for life's aims in terms that are actually ontological. Since Freud does

not couch these questions in spiritual or even sociological terminology, it leaves him open to the charge of advocating an exclusively biological model that neglects humanistic and intersubjective considerations. In fact, his argument in favor of a death drive is an *existential* theory. If we do not allow Freud the freedom to explore the individual's existence in relation to biology it becomes a purely psychological conception—but a psychology cut off from its roots, without a body.

This is why the word *death* in Freud's newer, more philosophical formulation should not be taken literally. When Freud was told by one of his followers that his notion of Thanatos was remarkably similar to the Buddhist conception of Nirvana—the elimination of all strife by overcoming desire—he promptly nicknamed his death instinct the Nirvana complex. This is because the aim of the death drive isn't literally death. Its goal is simply to eradicate suffering, an aim which, were it achieved, would eliminate life itself, figuratively speaking. Ironically, when this aim is employed by a neurotic conflict, it only substitutes one form of suffering for another. Short of actual death, the death drive, once it has gained ascendence, stifles our capacity to enjoy life since we are so obsessed with evading it. This is what Freud alluded to as the negative therapeutic reaction, which is a reaction against a truth that, once discerned, elicits intolerable levels of anxiety. We suffer because we desire. We either evade it or accept it as a fact of life. Analytic treatment, if it is successful, actually increases the suffering we associate with pleasure. This is paradoxical because, by trying to escape our suffering, we become more alienated from our existence. Analysis, which actually heightens our experience of suffering, may become intrusive and a new source of danger.

The End of Analysis

Is the near universal rejection of Freud's conception of a death drive due to its inherent biologism, or because of the profoundly existential dimension to the questions it compels us

to ponder? This remarkable paper, wide-ranging in its scope and free-wheeling in its excesses, is essentially a reappraisal of his views about the nature of suffering. Freud emphasized the limits imposed on one's efforts to even understand what suffering is about, much less relieve it. If the aim of analytic treatment is the relief of suffering, how does one reconcile this aim with the notion of a death drive whose purpose, pathogenic to be sure, is to eliminate suffering by any means?

Since the beginning of Western thought, philosophers, physicians, and mystics have been concerned with the nature of suffering. From earliest times we have insisted on understanding what suffering is about and finding ways of erasing it, accommodating it, and accepting it. Freud, though trained as a physician, was never willing to accept the specifically medical approach to suffering, that it should be relieved by any means possible, whatever the cost. He knew, from personal experience, that life entails suffering. The patients he treated suffered miserably, yet, they seemed peculiarly intolerant of it. Since their desires caused frustration, they would suppress those desires that gave rise to suffering. How could psychoanalysis help them? Whatever one might have hoped it could do, it could not be expected to relieve the kinds of suffering that life requires when one is in pursuit of life's aims. In other words, life subjects us to suffering. Life, in turn, eases the burden of suffering with pleasure. In fact, we are only capable of pleasure in the first place because we suffer. In turn, we suffer because we value pleasure so highly we cannot exist without it. How can we come to terms with this equation, which by its nature entails frustration?

Neurotics, by definition, find this equation difficult, if not impossible, to endure. They feel, to relative degrees, that life is cheating them. They resent suffering and want to rise above it. To the degree they are successful they miss the point of life entirely. They become so preoccupied with controlling their suffering that they forget what life is about. This was the type of person Freud wanted to help, the one for whom psychoanalysis

might be used for coming to terms with life, by living it without reservation. In *Beyond the Pleasure Principle* **(1920)**, where Freud introduced the death drive, he argued that, "strictly speaking it is incorrect to talk of the dominance of the pleasure principle over the course of mental processes. If such a dominance existed, the immense majority of our mental processes would have to be accompanied by pleasure or to lead to pleasure, whereas universal experience completely contradicts any such conclusion" (**1920**, p. 9). In other words, our existence is primarily concerned with suffering. Life *is* suffering. This is the context in which the life drive (actually, *love* drive) and death drive are juxtaposed. Because we suffer, life occasions a motive force to attain the good (pleasure) and to live one's life in the service of goodness, to feel good, give it, and receive all the good we can get. We are able to feel good only because we suffer, and we suffer when the good is threatened or taken away. The anticipation of losing what is good—the experience of danger—is a major source of suffering, which Freud called "perceptual unpleasure" (p. 11). Since the life drive, *Eros*, does not relieve suffering but causes it, our only recourse to relieve the suffering life occasions is to deaden our experience of those pleasures that we associate with living.

One of the most remarkable implications of Freud's conception of the death drive is the effect it has on our understanding of anxiety. The trend in analytic theory since Freud has been to attribute anxiety to (1) fear of castration and its relation to repression, or (2) the threat of loss, giving rise to a host of ever more archaic defense mechanisms. On the other hand, the death drive imposes a new conception of danger: life itself. Since life causes anxiety, the ego is forced either to accommodate the anxiety which life occasions or protect itself against it. But because we are fundamentally divided between life and death, strife and relief, participation and withdrawal, the relative importance of "defenses" against the anxieties life imposes receded in Freud's thinking. In this new model one's ambivalence about pursuing what is pleasurable, what is good, is determined by instinctual (actually, ontological) motives, not mental

mechanisms, per se. This was why Freud's death drive model found little cheer among analysts who were drawn to the inherently psychological language of the structural model, introduced in 1923, three years after *Beyond the Pleasure Principle*. The two revisions—the death drive in 1920 and the structural model in 1923—don't quite fit. The one emphasizes drives on the level of ontology; the other emphasizes defenses on the level of psychological mechanism. Freud never attempted to fit the two models together, perhaps because they're incompatible. This is probably why analysts who welcomed the structural model and the "analysis of defense" which it fostered, rejected the death drive so readily. If, following Freud, psychoanalysis shifted its emphasis from a "psychology of mental operations" to an ontology of suffering, it would become more philosophical and less scientific; less indebted to medical and psychological sciences and more conversant with ethics and epistemology, even metaphysics. Recent preoccupations with linguistics, though informative, miss this point.

When Freud returned to the death drive in "Analysis Terminable and Interminable," written seventeen years after he introduced the concept, he knew he was virtually alone in this new way of conceptualizing the nature of suffering. Though he adopted the sobriquet Nirvana complex from Buddhism as a metaphor for his conception of Thanatos, it was a pre-Socratic Greek philosopher to whom he turned to justify this controversial theory. Like Freud, Empedocles believed that life is governed by two basic forces, love and strife, which Freud equated with Eros and destructiveness (**1937a**, pp. 245-246). But Freud wasn't acquainted with Empedocles when he first conceived of the death drive, so he couldn't have been the inspiration for Freud's revised theory. It is significant, nevertheless, that Freud turned to a philosopher to defend his views against those of his own followers, and not just any philosopher, but a Greek. We needn't look as far back as Empedocles, however, for a philosopher with whom Freud was acquainted at the time he conceived the death drive, a philosopher who, through Franz

Brentano (Vitz, **1988**, pp. 50-52), had a profound impact on his thinking as a whole: Aristotle.

One of the principal themes which preoccupied Freud in his formulation of the death drive was the nature of suffering and its relationship to the good: pleasure. In the opening sentence to the *Nicomachean Ethics*, a book with which Freud was intimately familiar, Aristotle proclaimed that: "Every art and every inquiry, and similarly every action and choice, is thought to aim at some good; and for this reason the good has rightly been declared to be that at which all things aim" (p. 1729).

And what is the "good," in Aristotle? The good was equated with the pursuit of happiness. Aristotle observed that, for most people, pleasure was the purpose of life and, consequently, the highest good. But Aristotle believed there was a higher good still, virtue; not because it served utilitarian aims, such as relief from suffering, but because virtue is its own reward. The virtuous person is happy, at least with himself, while the person who pursues only pleasures is always in danger of losing them. The highest virtue of all was honesty, the epitome of Freud's fundamental rule of psychoanalysis.

Even a casual reading of the *Nicomachean Ethics* shows the enormous debt Freud owed to Aristotle's thinking about the nature of life. In his earlier conception of the pleasure principle, Freud translated the implications of Aristotle's ethics into one fundamental, motivating force in life: the pursuit of pleasure. In turn, this motive force complemented a specifically thoughtful side to the self, the ego, which is principally preoccupied with concerns about the consequence of one's behavior. In his earlier formulation, the ego was ostensibly concerned with virtue, which was oftentimes opposed to pleasurable aims. With his introduction of the death drive, Freud finally integrated Aristotle's ethics into his (Freud's) drive model so that the pursuit of the good now *included* virtue. They were no longer opposed. While Aristotle's and Freud's formulations are not entirely interchangeable (Aristotle lacked a conception of the unconscious), Aristotle's views about the limits of pleasure

approximate an uncanny resemblance to Freud's conception of Thanatos. In turn, the cultivation of virtue is consistent with Freud's conception of Eros when it serves the highest aim of all: the love of truth.

This is why honesty is so vital to the way psychoanalysis is employed. A capacity for honesty, in fact, a *love* of honesty for its own sake, is essential for anyone who aspires to alter his or her manner of being. Freud's conception of Eros finally offered a theory of the personality which justified his technique, the basis of which was fidelity to self-revelation. The fundamental aim in life, in the face of interminable suffering, is to feel good by being good; by endeavoring to be truthful and accepting realities. Psychoanalysis may indeed relieve suffering, but only in Zenlike fashion; not by trying to suffer less, but by submitting to what life is about. This partially explains Freud's somewhat sober tone in "Analysis Terminable and Interminable." The skill of analysts is important, but only insofar as they understand the nature of their role and are comfortable with it. The rest is up to their patients and the vicissitudes of their unconscious aims.

And what if those aims endeavor to serve the negative therapeutic reaction, whose purpose, after all, is "death"? First, it is important to remember that neurotic conflict is not actually *caused* by the death drive. The neurosis is independent of it. Yet, neurotic conflict compels us to avoid the anxieties we experience when disappointed with reality. We perceive reality—life—as dangerous and withdraw into phantasy. The neurosis is comprised of a conflict between phantasy and reality. We cannot accept reality for what it is. What epitomizes the reality we are unable to accept? Basically, it comes down to feeling unloved. Consequently, we deny we need the love we feel without and twist reality accordingly. But this is untenable, because we still desire what we pretend we do not. In fact, the persistence of desire is the basis of neurotic conflict. Though we employ repression in order to ease suffering, it is because we cannot help desiring that we seek help. When this conflict

is, in turn, analyzed, the analyst meets resistance. Most of these resistances are employed against knowing and telling; against knowing the truth of one's experience and telling the analyst about it. But there is another kind of resistance that seems to come from the deepest recesses of one's being, opposed to life itself. This type of resistance is not a product of neurotic conflict specifically; it is abducted by the neurosis to insure its survival. If the weight of frustration becomes unbearable, relief from suffering itself can become a resistance to treatment and even compete with it. The death drive, always at the ready in times of hardship, becomes an agent provocateur, providing asylum from one's suffering by deadening life itself **(Thompson, 1985)**.

Toward the end of his life Freud emphasized those resistances he believed emanated from drives, from desire. Unlike the majority of analysts today, he gradually distanced himself from a preoccupation with *defense* and, technically speaking, an analysis of it. He doubted that defense mechanisms could explain the prevalence of moral masochism, unconscious guilt, and the negative therapeutic reactions that were manifested by many of the patients he treated. He suspected that many failed analyses could be attributed to a deep-seated wish to circumvent the pain of living, even at the cost of living any kind of existence at all. In effect, we withdraw from life itself. The treatment, which aims to examine our suffering, becomes an instrument of the suffering we wish to disavow. Since the intolerance of suffering cannot be diagnosed, it cannot actually be treated. This seemingly radical assessment wasn't especially new in Freud's thinking. As early as 1905, Freud believed that poor character should not be confused with psychopathology. Some people are simply "good for nothing." They haven't the capacity to bear suffering, but just because they suffer does not mean they can always be diagnosed and treated for it. Nor does the successful treatment of a neurotic conflict necessarily improve one's character, though sometimes it helps. The disposition toward self-concealment does not necessarily foster the kind of moral conflicts that psychoanalysis was intended to resolve. If

we deceive, but do not experience conflict because of it, all the analysis in the world won't impose a solution on something we cannot acknowledge is amiss. Like Aristotle, Freud believed that character has to be cultivated and developed. One does not build character by devising ways of relieving suffering, but as a consequence of *bearing* it. This makes the goal of psychoanalysis, at the very least, ambiguous. That is because the kind of suffering analysis is intended to relieve isn't *pain*, specifically. It can only help us surmount the alienation we experience when our existence is a lie. The ability to overcome this lie, by being candid about it, relieves the alienation, but not suffering itself. This unsettling dimension to the aims and capacities of analysis was also noted by Winnicott. He linked the fear of suffering and one's need to abolish it to omnipotence, whose demands only distance us even further from actual living: "If we are successful we enable the patient *to abandon invulnerability and to become a sufferer*. If we succeed life becomes precarious to one who was beginning to know a kind of stability and a freedom from pain, even if this meant non-participation in life and perhaps mental defect" (Winnicott, **1989**, p. 199).

In other words, life without suffering is an illusion. Neurotics, to the degree they cannot tolerate the anguish that life imposes, hope to circumvent it. That is because their capacity for anguish is simply unequal to their reach. Yet, why does life elicit more anguish in some than others? Whether we follow Freud in his speculations about a propensity toward self-destructiveness, or, like most analysts today, reject it, the efficacy of the negative therapeutic reaction as a concept still retains its value. In fact, the term is commonly used even by those analysts who dismiss the very notion of a death drive. The term is now commonly used to characterize a reaction against treatment when one had anticipated progress. Since this reaction is elicited by the analysis itself, it is construed as an act *against the treatment*. As a technical term, it simply alerts us to those reactions we sometimes elicit from our patients precisely because the treatment is proceeding satisfactorily.

Perhaps this was why Freud, by today's standards, didn't believe in lengthy analyses. The Wolf Man, whose analysis and reanalysis lasted some five and a half years, was an exception to the rule. In fact, the prolongation of his analysis proved futile. Freud believed that even one year was a long time to stay in treatment. Ten years, not uncommon nowadays, was unthinkable. Perhaps we avoid termination by allowing analyses to go on as long as they do, hoping for some sign of recovery. In his later years, Freud frequently set a limit to the duration of a treatment at the beginning of the analysis, typically six months or a year. Though this was more usual in his didactic analyses, this practice was in stark contrast with the custom today, when even training analyses are often interminable.

The ambiguous tone of Freud's comments about termination is especially puzzling to those who still conceptualize analysis as a medical treatment for psychiatric illness. Many believe that Freud did not allow the vast majority of his patients sufficient time to achieve a more lasting benefit from the treatment. Was Freud constitutionally incapable of conducting lengthy analyses? Was he too impatient to tolerate the seemingly endless detours that most analytic treatments require? In fact, Freud believed that the prolongation of analysis is frequently a consequence of therapeutic ambition, a form of countertransference that is difficult to recognize. When we commit it, it is usually because we only want to help. On a narcissistic note, we may simply be too eager to cure every patient we treat. Sometimes, using Freud's analogy, the surgeon needs to sew up the wounds and let go, knowing he has done what he can. This was one of the reasons why Freud believed all therapists should submit to analysis themselves, to help them endure and understand the unique pressures of analytic practice. He never thought, however, that it should be as thorough as the analysis to which one's own patients are typically subjected. His reasoning was simple: Analysts shouldn't be *sick* (i.e., uncommonly devious) in the first place, so why should they require so lengthy a treatment? Instead, Freud emphasized character, the personality traits that

analysts happen to possess upon entering their training. Which character traits did Freud value the most? What qualifications did he believe every analyst should possess? "[H]e must possess some kind of superiority, so that in certain analytic situations he can act as a model for his patient and in others as a teacher. And finally he must not forget that the analytic relationship is based on a love of truth—that is, on a recognition of reality—and that it precludes any kind of sham or deceit" (**1937a**, p. 248).

All the analysis in the world won't make people more honest than they were capable of being at the beginning of treatment. This is just as true for future analysts as it is for the patients they analyze. If anything, the lengthier one's training analysis, the more likely it will serve as a standard for that analyst's future patients; and the more "interminable" those analyses will be, in turn. Given the nature of analysis—its limitations, the unpredictable nature of life, and the possibility for future outbreak of neurotic conflict—Freud advocated periodic reanalyses as a resource when one's personal life or one's patients become overwhelming. Freud expected this would happen and was loathe to attribute its efficacy to a failed or inadequate analysis. He never envisioned termination as a cessation, exactly. And even if analysis is never formally resumed, termination never entails a categorical end to one's experience of it. When analysis is over we continue to think about what happened in the course of it. We try to understand and make use of the things that eluded us at the time. We mine the material and conversations for the sense we might make of it, long after the analysis is finished. We may eventually opt to resume analysis, or not. But like a child who has left home, we take with us what is essential. We take care to protect it from danger, we keep it alive. We cannot leave it behind even if we try, because it has fostered our way of thinking, our manner of being in the world. Because it has given us our history, it shows the way to the future.

Freud knew that the potentially therapeutic effects of a psychoanalysis are not axiomatic. Termination guarantees nothing. In the end, we choose, in the existential sense, whatever importance we permit analysis to have. Indeed, the risk every analysis entails and the impossibility of foretelling its impact epitomize its inherently existential nature. Its end is a new beginning. This was demonstrated in a remarkable exchange that the Wolf Man had with Freud while he was still in analysis with him. It concerned the potential effects of termination **(Obholzer, 1982)**. The Wolf Man asked if he would be restored to psychic health once the dynamics of his childhood history became known. Freud replied that the answer to his question wasn't that simple: "Freud said that when one has gone through psychoanalysis, one *can* become well. But one must also *want* to become well. It's like a ticket one buys. The ticket gives one the possibility to travel. But I am not obliged to travel. It depends on me, on my decision" (p. 43; emphasis added).

The Wolf Man realized that this characterization of termination effectively refuted the common assumption that Freud believed in determinism. If our unconscious motives are said to determine our conscious decisions, what determines our unconscious? The line between the two isn't so easy to define. Surely, each determines the other. Our conscious choices help determine what becomes unconscious as well. The termination of analysis confronts each of us with a choice. Will we, in effect, use the "ticket" it gives us, or will we neglect it or, worse, lose it without a trace? We may use it initially but neglect to as time goes by. Fate, too, plays a hand. We may find that the future occasions fresh challenges that simply overwhelm our previously effective efforts. If that happens, we will have to choose what to do about those unforeseen consequences; whether to seek help or persist in our folly. Whatever we choose, whether that choice inhibits or transforms, we will have to wait and see.

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