The death instinct: Suppression of emotions, physiology, and illness.

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Abstract

Freud's concept of the death instinct is revisited and related to current research in cell biology and psychoneuroimmunology. Freud argued that externalisation of the death instinct in the form of aggressive and destructive expression is necessary in order to protect against our primary impulse to self-destruction. The implications of suppression-repression for disease development and/or progression are discussed from a psychoanalytic and empirical research perspective.

Introduction

Until his death in 1939 Freud maintained that mental illness results when repression fails (Solms, 2004, p. 84). Could the same be said about physical illness? After all, he always assumed that "for the psychical field, the biological field does in fact play the part of the underlying bedrock" (Freud, 1937, p. 252).

In this article we introduce Thanatos, suggesting that there may be life yet in Freud's largely neglected concept of the death instinct: both the instinct part and the death-seeking part. We do this by noting how studies in psychosomatic research bolster the death instinct concept while at the same time benefiting from this way of thinking. Positing that there is a continuum of conscious to unconscious barring of unwanted material from awareness - suppression-repression - we propose that this is what Freud was getting at with perhaps his most unpalatable idea, the death instinct.

Freud's dual-instinct model

Freud developed his death instinct theory in 1920. His clinical observations led him to question his earlier assumption that people are motivated by the desire to experience pleasure and avoid pain (unpleasure). In "Beyond the Pleasure Principle" he observed that some of his patients were indeed seekers of physical or emotional pain. The clinical phenomena of repetition compulsion (sadomasochism, melancholia, obsessional neurosis, trauma, the negative therapeutic reaction, aggression and self-destructiveness) led Freud to look beyond pleasure as the primary goal of human activity and to postulate that humans have not one but two primary instincts. He called the life-favoring instinct Eros, one of the Greek words for 'love', and the death instinct, Thanatos, the Greek word for 'death'. He suggested that all living creatures

have an instinct, drive, or impulse to return to the inorganic state from which they emerged. This todtriebe (drive toward death) is active not only in every creature, great or small, but also in every cell of every organism. He pointed out that the metabolic processes active in all cells have both constructive (anabolic) and destructive (catabolic) functions. Life goes on because these processes work together - they are opposing but not adversarial. Similarly, Eros and Thanatos function in a complementary manner in the personal and interpersonal lives of people.

The prevailing tendency of mental life, according to Freud, is reducing, keeping constant, or removing internal excitations. The tendency to return the individual to a state of equilibrium implies a dynamic process by which the psyche successfully removes internal excitations returning the individual to a state of equilibrium following each disturbance, preventing either the life or death instinct establishing a dominant position.

The death instinct, like all instincts, originates in every cell and is considered the primary source of internal excitations. Cathexis of internal excitations is achieved by the fusion of life and death instincts returning the human organism to a state of equilibrium. However, if excitations exceed the psyche's ability to return the individual to a state of equilibrium conflicts arise necessitating the psyche's utilisation of various defensive and other measures to regain stability. Keeping the quantity of excitation within the organism stable is important for the individual's wellbeing (Freud, 1920).

The death instinct hardly ever appears in "pure form" (Freud, 1923), as it is always partially "fused" with the life instinct. This fusion with erotic components renders the death instinct harmless. While the manifestations of the life instinct are considered to be conspicuous and noisy, the death instinct, the more powerful of the two, operates silently, tending the organism towards dissolution (Freud, 1930).

A portion of the death instinct is diverted towards the external world in the form of aggressiveness and destructiveness; this too is seen to serve the life instinct. Freud (1930) wrote:

> The organism destroys some other thing, whether animate or inanimate, instead of destroying its own self. Conversely, any restriction of this aggressiveness directed outwards would be bound to increase self-destruction (pp. 77-78).

Freud (1924) considered this portion of the death instinct to be sadism proper, while the portion that remained inside the organism was recognised to be the "original, erotogenic masochism" (p. 163) or primary masochism.

In principle, then, the death instinct - like the life instinct - is in itself neither good nor bad; they are both necessary and complementary.

However, the death instinct can become a problem in human life. Freud elaborated on this in "Civilization and Its Discontents" (1930) where he considered civilised man's extreme difficulties in taming his own aggression. Modern over-civilisation has given us great powers, but also demands great suppression-repression. Consequently it produces a terrible dilemma: by acting out his aggressivity man risks destroying civilisation; by internalising it he runs the risk of perishing with intolerable guilt.

This concept has not had a happy fate in psychoanalysis. "For all Freud's authority, not all the psychoanalytic movement followed his lead" (Gay, 1988, p. 402). This is putting it mildly: most colleagues would accept the idea of aggressiveness as a part of our endowment, but not a "primitive urge toward death, or primary masochism". For the doubters Freud's distinction between "the silent death drive working to reduce living matter to an inorganic condition" and "strong aggressiveness" gave them an out (p. 402); they opted for the latter.

Ferenczi (1929) was among those psychoanalysts who did elaborate on the manifestations of the death instinct in human development. He hypothesised that growth at the beginning of life occurs with astonishing profusion and speed, but only under favourable environmental conditions. The inability of the mother to respond benignly to the infant's needs is responsible for the immediate stirring of destructive instincts and the vulnerability to death. Many of these infants "proffered organic possibilities for a quick exit, or if they escape this fate, they keep a streak of pessimism and of aversion to life" (p. 126).

Klein (1952) is another who kept Freud's concept of the death instinct alive. Her work on early development gave her deeper insight into the vital clinical importance of Freud's concept of life and death instincts. She thought that the primary cause of anxiety is the fear of annihilation - fear of death - arising from the working of the death instinct within. Her work with children led her to the conclusion that under the impact of the struggle between the two instincts, one of the ego's main functions - the mastery of anxiety - is brought into operation from the very beginning of life. Klein, it can be said, is "a kind of specialist in showing the consequences of different ways the psyche deals with the death drive" (Eigen, 1996, p. xx). Anxiety, splitting, projective and introjective identification, denial and dispersal are some of the ego's responses to this inner destructive force. Proliferation of these strategies that serve to dampen the effects of the death drive leads to "impoverishment of the

ego" and the "dispersal of emotions" (p. 609). The result is inner deadness; the patient feels disintegrated, emotionless and depleted. While Klein used Freud's concept of the duality of instinct in her clinical work, she mainly attended to the conflict between love and hate of the object, considering hate as an expression of the deflected death instinct (Segal, 1993).

Segal (1993), Klein's most significant interpreter, argues that the concept of the death instinct is indispensable to clinical work. She refutes the common argument that the death instinct ignores the environment, arguing that "since the fusion and the modulations of the life and death drives which will determine the eventual development are part of the developing relationships to the early objects...therefore, the real nature of the environment will deeply affect the process" (p. 59). Like Klein, Segal focuses on the defensive manoeuvres adopted against the death instinct. These defensive manoeuvres "create vicious circles leading to severe pathology" (p. 59) which, when analysed and the death instinct confronted in the stable setting of analytic work, lead to a mobilisation of the life forces in the patient.

Perhaps the most controversial of many controversial psychoanalytic ideas, the death instinct has attracted ongoing debate concerning its philosophical status and its clinical usefulness (Feldman, 2000). A common criticism which manages to avoid discussing the concept itself says that Freud's personal experience with grief and loss and preoccupation with death were responsible for the elevation of the death instinct to a primal force and the final revision of the drive theory (Anderson, 2001; Chessick, 1992; Gronseth, 1998; Hamilton, 1976; Quinodoz, 2004; Virsida, 2001; Wallace, 1976).

Others argue that the theory relies on incredible biological concepts (Fox, 1943, Sternbach, 1975, Pedder, 1992, Ikonen & Rechardt, 1978) and that Freud's use of such mythological concepts as Eros and Thanatos demonstrates the intangible nature of instincts, and raises criticisms regarding their clinical usefulness (Chessick, 1992).

Historical and contemporary psychoanalysts debate whether the origins of aggression are instinctual. There are psychoanalysts who argue that aggression is instinctual, and is a manifestation of the death instinct. Others argue that aggression is instinctual, but they do not accept a death instinct. And most others - in particular object relations theorists - consider aggression as non-instinctual, it being brought about instead by frustration by the environment.

Trying to avoid splitting between drive and non-drive theories, Mitchell (1993) proposes preservation of the essential features of both drive and non-drive theory. While the drive models of aggression have expanded our

understanding of the inherent destructiveness in human motivation and its centrality in the development of the self, the non-drive models of aggression have expanded our understanding of the subjective context within which rage and destructiveness arise. It is the complex interaction between instinctual stirrings, constitutional sensitivities, environmental transactions, and the psyche that has a determining influence on the individual's emerging personality and ability to keep the death instinct in check.

Freud (1924) admitted to being without any physiological understanding of the ways and means by which this taming of the death instinct by the libido may be effected. He later suggested that "future investigations may some day be of great importance for the understanding of pathological process" (Freud, 1933, p. 105). Perhaps that day is at hand.

Back to instincts

It was typical of Freud to invoke Greek literature and mythology, and it was also characteristic of him to attempt to ground his ideas in the biomedical and physical sciences. A highly regarded neuroscientist in his day, Freud believed advances in neuroscience would some day mean that the deficiencies in his description of instinctual life would vanish and psychological terms would be replaced by physiological and chemical ones (Solms, 2004). Freud was convinced that specific neurochemical foundations for instincts existed. Of course it's not just the idea of a death instinct that puts many writers and therapists off, it is the idea of instincts per se. Modern research is now able to show neural equivalents to Freud's classification of human instinctual life.

Brockman (2000) expounds on the biological basis of automatic or instinctual behaviour. He notes that Freud's focus on the consequence of instincts arose out of his belief that instincts cannot become an object of consciousness and therefore cannot be addressed as either an idea or affective state. Freud (1933) looked to the mental field for instinctual manifestations. He asserted that "from its source to its aim the instinct becomes operative psychically" (p. 96). It was the psychical representation of the instinct Freud believed was amendable to analysis. Uncovering and interpreting the unconscious motives of these manifestations in analysis may provide a pathway to influencing instinctual life.

Brockman (2000) provides a psychobiological understanding of the nature of instincts. He defines an instinct as "a psychobiological organisation of memory-affect-anticipation-action, an organisation of cell bodies that can be brought together and taken apart" (p. 509). Convinced there are biologic connections between instinct and consciousness, he asserts it would be

incorrect to assume that an instinct cannot be fully known: "How one responds to a situation depends on how one perceives that situation" (p. 500). He compares contextual-fear and classical-fear conditioning to support his statement. Contextual fear conditioning is the biologically more complex. Brockman describes how in classical fear conditioning the amygdala and noradrenalin are essential, while for contextual fear conditioning, an intact hippocampus and glucocorticoid release are also necessary. The hippocampus and glucocorticoids are required for the distribution and integration of experience.

> This is important – both for learning in general and for psychoanalytic learning in particular because it provides one of the biological underpinnings for transference: data can be associated from a powerful emotional experience that may both remain unconscious mediated through the amygdala and connect to conscious experience mediated through the hippocampus. When one places the anatomy of the amygdala and its circuits in the context of hormonal and psychological factors, it seems plausible that they are the sites that regulate arousal abnormalities. It describes a frontier where the experience of one person could be transferred to another by virtue of an affective link (p. 503).

According to Brockman, this frontier is where instinct and consciousness meet. His theory provides important insights as to the occurrence of the compulsion to repeat experiences seemingly against the wish of the individual, the phenomenon that led Freud to hypothesise a death instinct. Brockman's findings provide a physiological basis for understanding how repressed experiences have a powerful impact on how we perceive situations. The benefits of uncovering and bringing these powerful experiences to consciousness to allow the individual to experience and integrate new experiences is now understood from a psychobiological perspective. These new discoveries also suggest there are "infinite pathways for the conscious mind to access – and modify – the unconscious mind and the body" (Pert, 1997, p. 141).

Research consistently demonstrates that deficient early environments create vulnerabilities and/or interact with genetically based vulnerabilities in infants that produce disruptions in emotional processing and in stress-responsive biological regulatory systems, including sympathetic-adrenomedullary and hypothalamic-pituitary-adrenocortical functioning (Repetti, et al., 2002). The need for children's developing physiological and neuroendocrine systems to repeatedly adapt to threatening and stressful circumstances increases the likelihood of biological dysregulations.

Although the endocrine system has the same basic design and functional architecture, each person's endocrine system functions somewhat differently because of genetic variation and environmental influences. Physiological regulatory mechanisms, such as the autonomic nervous system, sympathetic adrenomedullary and parasympathetic nervous system, hypothalamic pituitary adrenal axis, and limbic (serotonergic) system, have been shown to regulate several biobehavioural pathways that are significant for health.

Halfon and Hochstein (2002) extend this theory into the realm of illness. They point out that it has been found that different behavioural and autonomic reactivity patterns are associated with the development of acute illness and psychopathology. The damage done to physical health of individuals exposed to negative environments may come from the initiation of biologically dysregulated responses to stress, the effects of which may be cumulative over the lifespan. Chronic diseases such as hypertension, cardiovascular disease, diabetes, and some cancers may begin as early as childhood in these biological dysregulations.

We have seen how modern research has begun to lay the biological foundations of important psychoanalytic concepts, enhancing the death instinct's credibility and clinical usefulness. Advances in cell biology allow us to better comprehend the mutual interplay between psychical and biological stimuli and the physiological response to the death instinct's ascendancy. We have seen that psychological and biological functioning is interdependent and that psychological disturbances have impacts on the functioning of the body.[1]

Psychodynamic therapists generally write from a purely psychoanalytic perspective when considering the effects of psychic stimuli. The patients' unconscious fantasy is perceived as linked to their feelings of resignation and to the development of physical illness, but we seldom consider the biochemical link between the patient's feelings and physical illness. Psychoanalytic works predominately focus on unconscious fantasy and repression, whereas as we will now show empirical studies focus on the effects of suppression.

Suppression in psychoneuroimmunology studies

In order to present our case we describe in this section the results of some studies in the field of psychoneuroimmunology. But first, a word on suppression-repression. Throughout Freud's career he used the terms 'suppression' and 'repression' interchangeably (Erdelyi, 1990). The closest he ever came to distinguishing between suppression and repression was explained in a long footnote: "I have omitted to state whether I attribute

different meanings to the words 'suppressed' and 'repressed'. It should have been clear, however, that the latter lays more stress than the former upon the fact of attachment to the unconscious" (Freud, 1900, p. 606). Thus we advance the suggestion that the mal-effects of suppression which follow, may apply to all shades of suppression-repression.

The ability to suppress emotions and thoughts varies considerably from one individual to another, depending on the flexibility and overall character of the defence organisation (Werman, 1983). Suppression has been defined by Werman as the "volitional elimination or diminution from consciousness, by any means, of undesirable thoughts, feelings, or bodily sensations" (p. 413). The study of thought suppression has grown into a significant area of scientific inquiry. What has compelled the interest of the scientific community is the realisation that "suppression is not simply an ineffective tactic of mental control; it is counterproductive, helping assure the very state of mind one had hoped to avoid" (Wenzlaff & Wegner, 2000, p. 59).

Individuals often suppress emotional thoughts that arouse negative emotions as a way of regulating mood and reducing distress (Petrie, et al., 1998). According to Booth and Petrie, the suppression of emotions requires ongoing psychological 'work' in order to accommodate the disparity between what one is feeling and what one is experiencing. This work indicates an increase in sympathetic nervous system activity which may have unhealthy consequences if becomes habitual. The constant suppression of emotions affects the neuroimmune network resulting in immunosuppression, leading to adverse health outcomes says Booth (2005).

Wegner's (1992) study on "Instructed thought suppression" found paradoxically that the instruction to suppress a thought typically induces a remarkable preoccupation with that thought, and that the resultant sensitivity to these thoughts heightens emotionality. Furthermore Wegner recorded that during suppression of emotional thoughts, intrusive recurrences are associated over time with electrodermal responses. The conclusion is that emotional thoughts that are suppressed cause stronger psychophysiological responses than those that are not suppressed. Subsequent research measuring the tendency to suppress unwanted thoughts (Wegner & Zanakos, 1994) augments prior findings that suppression may be a precursor of psychopathological reactions ranging from obsession to depression to anxiety. Wegner and Zanakos conclude that the tendency to dislike negative thoughts and to react to them with suppression is associated with depression severity and they suggest that thought suppression is therefore a useful way of understanding how people may become depression-prone.

The emergence in recent decades of the discipline of psychoneuroimmunology has advanced knowledge of the relationship between psychosocial factors, the central nervous system, the immune system, and disease (Keller, Schleifer, Barlett, Shiflett, & Rameshwar, 2000). It is now known that psychological experiences such as stress and anxiety can influence immune function, which in turn may have an effect on disease development and progression (Azar, 1999).

The idea that emotions and physiology mutually influence one another suggests that the immune system as part of our physiology may be affected by the expression of emotion (Booth, 2005). The expression and non-expression of emotion has been studied in chronic illness and in the quality of life of people living with or recovering from illnesses (Lepore & Smyth, 2002). Research findings provide strong evidence that the health benefits of emotional disclosure may result partially from effects on immune function (Booth & Petrie, 2002). As our emotions change, "the structure of our bodies changes and we experience our lives differently" (Booth & Petrie, 2002, p. 159). In other words, physiological changes accompany expression and suppression of emotions.

In O'Leary's (1990) review of empirical evidence linking emotional processes to immune function in humans she found, along with the findings that reveal the adverse effects of chronic stress on immune function, that certain personality styles may also enhance or degrade immune response affecting disease susceptibility and progression. Personality traits and coping styles are of particular interest in psychoneuroimmunology research she suggests, because "some immunologic diseases are chronic or take much time to develop" (p. 374).

Tacon's (1998) study is the first known study to examine cancer from an attachment theory perspective. Fifty two women with breast cancer and fifty two without cancer between the ages of 35 and 55 participated in the study. Parental care and control in childhood, general attachment style, and emotional control in adulthood were measured. Emotional suppression or control of negative emotions, especially anger, was noted as a characteristic of the avoidant style of attachment. The most important finding of Tacon's study was that women with breast cancer scored significantly higher than did the comparison group on avoidant attachment and on emotional control.

A study of breast cancer progression shows that "neoplastic spread was associated with repression, reduced expression of negative affect, helplessness-hopelessness, chronic stressors, and comforting daydreaming" (Stein & Spiegel, 2000, p. 129). Strikingly, they found that positive personality

traits, for example, optimism and an optimistic explanatory style, appeared to negatively impact immune function too. Stein and Spiegel conclude that expression of intrapsychic distress may contribute significantly to delay in tumour progression. They argue "although spectators may prefer the patient to be pleasantly quiet, the immune system response does not justify this preference" (p. 130). This may suggest that 'difficult' noncompliant traits may predict a better prognosis than masochistic traits.

An earlier study conducted by O'Donnell (1993) drew similar conclusions. Semi-structured questionnaires were used to measure the psychological responses and psychosocial adjustment of 53 patients with early breast cancer to their illness. Blood was collected for serum estimation of natural killer cell activity. Patients were followed up after five years to determine disease recurrence and survival. Consistent with the initial hypothesis, suppression of anger was found to significantly predict recurrence of disease within five years.

The selection of studies examined indicates inconclusive evidence linking the development of cancer and inhibition of expression of negative affects. Ader (cited in Azar, 1999) cautions against premature claims that the mind can cure cancer and other diseases due to the lack of definitive evidence. However, he also says that we cannot deny a connection between the brain and the immune system just because researchers have yet to find a biological mechanism linking the two systems; absence of evidence of a link is not evidence of absence of a link.

We have seen how psychosocial factors, attachment style, and personality traits influence the individual's tendency to suppress emotions. This tendency to suppress emotions impacts negatively on immune function, which if experienced over a long period may have adverse health outcomes. Conversely, research shows that positive physiological change accompanies stressor modulation and expression of emotion.

Conclusion

Blockages preventing cathexis of the death instinct through the externalisation of aggressive and destructive impulses are seen as the primary cause of self-destruction according to Freud. Empirical studies reveal that suppression of emotions has a negative impact on immune function disturbing the equilibrium of the body, which in the longer term may lead to adverse health outcomes. Both psychoanalytic and empirical approaches suggest that physiological changes accompany emotional changes. These studies support Freud's contention that the repression of emotions presents

a significant psychical and physiologic burden to the individual leading to illness, psychological and somatic. Freud introduced talk therapy as a way of uncovering repressed conflicts through the technique of free association. This process clears blockages inhibiting the release of internal excitations, returning the individual to a state of equilibrium. This too has been empirically demonstrated in the field of psychoneuroimmunology.

While psychoanalytic knowledge is not measurable in the same way as empirical research on psychosomatic disorders, linking Freud's concept of a death instinct to empirical studies on psychosomatic disorders allows for measurable and practical knowledge gained from research to be integrated into the psychotherapeutic setting. These findings empirically support what Freud attempted to articulate in his 1920 publication: that the development of blockages impeding the external expression of aggressive and destructive impulses has grave psychological and physiological consequences for the individual's health. And conversely, positive psychological and physiological changes accompany expression of emotions.

We have seen that the repression of emotions, in psychoanalytic studies and the suppression of emotions, in empirical studies, have a negative effect on health. Without denying other external contributing factors, the psychoanalytic literature calls attention to the unconscious motive of the individual when evaluating disease in patients. Identifying and relating specifically the emotional factors contributing to somatic disease is the task of psychotherapy. Treatment involves working-through (Freud, 1914), clearing blockages to repeated healthy expression of these emotions, thereby returning the individual to a state of equilibrium through the mobilisation of the life force in the patient.

For example, Goldberg (1995) draws on scientific research and her clinical experience to suggest that people with cancer are "typically extremely constricted when it comes to consciously experiencing their anger" (p. 84). Goldberg considers her patients' illness as a manifestation of the death instinct and urges modern analysts to embrace the "dark" aspects of being human. To be human, Goldberg suggests, is to be able to allow oneself to feel and express anger, hate, vindictiveness, the wish to hurt and harm as well as the wish to be hurt and be harmed - to acknowledge "the dark, ugly" feelings as well as the "sweet, pleasant ones" (p. 84). She recommends that analysts be authentic in their own expression of emotion with clients by using induced feelings, differentiating one's own self from the other, and using thoughts and feelings to stimulate in patients their own thoughts and feelings.

Rosenbaum hypothesises in her article "Groupicide" that institutions, by limiting external expression of aggression, may produce self-destruction in the form of physical illness. This is akin to Freud's (1933) view on civilisation's suppressive aim in taming instincts. "Raw unmodified aggression is like any other basic drive, it must eventually find expression and only so much can be absorbed by our guilt system and turned back against the self" (Rosenbaum cited in Tabachnick, 1972, p. 55-56).

Understanding the unconscious significance of the patient's psychosomatic manifestations therefore becomes the primary therapeutic aim. The creation of a safe and supportive environment in which the patient and therapist are able to explore the patient's associations, transference feelings and fantasies, metaphors and dreams facilitates the patient's ability to access buried conflicts, primitive fantasies and forgotten memories, as well as more consciously suppressed material. Equally important is careful observation and capture of the patient's subtle non-verbal communication to trace the gradual coming into consciousness of the as yet unverbalised apprehensions struggling for expression. These regressive and archaic forms of communication may provide insights into the relationship between the patient's unconscious motivation and their psychosomatic symptoms revealing the hidden symbolic meaning of their illness. Man's psychic creativity provides a defence against psychic loss in traumatic circumstances and in the long run against his biological destruction (McDougall, 1974). While the psyche adapts in whatever way is necessary to preserve life itself, should the psyche's creations falter, one may be threatened with biological death.

Through the process of psychotherapy biologic expressions can be translated into psychologic expressions.[2] Bringing these expressions to consciousness, and from consciousness to expression, we are able to explore their meaning, releasing their intractable and destructive influence, re-establishing links between the soma and psyche. Confronting the death instinct by identifying and understanding the defences created against negative emotions, the patient is able to begin to recognise their aggression and come to regard all their emotions as healthy and natural. Using countertransferential feelings the therapist is given a sense of the patient's fears and the way in which they survived early psychic trauma. This allows the therapist to further her understanding of the defensive value of the patient's symptoms as a sign of deep, unrecognised distress. Facilitating the patients' awareness of her internal dynamics strengthens the patient's capacity to utilise multiple pathways and outlets for her internal excitations. The patient is then more able to recognise the consequences of the internal and external forces and events on her psyche.

The patient can begin to differentiate and flourish as dictated by internal and environmental reality strengthening the ability to maintain the death instinct in check. Research suggests that the course of the patient's illness may change through this rechannelling of bound up emotions.

Apparently outdated and surpassed ideas of Freud are receiving second looks. Freud "is back" says neurologist Solms rather optimistically.[3] Readers of popular magazines will have noticed articles reconsidering the value of Freud's ideas on dreams (Solms, 2000), the talking cure (Williams, 2007), and the structural model of the mind (Solms, 2004) in the light of recent scientific research.

In this article we contribute to this reinstating and integrating trend by considering another fundamental of Freud's thinking - the dual instinct model, in particular thanatos, or the death instinct.

References

Anderson J.W. (2001). Sigmund Freud's life and work: An unofficial guide to the Freud exhibit. *Annual of Psychoanalysis,* 29, 9-34.

Azar, B. (1999). Father of PNI reflects on the field's growth: Robert Ader finds the rise in popularity of psychoneuro-immunology gratifying and frightening. Retrieved May, 4, 2006 from: http://www.apa.org/monitor/jun99/pni.html.

Booth, R. (2005). Emotional disclosure and psychoneuroimmunology. In K. Vedhara and M. Irwin (Eds.). *Human psychoneuroimmunology* (pp. 319-341). Oxford: Oxford University Press.

Booth, R.J., & Petrie, K.J. (2002). Emotional expression and health changes: Can we identify biological pathways? In S.J. Lepore & J.M. Smyth (Eds.). *The writing cure: How expressive writing promotes health and emotional well-being,* (pp. 157-175). Washington DC: American Psychological Association.

Brockman, R. (2000). Instincts and their physiologies – A clinician's perspective. *Journal of American Academy of Psychoanalysis,* 28, 501-512.

Broom, B. (1997). *Somatic illness and the patient's other story.* London: Free Association Books.

Broom, B. (2007). *Meaning-full disease. How personal experience and meanings cause and maintain physical illness.* London: Karnac.

Chessick, R.D. (1992). The death instinct revisited. *Journal of the American Academy of Psychoanalysis,* 20, 3-28.

Eigen, M. (1996). *Psychic deadness.* New Jersey: Jason Aronson.

Erdelyi, M.H. (1990). Repression, reconstruction, and defense: History and integration

of the psychoanalytic and experimental frameworks. In J.L. Singer (Ed.). *Repression and dissociation: Implications for personality theory, psychopathology, and health* (pp. 1-31). Chicago: University of Chicago Press.

Feldman, M. (2000). Some views on the manifestation of the death instinct in clinical work. *International Journal of Psychoanalysis,* 81, 53-65.

Ferenczi S. (1929). The unwelcome child and his death instinct. *International Journal of Psycho-Analysis,* 10, 125-129.

Freud, S. (1900). The interpretation of dreams. In *The standard edition of the complete psychological works of Sigmund Freud: 4.* (J. Strachey, Trans., pp. 1-338). London: Hogarth Press.

Freud, S. (1914). Remembering, repeating and working-through. In *The standard edition of the complete psychological works of Sigmund Freud: 12.* (J. Strachey, Trans., pp. 145-156). London: Hogarth Press.

Freud, S. (1920). Beyond the pleasure principle. In *The standard edition of the complete psychological works of Sigmund Freud: 18.* (J. Strachey, Trans., pp. 3-64). London: Hogarth Press.

Freud, S. (1923). The ego and the id. In *The standard edition of the complete psychological works of Sigmund Freud: 19.* (J. Strachey, Trans., pp. 3-66). London: Hogarth Press.

Freud, S. (1924). The economic problem of masochism. In *The standard edition of the complete psychological works of Sigmund Freud: 19.* (J. Strachey, Trans., pp. 157-170). London: Hogarth Press.

Freud, S. (1930). Civilization and its discontents. In *The standard edition of the complete psychological works of Sigmund Freud: 21.* (J. Strachey, Trans., pp. 59-145). London: Hogarth Press.

Freud, S. (1933). Anxiety and instinctual life. In *The standard edition of the complete psychological works of Sigmund Freud: 22.* (J. Strachey, Trans., pp. 81-111). London: Hogarth Press.

Freud, S. (1937). Analysis terminable and interminable, In *The standard edition of the complete psychological works of Sigmund Freud: 23.* (J. Strachey, Trans., pp. 209-253). London: Hogarth Press.

Gay, P. (1988). *Freud: A life for our time.* New York: Doubleday.

Goldberg, J.G. (1995). Psychoanalysing the body. *Modern Psychoanalysis,* 20(1), 79-91.

Gronseth, R. (1998). On the question of the death instinct. *Nordisk Psykologi,* 50(1), 42-59.

Halfon, N., & Hochstein, M. (2002). Life course health development: An integrated framework for developing health, policy and research. *The Milbank Quarterly,* 80(3), 433-596.

Hamilton, J.W. (1976). Some comments about Freud's conceptualization of the death instinct. *International Review of Psychoanalysis,* 3, 151-164.

Hobson, J.A. (2004) Freud returns? Like a bad dream, *Scientific American,* May, 89.

Hoffman, T. (2004). Revival of the death instinct: A view from contemporary biology. *Neuro-psychoanalysis,* 6(1), 63-75.

Ikonen, P., & Rechardt, E. (1978). The vicissitudes of thanatos: On the place of aggression and destructiveness in psychoanalytic interpretation. *Scandinavian Psychoanalytic Review,* 1, 79-114.

Keller, S.E., Schleifer, S.J., Bartlett, J.A., Shiflett, S.C., & Rameshwar, P. (2000). Stress, depression, immunity, and health. In K. Goodkin & A.P. Visser (Eds.). *Psychoneuroimmunology: Stress, mental disorders, and health* (pp. 1-25). Washington DC: American Psychiatric Press.

Klein, M. (1952). The mutual influences in the development of ego and id - discussants. *Psychoanalytic Study of the Child,* 7, 51-53.

Lepore, S.J., & Smyth, J.M. (2002). The writing cure: An overview. In S.J. Lepore & J.M. Smyth (Eds.). *The writing cure: How expressive writing promotes health and emotional well-being,* (pp. 3-14). Washington DC: American Psychological Association.

McDougall, J. (1974). The psychosoma and the psychoanalytic process. *International Review of Psychoanalysis,* 1, 437-459.

Mitchell, S.A. (1993). Aggression and the endangered self. *Psychoanalytic Quarterly,* 62, 351-382.

O'Donnell, M.C. (1993). Psychosocial factors predicting recurrence in breast cancer patients: Neuroimmunological correlates. *Dissertation Abstracts International,* 55(02), p. 625.

O'Leary, A. (1990). Stress, emotion, and human immune function. *Psychological Bulletin,* 108(3), 363-382.

Pedder, J. (1992). Psychoanalytic views of aggression: Some theoretical problems. *British Journal of Medical Psychology,* 65, 95-106.

Pennebaker, J.W. (1997). *Opening up: The healing power of expressing emotions.* New York: The Guilford Press.

Pert, C.B. (1997). *Molecules of emotion: Why you feel the way you feel.* London: Simon & Schuster.

Petrie, K.J., Booth, R., & Pennebaker, J.W. (1998). The immunological effects of thought suppression [Personality processes and individual differences]. *Journal of Personality and Social Psychology,* 75(5), 1264-1272.

Quinodoz, J.M. (2004). *Reading Freud: A chronological exploration of Freud's writings.* London: Routledge.

Repetti, R.L., Taylor, S.E., & Seeman, T.E. (2002). Risky families: Family social environments and the mental and physical health of offspring. *Psychological Bulletin,* 128(2), 330-366.

Segal, H. (1993). On the clinical usefulness of the concept of death instinct. *International Journal of Psychoanalysis,* 74, 55-61.

Stein, S., & Spiegel, D. (2000). Psychoneuroimmune and endocrine effects on cancer progression. In K. Goodkin & A.P. Visser (Eds.). *Psychoneuroimmunology: Stress, mental disorders, and health* (pp. 105-151). Washington DC: American Psychiatric Press.

Sternbach, O. (1975). Aggression, the death instinct and the problem of sadomasochism. A reinterpretation of Freud's second drive theory. *International Journal of Psychoanalysis,* 56, 321-333.

Solms, M. (2000) Freudian dream theory today, *Psychologist,* 13(12), 618-619.

Solms, M. (2004) Freud returns, *Scientific American,* May, 83-88.

Tabachnick, N. (1972). Theories of self-destruction. *American Journal of Psychoanalysis,* 32(1), 53-61.

Tacon, A.M. (1998). Parent-child relations, attachment, and emotional control in the development of breast cancer (Doctoral dissertation, University of Texas). *Dissertation Abstracts International,* 59(03), p. 972.

Virsida, A.R. (2001). The death drive: Psychic construction or destruction? *Psychoanalytic Review,* 88(4), 511-524.

Wallace, E.R. (1976). Thanatos – a re-evaluation. *Psychiatry,* 39(4), 386-393.

Wegner, D. (1992). You can't always think what you want: Problems in the suppression of unwanted thoughts. In M. Zanna (Ed.), *Advances in experimental social psychology,* (pp. 193-225). San Diego: Academic Press.

Wegner, D.M., & Zanakos, S. (1994). Chronic thought suppression. *Journal of Personality,* 62, 615-640.

Wenzlaff, R.M., & Wegner, D.M. (2000). Thought suppression. *Annual Review of Psychology,* 51, 59-91.

Werman, D.S. (1983). Suppression as a defense. *Journal of the American Psychoanalytic Association,* 31(S), 405-415.

Williams, D. (2007). Back to the couch, *Time,* February 19, 43.

(Endnotes)

[1] We employ dualistic body/mind wording here, but it should be clear that what is at work is a body-mind holism. See Broom (1997 and 2007).

[2] Of course there are other ways to accomplish this. See, for example Pennebaker's (1997) work on writing (and speaking to tape) to improve immune function.

[3] This is far from being a generally accepted trend. Hobson flatly contradicts it, saying, "Psychoanalysis is in big trouble, and no amount of neurobiological tinkering can fix it" (2004, p. 89).