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Revisiting 'Analysis terminable and interminable' – expressions of death instinct by patients and analysts.

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"… 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? " [Freud 1937 p 219]

Most analysts will have had the experience of patients bringing about good and solid change as a result of analytic work, whether this be prolonged 5 x weekly or brief psychoanalytically informed psychotherapy. As Freud comments:

> "Every analyst will have treated a few cases which have had this gratifying outcome. He has succeeded in clearing up the patient's neurotic disturbance, and it has not returned and has not been replaced by any other such disturbance" [Freud 1937 p 220]

Freud observed that these fortunate outcomes tend to occur where the origin of the neurosis has been predominantly traumatic rather than resulting from a constitutional strength of the instincts or a malformation of the ego. He went on to argue that formidable resistances oppose cure through analysis and that these needed to be the subject of further investigation:

> "In this field the interest of analysts seems to me to be quite wrongly directed. Instead of an enquiry into how a cure by analysis comes about (a matter which I think has been sufficiently elucidated) the question should be asked of what are the obstacles that stand in the way of a cure." [Freud 1937 p 221]

Freud notes several different factors that seem to function as obstacles to a cure. First he refers to an 'adhesiveness of the libido':

> "The processes which the treatment sets in motion in them are so much slower than in other people because, apparently, they cannot make up their minds to detach libidinal cathexes from one object and displace them on to another, although we can discover no special reason for this cathectic loyalty". [Freud 1937 p 241]

But then he also mentions "an opposite type of person, too, in whom the libido seems particularly mobile; it enters readily upon the new cathexes suggested by analysis, abandoning its former ones in exchange for them". However, he notes that with this type of patient "the results of analysis often turn out to be very impermanent: the new cathexes are soon given up once more, and we have an impression, not of having worked in clay but of having written on water." [p 242]

Perhaps today we would consider patients of the first group, displaying adhesiveness of libido, as having some degree of autistic spectrum disorder, which seems to make processing of emotional information very slow, along with an inherent resistance to change. This autistic spectrum component may also play a part in a third group of patients Freud describes, who display a "depletion of plasticity, the capacity for change and further development, which we should ordinarily expect" [p 241]. Here he finds that "all the mental processes, relationships and distributions of force are unchangeable, fixed and rigid". [p 242]

Those Freud describes as showing an abnormal mobility of cathexes perhaps correspond to patients we might today think of as having a borderline personality disorder, with shifting unstable identities and relationships, perhaps also having manic or bipolar traits. Attention Deficit Hyperactivity Disorder may also be present as a hidden constellation giving rise to very fluid cathexes. With such patients we may find that insights and new learning appear easily forgotten, enthusiasms come and go, and that the preoccupations of each session are presented as the most important, seemingly forgetting what had seemed so urgent in the previous session.

The role of the death instinct

The first three obstacles discussed by Freud all relate to vicissitudes of the libido – its adhesiveness, rigidity, or mobility – and the general openness to change of the psychic system. Freud goes on to discuss what he regards as more fundamental problems arising from the instinct of destructiveness.

> "Here we are dealing with the ultimate things which psychological research can learn about: the behaviour of the two primal instincts, their distribution, mingling, and defusion … No stronger impression arises from the resistances during the work of analysis than of there being a force which is defending itself by every possible means against recovery and which is absolutely resolved to hold on to illness and suffering." [Freud 1937 p 242]

Freud comments that part of the expression of this destructive force is found in the unconscious sense of guilt and need for punishment, and is located in the ego's relationship to the superego. If expressed as a succinct thought, this would correspond to "I do not deserve to be well and happy". In a derivative of psychoanalysis within the broad genre of 'energy psychology' (Psychoanalytic Energy Psychotherapy: Mollon 2008), which explores the body's direct response (through variants of ideomotor signalling) to a variety of test statements, I have found the problem of 'not deserving to be well' to be both common and a substantial block to any real progress until it is addressed. The roots of such a belief can be very deep and early – originating, for example, in an infantile feeling of being unwanted, or a disappointment (perhaps not being the gender that the mother wanted), or of guilt over surviving when a sibling died. I have also found a ubiquitous but unconscious sense of guilt at belonging to the human species that is responsible for so much destruction of other species, the planet and environment, as well as against its own intra-specific members. All such factors may work powerfully against people enjoying guilt-free happiness and wellbeing.

There can be no doubting the importance Freud attached to the instinct of destructiveness and its effect on human behaviour and well-being:

> "If we take into consideration the total picture made up of the phenomena of masochism immanent in so many people, the negative therapeutic reaction and sense of guilt found in so many neurotics, we shall no longer be able to adhere to the belief that mental events are exclusively governed by the desire for pleasure. These phenomena are unmistakable indications of the presence of a power in mental life which we call the instinct of aggression or of destruction." [Freud 1937 p 243]

and moreover:

> "The subject is … too important for me to treat it as a side issue in this discussion." [p 243]

Freud saw this innate destructiveness as a profound obstacle to wellness:

> "… we must bow to the superiority of the forces against which we see our efforts come to nothing. Even to exert a psychical influence on simple masochism is a severe tax upon our powers." [p 243]

Freud's concept of the 'death instinct' is not often cited by analysts today, except perhaps by some Kleinians (e.g. Segal 1973; Lucas 2009), yet the phenomena to which it refers are surely ubiquitous. Human beings are, both collectively and individually, often intensely destructive, and find aggression, competition, and sadistic treatment of other species as well as intra-specific members, highly pleasurable. Moreover, ostensibly good and loving activities, supposedly devoted to the care of others and support of life, often turn out to have shadow aspects that are deeply destructive – such as the malign, exploitative, or abusive activities often found within church or spiritual groups. It is frequently observed that the human feeling of intense love can subsequently be transmuted into equally intense hate. Those who consciously feel happy or content in a relationship may engage in actions that bring about a destruction of that happiness – perhaps subsequently resorting to spurious post hoc explanations of why the happiness was not real. War has always been popular, despite its horrors and the fear it induces. The content of addictive video games is often violent and warlike.

The bleak implications of our inherent destructiveness may provide part of the explanation of why psychoanalysts have, on the whole, ignored or minimised the significance of Freud's speculations regarding the death instinct. If each of us is born with inherent destructiveness, that is opposed to our strivings for loving bonds with others, then there is more than sufficient conflict embedded in the human constitution to make happiness and well-being near impossible to achieve or maintain. The existence of sadism, cruelty, and other forms of destructiveness woven into the very fabric of our being will generate deep feelings of guilt that undermine and sabotage strivings for happiness. The guilt will be driven by a combination of inwardly directed aggression, channelled through the superego and an authentic perception of one's own destructiveness. Whilst human beings will try to deny, repress, project, or rationalise their destructiveness and ensuing sense of guilt, it will inevitably remain active unconsciously, corroding happiness and well-being.

Given this inherent destructiveness and associated unconscious feelings of guilt, is it possible for a patient to sustain a ‘cure through analysis’? Do analysts always behave in ways that are loving and rational? Do those who have undergone analysis usually manage to sustain lasting relationships of love and commitment? Is the work of analysis always constructive and healing? It is surely not hard to think of examples that suggest psychoanalysts and others who have undergone analysis may behave as destructively as anyone else.

Are there healthy and perverse forms of psychoanalysis? When the term ‘perversion’ is applied to forms of love and sexuality, it tends to mean that destructiveness has intruded in such a way that Eros has been twisted into something that essentially serves destructiveness. This is most clearly the case in instances of sexual abuse of children, or the rape or torture of unwilling victims, or where relationships of care undergo malign transmutation, such as the nurse or doctor who poisons the patient, or the priest who violates a child. Some seemingly perverse activities, such as consensual S&M, are not really so since the sadism and masochism are contained within strict rules and an agreed ‘theatre of play’, such that the overall relationship is characterised by respect and love and thus a dominance of Eros. One patient who had been prone to frequent cutting of her body was able to reduce this when she began to participate in S&M practices. These were consensual and pleasurable, and highly arousing, involving a partner who was exquisitely attuned to her. By contrast, another patient, who married her S&M partner, found their relationship ran into difficulties when the sado-masochistic play of dominance and submission began to leak out of its sexual theatre and invaded the rest of their interactions. Do psychoanalysts manage to avoid analysis becoming perverted, such that it serves destructiveness rather than Eros? The expressions of destructiveness are not always obvious and may take subtle forms.

Here are some of the more obvious ways that analysis can become perverted in the service of destructiveness toward the patient.

- Making hurtful interpretations
- Aggressively imposing a theory on the patient
- Being disparaging of other analytic theories that the analyst does not favour
- Charging very high fees, or raising them unduly
- Allowing a patient to spend a very high proportion of his or her income on psychoanalysis
- Coercing, by means of ‘interpretation’, the patient to have more sessions per week
- Discouraging independent and autonomous action or decision by the patient without the issues being first explored extensively within the analysis
- Maintaining the patient in a position of infantile dependence on the analyst
- Placing emphasis upon the patient’s psychopathology – including pathologising aspects that are actually common within the population

- Discouraging the patient from ending analysis, on the grounds that the analysis is not 'finished'
- Allowing the patient to idealise analysis and persist with it, despite a lack of evidence that he or she is benefiting
- Allowing the patient to continue in analysis despite indications that his or her libido is so bound up with the analysis and the analyst that life is passing by – so that the analysis has become a substitute for life rather than a stepping stone into a more rich and free life
- Sticking to a strict analytic stance (e.g. avoidance of friendly gestures, only interpreting here-and-now transference, or other modern fashions of technique) that is in the service of sadistic control and withholding
- Subtly denigrating or dismissing the patient's own insights and perspectives

Of course, as Freud indicated, patients too make their contribution to destructive aspects of psychoanalysis. Many forms of psychopathology involve inwardly directed aggression, most obviously in severe depression, OCD, the experience of malign hallucinatory voices, and all kinds of sabotage patterns and self-harm (including common addictions, such as smoking). The inherent destructiveness provides a motive for remaining unwell, dysfunctional, and unhappy. This motive will lead patients to remain in extensive and expensive psychoanalytic treatment *without getting better*. The cost and suffering of analysis will feed the self-directed destructiveness – perhaps also expressing aggression vicariously at those alleged to have made the patient unhappy (e.g. parents). In such instances, remaining in prolonged treatment functions as a badge of suffering, and a reproach against family or others for their neglect, rejection, or abuse. With so much invested in a perverse motive for psychoanalysis, it would be surprising if the outcome were positive. In the case of one young man, when it became explicitly acknowledged that his prime motive for psychoanalytic therapy was an expression of reproach and vengeance against his mother, who assisted him financially with the fees, and that on this basis he wished the procedure to continue as long as possible without therapeutic benefit, there was a mutual agreement to cease the work.

Yet another motive for remaining in a prolonged psychoanalytic treatment that is not developmentally fruitful is that being 'in analysis', or in other ways involved in psychoanalysis, may become part of the person's identity. Obviously this is the case with those who go on to become psychoanalysts, but the investment of time, money, and emotional energy in psychoanalysis is likely to require or encourage an identification with the culture and beliefs of psychoanalysis, much more so than is the case with more limited forms of psychotherapy. It is not uncommon for several members of a family, both adults and children, to be in psychoanalytic treatment concurrently. As a result, the process of ending analysis may involve profound loss and grief – not just the ending of a therapeutic relationship, but the loss of a structure to the week (as life becomes organised around the analytic sessions) and the year (as this becomes structured around analytic terms and breaks), the daily availability of person with whom to discuss personal preoccupations, and an identity and set of cultural references based around psychoanalysis. No

wonder analysands would want to collude with the ‘timelessness’ of the unconscious! The damaging nature of these identifications with psychoanalysis would tend to be invisible since they would be likely to be egosyntonic for both patient and analyst.

A similar phenomenon, but at the more disabled end of the psychiatric spectrum, is shown by those patients who, lacking any other form of viable social identity, take refuge in that of ‘psychiatric patient’. For such people, ongoing support from psychiatric or psychotherapeutic services is required so long as it does not threaten any form of ‘getting better’ that might lead to loss of identity as psychiatric patient. In order to function as coherent social beings, we need an identity as an ordering structure of the psyche – and any threat to this will be experienced as posing the danger of psychic disintegration.

Perspectives from Kohut’s self psychology

The clinical observations and theorising of Heinz Kohut (Kohut 1971; 1984; Mollon 2001) offer some alleviation of these dangers of a damaging psychoanalytic process. This is primarily because Kohut’s ‘self psychology’ does not rest upon a concept of cure through insight, but upon facilitating the unfolding of a selfobject transference that is inherent in the patient’s psyche. A selfobject transference is a use of the analyst as provider of psychological functions (such as the regulation of affect and self-esteem) that have not yet been internalised. Given facilitating conditions, of an adequately empathic analyst who does not disrupt the process with inappropriate interpretations, the patient will unconsciously resume crucial childhood developmental processes that had been derailed at an earlier point. These thwarted developments involve re-establishing selfobject transferences in either the mirroring, idealising, or twinship lines of narcissism. Within the selfobject framework, the analyst does not seek to ‘interpret’ or create insight within the patient’s psyche (although insight and expanded self-awareness may certainly develop), but instead to monitor the development of the structure-developing selfobject transferences. Progressive independence and autonomy is facilitated through a process of ‘transmuting internalisation’ – the repeated minor increments of internalisation and structure building that result from the inevitable disruptions of the patient’s experience of accurate empathic mirroring and/or idealisation of the analyst.

The psychoanalyst informed by self psychology enhances autonomy by mirroring and validating the leading developmental edge of the patient’s strivings. This could take simple forms such as: “it seems you are wondering whether you might be ready to have a baby” or “perhaps you are wanting to find more space for play in your life” – or, if the issue has a more directly transferential aspect, “you are pondering whether you might be able to tolerate knowing I have other patients”, or “you are trying to find out whether I would allow you to become yourself or would want to impose my own vision on you”. Similarly, there might be recognition that the patient is beginning to explore hitherto warded off states of mind, as in “you are perhaps finding the courage to contemplate the despair you feel on realising you have never felt real”.

What seems less helpful, in my own experience as both patient and analyst, is interpretations along the lines of “I think you are doing X in order to avoid Y”, or in other ways informing the patient of the analyst’s insight. Not only are these likely to be experienced as alien ideas, to be either spat out or introjected and identified with, but their presentation by the analyst may rob the patient of the opportunity of self discovery. Even if the analyst’s understanding corresponds to some extent to the patient’s eventual perspective, this is likely to be only a partial approximation and the crucial nuances must come from the patient. I am continually impressed by the extent to which analysands will arrive at their own ever deepening understanding if given an therapeutic environment facilitative of internal enquiry. The presence of the listening analyst, thoughtfully preoccupied with what is being communicated, seems often sufficient to catalyse the patient’s own thought and mutative insight. When conducted along these lines, the analyst’s experience is of being a listening facilitator of the analysand’s inherent developmental processes.

Most of Kohut’s clinical illustrations correspond in some way to his diagram on page 171 of *The Analysis of the Self*, which illustrates the vertical and horizontal splits within the psyche and their role within a typical and common form of narcissistic disturbance. On the left side of the vertical split is a state of mind and behaviour of overt grandiose display, corresponding to a false self identification with the mother’s desire – being the kind of child the mother wanted. On the right of the vertical split is a horizontal split, denoting a repression barrier. Underneath the horizontal split, or repression barrier, is the repressed authentic ‘grandiose self’, whilst above this is a state of depletion and depression resulting from being cut off from the deeper life energies. The psychoanalytic work must lead to a weakening of both vertical and horizontal splits, so that the repressed authentic ‘grandiose self’ may find expression.

Many years ago, I worked with a patient, Mr M, whose childhood had been a preparation for a career in performing arts. He had felt doted upon by his adoring but controlling mother and was sent to a school focusing on dance. Access to his father was restricted – a reclusive man who spent much of his time in his study. This early situation was oedipally highly gratifying – but developmentally a disaster. Mr M’s relationships with women were deeply troubled, pervaded by hatred, rage, and sado-masochism. His career was characterised by repeated self-sabotage. Mr M was unconsciously very angry. His overt presentation was somewhat flamboyant, theatrical, and undoubtedly entertaining. Gradually this changed. He became more quiet and thoughtful, and his interests shifted away from display of self. Spiritual preoccupations emerged, along with an engagement in martial arts and an idealisation of a teacher of this. A relatively silent idealisation of the therapist was apparent, indicated by references to a perception of him as wise, calm, mature etc. In this way, the warded of ‘place of the father’ in his psyche was acknowledged, and the lessening of both vertical and horizontal splits led to a decrease in false self displays and an emergence of more authentic strivings. Mr M became calmer and happier, and his relationships with women more loving. These developments did not take place as a result of clever interpretations

and insights provided by the therapist, but by means of allowing an inherent developmental process to occur.

Fuelling the death instinct

It appears to be a thwarting of developmental needs that results in a fuelling of 'death instinct' phenomena – as if the thwarting of Eros leads to its shifting into its reverse and becoming anti-life, destructive, and death seeking. Kohut described the phenomenon of 'narcissistic rage' when needs for selfobject responsiveness are not met, when strivings to be recognised, empathically understood, or validated are thwarted. It would seem that many forms of psychopathology are variants of chronic narcissistic rage. For example, a woman who experienced her mother as constantly invalidating her communications would continually cut herself whenever a current interaction reminded her of the childhood experience. A man whose father constantly criticised him and made him feel he could not make competent decisions of his own developed a psychotic depressive illness after a period of bullying by a manager. His rage took the form of identification with his father's criticisms and a continual sadistic condemnation of himself. A woman who experienced her mother as forbidding any expression of joy or spontaneity, as well as discouraging any relationship with her father, developed hallucinatory voices that constantly mocked and undermined her in a most cruel and sadistic manner. A man whose effeminate father discouraged his masculinity and repeatedly humiliated him by kissing him in front of his school friends developed an OCD in which he would taunt himself with the idea that he might himself be homosexual. These are all forms of internal rage and bullying, derived from childhood circumstances of thwarted developmental strivings, often associated with shame and humiliation – in accord with Freud's principle that "under the influence of education, the ego grows accustomed to removing the scene of the fight from outside to within, and to mastering the *internal* danger before it has become an *external* one" [1937 p 235]. It is not difficult to see that such narcissistic developmental frustrations exacerbate the Freudian 'death instinct' – although I would not see these as the ultimate cause. The link between shame and death is readily apparent (Ikonen & Rechardt 2010) – in states of extreme shame there is a wish not to exist, and performers will speak of 'dying' on stage when they fail to engage the required audience response.

Although such fuelling of the death instinct may occur during childhood, it may also occur quite readily during psychoanalysis. Whenever an analyst imposes his or her own agenda, speaks woundingly and without adequate empathy, invalidates the patient's own insights or perspectives, discourages autonomy, mocks ideas (religious, political, or cultural) that the analyst considers foolish, or in other ways presents him/herself as *knowing more*, then there is the potential to fuel narcissistic rage and death instinct phenomena. Humiliating the patient in psychoanalysis will always be damaging, causing injury to self-esteem and stimulating death instinct (Mollon 2002). What makes the patient particularly vulnerable is that his or her neurosis and previous experiences are likely to render humiliations and invalidations ego-syntonic – they are felt to be truthful and deserved. They may even result in a temporary improvement in wellbeing as a result of satisfying masochistic trends. This may lead to

repetition of speech and behaviour that will provoke further humiliating responses from the analyst. The analysis then becomes a scene of abuse and shame, imprisoning the patient as in a situation of childhood abuse.

Do I know directly of analyses that have taken this course? No. Do I think they are common? No. However, I do believe, on the basis of accounts from colleagues and patients, that they can occur. Of course, the reports of analysands about their analytic experiences can be subject to distortion, but it seems not entirely rare that a patient might be told he or she 'needs' analysis, or that they are 'attacking the analysis' if voicing criticism, or that their wish to end the analysis is driven by their pathology. The difficulty is that whilst there can be elements of truth in such statements, they are therapeutically useless unless the patient experiences them as grounded in respect for autonomy and genuine empathy. Psychoanalytic respect for autonomy means allowing a patient to persist with a point of view the analyst believes to be incorrect or misguided, or even to end the analysis for irrational or defensive reasons. In order to remain in an essentially psychoanalytic position, the analyst can only offer a willingness to listen and an alternative perspective, but can never claim to offer truth or a superior perspective.

However, in working with deep levels of disturbance, the analyst may encounter instances whereby, despite his or her best efforts to be empathic and respectful of autonomy, the work becomes pervaded by a kind of mind virus that has taken executive control of the patient's psyche. In these cases, the patient experiences passivity in the face of malignant voices or other expressions of dissociated particles of death instinct. These are opposed to love, life, growth, and reality, continually undermining the patient with cruel scorn, threats, and beckoning seductively toward psychosis and death. What makes psychoanalytic work with such conditions so difficult is that the malign voices often become violently agitated in response to being spoken of. Even if not directly referred to, they will exert a destructive influence, twisting the analyst's words and meanings, and distorting the patient's perceptions and memories to such an extent that analytic meanings become hopelessly scrambled or reversed. This destructive activity may not easily become apparent – indeed it is, in its nature, hidden and elusive. The clinical picture described here is not quite the same as (although may be related to) the more overt dissociation encountered with Dissociative Identity Disorder, but is similar to observations made by others such as Bion (1959) and Rosenfeld (1971). As a result of these malign processes, apparent analytic work may go on for years, with any potential gains being continually undone. Unfortunately, the analytic tools of listening, empathy, interpretation, and the provision of selfobject partnership, are usually impotent against these autonomous constellations of death instinct – just as the patient's ego is helpless against them. Such psychological circumstances seem to come about (in some instances) as a result of the normal parental selfobject functions failing to such a degree (whether through deficits in the parental capacities or abnormalities in the child's neurobiological constitution) that rage and fragmentation are continually unleashed, eventually forming constellations of concentrated and energised 'Thanatos' turned against the self. Once established, these psychic islands of malevolence, which now function like

‘anti-selfobjects’, will pursue their own agenda and may not be capable of being integrated – and certainly not willing to be so. Although they can be suppressed with strong medication, their activity rarely ceases completely.

Benign results of long term therapy

I have one example that runs counter to the pessimism of the previous paragraph. Jessica was a young woman of 19 when first referred to me (a longer account is given in Mollon 2001, p 167-178). The psychiatrist who had assessed her considered her to be socially anxious and depressed. After some weeks of sessions, in which she would struggle to communicate various aspects of her distress, Jessica suddenly whispered “its hard to speak because they are listening”. This was the beginning of her revealing the presence of very controlling parts of her mind that she termed ‘the Outside People’. These psychological entities did not appreciate being spoken of, were hostile to me, and denigrated Jessica relentlessly. She could scarcely ever refer to them explicitly but would whisper and point to the back of her head. Despite this, Jessica did continue seeing me once a week in a hospital setting, managed to continue working for some years, and avoided hospitalisation. She would convey her troubled psychotic thoughts during the sessions and in long letters, and would be soothed by my finding some simple essential meaning in these and helping her to understand the links between her experiences (for example, interactions with her mother) and her subsequent confused and confusing thoughts. We came to understand together how she had learned to dismantle her mind under the impact of onslaughts from her mother, such that the components of her perception would dis-integrate. She would observe fragmented aspects of her mother, bits and pieces of her face and body, words seen coming out of her mouth, and so forth, whilst feeling completely calm and distant. We also came to see that her ‘outside people’ were composed of reconfigured bits and pieces of her experience of her mother, ‘bizarre objects’ whose stern hostility towards her formed what she viewed as a kind of exoskeleton, without which she would be formless and fluid. Thus she needed them, since the prospect of complete loss of structure was most frightening of all. About 17 years later, at a time when we met just now and again, Jessica reported that her ‘Outside People’ had ceased their hostility and were now helpful friends. Then, about 23 years after we had first met, Jessica wrote to me to say that these entities had ‘departed’ completely. During these years, Jessica has successfully negotiated many challenges of life. This was an example in which a patient was able to make use of psychoanalytically based therapy, over a long period of time, despite the presence of seemingly very destructive mental structures.

One aspect of the slow therapeutic work was Jessica’s recognition of her sexual and aggressive instincts, which she experienced as posing considerable danger to her. Initially she believed herself not to be a sexual being, that she was an alien, and would complain of ‘black lightening’ and pains emanating from her vagina. Years later she became increasingly curious about sexual desire, allowing herself to watch erotic scenes in TV movies. However, she remained for some time extremely cautious about the potential overstimulation and destabilization of sexual arousal, describing how she would wake in great anxiety and a pain in her vagina, having had a dream

where she was beginning to experience arousal. The thought of engaging in any sexual activity, including masturbation, filled her with dread, threatening chaos and confusion. Awareness of her potential for anger and aggression came even later, and with even more anxiety. One day she remarked that she had been startled to notice an intense feeling of rage when a motorist drove by too closely, clipping her wing mirror. With further exploration of her potential for rage, she concluded that she rarely experienced anger, but did notice, as if from a distance, violent thoughts and images appearing in her mind. Later, she was able to acknowledge intense and primitive violent rage, such as fantasies of conducting a mass killing at her place of work. These caused her great anxiety. She commented: “Sometimes I think I am about to get a violent thought about my mother but then I stop myself”. In this way, the intense self-directed rage, originally expressed as concentrations of death instinct in her ‘Outside People’, became more integrated within the domain of her ego.

Are there other conditions under which very long term, or recurrent analysis, may be valuable and serve life? I believe there are. Some patients have subtle neurobiological deficits, such as autistic spectrum problems or ADHD, which are often not immediately obvious but make psychoanalytic progress very slow. Any form of autistic spectrum phenomena, including Aspergers, means that processing of emotional information and emotional learning are slower than with other people, although the work does take place. There are also those for whom the normal Kohutian transmuting internalisation of the selfobject relationship, whereby the functions provided by the psychological partner (originally a parent and later the analyst) are gradually internalised in response to innumerable small and manageable failures of empathy and attunement, does not take place, or does so only very slowly (but this is not due to the activity of malevolent ‘anti-selfobjects’. These people may require a prolonged availability of selfobject functions provided by the analyst (or other person) in order to assist in managing affect, states of mind, and in facilitating thought. It is similar to what used to be called an ‘auxiliary ego’. This availability of selfobject functions does not have to take the form always of regular face to face or on the couch sessions, but can be in the form of less frequent sessions, or letters, e mails, or phone calls. Kohut himself liked to emphasise that none of us fully outgrows a need for selfobjects, although much of the time these may be provided through family or friendships.

Conclusions

Freud’s 1937 paper *Analysis terminable and interminable* outlined some of the obstacles to psychoanalytic cure. One of the factors he emphasised was the operation of the death instinct. He viewed this as not only maintaining unconscious guilt and the need for suffering, but also as perpetuating illness and an absence of well-being in more obscure ways. This author’s impression is that the unconscious sense of not deserving to be well is a common contributor to lengthy but unproductive treatments. Another factor can be an identification with psychoanalysis and the status of being ‘in analysis’, with myriad secondary gains as well as the maintenance of a structure to both life and identity. Yet another motive for unproductive treatment is the expression of rage against others (such as family members) through apparently being in

need of endless analysis or therapy. Perhaps the most severe obstacle to the achievement of health through analysis is the presence of intense constellations of autonomous death instinct that distort and undo analytic meaning. Whilst there can be dynamics within the patient that derail the psychoanalytic work in the service of the death instinct, there can also be a range of contributions from the analyst that fuel this by thwarting the analysand's developmental needs and promoting shame. Despite all these factors that potentially undermine or pervert the process of psychoanalysis, there are instances where very long term treatment bears fruit. There are some patients whose neurobiological temperament is such that emotional learning and the Kohutian process of transmuting internalisation are particularly slow, but the do occur.

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