

## The concept of the death drive: A clinical perspective

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(Final version accepted 30 March 2009)

*This paper discusses Freud's theory of the death drive in the light of clinical experience with severely self-destructive personality disorders, and contemporary object relations theory. Repetition compulsion, sadism and masochism, negative therapeutic reaction, suicide in depressed and in non-depressed patients, and destructive group processes are explored from this perspective. The paper concludes that the concept of the death drive is clinically relevant, but that this condition needs to be traced to the general dominance of aggressive affects as the primary etiological factor; only under severely pathological circumstances does this dominance lead to a focused drive to self-destruct.*

**Keywords:** aggression, affect theory, dual drive theory, group regression, masochism, negative therapeutic reaction, repetition compulsion, self-mutilation, therapeutic statements, suicide

I believe that it is quite evident that the two major controversies that have been raised by Freud's monumental discoveries are his theory of libido or the sexual drive and his theory of the death drive, representing, respectively, the struggle between life as centered in erotic impulses, and aggression. Freud considered both drives as the fundamental motivational principles determining unconscious conflict and symptom formation (Freud, 1920). In a broader sense, they were what drive human beings toward the search for gratification and happiness, on the one hand, and to severely destructive and self-destructive aggression, on the other. Freud's stress on the infantile origins of sexual orientation, infantile sexuality, and particularly its sado-masochistic components have raised shock, opposition, and efforts at denial in the general culture (Freud, 1905). The death drive runs deeply against more optimistic views of human nature, based on the assumption that if severe frustrations or trauma were absent in early development then aggression would not be a major human problem.

These perennial cultural reactions toward Freud's theories are mirrored within the psychoanalytic community proper. Recent tendencies, particularly in American psychoanalysis, reflected by the relational approach, tend to de-emphasize both infantile sexuality and aggression, in contrast to their centrality in the psychoanalytic focus in European and Latin American psychoanalytic contributions (Kernberg, 2001). Additionally, Freud's concept of the death drive has been questioned within American ego psychology, and the debate about whether aggression is primary or a secondary response to trauma and frustration permeates the psychological field widely beyond psychoanalysis proper.

In this paper I wish to focus exclusively on the controversies surrounding Freud's theory of the death drive. The importance of this controversy relates directly to the social and cultural problems of the 20th century and the beginning of this new century. The fundamentalist regimes of the last century were unprecedented in their primitive and brutal aggression, both systematic and daily. The tens of millions killed in the name of German National Socialism and Marxist communism are beginning to be replicated under new banners in this century. But no society, no country is free of the history of senseless wholesale massacre of imagined or real enemies. The relative ubiquity of these phenomena throughout the history of civilization cannot be ignored. The question of the existence of the death drive as part of the core of human psychology is, unfortunately, a practical and not merely a theoretical problem (Kernberg, 2003a, 2003b).

To begin, regarding Freud's theory of motivation: the study of the unconscious conflicts that patients with neurotic syndromes and character pathology experience led Freud to successive formulations regarding the ultimate drives, culminating in the dual drive theory of libido and the death drive. The practical implication of these proposed two major motivational systems is that, as mentioned before, at the bottom, all unconscious conflicts involve conflicts between love and aggression at some level of development. This, I believe, makes eminent sense clinically, and so does Freud's careful warning that the only thing we know about these two drives is their expression in mental representations and affects.

Here begins the problem: Freud had postponed linking psychological functions and structures with underlying neurobiological developments because of the primitive nature of the neurobiology of his time. He expressed the hope, however, that, eventually, more specific relationships between psychological functions and neurobiological developments might become clearer. From today's developments in neurobiological science and advances in our knowledge about instinctive behavior and its organization in mammals, particularly primates, it emerges that the primary motivational systems consist of affects of a positive and negative kind. Affects are primary motivational systems in the sense that their activation, under certain circumstances, by mechanisms of the limbic brain, initiates strong motivation to movement toward other objects or away from them. The entire series of libidinal affects: joyous encounter, euphoria, sensual gratification, and erotic arousal are all directed toward early libidinal objects, while the negative affects of rage, anger, disgust, anxiety, and, later, envy and hatred motivate us to withdraw from dangerous objects or attempt to control or eliminate them (Panksepp, 1998). All affects are embedded in mental representations, that is, a cognitive organization of the context in which affects emerge, an emerging definition of the desired objects, as well as of the feared and hated ones, and wishful fantasies toward erotic objects as well as about the elimination of threatening objects. The very fantasies that reflect unconscious conflicts between love and hatred are always representations embedded in respective positive or negative affects.

In the study of patients with severe psychopathology, the borderline conditions, at the Institute of Personality Disorders at the Weill Cornell Medical

College, we have been able to confirm that borderline patients who suffer from inordinate aggressive impulses and lack of impulse control, in other words, a strong predominance of negative affects and impulsivity, regularly show hyperactivity of the amygdala, a limbic structure related to the activation of negative affect. They also show a primary inhibition of the dorso-lateral prefrontal cortex that is related to cognitive framing of affects and the establishment of priorities of focus, attention and action following such affective activation (Silbersweig *et al.*, 2007). These and other related findings have been confirmed also in various other centers, so that we are at the beginning of establishing a more direct relationship between neurobiological function and affect activation. But what does all of this say to the theory of drives?

The psychoanalytic community is struggling nowadays with the problem of whether drives should continue to be considered as the primary motivational systems or whether they should be replaced by the consideration of affects as primary motivational system (Kernberg, 2004a). The absence of any biological evidence for the original, primary nature of drives, the abundant evidence for the primary motivational function of affects, and the fact that affects always imply representations at the same time raise the question whether affective representations are the building blocks of more complex human motivational developments, thus replacing the concept of drives. Against such a radical assumption lies the fact that, clinically, the replacement of drive theory by affect theory does not do justice to the stable organization of unconscious conflicts. The multiplicity of affects and the shifting affective relationship to objects and their representations does not lend itself to meaningful conceptualization of the organization of those conflicts. On the other hand, a pure drive theory that does not consider the specific vicissitudes of affects tends to acquire over-generalized and rigidly dogmatic aspects that also run counter to clinical experience: to explain unconscious conflict as simple struggles between libido and aggressive drives does not do justice to the complexity of clinical experience.

I have proposed, years ago, and am no longer alone in this view, that affects constitute the primary motivational system, and that they are integrated into supraordinate positive and negative drives, namely, libido and aggression. The drives, in turn, manifest themselves as activation of their constituent affects with varying intensity, along the line of libidinal and aggressive investments. In short, I believe that affects are the primary motivators. They organize into hierarchically supra-ordinate motivations, or the Freudian drives, and the drives, in turn, become activated in the form of their component affectively valenced representations manifest as unconscious fantasies (Kernberg, 1992).

Within the context of these formulations, I shall propose, in the present paper, that the concept of the death drive as a designation for the dominant unconscious motivation toward self-destructiveness is warranted in severe cases of psychopathology. I shall question, however, whether severe self-destructive aggression is a primary tendency, and propose that the unconscious function of self-destructiveness is not simply to destroy the self, but to destroy significant others as well.

It will be noticed that, earlier in this paper, I have talked about aggression and, then, aggressive drive rather than the death drive *per se*. That our patients suffer from conflicts involving love and aggression, from their ambivalence toward those they love and need and who gratify and frustrate them, who can never satisfy all desires and sometimes dramatically withhold the gratification of basic psychological needs, seems reasonable enough. We are talking here about aggression secondary to frustration, which conforms with the type of aggression delineated by Freud as arising from the conflict between the pleasure principle and the reality principle. And the basis of such aggression, mingling with our deepest needs for closeness and love, may naturally be related to the biological disposition to aggression, as inborn as that to love and eroticism, and which we encounter as a common property of all mammals. I am referring to the aggressive dispositions that are a normal mechanism in the defense of the newly born mammal and its early development that requires parental protection; the aggression at the service of territoriality that protects the sources of nutrition, and the aggressive disposition involved in the competition of males for the possession of females. These biologically anchored instincts have the correspondent instinctive dispositions in human beings as well, and explain the mechanism of aggression secondary to danger or frustration. But Freud discovered clinical phenomena in which aggression could not be accounted for by mere frustration of the pleasure principle, and became an overriding, self-destructive motivation that proved to offer enormous resistances to its modification in psychoanalytic treatment. The clinical experience accumulated, throughout time, on the basis of psychoanalytic practice has added new evidence in support of the prevalence of severely self-destructive psychopathological constellations, indirectly supporting the theory of a death drive.

The phenomena that led Freud to the establishment and, later, to the reinforcement of the hypothesis of the death drive as opposed to a simple aggressive drive include (Freud, 1920, 1921, 1923, 1924, 1930):

- i. The phenomenon of repetition compulsion
- ii. Sadism and masochism
- iii. Negative therapeutic reaction
- iv. Suicide in severe depression (and in non-depressive characterological structures)
- v. Destructive and self-destructive developments in group processes and their social implications

Let us examine them. First, regarding repetition compulsion, the main clinical constellation referred to by Freud in his original proposal: as the name implies, the patient engages in an endless repetition of the same, usually destructive behavior that resists the interpretation of assumed, and very often well-documented, unconscious conflicts involved. Originally described as a 'resistance of the id', a somewhat mysterious force from the dynamic unconscious, clinical experience has demonstrated that repetition compulsion may have multiple functions that have different prognostic implications. Sometimes it is simply the repetitive working through of a conflict that demands patience and gradual elaboration; at other times, it represents the

unconscious repetition of a traumatic relationship with a frustrating or traumatizing object, with the hidden hope that 'this time' the other will gratify the needs and wishes of the patient, thus being transformed, at last, into the much needed good object. Many unconscious fixations to traumatic situations have this origin, although they may sometimes reflect more primitive neurobiological processes. These primitive processes deal with the incessant rekindling of a very early behavioral chain deeply engrained in the limbic structures and their neural connections with the prefrontal and preorbital cortex. In many cases of post-traumatic stress disorder we find that repetition compulsion is an effort to come to terms with an originally overwhelming situation. If such a repetition compulsion is tolerated and facilitated in the context of a safe and protective environment, gradual resolution may obtain.

In other cases, however, particularly when post-traumatic stress syndrome is no longer an active syndrome but operates as an etiological factor behind severe characterological distortions, the repetition compulsion may reflect an effort to overcome the traumatic situation by an unconscious identification with the source of the trauma. Here the patient identifies with the perpetrator of the trauma, while projecting on somebody else the function of victim. It is as if the world had become exclusively a relationship between perpetrators and victims, and the patient, unconsciously, repeats the traumatic situation in an effort to reverse the roles and place somebody else in the role of victim (Kernberg, 1992, 2004b). The unconscious triumph that such a reversal may provide the patient then maintains repetition compulsion endlessly. There are still more malignant cases of repetition compulsion, such as the unconscious effort to destroy a potentially helpful relationship out of an unconscious sense of triumph over the person who tries to help, who is envied for not having suffered what the patient, in his mind, has suffered. It is an unconscious triumph which, at the same time, coincides, of course, with the defeat of the patient himself.

André Green, a leading contributor to the exploration of severe psychopathologies, has described the unconscious identification with a 'dead mother', that is, a severely depressed mother who had chronically frustrated the needs for love and dependency of her infant and child. At the same time, such a mother, desperately needed, cannot be abandoned. The patient, in unconscious identification with a fantasied 'dead mother' denies the existence of all live relationships in reality as if he himself were dead to the world (Green, 1993a, 1993b).

In patients with severe narcissistic pathology repetition compulsion may have the function of an active destruction of the passage of time, as an expression of denial of aging and death, combined with the triumphant destruction of the work of the envied therapist. That denial, on the surface, reassures the patient, and protects him from the anxiety over his self-destructive avoidance of his life tasks, including the analytic work. It is a manifestation of what Kleinian authors describe as a destructive narcissistic organization (Rosenfeld, 1971). Repetition compulsion, in short, provides clinical support to the theory of a relentless self-destructive motivation, one of the sources of the concept of the death drive (Segal, 1993).



Severe manifestations of sexual sadism and masochism are a second type of a fundamental drive to self-destruct. Cases of sexual perversion, that is, a significant restriction of sexual behavior to a specific interaction that becomes an indispensable condition for sexual excitement and orgasm, may be linked to a dangerously sadistic or masochistic behavior, reflected in severe self-injurious or self-mutilating behavior as a precondition for sexual enjoyment. Inordinate cruelty toward others and inordinate cruelty toward the self are often combined in the most severe cases. Patients with borderline psychopathology often show severe self-mutilation, cutting, burning and, in the most severe cases, self-mutilation leading to the loss of limbs as a relentless drive which, at times, causes all therapeutic efforts to fail. The frequent syndrome of anorexia nervosa, particularly in its most severe manifestations, may also correspond to such relentless, irreducible self-destructiveness. The unconscious conflicts of anorectic patients cover a broad spectrum of dynamics: from oedipal rivalry and rebellious protest against mother, and unconscious guilt over a girl's developing sexuality, to primitive hatred of the patient's own body identified with an extremely sadistic maternal image, and the enactment of a self-destructive unconscious omnipotence (Kernberg, 2004d).

One clinical syndrome that is particularly difficult to handle is that of perversity (not sexual perversion). Perversity involves the recruitment of love at the service of aggression, the effort to seduce another person toward love or helpfulness as a trap that will end with the destruction, symbolic or real, in a social and sometimes even in a physical sense of the person so seduced (Kernberg, 1992). In normal love relations small doses of aggression intensify erotic pleasure. However, under pathological conditions perversity may destroy erotic pleasure and even more so its object. The mildest cases of all these sadomasochistic developments are found in those patients who, because of unconscious guilt, usually related to profoundly forbidden oedipal urges or unconscious aggression to an early object of their dependency needs, destroy what they received. These developments are easier to understand and to treat; here self-destructiveness has the function of the 'price' that must be paid in order to permit a gratifying relationship to develop, and does not have the primary function of destruction of a potentially good relationship.

This brings us to the third type of manifestation of severe self-directed aggression, namely the negative therapeutic reaction. Freud described one type of negative therapeutic reaction in his clinical observation of patients who appeared to get worse under conditions when they experienced a helpful intervention by the analyst, as an expression of unconscious guilt over being helped (Freud, 1923). Negative therapeutic reaction out of unconscious guilt is, in effect, the mildest form of this reaction. A much more frequent and more severe, although eminently treatable, form is the negative therapeutic reaction out of unconscious envy of the therapist, particularly characteristic of narcissistic patients. It is an expression of the humiliating envy on the part of the narcissistic patient of the therapist's capacity to help him, of the analyst's creativity in his efforts to help the patient.

There is an even more severe form of negative therapeutic reaction, and one which has the unmistakable signs of a highly motivated self-destructiveness, namely, an unconscious identification with an extremely sadistic object, so that it is as if the patient felt that the only real relationship he may have is with somebody who destroys him. This dynamic constellation is prevalent in the case of patients presenting severe self-mutilating behavior. One patient successively cut off segments of fingers of her hands and severed major nerves in one arm: she presented the syndrome of malignant narcissism, and her psychoanalytic psychotherapy was carried out, in part, during extended hospitalizations. She was not psychotic at any point. In the transference, the identification with an extreme aggressive and incestuous paternal image was a dominant element. It is difficult to understand this development from a position of ordinary common sense, but there are patients who relentlessly provoke the analyst until the analyst succumbs to an uncontainable negative countertransference reaction. The analyst, maneuvered into a countertransference enactment, manifests some negative behavior to which the patient triumphantly responds with further escalation of his provocative self-destructive behavior. Very often these treatments end precipitously, leaving the therapist with a sense of impotence, frustration and guilt feelings. These patients represent severe borderline conditions, and what I have described as the syndrome of malignant narcissism, that is, patients with severe narcissistic features, paranoid tendencies, egosyntonic aggression against self and others, and antisocial behavior. These patients may utilize the treatment as a perversely gratifying form of self-destruction because they draw others into their deadly self-attacks. One of our patients presenting this syndrome repeatedly consumed rat poison, which interferes with blood clotting, to the extent of provoking severe internal hemorrhages, while she smilingly denied to her therapist and to the staff that she had done so. Even hospitalized, and with the prothrombin time extending by the day, and careful searches by the nursing staff, we were not able to control the self-mutilating behavior and the pleasurable nature with which this patient expressed it, to the extent that, finally, she was transferred for custodial care to another institution.

A fourth type of severe self-destructive impulse is reflected in suicidal urges and behavior. Freud considered suicidal tendencies in melancholia as another expression of the death drive. He described the essential mechanism of this development as the introjection of an ambivalently loved and lost object that would then draw the aggression toward that object into the ego which is now identified with the lost object. Although Freud (1917) had originally explained suicide in melancholia as a result of turning hatred of the lost object inward, after the formulation of his dual drive theory (Freud, 1920) he revised his view in *The Ego and the Id* (Freud, 1923, p. 53), stating about melancholia: "What is now holding sway in the super-ego is, as it were, a pure culture of the death instinct, and in fact it often enough succeeds in driving the ego into death, if the latter does not fend off its tyrant in time by the change round into mania."

The work of Melanie Klein showed that such ambivalence is a normal aspect of all love relations (Klein, 1940, 1957). She described the task of the depressive position in overcoming the split between positive, idealized inter-

nalized relations with the object and aggressively invested and projected relations with the object of a persecutory type. She described, in short, the normal integration between split-off idealized and paranoid relationships as part of normal development, the depressive position, in contrast to the earlier, splitting-dominated paranoid–schizoid position. This integration, Melanie Klein convincingly proposed, constitutes a normal early developmental phase, repeated in all later mourning processes, so that in all losses there is not only the loss of an external object, and the working through of that loss by its internalization, but a reactivation of the depressive position with the working through of ambivalences toward all earlier object losses. In short, normal ambivalence is an unavoidable aspect of all mourning reactions.

It is only under conditions of severe aggressive, particularly unconsciously aggressive, impulses towards the lost object where the pathology of the depressive position evolves in the form of relentless self-attacks now derived from the internalization of aggressive aspects of the object into the superego and an attack of the self from the superego, and the simultaneous identification of the object with the ego or the self. This combination leads to potentially severely dangerous and very often actualized suicidal tendencies. But we do find such self-destructive suicidal behavior also in patients who are not depressed, precisely in severe narcissistic personalities. Here a sense of defeat, failure, humiliation, in essence, the loss of their grandiosity, may bring about not only feelings of extremely devastating shameful defeat and inferiority, but a compensatory sense of triumph over reality by taking their own life, thus demonstrating to themselves and to the world that they are not afraid of pain and death. To the contrary, death emerges as an even elegant abandonment of a depreciated, worthless world (Kernberg, 2007).

We have seen that severe self-destructive psychopathology warrants the clinical assumption of powerful, sometimes uncontrollable self-destructive impulses reflected in the phenomena of repetition compulsion, sadism and masochism, negative therapeutic reaction and suicide, both in severe depression as well as in other forms of psychopathology. But, in addition, Freud also described severe self-destructiveness as a social phenomenon in the behavior of large social group processes, in human masses as ideologically united conglomerates, in mutual identification with a grandiose and aggressive leader (Freud, 1921). In this process, the group projects their individual superego functions onto the group leader, with the consequence of group-sanctioned expression of primitive, ordinarily suppressed impulses, particularly of an aggressive type. A mass movement may coalesce around a drive to search and destroy enemy formations, the sense of power derived from their liberated, now focused aggression, their sense of protected dependency by their allegiance to the leader, and the regression to the most primitive dissociation of object relations into idealized and persecutory ones. This development represented for Freud the activation of severe destructiveness at a social level. The projection of the superego onto the leader, the mutual identification of all participants with him or her, as well as the sanctioned expression of aggression are the fundamental explanation for the aggressive behavior of mass movements and large social structures, applying even to



international conflicts. But the aggression activated in regressive group processes may also be channeled onto the group itself, guided by a grandiose, self-destructive leader, ending in a religiously or ideologically rationalized mass suicide.

Freud's theory of mass psychology, dramatically demonstrated in a thousand forms in the mass psychology of the fundamentalist movements of the last century, has been complemented by Bion's (1961) work with small groups of 10 to 15 individuals, and Pierre Turquet (1975) and Didier Anzieu (1981) with large groups of 100 to 150 individuals. I do not have space here to describe in detail all these findings, but would summarize them by stating that, when small or large groups are unstructured, that is, without a clear task and its corresponding structure relating that group constructively to its environment, and when, in contrast, the only task of such groups is meeting to study their own reactions for, say, an hour and a half during a sequence of several days or a few weeks, they present striking and similar phenomena. They show the immediate activation of intense anxiety, and an effort to escape that anxiety by some soothing *ad hoc* philosophy expounded by a friendly, mediocre, grandfatherly leader who calms down the group's anxiety with clichés. When this effort fails, they show a tendency to the development of intense violence, the search for a paranoid leader, the division of the group itself, or its perception of the surrounding social environment, into an idealized and a persecutory one, with active aggression directed against what is perceived as the hostile segment of the world in order to protect the perfection and the security of the ideal group.

Vamik Volkan (2004), who has applied psychoanalytic theory to the study of inter-group and international conflicts, has expanded these observations by systematically studying the nature of the ideal world of fundamentalist groups, the reason for their need to search for and destroy enemies, their strivings to preserve rigid boundaries and the purity of their group, and the obvious connection between these categories and fundamentalist political, racial, and religious movements. In conclusion of this point, there is impressive clinical and sociological evidence for a universal potential for violence in human beings that can be triggered too easily under certain conditions of group regression and corresponding leadership, and that, from the perspective of survival of human societies, may be considered as fundamentally self-destructive.

These are the leading clinical arguments in support of Freud's theory of the death drive. Freud also attempted to link it to biological disposition to self-destruction, tracing a parallel of the psychological attraction of the 'nirvana principle' with the physiological mechanisms of self-destruction in biology. In effect, the biological function of apoptosis, the controlled orders for self-destruction of certain cells, may be seen as one illustration of such a biological mechanism. While it may be tempting to explain psychological functions by analogical ones from biology, this runs the risk of reductionism by relating complex phenomena at widely different structural levels to each other. What we do have is the powerful clinical evidence for severe, relentless self-destructiveness in many cases of psychopathology. If anything, the experience with severe types of character pathology and the borderline

conditions in the last 30 years has given even further evidence to the fundamental nature of deep self-destructive tendencies in human beings that clinically would support the concept of a death drive.

If we accept that severe self-destructiveness functions as a major motivational system, we may explore, from this perspective, the concept of the death drive. In my view, one solution to this theoretical challenge is a combination of several conclusions. First, if death drive is a designation for the dominant unconscious motivation toward self-destructiveness in severe cases of psychopathology, this concept is, undoubtedly, warranted. Second, severe self-destructive aggression, however, is not a primary tendency, as far as we can tell, but a particularly grave, organized motivational system that is not simply 'secondary to trauma', although it may be influenced and stimulated by traumatic experience. Third, the unconscious functions of self-destructiveness are not simply to destroy the self, but, very essentially, to destroy significant others as well, be it out of guilt, revenge, envy, or triumph.

Exploring jointly the clinical constellations that reflect most clearly the dominance of self-destructive impulses, they all reveal intrapsychic struggles between internalized sadistic representations of objects and masochistically submitting representations of self. Internalized sadistic object representations may represent both projected and reintrojected aggressive impulses and realistic traumatic experiences, while masochistic self-representation may represent a combination of erotization of painful, traumatic experiences, and unconscious guilt-induced expiational suffering. In the case of repetition compulsion, I have referred to the unconscious identification with perpetrator and victim of a traumatic past, the unconscious identification with a 'dead mother', and the triumph over a potentially helpful yet envied object by destruction of the self. In the cases of sado-masochistic pathology, the strong predominance of aggressive conflicts may turn the internalized relation with a sadistic object into overwhelming self-destructiveness. In the case of negative therapeutic reaction, the spectrum of self-directed aggression may vary from the superego-induced attacks on the self in better integrated patients to the primitive intrapsychic relation with a battering object of dependency. Freud and Melanie Klein's clarification of the psychopathology of suicidal depression first pointed to the self-destructive consequence of a sadistic superego. So that what is sought in self-destructive motivation is not simply 'nirvana', but active destruction of significant libidinal relations with significant others.

In short, aggression as a major motivational system is always present in the mind, based on the integration of primary negative affects, but I propose that it deserves the designation of death drive only when such aggression becomes dominant, when it recruits libidinal impulses such as in the syndrome of perversity, and when its main objective is, to use André Green's (1993a) terms, the achievement of 'de-objectalization', the elimination of the representations of all significant others and, in that context, the elimination of the self as well. The death drive, I propose, is not a primary drive, but represents a significant complication of aggression as a major motivational system, is central in the therapeutic work with severe psychopathology, and as such is eminently useful as a concept in the clinical realm.

What determines whether aggression will be predominantly structured into internalized object relations that direct it externally, or against the individual's own body or mind? Under what circumstances will self-directed aggression become the dominant unconscious motivational system? I believe we have only partial answers to these questions at this time. There is evidence for genetically determined and constitutionally given dominance of negative affect activation and for inadequate cognitive contextualization of affect, expressed in temperamental dispositions that influence the internalization of early object relations. Insecure attachment may significantly contribute to a disposition for predominantly negative affect activation. Traumatic experiences in infancy and childhood and severely disorganized family structures are clearly related to severe personality disorders with self-destructive tendencies (Paris, 2009). But some patients with severe self-destructive tendencies do not evince such a background. Clinically, however, in those latter cases, as well as in the most severe cases of major self-destructiveness, we typically find narcissistic personality disorders, both of the apparently milder, self-assured, grandiose kind, and the most regressed, aggression-infiltrated pathological grandiose self of the syndrome of malignant narcissism (Kernberg, 1992), the cases that Kleinian authors describe as destructive narcissism (Britton, 2003) or pathological organization (Steiner, 1993), and as negative narcissism (Green, 1983) and de-objectalization (Green, 1993a). In short, a combination of intensity of aggressive affect and the particular structuralization of internalized object relations of narcissistic personalities emerge as leading aspects of the malignant transformation of aggression into a dominant motivation for self-destruction.

The self-destructiveness of melancholia, its superego-determined suicidal tendencies, constitutes a special case, again illustrating the influence of both genetically and environmentally determined hyperreactivity of depressive affect activation and the importance of a particular structuralization of internalized object relations, namely, the pathological superego of these patients (Panksepp, 1998).

This brings us, of course, to the question of the therapeutic implications of this conceptualization: where do we stand, what has psychoanalysis achieved in this regard? Under the influence of contemporary object relations theory, psychoanalytic structural theory has evolved into the analysis of the building blocks of ego, superego and id, namely, their constituent internalized relations with significant others that are integrated in the form of primitive, affectively determined representations of self and significant others or objects (Kernberg, 2004c). I have proposed that dyadic representations of self and others, under the dominance of a particular affective valence, are internalized as a parallel series of positive and negative internalized object relations. They consolidate according to their specific function into superego structures when they have a commanding or prohibitive quality, or into ego structures when they correspond to potentially conscious and preconscious identifications and the organization of character formations, and id structures when such internalized object relations correspond to primitive, aggressive or erotic, fantasied desired and feared relation with objects that cannot be tolerated in consciousness.

The importance of this reformulation of the psychic structures in terms of the internalization of object relations resides in the fact that in the most primitive types of structures that we find in severe psychopathologies, such as early split idealized and persecutory object relations dominate the transference field rather than the manifestations of mature ego and superego functions, and the treatment has to be centered in the analysis of each of these dyadic units as they emerge in the transference. Regarding our understanding of these psychopathologies, perhaps the greatest advance in recent years has been in the treatment of severe character pathologies, particularly narcissistic and the borderline conditions.

In typical cases of predominantly self-destructive efforts in the transference, behind what appears to be a disdainful rejection and ruthless tearing apart of the analyst's interpretative interventions, the problem is not a simple manifestation of the death drive, but its reflection in an internalized object relation between a sadistic, murderous object representation and a submissive, paralyzed representation of self that enters into collusion with the aggressor. It is the collusive aspect of the self that, at first, becomes evident in the patient's manifest ignoring of the analyst's interventions and the lack of concern for himself. The unconscious pleasure in the defeat of the analyst, out of hate or envy, emerges more slowly in the transference situation. The analyst's tolerance of such regressive transferences is the key to their eventual resolution.

Our application of psychoanalytic principles to the descriptive and structural characteristics of these patients has permitted a clearer indication of differential treatments based on a psychoanalytic modality.

It is important to diagnose early syndromes in which severe self-destructive aggression may dominate. These include particularly the syndrome of the 'dead mother', that I referred to, and the syndrome of malignant narcissism; cases with severe ego-syntonic aggression manifest in arrogance, perversity, and identification with a sadistic superego, as well as self-destructive behavior that affects patients' survival in their social environment (Kernberg, 1992, 2004b, 2007). With these cases, it would seem essential to analyze the developments of such self-aggressive tendencies in the transference from the very beginning of the treatment, with particular attention paid to tendencies to destroy what is provided by the analyst, and to whatever hope the patient may have for the survival of the therapist in spite of the patient's aggression. It may become important to structure the treatment, in the sense of assuring the stability of its boundaries. We have learned how to prevent severe, physical acting out of aggression that would threaten the treatment boundaries by careful initial contract setting, and to analyze any countertransference deviation from technical neutrality, that is, from the normal attitude of concerned objectivity of the analyst as a result of intensively hostile transferences.

It may become particularly important to explore the pleasure in the patient's aggression against the self and others. In this regard, we might say that the death drive is not inconsistent with the pleasure principle, as evidenced by the triumphant pleasure these patients get in defeating all efforts to help them. I have suggested in earlier work (Kernberg, 1992) that

it is important to transform psychopathic transferences in which the patient manifests dishonesty or dangerous withholding, and perverse transferences in which the patient tries to recruit the benign efforts of the therapist for malignant purposes. We have to transform these psychopathic transferences into paranoid ones, that is, to analyze why the patient has to behave in a deceptive way to avoid deep fear and suspicion of the analyst, on to whom such aggressive impulses are projected. Full development of paranoid transferences is the first step to a gradual recognition of the projection, the acknowledgement of the origin of aggression in oneself and the development of depressive transferences, that is, transferences in which, under the influence of the development of guilt feelings related to the recognition of his own aggression, the patient may be able to integrate and elaborate his aggressive tendencies.

In some cases, one needs to be alert to both absence of affects or absence of representations in what may appear to be 'pure' affects, so that both affect storms, on the one hand, and apparent total absence of affect have to be explored systematically to unveil the underlying activated object relations. Some cases with extended therapeutic stalemates in reality are deadly repetitions of self-destructive efforts to escape conflicts and to deny the passage of time. There are times where, under the influence of extreme aggressive impulses and their projection, the reality testing of the patient decreases. The patient may develop micro-psychotic episodes in the sessions, and it may become important for the analyst to spell out the existence of incompatible realities in which patient and analyst live, how to understand them, and how to resolve them.

In short, an object relations perspective on the predominance of severely self-destructive transferences has provided analytic tools to treat such patients, and, we might say, has become a major front on the struggle to apply psychoanalytic principles to this area of most challenging and prognostically reserved cases. Whether the growing psychoanalytic understanding of aggressive and self-aggressive behavior of large groups and its relation to regressive processes in the social realm will lead to a contribution to their prevention and management remains to be seen. In conclusion, Freud's dramatic concept of the death drive may not reflect an inborn disposition as such, but is eminently relevant in clinical practice.

### Translations of summary

**Das Konzept des Todestriebs: eine klinische Betrachtung.** In dieser Abhandlung wird Freuds Theorie des Todestriebs im Lichte der klinischen Erfahrung mit schweren, selbstdestruktiven Persönlichkeitsstörungen und anhand zeitgenössischer Objektbeziehungstheorien diskutiert. Wiederholungszwang, Sadismus und Masochismus, negative therapeutische Reaktion, Suizid bei depressiven und nicht-depressiven Patienten und destruktive Gruppenprozesse werden unter dieser Perspektive untersucht. Die Abhandlung kommt zu dem Schluss, dass das Konzept des Todestriebs klinisch relevant ist, aber dass man bei diesen Persönlichkeitsstörungen der generellen Dominanz aggressiver Affekte als primärem ätiologischen Faktor nachgehen muss; nur unter schwer pathologischen Umständen führt diese Dominanz zu einem gezielten Antrieb zur Selbstzerstörung.

**El concepto de pulsión de muerte: una perspectiva clínica.** Este artículo discute la teoría de la pulsión de muerte de Freud a la luz de la experiencia clínica con desórdenes de personalidad severamente autodestructiva y de la teoría contemporánea de las relaciones objetales. Desde esta perspectiva se



explora la compulsión a la repetición, el sadismo y el masoquismo, la reacción terapéutica negativa, el suicidio en pacientes deprimidos y no deprimidos, y los procesos grupales destructivos. El artículo concluye que el concepto de pulsión de muerte es clínicamente relevante, pero que esta condición debe atribuirse al predominio de afectos agresivos como principal factor etiológico, y que solo bajo circunstancias severamente patológicas este predominio lleva a una pulsión centrada en la autodestrucción.

**Le concept de pulsion de mort: une perspective clinique.** Cet article examine la théorie de Freud sur la pulsion de mort, compte tenu de l'expérience clinique avec des personnalités gravement auto-destructrices, et des théories de relation à l'objet contemporaines. La compulsion de répétition, le sadisme et le masochisme, la réaction thérapeutique négative, le suicide chez le patient déprimé et non-déprimé, et des processus de groupe destructeurs sont explorés dans cette perspective. L'article conclut que le concept de pulsion de mort a une pertinence clinique, mais que cette condition doit être retrouvée dans la dominance générale des affects agressifs comme un facteur étiologique primaire; c'est seulement dans des circonstances gravement pathologiques que cette dominance donne lieu à une pulsion de mort qui vise l'auto-destruction.

**Il concetto di istinto di morte: una prospettiva clinica.** Il saggio discute la teoria freudiana dell'istinto di morte alla luce di un'esperienza clinica con disordini della personalità estremamente autodistruttivi, e di una contemporanea teoria delle relazioni oggettuali. Coazione a ripetere, sadismo e masochismo, reazione terapeutica negativa, suicidio in pazienti depressi e non depressi, processi di gruppo distruttivi vengono analizzati sulla base di questa prospettiva. Il saggio giunge alla conclusione che il concetto di istinto di morte è clinicamente rilevante, ma che tale condizione debba essere attribuita all'influenza generale di affezioni aggressive come primario fattore etilogico; solo in caso di circostanze patologiche gravi, può questa influenza condurre a un impulso focalizzato di autodistruzione.

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