THE REPETITION COMPULSION AS NARRATIVE ACTION:
AN INTERPRETIVE INQUIRY
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What if some day or night a demon were to steal after you into your loneliest loneliness and say to you, “This life as you now live it and have lived it, you will have to live once more and innumerable times more, and every thought and sigh and everything unutterably small or great in your life will have to return to you, all in the same succession and sequence.” (Nietzsche, 1887/1974).

INTRODUCTION: Freud’s concept of the Repetition Compulsion

The concept of the repetition compulsion (Freud, 1914; 1920) has been the source of much controversy and the subject of various interpretations throughout the development of psychoanalysis. This is due in part to the fact that Freud himself offered at least two somewhat distinct aspects to the repetition compulsion. There is confusion as to whether the compulsion to repeat is seen in the service of resistance, a powerful obstacle opposed to recovery or is the most important force toward cure. In the present paper, I will take the hermeneutic position that the repetition compulsion is not only a necessary, but is an inevitable aspect of any analytic or depth psychotherapy.

My thesis is that the compulsion to repeat, in the context of the clinical situation, and especially with more primitive or regressed aspects of the transference neurosis, can best be understood as a form of communication and of remembering. This view of the repetition compulsion is based on the idea of action as narrative, i.e. the past as embodied and enacted in the present reveals its own story. The work of analysis is therefore to attend to the entire transference field of action and interaction that is created between patient and therapist. This is often the only way that the primitive (prelinguistic, presymbolic, prerepresentational) aspects of traumatic early history can be understood and constructed.

The repetition compulsion refers to the way that the past has been appropriated and incorporated into the patient’s generalized, embodied way of being (or, in other words, their character style). In analytic psychotherapy, the best access to this realm of being, to uncover the forces that empower the patient’s embodiment, is to attend to the manner with which the patient’s material is presented. The mode of communication, particularly the nonverbal reactions and style of speaking, and their effects on the therapist, offers an important inroad into the patient’s early life history (or, as I would prefer to say, to the tacit background horizon) particularly primitive affective states, internal object relations and preverbal trauma. This is enacted within the transference/countertransference (i.e. intersubjective) field. I will attempt
to demonstrate the importance of focused observation and interpretation of embodied enactments, especially acts of speech. With careful observation, we can notice “breaks” in the compulsive repetitions, within which the horizon opens up, and affects as well as bodily reactions associated with early life trauma and infant danger situations emerge.

The whole concept of the analytic transference is predicated on the notion that the patient repeats with the analyst important aspects of his early life history. Transference as repetition is particularly important with regards to the concept of “transference neurosis.” The analytic situation, as Loewald (1975) has described, is a “dramatic play” being unconsciously staged by the patient with the analyst as director of the play. The transference neurosis involves a “reenactment,” a “dramatization,” “an emotionally experienced recapitulation of the patient’s inner life history in crucial aspects of its unfolding” (Loewald, 1975, p. 278-279). It becomes a “fantasy creation,” an “imitation in action of an original action sequence” (p. 279).

Transference actions, as “imitations of earlier actions” (Loewald, 1975, p. 281) are gradually revealed as forms of memory, “a repetition of earlier action” (p.285), that enacts in a new guise similar themes as earlier actions. As Loewald (1975) states,

> Thus the transference neurosis again and again is revealed as imitation of action, a dramatic play having its roots in the memories of original action and deriving its life as a present creation of fantasy from the actuality of the psychoanalytic situation and its interactions (p. 285).

Freud (1905) described transference reactions “as new editions or facsimiles” of various fantasies and psychic tendencies and conflicts that get aroused in analysis. These reactions get displaced onto the person of the analyst. Freud showed how his failure to sufficiently analyze Dora’s negative transference toward him (as displaced feelings toward her lover) had led to these feelings being discharged in action (i.e. were “acted out”).

> She took her revenge on me as she wanted to take her revenge on him, and she deserted me as she believed herself to have been deceived and deserted by him. Thus she acted an essential part of her recollections and phantasies instead of reproducing them in treatment. (Freud, 1905, p. 141).

The patient’s tendency to express in action, to reproduce in treatment that which should be remembered or reproduced in the psychic realm is a point that Freud made in several additional early writings on transference and technique. In 1912, he discussed how early childhood dispositions and libidinal attachments form a “cliché or stereotype... which perpetually repeats and reproduces itself as life goes on” (p. 106). At this point in his formulations, he viewed transference as the “strongest resistance to the cure” in the sense that it inhibits free association, thus becoming an obstacle to the recovery of childhood memories (i.e. the “pathogenic memory” model, Ellman, 1991).

> The unconscious feelings strive to avoid the recognition which the cure demands; they seek instead for reproduction, with all the power of hallucination and the inappreciation of time characteristic of the unconscious. The patient ascribes, just as in dreams, currency and reality to what results from the awakening of his unconscious feelings; he
seeks to discharge his emotions, regardless of the reality of the situation. The physician requires of him that he shall fit these emotions into their place in the treatment and in his life – history, subject them to rational consideration, and appraise them at their true psychical value. This struggle between physician and patient, between intellect and forces of instinct, is fought out almost entirely over the transference – manifestations. (Freud, 1912, p. 114)

Thus, we can see here that Freud views transference repetitions as the “battleground” and the source of “greatest difficulties.” They become the strongest resistance to cure in that the unconscious emotions are seeking to be discharged from action, rather than being acknowledged, remember and understood. At the same time, Freud recognized that these affective manifestations are also the “vehicle of the healing process, necessary condition for success...” (Freud, 1912, p. 107) “for in the last resort no one can be slain in absentia or in effigie.” (p. 115).

In this paper “Observations on transference-love,” Freud (1915) argues that the patient’s transference emotions consist of “new editions of old traces.” This new edition in the present “repeats infantile reactions” (p. 176). The powerful pull or force within the patient seeks to actualize the transference feelings (i.e. love emotions) with the analyst. Freud warns of the danger of analysts; actively participating in act-out the patient’s drama.

She would have succeeded in one all patients struggle for, and expressing action, reproducing in real life, what she ought only to remember, to reproduce only in the content of her mind to retain within the mental sphere. (p. 174)

In these early writings, Freud takes a wide view of repetitions in analysis. The transference itself is a “new edition” (repetition) of repressed memory traces now being displaced onto the person of the analyst. He delineates the dynamic tension within the transference between the tendency to reproduce in action these early events and feelings, and the analytic work of fostering conscious recollection of repressed material. The analyst attempts to confine his transference reactions verbal sphere. Thus, repetitions were viewed as being in the service of defense and resistance to memory.

It was in his seminal paper, “Recollection, repetition and working through” that Freud made his first explicit use of the term “repetition–compulsion.” Freud (1914) gave what is now its classic definition:

the patient remembers nothing of what is forgotten repressed, but that he expresses it in action. You reproduces is not in his memory but in his behavior; he repeats it, without of course knowing that he is repeating it. (p. 160).

Freud (1914, p.164-165) goes on to say that

The patient reproduces instead of remembering... or expresses in action... everything in the reservoirs of repressed material that has already permeated his general character – his inhibitions and disadvantageous attitudes of mind, his pathological traits of character.... We have to treat his illness as an actual force, active at the moment, and
not as an event in his past life... And while the patient lives it through as something real and actual, we have to accomplish the therapeutic task, which consists chiefly in translating it back again into the terms of the past (italics added).

Even though Freud is still emphasizing the recovery of pathogenic memories as the central aspect of cure, (thus viewing the repetition compulsion is resistance to remembering), he is also advising that the repetitions be allowed to expand within the transference situation (cf. Gill, 1979). As he says,

> We admit it into the transference as a playground, in which it is allowed to let itself go in almost complete freedom and is required to display before us all the pathogenic impulses hidden in the depths of the patient's mind. From the repetition – reactions which are exhibited in the transference, the familiar path leads back to the awakening of the memories which yield themselves without difficulty once the resistances have been overcome (Freud, 1914, p. 164 – 165)

In one of his last works, *An outline of psychoanalysis*, Freud (1940) reiterates the importance of confining the compulsion to repeat to the analytic situation.

> We think it is most undesirable if the patient acts outside the transference instead of remembering. The ideal conduct for our purposes would be that he should behave as normally as possible outside the treatment and express his abnormal reactions only in the transference. (p. 34).

As Freud describes, the repetition -actions, within analysis actually form the core material out of which treatment proceeds. They are the current manifestations of the patient's characteristic ways of being. In his formulation, the repressed memories being lived out in analysis form the basis of the transference neurosis. Thus, the transference neurosis here signifies that the patient is fully in the grip of the repetition compulsion within the analytic field. The power of the transference to impel action has been sufficiently contained so that a transitional state develops within which "a translation of a private code into a common language" (Reed, 1990, p. 434) occurs. The past infuses the present with the uniting of remembering and experiencing (Reed, 1990) or of fantasy and reality (Loewald, 1975). In this way, the patient repeats the core of his/her pathology, in all of its emotional intensity within the confines of the analytic situation. The “past" (or as I would prefer to say, the implicit background structure that has become sedimented as a generalized life – history) is alive and feels real as a contemporary experience to the patient.

The repetition compulsion thus refers to the tendency to express in action what is not consciously remembered, experienced or expressed (i.e. the past story is “acted-out”). The term "acting-out" has developed a pejorative significance in recent years. The treatment of severe borderline personality and other character disorders has highlighted that certain types of impulsive actions can be destructive to the patient and detrimental to the treatment. However, while it is certainly true that some overly dangerous and self-destructive behaviors need to be confronted and/or contained, it is my view that most forms of repetitive actions can
be better understood as being part of a narrative performance (Schafer, 1983) within the therapy situation (as well as in our everyday lives).

This is what Freud seemed to have in mind about the positive function of transference actions when he states that:

The patient produces before us with plastic clarity an important part of his life-history, of which he would otherwise have probably given us only an insufficient account. He acts it before us, as it were, instead of reporting it to us. (Freud, 1940, p. 33, italics added).

Thus, the patient in treatment, through repetition in action, is, in effect, unknowingly telling the story or reliving history. Where I would dispute Freud in this regard, and which forms a central aspect of my paper, is his distinction between enacting and reporting. In my experience, the patient's speech, viewed as a performative action, is often a central aspect of the repetition compulsion. Thus, while attempting to free associate and verbally communicate thoughts and feelings, the patient's way of communicating (with its effects on the therapist) are the repetitions in action to which Freud refers.

Freud stresses, as we have seen, the importance of allowing the repetition compulsion to unfold within the treatment situation. What did Freud have in mind when he called repetition compulsion within transference as "new editions" of past history now being reenacted on the analytic "stage?" Freud (1914) here provides some examples:

For instance, the patient does not say that he remembers how defiant and critical he used to be in regard to the party of his parents, but he behaves in that way toward the physician. He does not remember how he came to a helpless and hopeless deadlock in his infantile searching after the truth of sexual matters, but he produces a mass of confused dreams and associations, complaining that he never succeed at anything, and describes his fate never to be able to carry anything through. He does not remember that he was intensely ashamed of certain sexual activities, but he makes it clear that he is ashamed of the treatment to which he has submitted himself, and he does his utmost to keep a secret; and so on. [Or]... he has nothing to say. He is silent and declares that nothing comes into his mind. As long as he is in treatment he never escapes from this compulsion to repeat; at last one understands that it is his way of remembering. (p. 160 - 161)

In 1920, Freud returned to the theme of the repetition – compulsion. He describes how the patient is impelled to reenact in treatment what was repressed and forgotten, especially aspects of a traumatic nature.

The patient cannot remember the whole of what is repressed in him, and what he cannot remember may be precisely the essential part of it. He is obliged to repeat the repressed material as a contemporary experience instead of... remembering it as something belonging to the past. (p. 39)
When these reproductions become the primary part of the treatment, the patient is in the throes of the “transference neurosis. The primary task of the analyst is thus to contain the transference and

to force as much as possible into the channel of memory and to allow as little as possible to emerge as repetition. He must get him to re-experience some portion of his forgotten life....[and] to recognize that what appears to be reality act only a reflection of a forgotten past. (1920, p. 39 – 40)

Freud attributes the compulsion to repeat the power of the “unconscious repressed,” i.e. id impulses which are pressing toward consciousness and discharged through action. In support of his theory of the instinctual nature of the repetition compulsion, Freud was most struck by how the patient tends to reenact within the transference dramatic and painful childhood events, particularly associated with loss of affection and narcissistic wounds.

Here, the repetition compulsion is manifest in the ways patient acts in analysis and its impact on the analyst. The patient is actively (although usually unconsciously) attempting to place certain roles on the analyst and elicit responses similar to those of significant figures from childhood. These active repetitions can be seen as

an essential character-trait which always remains the same and which is compelled to find expression in a repetition of the same experiences. (1920, p.45).

Freud (1920) goes on to describe how patients in analysis repeat unpleasurable events and painful affects from childhood:

The patient behaves in a purely infantile fashion and thus shows us that the repressed memory-traces of his primeval experiences are not present in him in a bound state and are indeed in a sense incapable of obeying the secondary process (p. 66-67).

According to this statement, the compulsion to repeat in action is evidence of the existence of unbound (i.e. unmastered) primitive experiences which have remained cut-off from the coherent ego and continue to exert a powerful influence over behavior. Using the distinction between bound and freely mobile energy (first elaborated by Breuer, in Breuer and Freud, 1895), Freud has alluded that the repetition compulsion is rooted in the body. Certain energies are contained or enclosed within embodied states which are repeated in action without conscious awareness “actual force,’ i.e. the body’s life-force

Thus, the “action” that Freud describes is a repetition of, and an affective link to, earlier emotional dispositions, the connection to which are now forgotten or repressed. The analyst strives to prevent or contain the urge to express in action these emerging impulses and emotions. The main vehicle for accomplishing this task is the analytic transference. The compulsion to repeat thus should be allowed to unfold within the analysis.

In later writings, after formulating the structural model, the repetition compulsion is viewed as a fixation through primal repression, especially of early childhood dispositions. A libidinal attachment to an unconscious prototype (i.e. the repressed impulse) acts like a “driving force” (Freud, 1923) which channels the new impulses along an already formed pathway. Thus, the
patient reacts as if an old dangerous situation still exists in the present. The "action" becomes
fixated, narrowed and rigidified, unconsciously reproducing past situations, as the "unconscious
id's compulsion to repeat" (Freud, 1926, p. 79). The repetition compulsion is now seen as the
most primitive form of resistance, one which persists even after the patient is willing to
cooperate with treatment and ego resistances to recovery our lessened ("the resistance of the
id," Freud, 1926).

Later, Freud (1939) describe how the patient is compelled to re-create a traumatic experience:

[The patient] endeavors to revive the trauma, to remember the forgotten experience,
or, better still, to make it real - to live through once more a repetition of it; if it was an
early affective relationship it is revived in an analogous connection with another person.
These endeavors are summed up in the terms “fixation to trauma” and “repetition –
compulsion.” The effects can be incorporated into the so – called normal Ego and in the
form of constant tendencies led to it immutable character traits, although – or rather
because – their real cause, their historical origin, has been forgotten. Thus a man who
has spent his childhood in an excessive and since forgotten “mother – fixation” may all
his life seek for a woman on whom he can be dependent, who will feed and keep him. A
girl who was seduced in early childhood may orient her later sexual life towards
provoking such assaults over and over again. It will thus be seen that to understand the
problems of neurosis enables us to penetrate into the secrets of character – formation
in general. (p. 95, italics added)

The patient’s character is thus a result of the embodiment and repetitive compulsive
reenactment of an early life trauma. The traumatic or painful experience becomes a prototype
that is endlessly reproduced through characteristic ways of behaving and relating to others. In
this way, Freud has called the repetition compulsion “demonic,” “beyond the pleasure
principle,” and related to a “death instinct.”

In the present context however, I want to focus on Freud’s important observation that the
repetition compulsion is an “upward force” that strives to actualize, to make real what has been
forgotten. It is the patient’s “way of remembering.” In a curious statement, Freud (1914) goes
further and states that

something is “remembered” which could never have been “forgotten,” because it was
never at any time noticed, never was conscious. (p. 159)

What I take this to mean is that the repetition compulsion expresses in action, elements of
early infantile trauma that have no mental representation (Giovacchini, 1986). The traumatic
experiences have been registered but have never been coded into conceptual memory or
The origins and mechanism of the repetition compulsion: Freud

Freud (1920) in his major treatise on the compulsion to repeat discussed the organism's response to stimuli, particularly in relation to the system of perception (Pcpt.Cs). According to Freud, perception is based on a balance between reception of and protection against stimuli and excessive excitation. Freud's arguments are derived in part on some of his earliest work with Breuer (1895) on bound (quiescent) energy and free (mobile) energy in the psychical system. The main function of perception is to protect the organism against overstimulation from the external world.

*Protection* against stimuli is an almost more important function for the living organism than *reception* of stimuli (p. 53)

Freud differentiates between consciousness and memory – traces. In the outer layers, where excitatory stimuli are first encountered, there are no memory traces. The purpose of the outer layer is to filter incoming stimuli, allowing only small portions of the external world to be received. This layer forms a hard "crust" such that it would present only the most favorable possible conditions for the reception of stimuli and become incapable of any further modification. (p.51)

Underneath this outer crust lies an inner layer, the receptive cortical layer, which receives stimuli from the external world. This living layer would be overwhelmed by these external forces were their effects not somehow diminished. Thus, the outer layer acts as a “protective shield against stimuli” (p. 52) whose purpose is to filter and dilute incoming stimuli. It forms a “special envelope or membrane resistant to stimuli,” (p.52) which only allows a portion of the external world to pass through to the organism. The receptive layer (Pcpt.Cs), now spared of excessive impingement, also utilizes its own mechanisms (such as sensory apparatus) to further protect against excessive or undesirable stimuli. Reception of stimuli involves taking in only small amounts or “samples” of the external world.

They may perhaps be compared with feelers which are all the time making tentative advances toward the external world and then drawing back from it. (Freud, 1920, p. 54)

Freud (1925 a, b) later hypothesized an even deeper, innermost layer, i.e. the unconscious, where the memory traces are ultimately stored and repressed.

The permanent traces of the excitation which have been received are preserved in “mnemic systems” lying behind the perceptual system. (1925b, p. 208)

The receptive surface, which later Freud equated with the reality function of the ego (cf. 1933), turns toward and withdraws from the external world. Perception is thus an active process whereby the unconscious sent out cathected energy through the Pcpt.Cs (i.e. the ego) in order to sample and receives stimuli and pass it back through to the unconscious mimetic system. The ego utilizes judgment to decide on the pleasure/unpleasure of excitation and direct its course accordingly. It is in this regard that Freud terms thought as “experimental action,” (1925a, p. 216) with a minimum expenditure of energy and risk.
It is as though the unconscious stretches out feelers, through the medium of the system Pcpt.Cs towards the external world and hastily withdraws them as soon as they have sampled the excitations coming from without (1925b, p. 212).

Should any undesirable or excessive stimuli enter the receptive surface, there occurs a withdrawal of cathexis, a shut-down of the system and a lapse of consciousness. In severe instances, there is a complete break in the contact between the Pcpt.Cs and the unconscious. The development of a massive or severe anti-cathexis is the mechanism for primal repression (1915a, b) an unconscious fixation to early infantile impressions (especially painful, unpleasurable ones).

The human organism is seen as being extremely sensitive and vulnerable to the intrusion and impingement of the external world. It’s survival is based, in large part, on defensiveness and self-protection in guarding against annihilation and destruction by external overstimulation. In addition, and even more importantly, the organism must also be protected against overstimulation from the inside. However, the protective shield against external excitation is ineffective with regard to stimulation from within.

Towards the inside that can be no such shield; the excitations in the deeper layers extend into the system directly and in undiminished amount, insofar as certain of their characteristics give rise to feelings in the pleasure-unpleasure series. (1920, p. 55)

These feelings of pleasure/unpleasure take precedence over external stimuli. When there is too great a measure of unpleasurable excitation, the organism utilizes a particular mechanism to cope with them.

There is a tendency to treat them as though they were acting, not from the inside, but from the outside, so that it may be possible to bring the shield against stimuli into operation as a means of defense against them. This is the origin of projection. (1920, p. 56)

Projection (or externalization) is the prototypical method by which the organism copes with threatening internal stimuli. These internal threats take on increased significance as the repressed memories of past events (including early object relations) and dangerous instinctual impulses and drive derivatives. The repressed danger-situation, now experienced within the organism, becomes the unconscious prototype that is fixated and yet is impelled to repeat itself, as in the transference neurosis. Melanie Klein (1952) in her paper “The origins of transference” states that

I believe that the pressure exerted by the earliest anxiety situation is one of the factors which brings about the repetition compulsion. (p. 51)

The compulsion to reenact primary situations especially of a traumatic nature is most clearly seen in the primitive aspects of the transference, which usually emerges through non-verbal or para-linguistic enactments. Thus, Klein (1952) emphasizes the transference based on “total situations transferred from the past into the present” (p.55). According to this view, the repetition compulsion is empowered by cycles of projection and introjection wherein the
patient attempts to create external dangerous situations that represent primitive internal anxiety-situations (Mitchell and Greenberg, 1983, p. 134).

By reacting is what is inside as if it were from the outside, the world takes on the quality of fantasy, allusion, metaphor, illusion in the sense that what is experienced as true is in actuality a self-created reality. One becomes the actor in a story of which one is also the author, without recognizing that this is the case. Allusion, as indirect reference, and illusion, as fantasy creation, are both based on the Latin, ludere, which means "to play." This metaphoric or illusory quality is most pointedly enacted in the transference neurosis, where one is caught in the grip of the repetition compulsion. What is alluded to is "a depth dimension that is not immediately present" (Chapelle, 1986, p. 177). This has important implications in understanding the behavioral enactments of patients in analytic therapy.

There is a final an important aspect to this discussion of the origins of the compulsion to repeat, especially when the compulsion appears to fall outside the domain of the pleasure principle. Remember that Freud discovered the phenomenon he named repetition compulsion based on the tendency of patients to repeat situations that appear to bring pain, displeasure or other negative consequences. He also used children's play as well as the recurring dreams in traumatic neurosis as examples of this phenomenon.

In exploring why there would be a tendency to repeat or to return to situations and experiences of distress, Freud introduced the role of trauma.

We describe as "traumatic" any excitations from outside which are powerful enough to break through the protective shield. Such an event as an external trauma is bound to provoke a disturbance on a large scale in the functioning of the organism's energy and set in motion every possible defensive measure (1920, p. 56).

To understand the effects of trauma we return to Freud's earlier discussion of the difference between anxiety, fear, and fright and their relation to dangerous situations.

"Anxiety" describes a particular state of expecting the danger or preparing for it, even though it may be an unknown one. "Fear" requires a definite object of which to be afraid. "Fright," however, is the name we give to the state a person gets into when he has run into danger without being prepared for; it emphasizes the factor of surprise. (p. 29 – 30)

Fright, then, is a reaction to the traumatic situation, "caused by lack of any preparedness for anxiety" (p.59). Anxiety, on the other hand, is a state of preparedness, served to protect against fright and thus to avoid trauma. Freud (1926) expanded on this theme in the discussion of the signal function of anxiety. Fright is a passive response to a traumatic danger situation (e.g. the anxiety of birth) which becomes the prototype of any anxiety state that is automatically reproduced in situations analogous to the original dangerous situation. Anxiety is an active response to danger, occasioned by the threat of a repetition of the "traumatic moment," i.e. an experience of highly tense excitation (1933, p.83).
A danger situation is a recognized, remembered, expected situation of helplessness. Anxiety [or fright as used earlier] is the original reaction to helplessness in the trauma and is reproduced later on in the danger – situation as a signal for help. The ego, which experienced the trauma passively, now repeats it actively in a weakened version, in the hope of being able itself to direct its course. In thus changing from passivity to activity they attempt to master their experiences psychically (1926, p.92).

Freud elaborated on the signal function of anxiety, as preparedness for danger:

The ego subjects itself to anxiety as a sort of inoculation, submitting to a slight attack of illness in order to escape its full strength. It vividly imagines the danger-situation as it were, with the unmistakable purpose of restricting that distressing experience to a mere indication, a signal (1926, p. 88).

It is the subjective sense of helplessness in the face of some overwhelming stimuli that determines what is traumatic, not necessarily the event itself. The conditioned appraisal of passive vulnerability due to the threat of destructive overstimulation impels the need to repeat the trauma, but in small doses. This compulsion to actively reenact the danger – situation enables the organism to turn fright, as unpreparedness for danger, into anxiety, as a signal i.e. as preparedness for danger.

Gaining mastery over the excessive flood of excitation due to the traumatic breach in the protective shield becomes the organism's primary task, which, while in operation, assumes predominance over the pleasure principle. Freud defines this task as

the problem of mastering the amounts of stimulus which have broken in and of binding them, in the psychical sense, so that they can then be disposed of. (1920, p.57)

The task of mastery is a process of finding excessive stimuli and thus converting unbound, freely mobile energy into a quiet cathexis. The greater the quiet cathexis, the stronger is its binding power, i.e. the more resistant is the protective shield to external impingement. There remains a hyper cathexis at the site of the breach (at the stimulus barrier) while a massive anti—cathexis (or withdrawal of psychic energy) occurs at the interior of the organism. The lower the cathexis, i.e. the greater its unpreparedness, the more the organism remains vulnerable to a breach in the shield and the worse will be the consequences of such an intrusion.

It can now be seen that the task of binding free energy (forming a hyper cathexis) especially the binding of traumatic impressions, is analogous to the development of anxiety as preparedness for danger. Freud thus assigns priority to this function of defense over that of the pleasure principle in the earliest processing of stimuli. The compulsion to repeat, as evidenced by dreams and traumatic neurosis, has, as its prime function

...to master the stimulus retrospectively, by developing the anxiety whose omission was the cause of the traumatic neurosis (1920,.p. 60).
And, as stated by Ricoeur (1970),

Preparedness for danger, the positive and characteristic function of anxiety, is the equivalent to a shield against stimuli; when such preparedness is lacking, we have a breach in the shield, or trauma (p. 288).

In his paper "The Uncanny," Freud (1919) refers to this process of projection in the formation of the “double.” The ego, fearing its own destruction, projects mental contents outwards “as something foreign to itself," (p. 389) as part of its impulse for self – protection. The external object (i.e. the double) now possesses the attributes similar to the self. As an example, the well-known “dread of the evil eye” is based on the projection of envy to others who then appear to exhibit envious retaliation and persecution towards oneself.

Freud (1937) returns to this theme of the danger of stimuli from within, though now he describes it in structural terms, i.e. as the ego’s defensive reactions to id impulses and instinctual demands. If these defensive reactions of the ego are extensive (as in cases of severe or prolonged trauma), it can create a more or less permanently fixed “modification of the ego” (p. 253). The organism’s own stimuli, as instinctual demands, are treated like external dangers and the ego learns “to master the inner danger before it becomes external” (p. 253).

But one cannot flee from oneself and no flight avails against danger from within; hence the ego’s defensive mechanisms are condemned to falsify the inner perception (p. 255).

The defensive maneuvers of the ego, which were initially used (through the system (Pcpt.Cs) to ward off external dangers, i.e. the threat of destructive overstimulation, have now turned its defenses against the threat from within. Freud shows how the ego defenses persist and become an integral part of the compulsion to repeat.

These [mechanisms of defense] become fixated in the ego, establishing themselves as regular modes of reaction for that particular character, which are repeated throughout life whenever a situation occurs similar to that which originally evoked them. The adult ego with its greater strength continues to defend itself against dangers which no longer exists in reality and even finds itself impelled to seek out real situations which may serve as a substitute for the original danger, so as to be able to justify its clinging to its habitual modes of reaction (1937, p. 255 – 256, italics added).

The compulsion to repeat in action would seem to be precisely this process of re-creating and reenacting (restaging) the original situation of danger within the context of the analytic transference. This compelling force serves both as a resistance against the efforts of the analyst (and against recovery) both of which are perceived as renewals of external dangers, via the mechanism of projective externalization. At the same time, however, it allows both the patient and analyst to recognize and experience, in vivo, what usually occurs automatically and unconsciously. By thrusting forward into the light of observable behavior and reactions, it paves the way for recollection, ego observation, and for the reorganization of defensive patterns.

In later writings that are rooted in the structural model, Freud (1940) discusses the task of receiving and excluding stimuli and binding energy as being ascribed to the ego. The ego
operates on the basis of self-preservation. It protects from danger (an increase in unpleasure) by the use of anxiety as a signal, which anticipates the danger-situation and take steps to avoid the threatening unpleasure. It is the ego's function, through the use of “experimental actions” to decide on appropriate means to gain satisfaction or avoid dangerous situations. Freud makes clear this connection between the ego, signal anxiety and perceptions of danger, and mentions how the act of speaking itself can be a threatening activity.

The ego is governed by considerations of safety. It makes use of the sensations of anxiety as a signal to give a warning of dangers that threaten its integrity. Since memory-traces can become conscious just as perceptions do, especially through their associations with residues of speech, the possibility arises of the confusion which would lead to a mistaking of reality (1940, p. 56)

Thus, impressions from early traumata are stored in memory traces which, through repression, become unconscious and operate in the id, i.e. according to primary process thinking. Freud considers these memory traces to be mental ideas or representations, or, as he says “thought-dispositions,” which, although unconscious, can be activated via the function of speech, when linked with analogous perceptual impressions in the present.

The origins of the repetition compulsion: recent studies

Recent research on infant development has shown that the neonate is a much more active, aware and interactive organism than had previously been theorized (c.f. Emde, 1982; Lichtenberg, 1983; Stern, 1985; Wilson and Malatesta, 1989 for an excellent review of research on early infant development). The infant seems to have the capacity to recognize objects in its environment and register early life events through rudimentary channels of sensation and perception. This early sense of subjectivity (Stern’s emerging sense of self) is formed through repetitive interactions with the infant’s primary caregivers. The infant’s reactions are based primarily on biologically coded needs (for food, warmth, physical comfort/touch, stimulation, emotional contact, etc.) which are communicated through various bodily signals. These signals are primitive forms of affective reactions and communications. It is the responsibility of the primary objects to interpret and respond to these affective, bodily signals.

The mother is the stimulus barrier, the “protective shield” (Freud, 1920). Appropriate responses will meet the infant’s needs and protect the infant from the dangers of over (or under) excitation. These early affective interactions provide the infant with a somatic and psychic “equilibrium” (Giovacchini, 1989, p.82) that serves as a tension-reducing physiological mechanism. This is what Freud (1920) refers to as the phenomena that occurs “beyond the pleasure principle,” i.e. developmentally prior to the pleasure/unpleasure seeking of the child. Infantile soothing seems to be a necessary precondition for the development of more advanced mentation and psychic structure (Givovacchini, 1989).

The failure of these processes, whether through a lack of appropriate responsiveness, (i.e. lack of a holding environment, Winnicott), over-responsiveness such as impingement and/or the infant’s innate predispositions toward oversensitivity for example, will be registered as
traumatic. There is a loss of the protective shield, and the infant remains helpless to the onrush of excessive external stimuli as Freud has described. However, these experiences have never been encoded into mental representations or verbal language. Therefore, they are not available for recollective memory or psychic elaboration (such as into symbolic transformations).

The preverbal states which contain the affective traces of early traumata and primary object relations recede into the background (Wilson and Malatesta, 1989). This pre-representational, affective, bodily form of knowledge remains active in the personality and forms the basis of the repetition compulsion.

The primitive basis of the repetition compulsion has also been explored by Gedo (1981; 1986; 1988; 1991). He developed a model of archaic mentation that precedes the development of symbolic functioning. These earliest stages do not, according to Gedo, require the usage of the libido theory, which Freud himself implied (but did not repudiate) in his elaboration of the repetition compulsion. In Gedo’s schema (1981), the earliest (preverbal) stage of development (mode 1) is primarily rooted in sensorimotor patterns with the primary aim being to ward off dangers of traumatic overstimulation and fragmentation. The earliest affective patterns and modes of adaptation established in this preverbal stage become the basis of the repetition compulsion, which Gedo views as being necessary to maintain a fundamental sense of selfhood and avoid the dangers inherent in its loss.

According to Gedo’s formulation, the primitive repetition compulsion (“primal repetition”) is a pre-psychological, biologically-based, psychosomatic process whereby the infant automatically enacts a “ground plan,” i.e. repeats certain early behavioral patterns, ones that reproduce primal affective, object-related patterns.

Their characteristic patterning in early life gives the person an initial core of individuality to which he or she will continuously tend to return through active repetition (1991, p. 81).

Freud, according to Linnell (1990), had at one time differentiated between registration of experiences as being unconscious and their representations which were stored as word cathexis of the conscious. He later abandoned this position and viewed all registration is conscious. However it is the unconscious (blind) registration of trauma that forms the basis of the repetition compulsion, a point that Freud had difficulty reconciling. Thus, Linnell also postulates a non-representational core to the repetition compulsion, wherein early, overwhelming experiences impinge on and threaten the organism without being represented in the mind as a specific content or symbolic memory.

Severe early trauma that is blindly registered at the preverbal level becomes organized as sensorimotor, behavioral, or enactive memory (Anthi, 1983; Stern, 1985; McLaughlin, 1986; Dowling, 1990; Busch, 1989). This type of memory is characterized by the unwitting reproduction via behavior of the early trauma situations. I would agree with Dowling’s argument that the presence of behavioral memory does not indicate that young infants have unconscious fantasies or representational memories about these earliest experiences. “Its sole mode of expression is in behavioral repetition or physical sensations,” (Dowling, 1990, p. 106).
The repetition compulsion, as we are beginning to see, contains his own form of intelligence, rooted in the infant’s earliest experiences. This is different from the form of repetition characterized by neurotic formulations, usually manifest in the transference neurosis as displacement of childhood libidinal wishes and impulses onto the figure of the analyst. These latter experiences, which Freud has shown stem from ages 2 to 5, are already stored in memory as linguistic/symbolic representations and fantasies. I believe that Freud began to move in this direction when he differentiated between transference resistance (the compulsion to repeat of 1914) and what he called “unconscious (id) resistance” in subsequent work (c.f. 1926, 1937). In these later formulations, it is primal repressions with attendant early fixations that structure the conditions for the later repetitions in action, e.g. of early danger situations such as associated with trauma and psychic/physical survival. Without symbolic encoding into language, the experiences remain “unbound.” In this way, repetition through action is an alternative to, or becomes its own form of “living” memory (Ellman, 1991).

This point has been developed by Wilson and Malatesta (1989). They distinguish between two forms of repetition, “primal repetition” and “symbolic repetition.” The latter is characterized by verbal language, symbolic processes and representational states, which manifest in the transference as wish, fantasy and conflict/defense. The former, which they feel should be reserved for the phenomenon “repetition compulsion,” is a more primitive form of preverbal mentation. Primal repetition is a pre-symbolic, psychobiological mode of representation which contains the archaic, affective knowledge of the earliest infant –caregiver dyad. With the development of symbolic functions in the onset of verbal language, these primitive states recede into the background and form the core of the personality. They continue to exert a powerful motivational influence on behavior and experience outside of conscious awareness.

A similar point has been made by Stern (1985) who describes how the development of verbal language (i.e. a sense of verbal self) serves the dual function of allowing the child to be both the narrator of his life story as well as being the one narrated about, i.e. to be both the subject – participant as well as the object – observer. Verbalization and the ability to symbolize and imagine give the child the ability to transcend immediate, lived experience and the whole of reality in order to create fantasy scenarios and representations about these experiences.

Language and symbolization open a whole new range of possibilities to understand and interact with the world (to “play” with reality). In the ideal sense, words provide a condensed and active version of experience –as–lived. However, as Stern points out, in many, if not most instances, the nonverbal, affective, kinesthetic, global experience is either poorly represented by verbalization or (as in the case of early severe or prolonged trauma) is not represented at all by verbal language. As Stern (1985) states

Such experiences then simply continue underground, nonverbalized, and lead to an unnamed (and, to that extent only, unknown) but nonetheless very real existence (p. 175).

This global subjective world of emerging organization is and remains the fundamental domain of human subjectivity. It operates out of awareness is the experiential matrix
from which thoughts, and perceived forms and identifiable acts and verbalized feelings will later arise. It also acts as the source for ongoing affective appraisals of events (p.67)

Both Wilson and Malatesta, as well as Stern, describe how verbal language creates a sense of alienation or estrangement from direct, lived experience. Thus, many of the infant’s earliest intersubjective experiences remain verbally unencoded and unrepresented in the mind. They are involved in motor memory and “subtle nuances of affectivity rather than through language” (Wilson and Malatesta, 1989, p.298). This would require that the analyst be able to detect “subtleties of action precipitated by the trigger of primal repetition...”(p. 299) through “examining and bringing insight and language to bear on the repetitive nature of recurring archaic affective knowledge to trigger particular actions...” (p. 303). Doing so would enable the patient to place the heretofore inchoate affects and actions within a context that gives them meaning.

Despite the value in their attempt to delineate a more concise definition of “repetition compulsion,” I disagree with Wilson and Malatesta when they claim that the hermeneutic approach to the psychoanalytic narrative is unable to account for the repetition compulsion as an expression of preverbal experience which they claim is “beyond subjectivity and narrativization” (p. 306). In addition, they do not provide clinical examples as to how the actions of primal repetition would emerge in the analytic situation. It is to these two issues that I would like to turn.

Repetition compulsion as narrative action: a hermeneutic approach

I follow Schafer (1982; 1983), amongst others (cf. Ricouer, 1977; Spence, 1982; Polkinghorne, 1988) in placing emphasis on the narrative function of analytic interpretation and (re)construction. It is my experience that the hermeneutic function of speech and action can be applied even to primitive affective states that have not been symbolically encoded. As described in the previous section, there is a difficulty in the use of mental representations (i.e. unconscious ideas; self/object representation; repressed memory) to explain behavior and symptoms that are viewed as manifestations of primal repetition. Increased understanding of the derivatives of early experience as expressed in concrete enactments and character pathology seems to show evidence that the individual has an implicit “knowing” about existence prior to conscious thought or verbal language. This is closely allied with the fundamental tenant of hermeneutics, particularly within the existential – phenomenological tradition, what Wakefield (1988) calls the “distinctiveness thesis.”

The distinctiveness thesis implies that interpretation cannot be carried out as a traditional causal – explanatory inquiry in the mind... (P. 138).

This approach to hermeneutics, rooted in the work of Heidegger (1926/1962) and Merleau–Ponty (1945/1962), distinguishes between interpretation as lived activity and interpretations as formulated activity. Concrete modes of behavior in the everyday world are primarily nonrepresentational and non-explicit ways of enacting lived-meaning. Interpretation, as the
activity of the therapist or researcher, must be an explicit formulation of meaning, some of which may be placed in language that echoes representational states.

According to Merleau-Ponty and Heidegger, most human activity involves a direct relation to the world unmediated by internal mental representations. Merleau-Ponty emphasizes the bodily background of behavior and cognition. The body organizes itself in meaningful and directed ways in the world, an idea he terms "body (or operative) intentionality." He has also referred to this sense of an embodied self as the corporeal or postural schema, a bodily structure that frames and is disclosed via one’s conduct in the world. According to Merleau-Ponty (1964), the child’s earliest sense of his body and his affective relations with others are inseparable processes. The child is developing a language, a whole way of perceiving and organizing the world, an “entire form of thinking” (p. 113) via embodied stances and interactions. These form a global disposition or conduct that cannot be reduced to specific mental representations or beliefs. As Merleau-Ponty (1964) emphasizes

They all have in common a certain style of action, a certain gestural meaning that makes of the collection a certain organized totality (p. 118).

Thus, the way one conducts oneself in the world (i.e. our comportment) is a direct result of this sense of one’s own bodily being as lived and one’s perception of others (or one’s sense of others perceptions of oneself). The latter is involved in the development of a constructed self, a specular image of the body – self as being out in the world (as in gazing at a mirror). This results in an alienation between live self and constructed self.

I am no longer what I felt myself, immediately to be... Thereupon I leave the reality of my lived me in order to refer myself constantly to the ideal, fictitious, or imaginary me...
I am torn from myself. (p.136) T

This bifurcation can result in a phenomenon he terms “transitivism,” i.e. the absence of the division between myself and others (p. 135). “Transitivism consists in attributing to others what belongs to the subject himself” (p. 148). This lack of boundary between what is self and what is other results in the development of certain fixed dispositions which are constantly repeated since the child cannot distinguish one perspective from another.

Childhood is never radically liquidated; we never completely eliminate the corporeal condition that gives us, in the presence of the mirror, the impression of finding something of ourselves. This magic belief, which at first gives the specular image the value not of a simple reflection, of an “image” in the proper sense, but rather of a “double” of oneself – this belief never totally disappears. It re—forms itself in the emotional makeup of the adult... as a re-structuration of our entire matter of being... (p. 138, italics added)

We can see the similarity to the psychoanalytic use of the term “projection” or “externalization.” In the adult, this phenomenon is characterized by the inability to symbolize experience, so that everything becomes a sign which refers the subject back to a familiar, sedimented style of conduct. As Merleau-Ponty states, it is a total way of being that is repeated and not a specific representational state.
Mimesis is the primary process by which the child incorporates the conduct of others into its own body – self and makes that conduct its own. It would be analogous to the terms “introjection” or “internalization.” According to Merleau-Ponty (1964)

Mimesis is the ensnaring of me by the other, the invasion of me by the other; it is that attitude whereby I assume the gestures, the conducts, the favorite words, the way of doing things of those whom I confront. Mimesis, or mimicry, is the power of assuming conducts or facial expressions as my own; this power is given to me with the power I have over my own body (p. 145).

The child’s body is, in a sense, taken over by a “postural impregnation” which is then expressed in imitative gestures and mannerisms. In this way, the child learns and incorporates into the corporeal schema the values, emotions, and attitudes of his parents. The child’s perceptions become colored and altered by the taking in of others through this process of mimesis which results in a “reorganization of motor conduct” (p. 145). It is precisely the association between perception and motility that is the driving force in the compulsion to repeat in action. Motor conduct is organized by and inseparable from perceptual processing, especially those with strong affective colorings.

We can see in the adult, then, that many mannerisms, affective dispositions and patterns of conduct are repetitions of these early imitations. Thus for example a patient who perceives the therapeutic situation is dangerous or threatening will also motorically enact signs of fear as well as seek to establish a way to negate the felt sense of danger by trying to establish a feeling of safety or comfort. These are manifestations of the early phase of “pre-communication” (p.146). In this phase, the child’s way of being (i.e. the body – or embodied – self) is totally immersed in the world in which the child inhabits. Merleau-Ponty describes how

The child is, in fact, the situation and has no distance from the situation is taken at its most immediate meaning (p. 147).

What Merleau-Ponty describes as this immediate, pre-reflective, (I would add, affective) understanding of one’s bodily –being –in –the –world becomes the nonrepresentational background out of which specific modes of behavior and mental contents arise and gain meaning. This point is made by Wakefield (1988) who shows how a phenomenological interpretation, while perhaps utilizing language of representational states, is actually referring to the patient’s nonrepresentational background, which may not correspond to a representational state in the patient’s mind (p. 144).

The hermeneutic position described above, as adopted from both Heidegger and Merleau-Ponty, suggests that there is a direct relation and adjustment between body and world without intermediate mental states. These bodily stances emerge from an implicit, unarticulated background horizon or context. The process of making explicit what is tacitly known and concretely lived out in the world is the core of hermeneutic activity. As Wakefield (1988) says

An interpretation is an attempt to explicitly to represent the meaning of the text. Hermeneutic interpretation is precisely an attempt to give an explicit interpretation of these nonrepresentational every day response (p. 145). Interpretation has to go beyond
the representational contents of the line to encompass the bodily tendencies and stances of the person, as well as cultural context in ways that are not represented in the mind of the person being interpreted (p.146).

From a phenomenological-hermeneutic perspective, therefore, all human action (including “disturbed” behavior) is purposeful, meaningful, and in some sense adaptively organized (cf. Halling and Nill, 1989; Moss, 1989). Meaning is derived from the context, i.e. the patient’s global perception and personal experience of his/her situation. This context is not a set of discrete beliefs or schematic mental representations (although these may be involved), but primarily is an embodied way of being. It could be said that while embodied action is directed toward the world, i.e. is intentional, its meanings are “carried” in the living body.

The way a patient talks, tones of voice, facial expressions, gestures, behavioral enactments, and affective reactions are all embodied ways of expressing meaning, most of which may be totally unknown to the patient. This “personal language,” the manner in which the patient communicates, portrays the background structure of the patient’s world. As Moss (1989) states, “Therapeutic speaking is a direct hermeneutics of experience” (p. 207). Over a period of time, the implicit embodied background can be brought into the foreground of shared dialogue through the interpretive activity of the therapist.

Character style and the development of character pathology can be understood as a process of “ontological generalization” (Dreyfus and Wakefield, 1988). This dynamic notion provides, I believe, a more comprehensive account for the development of the compulsion to repeat in action. As described earlier, specific modes of behavior and mental states develop and emerge out of a context. Heidegger (1927/1962) termed this context a “clearing,” i.e. the implicit background understanding of what it means to be. The process of generalization occurs when a specific way of being expands to become a way of relating to all situations. In an analogous way, totalization (Dreyfus and Wakefield, 1988) happens when a particular emotion gains a pervasive coloring over all situations. What was once the content of one’s experience is merged into and becomes the context of one’s total being. Thus, for example, a child’s “resolution” of a painful or traumatic situation often becomes generalized into an overall way of being, i.e. is embodied in fixed postural stances that are endlessly repeated. Merleau-Ponty (1945/1962) provides a view of repression and trauma that shows how this process of content becoming context occurs and its relationship to the timelessness of repetitious behavior. In a very powerful passage, he states that

Time in its passage does not carry away with it these impossible projects; it does not close up on the traumatic experience; the subject remains open to the same impossible future, if not in his actual thoughts, at any rate in his actual being. One present amongst all presents thus acquires an exceptional value; it displaces the others and deprives them of their value as authentic presents. We continue to be the person who once entered on this adolescent affair, or the one who once lived in this parental universe. New perceptions, new emotions even, replace the old ones, but this process of renewal touches only the content of our experience and not its structure. Impersonal time continues its course, but personal time is arrested (p.83).
He goes on to describe how this one way of being is not represented as a specific mental state nor is it recorded into memory, since this way of being, once a part of the past, now has become the background for one’s total being.

Of course this fixation does not emerge into memory; it even excludes memory insofar as the latter spreads out in front of us, like a picture, a former experience, whereas the past which remains our true present does not leave us but remains constantly hidden behind one’s gaze instead of being displayed before it... The traumatic experience does not survive as a representation in the mode of objective consciousness and as “dated” moment; it is of the essence to survive only as a manner of being and with a certain degree of generality... I retain from time one of the momentary worlds which I have lived, and make it the formative element of my whole life (p. 83 – 84, italics added).

This “manner of being” becomes “frozen” or “sedimented” into particular embodied states and postures that are repetitively enacted and which subsequently structure how the world is perceived – as well as how others react. These embodied repetitive enactments become prototypes or “paradigms” (Dreyfus and Wakefield, 1988, p. 280) which shut down the openness of the clearing and restrict or narrow the possibilities of existence into fixed, characteristic ways of being. Merleau-Ponty (1963) has outlined a similar process in the development of an unconscious, or repressed complex.

There is repression when integration has been achieved only in appearance and leaves certain relatively isolated systems subsisting in behavior which the subject refuses both to transform and to assume. A complex is a segment of the behavior of this kind, a stereotyped attitude, an acquired and durable structure of consciousness with regard to a category of stimuli. A situation which could not be mastered at the time of our initial experience which gave rise to the anguish and the disorganization which accompanies failure is no longer experienced directly: the subject perceives it only through the physiognomy that it assumed at the time of the traumatic experience. In these conditions, each new experience, which in reality is not a new experience, repeats the result of the preceding ones and renders its return even more probable in the future (p.177-178, italics added).

The complex exists, not as an isolated fragment buried within the depths of the psyche, but as an ever-present embodied stance, a pervasive attitude or narrow perspective that leads to a “rigid and stable structure (p. 178).” It gives meaning to a range a situations which lends a certain “adhesiveness,... inertia of certain structures of behavior” (p. 178). One pre-reflectively takes up and lives out these meaning structures in embodied states of being. According to Merleau-Ponty, the cause of these structures cannot be located in the past, whether as memory or as a historical event, but is evident in the “here and now’ as bodily ways of being.

The childhood memory which provides the key to a dream and the traumatic event, which provides the key to an attitude... are not therefore the causes of the dream or the behavior. They are the means for the analyst of understanding a present structure of attitude (p. 178).
Regression, complexes, and the unconscious repressed are latent aspects of consciousness and conduct that can become activated in the immediate present. Thus, “consciousness becomes infantile consciousness...” (p. 178), “the subject lives after the manner of children...” (p. 179) i.e., they “manifest the return to a primitive manner of the organized conduct” (p. 179).

**Speech as bodily enactment**

Merleau-Ponty has expanded the significance of human embodiment to include language. According to Merleau-Ponty, language and thought cannot be separated from human bodily existence. Experience and language are derivative of primary perceptual, i.e. bodily experiences. It is language, especially as enacted through speech that encodes primordial embodied perceptions into human significance, i.e. bodily felt meaningfulness. Utilizing Merleau-Ponty's thesis of the nature of language, Polkinghorne (1988) describes speech as “an expression of bodily existence in the world” (p. 29). As he describes,

It is the body which creates meaning, and speaking is a bodily activity which refines preverbal behavior and communication, such as gesturing. (p. 28)

Body intentionality in the realm of acts of speech would therefore involve, as stated by Von Eckartsberg (1986)

preverbal thought ("thinking that exists in action") or the pre—personal dimension of bodily intentions and meaning (p. 13). Bodily existence itself is the giver of meaning (p.14). Our body moves in terms of pre-reflective intelligence and lived involvement which exceeds our conscious awareness and control. ... [an] autopilot intentionality (p.15). [It is] the total embodied human response to a perceived situation (p.11).

One's “psyche” is embodied, is always a part of the world, and is known primarily through bodily conduct. The child does not imitate or internalize a person, but rather their actions or conduct, which forms the core of our “postural or corporeal schema.’ Merleau-Ponty says

They all have in common a certain style of action, a certain gestural meaning that makes of the collection an already organized totality (1962, p. 118).

Speech reveals the tacit accumulation in living memory of an embodied history “and its alleged power of recapitulating and actually enclosing the whole process of expression into a single act" (Merleau-Ponty, 1962, p. 88). In an important passage, Merleau-Ponty (1962) states that

Speech... pretends to recapture, recover, and contain the substance of the past. Since speech cannot yield a living past unless it repeats the past textually, speech makes the past undergo a preparation that enables the past to reveal itself in speech: speech wants to give us the truth of the past. Speech wants to conserve the past either in its spirit or in its meaning (p. 99 – 100).

The act of speaking itself is a dimension of body intentionality, in which aspects of the lived past are implicitly carried forth and revealed. Rather than being symbols of something absent, speech acts are signs that implicitly embody meaning. As Merleau-Ponty (1962) has stated,
meaning is immanent in behavior. However, this meaning is not already formed, but is nevertheless being lived out. It is the task of interpretation to make explicit what is unformed in speech. The function of speech, therefore, is a process of

throwing the other toward what I know which he has not yet understood, or in carrying oneself toward what one is going to understand (p. 131). Speech must bring meaning into existence (p.141).

The pre-reflective past is expressed through the bodily aspects of speech. Just as the body’s motility is an expression of primordial perception, so too does speech make present the pre-reflective basis of experience. Language expresses a style of existence. It emanates from the pre-personal, and as part of a motor framework of recollection. The embodiment of memory is such that it not only constitutes the past but is “an effort to reopen time on the basis of the implications contained in the present” (p. 181). The body incorporates attitudes and conduct from the past constructs “pseudo-presents” which organize perceptions of time as well as space. The body's way of remembering through speech is likened to the function of projection. "The body converts a certain motor essence into vocal form..." (p. 181) which takes up and expresses a former attitude in the act of speaking as a projected intention to (reen)act something from the past. This process is similar to Bergson’s notion of “habit memory” (cf Sedler, 1983), and to the psychoanalytic studies of early infantile preverbal "memory,' one based in sensorimotor conduct and experience (Busch, 1989).

The style of speech (as one bodily mode of expression) thus enacts and reveals in microcosm, the generalized, tacit structure of being that is usually acted – out in one’s everyday relations with others and in conduct in the world. Speech thus helps reopen time by bringing forth the primordial realm of existence that has become buried or sedimented, covered over by later developments, but which still operates in a state of "pre-communication.” It expresses an emotional essence, as a generalized form of behavior which is detached from its origins and which occurs in a field of action. The patient’s style of speaking conveys an “existential meaning,” one that is prior to conceptual thought and mental representations of experience. It is itself the embodiment and expression of dispositions or intentions which are unknown to the patient. These embodied expressions, or bodily ways of being, take on a life of their own – often different from and even in (seeming) opposition to conscious intentions and desires.

Thus, as Merleau-Ponty (1962) has shown, it is through expressive actions, especially acts of speech that these underlying realms (i.e. undercurrents of feeling and energy) can be brought to meaningful awareness “The process of expression brings the meaning into being..." (p.183). The bodily aspect of speech, as a concrete manifestation (e.g. action, gesture, word, style of speaking), is a direct link with, and a reflection of, the pre-reflective (primordial) level of being.

[Speech]... before being a thought or a form of knowledge, is a certain manner of relating oneself to the world, and correspondingly, a style or shape of experience (p.191, italics added).... The body must in the last analysis become the thought or intention that it signifies for us. It is the body which points out, and which speaks... It has a gestural meaning and acquires a "figurative significance" (p.197).
What this implies is the importance of careful attention to, and embodied engagement with, patients’ characteristic ways of bodying forth in sessions, i.e. styles of expressing, speaking, and reacting in order to waken and release the primal life-energy carried within repetitive patterns.

Repetition compulsion as narrative action in analytic therapy

Merleau-Ponty's conception of language and embodiment forms the context for the discussion of one way that the repetition compulsion (i.e. primal repetition) is manifest within the transference field of the psychoanalytic situation. The observation of patient’s acts of speech can now be understood as a form of “narrative action” (Polkinghorne, 1988,, p.142-146). The patient’s embodied actions within the analytic field reveal a plot that can be used to form a lived- story. The “cause” of the action is its meaning within a narrative context, which is not necessarily its historical origins. Polkinghorne (1988) describes narrative action as follows:

Acting is like writing a story, and the understanding of action is like arriving at an interpretation of a story. Human action is the physical texture of embodied agent’s meaningful statement and bodily movement is “caused” by the meaning to be expressed (p. 142).

Narrative is the form of hermeneutic expression in which human action is understood and made meaningful. Action itself is the living narrative expression of a personal and social life (p. 145).

Narrative plots gather up events, experiences and interactions into a life story. The “plot” is unknown to the actors but forms the sedimented, taken – for – granted background that structures perception and experience. It is unconsciously lived out through the body and expressed through bodily action in the world. Within this framework, the repetition compulsion can now be described as the repetitive enactment of the core story. The analytic situation, and especially the transference neurosis (or psychosis) provides a stage where these plots are enacted in their affective intensity. Chappelle (1986) in an in-depth psychological and philosophical study of the eternal recurrence of compulsive repetition has stated that

the repetition compulsion fixates man into a personalized metaphor which must be enacted again and again... a recurring embodied metaphor (p. 166).

Here repetition gave man knowledge about plots that govern his individual history and destiny. It makes him witness to history and destiny, an informed participant in their enactment (p. 200).

The repetition-actions (as given in Freud’s 1914 paper) are not restricted to, nor even primarily based on pronounced episodes of acting-out with certain patients. What Freud (1914) seems to be referring to are instances of the repetition-compulsion (based on his concrete examples) that are observations of what patients’ are actually doing, and the way they are acting in the session. According to Webster’s dictionary, action is defined as “the process of acting or doing (something); a movement or sequence of movements; manner of movement; the plot of the story or play.” Thus, the repetition compulsion in action refers to ways of acting, moving, which
disclose a manner of being (as articulated by Merleau-Ponty). This manner or style (our embodied comportment) now can be “read” as implicitly revealing the plot or theme of a drama being played out in the therapy situation. This would now be called “acting-in,” or “acting-out within the transference.” It refers to the patient’s emotional reactions to the transference as expressed through affective states or tones, various ways that the material is presented, bodily comportments and their countertransference effects on the therapist that are the repetitions in action. Therapist and patient become participants in the body dramas being enacted- a type of “theater of the body” (McDougall, 1985)- as well as aware observers.

The compulsion to repeat is thus a form of remembering through action, as evidenced within the confines of transference. The primary way this becomes manifest in therapy is through the patient’s modes of talking, or, in other words, as embodied acts of speech. Gill (1979), in his emphasis on the “here and now” of transference, has pointed out that transference repetitions may not necessarily be enacted in motor behavior, but our “acted” through the patient’s attitudes and feelings toward the analyst. Boesky (1982) in his important paper on acting-out has made a similar point. In accord with the present thesis, Boesky describes how the patient can “act-out” through the use of speech, as when

the patient attempts to impose certain roles on the analyst by using no other form of behavior than conversation. In this sense verbalization is the major mode of acting-out in any analysis (p. 43).

The distinction between reporting and enacting can thus be spurious, since as Boesky states, it is the patient’s way of speaking that is the manifestation of the repetition compulsion. Rather than being solely a form of resistance, acting through speech is often an important mode of expressing aspects of the patient’s life history. The patient often shifts from verbalization/ introspection to action (e.g. bodily movement, altering attention, etc.) in order to avoid painful affects that arise within the therapeutic (transference) relationship in the “here and now.”

The observation of the patient’s speech as enactment, when viewed as a manifestation of the repetition compulsion, can provide inroads into the patient early life history and childhood traumas. Gaddini (1982) for example shows how certain forms of acting-out are part of the analytic process. These forms of acting-out are a direct derivative of early mental development which serves to regulate tensions and primitive anxieties associated with the infant’s initial reaction to a sense of separateness. These are encoded in action sequences which would include the use of speech. Early traumas and conflicts remain active in the personality, becoming re-signified and emerging within the transference in the “here and now” as pre- or para-verbal (action) language (Etchegoyan, 1982). Schafer (1982) also refers to the “here and now” of the transference as the dynamic interrelation of the present (perception) in the past (remembering; interpretive reconstruction).

Since most of the “action” in analytic therapy is enacted through speech, we can see that the way the material is presented, how the patient speaks becomes the compulsion to repeat in action. It is the patient’s way of remembering as Freud (1914) described, by becoming an embodied and dramatic enactment of the patient’s life history on the analytic “stage.” This
stance has been made by other analysts. Schafer (1983) has advised that we observed the patient's modes of talking and disruptions of talking as a "narrative performance."

The analyst... scrutinizes these narrative performances for cues as to the most timely, effective, and beneficial interventions to make. In this respect, the analyst attends not only to content but to nonverbal motoric and affective signs, selective use of figurative language, and many other features of the situation, including his or her own fantasizing and countertransference (p.186-187, italics added).

The analyst is thus linking the unintentional aspects of subjective experience being enacted as a way to construct the patient's implicit narrative account and life story. Interpretation is the process of making explicit what is being acted – out by reconstructing the life story. The analyst is "engaging in acts of retelling or narrative revision" (p. 187).

McDougall (1985, 1989) has used the metaphor of the analytic theater to describe how archaic scenarios are being enacted on the analytic "stage." She shows how even primitive psychotic and psychosomatic ("body theater") enactments can be viewed as "stories without words" with all the internal characters and psychic dramas being played out with the analyst. By attending to the patient's tones of voice, affective states, manner of speaking, body postures and gestures, the latent significance (the "sub – text") can come to life. In some forms of "primitive communication," McDougall shows how the analyst's countertransference affective reactions may be the only means to decipher what is being enacted, particularly in relation to preverbal, infantile traumas.

The metaphor of transference as a dramatic play has been most lucidly expressed by Loewald (1975). He views the patient's repetitions as "re-experience by reenactment of the past" (p. 286). The memories of the past "as a living force within the patient" (italics added) gain intensity within the transference. Narration tends to be more objective, wherein the patient maintains a distance from, and contemplates the significance of, the action. However, during analytic treatment, narration often merges with reenactment, as the patient becomes more and more immersed within the transference situation.

Language and speech now become part of the dramatic enactment as a "symbolic expression of action" (p. 293), whereby how the patient speaks becomes the transference dramatization (i.e. the reproduction in action), as passive repetition (Loewald, 1971). Loewald is quite explicit about the importance of analyzing what is presented in speech as the "action" that now itself becomes the reliving of the dynamic past in the here and now.

In the course of psychoanalytic process, narrative is drawn into the context of transference dramatization, into the force – field of reenactment... Narrative in psychoanalysis is increasingly being revealed in its character as language action, as symbolic action (italics added) and in particular as language action within the transference force – field. The emphasis, in regard to content and emotional tone of the communications through narrative, shifts more and more to their relevance as transference repetitions and transference actions in the psychoanalytic situation. One might express this by saying that we take the patient less and less as merely speaking
about himself, about his experiences and memories, and more and more as symbolizing action in speech (italics added), as speaking from the depth of his memories, which regain life and poignancy by the impetus and urgency of re-experience in the present of the analytic situation (p. 293 – 294).

A recent paper by Busch (1989) has made a similar point regarding the importance of attending to the patient’s manner of speaking as a manifestation of compulsive repetition in action.

While the patient is consciously trying to tell us his thoughts, he is in the process of doing something else. It is such things as the changes in affective tones or the confusing way in which the material is presented that are the repetitions in action (p. 535).

He terms these repetitions “action – thoughts” to convey the notion that the patient’s actions themselves convey a series of thoughts. He differentiates these action – thoughts which refer to how the material is presented from acting – out which refers to the dynamic meaning of action as the defense and resistance.

Action – thoughts as they appear in adult analysis are a form of thinking, from an earlier time, frequently with multiple meanings, which are the result of earlier compromise formations. The vehicle by which action – thoughts are particularly suitable to be expressed in analysis is via the patient’s manner of talking. Thus, while the patient is expressing thoughts via words, their way of talking is expressing something else (p. 540).

I would agree with Busch that these “actions” are a form of communication (he bases his ideas on Piaget’s sensory – motor level of intelligence). However, I would reframe this to say that the patient, through what they are doing (and doing to the therapist) directly reveals primitive meanings and energies/forces that have not been coded into verbal/symbolic language. They are the generalized style of embodied existence that Merleau-Ponty has articulated. These meanings or themes, as well as the felt sense of these primal bodily energies, can then be constructed into a narrative “plot” and interpreted to the patient. As Polkinghorne (1988, p. 17) states, “Human actions are expressions and enactments of meaning.” These meanings, however, are implicit in the action sequences and bodily expressions. They require careful observation and sensitive articulation in order to bring to awareness and make their felt meanings more explicit. In this way, early traumas and deeply ingrained patterns can be re-experienced and the underlying energies restored to consciousness.

The plot of the repetition compulsion

I have not focused specifically on the content of the repetition compulsion in this paper. In concluding, it has been my experience that patients with severe character pathology have suffered very early trauma. The regressive pull of the therapeutic situation brings the patient closer to the horizon within which the trauma has been embodied. In therapy, the patient both enacts the traumatic constellation without conscious memory or awareness, while also attempting to use the therapist to deal with these anxieties. In working with regressed patients, I have paid attention to these repetitive enactments with particular focus on the “breaks” in the
session, i.e. those places that provide an opening into the primitive background of vulnerability and dread. The "memories" have remained unconceptualized, without meaning, and are usually presented in "action." I have found it particularly important to focus on the patient's speech- more specifically, the patient's manner of speaking and characteristic ways of talking, including their effects on the therapist.

The regressive pull of the transference relationship leads to a reactivation of the original danger – situation that led to the predominance of defense over that of the pleasure principle. The heightened affective arousal within the transference signals the possible return of primitive states of passive vulnerability and perceived helplessness. The patient attempts to retroactively master this early threat of annihilation or destruction by re-creating the protective shield against the efforts of the therapist. The defensive function, while signaled by anxiety, is propelled by projection or externalization, as an active reaction to the perceived threat of the analytic situation.

These transference phenomena, produced by the repetition compulsion, are retroactive attempts at defense against the threat of annihilation..., against the original and repressed discovery of vulnerability (Chapelle, 1986, p. 239).

Perceiving and feeling something as being threatening in external reality were in fact none exists is what gives the transference its potency and quality of metaphor or allusion. The patient, with diminished reality testing, is now fully under the power of the repetition compulsion. It is within this context that recurrent behavioral enactments have been explored in the metaphoric language of action. They allude to a primitive reality in which the patient is totally unaware. The often painful and destructive aspects of the repetitions both in treatment and in life can evoke images of a “death instinct.” However, I have found it more useful to conceive of the repetition compulsion as being driven by a primitive fear of death (or annihilation) as articulated by Melanie Klein (1946; 1948; 1958).

At the core of this inner dread is the deep awareness of our body being fragile, vulnerable to many actual as well as perceived dangers, i.e. threats to our physical survival and psychic integrity. Thus, the genesis (as well as continual source) of the driving force behind the compulsion to repeat patterns is to ward off these dangers- i.t. to create a (pseudo-) sense of safety and familiarity. As long as our sense of being in the world is based on the primal awareness of separation, being alone, and under siege, much of the body's life force is relegated to protecting against dangers from within and without. It is the task of analytic therapy to bring more awareness to these repetitive patterns, help link with patients' history and traumas, and to begin the process of creating a bodily felt sense of safety, so that the life-force can be restored and the energy bound up within survival patterns be released and restored.
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