Psychotherapy Volume 28/Summer 1991/Number 2

Editor's Note: Our last issue, Vol. 28, No. 1, was a Special Issue on Psychotherapy with Victims, guest-edited by Frank M. Ochberg and Diane J. Willis. We received so many worthy papers on the topic that we could not publish all of them in one issue. The following seven articles may be considered a supplement to the Special Issue. —D.K.F.

THE REPETITION COMPULSION REVISITED: RELIVING DISSOCIATED TRAUMA

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Recent findings have suggested that trauma plays a major role in the development of psychiatric illness. Freud's theory of the repetition compulsion has proved very useful in attempting to understand how overwhelming trauma is repressed and dissociated, only to return to be reexperienced in dreams, nightmares, flashbacks, and other aspects of current life. A conceptual framework as to how such episodes occur and present, as well as numerous clinical illustrations, are presented.

Introduction

The association between trauma and the development of psychiatric illness has been known since Janet (1907) and others studied hysteria in the nineteenth century. However, the importance of trauma as a causative factor in mental disorders has been variably acknowledged over the subsequent decades. Although Freud (1896) originally postulated that sexual trauma resulted in hysterical illnesses, he later came to believe that intrapsychic conflict rather than actual trauma caused emotional illness. This contributed to generations of mental health professionals ignoring or deemphasizing the role of trauma in their patients. The reality of child abuse in this society has largely been met with disbelief and denial (Summit, 1983). Additionally, the tendency of trauma victims to deny or minimize past traumatic experiences, or to report them unbelievingly, has compounded professional denial of the magnitude (Goodwin, 1985).

In this age of increasing biomedical sophistication, the importance of traumatic etiologies in the development of psychiatric illness continues to be often ignored. However, a number of recent studies have revealed astonishingly high rates of childhood physical and sexual abuse in adult psychiatric patients (Bryer, et al., 1987; Carmen, Rieker & Mills, 1984; Chu & Dill, 1990; Emslie & Rosenfeld, 1983; Husain & Chapel, 1983; Rosenfeld, 1979). For example, two studies on female psychiatric inpatients have shown a nearly two-thirds prevalence of such abuse (Bryer et al., 1987; Chu & Dill, 1990). These kinds of childhood experiences are far from benign. Childhood abuse has been associated with a wide variety of adult psychiatric difficulties incuding depression, anxiety, self-blame, self-destructive behaviors, sexual problems, substance abuse, and eating disorders (Courtois, 1979; Gelinas, 1983; Finkelhor, 1984; Hall et al., 1989; Herman, 1981; Herman, Russell & Trocki, 1986; Russell, 1986; Shapiro, 1987; Swanson & Baggio, 1985; van der Kolk, 1987).

While not all persons who have been abused develop psychiatric syndromes, certain groups of psychiatric patients have shown a strikingly high incidence of childhood abuse. Certain posttraumatic stress disorders and some dissociative disorders, particularly multiple personality disorder, are clearly associated with overwhelming childhood trauma (Kluft, 1985; Putnam et al., 1986; van der Kolk, 1987). Our recent research findings suggest that dissociative symptoms are relatively common (although clinically underestimated) in inpatient populations with nearly one-quarter of our subjects reporting dissociative symptoms at or above the established median for posttraumatic stress disorder. Recent literature has also associated

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childhood trauma with the majority of patients with borderline personality disorder (Herman & van der Kolk, 1987; Herman, Perry & van der Kolk, 1989; Ludolph et al., 1990; Zanarini, Gunderson & Marino, 1987). The overwhelming weight of evidence suggests that trauma has a major role in the development of at least some psychiatric disorders, and trauma appears to result in the extensive use of the defenses of repression and dissociation. Particularly in children, emotional, physical or sexual abuse, or pervasive neglect and other forms of trauma cannot be tolerated and integrated into the psyche. Instead, these experiences are frequently repressed and dissociated from consciousness, only to appear later in life in the context of a variety of psychiatric disorders.

The Repetition Compulsion Revisited

Despite his disavowal of actual trauma as an etiology in the development of emotional illness, Freud's concept of the repetition compulsion is enormously hepful in understanding the role of trauma in psychiatric illness. In his 1920 paper, *Beyond the Pleasure Principle*, Freud described the role of repression in the development of the repetition compulsion, which he saw as the emergence of repressed instinctual conflicts which became superimposed on current reality. He wrote,

> 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 in the past.

Current clinical experience has demonstrated that actual trauma (and not just intrapsychic conflict) which has been repressed is often repeated. Persons who have experienced past trauma find that these experiences intrude into their current reality. Past events, affects, behaviors, or even somatic sensations appear in dreams or are superimposed on their current experiences. As in Freud's description of the repetition compulsion, such persons are obliged to repeat these experiences rather than simply remembering them.

It is important to understand that there is a true compulsion for traumatized persons to repeat repressed experiences. Even if the person endeavors to keep the memory repressed, there is an opposing need on the part of the psyche to force the repressed material into consciousness. As Freud noted, the need for repressed material, however unpleasant, to emerge into consciousness is more powerful than the pleasure principle. Thus, repressed and dissociated events emerge to be reexperienced, often first in dreams and nightmares (during sleep when conscious control must be let go), and then in waking hours as well. Our clinical experience suggests that the compulsion to repeat takes on an almost biologic urgency. Perhaps the most familiar physiologic analogy is the need to urinate. One can postpone the event up to a point, but eventually one must urinate.

The most striking examples of the emergence of repressed and dissociated experiences are the flashbacks which are frequently seen in patients with posttraumatic stress disorder and some dissociative disorders. These patients are thrust back into the traumatic events both in their dreams and while awake. Any therapist who has experienced a patient's full-blown flashback has felt the powerful pull into the actual experience of the events along with the patient. The reliving of the trauma is experienced as a real and contemporary event. That is, the patient does not talk about feeling as if he or she remembers the experience; rather, he or she feels the experience in the present. The power of such an experience is phenomenal, and points to the ability of the psyche to repress and dissociate overwhelming experiences, as well as to bring them back into consciousness with full force.

It is crucial to understand that the reliving of previously dissociated trauma is experienced as a contemporary event. Therapists who work with such patients are familiar with patients who are so pulled into old experiences that they lose awareness of their surroundings and the current reality. Patients are thrust back into the trauma. They commonly visualize previous surroundings and other people, and may feel that they are the same age as when the trauma originally occurred. They are certainly subject to the same overwhelming affects and even bodily sensations that they once felt. Therapists are all too familiar with the difficult task of attempting to help patients keep one foot in current reality at the same time as they experience the past. Even this may have untoward results as the patients then superimpose their experience onto the current situation.

Case Illustration

> After extreme resistance to remembering a very traumatic rape, the patient began to relive the experience in her therapist's office. At first, the therapist was unable to make any contact with her, but eventually was able to break through the episode enough so that she realized he was there. She vividly described the abusers to him and he tried to remind her that she was in his office and that there was no one else present. To this she replied, "Then why are *you* hurting me?"

Despite the pitfalls of being confused with the perpetrators of abuse, it is exactly this contact between the patient and another person (the therapist) which begins a process that is therapeutic and potentially curative. Childhood abuse often occurs in the context of extreme familial disruption and chaos in the child's social milieu. In the absence of adequate interpersonal support, the trauma results in overwhelmingly dysphoric affects which are repressed and dissociated. When the trauma is reexperienced, the trauma is again overwhelming, and it is only the sharing of the experience which makes it bearable. In this way, the intense *aloneness* of being abused without help from another person is changed. The events are tolerated, and most importantly, retained and integrated into memory as past experience, rather than remaining a dissociated time bomb which is waiting to explode into consciousness. This is a crucial factor since reliving trauma without appropriate interpersonal support is simply to be overwhelmed again by the experience and to be retraumatized. Reliving traumatic events in the context of an interpersonal relationship enables true abreaction possible and begins the curative process.

Clinical Presentations

Normal experience involves an integrated sense of cognition, affect, sensation and behavior. As some investigators have noted, any one or more of these parameters can be dissociated (Braun, 1988). For example, one may recall certain traumatic events but be quite removed from the feelings and sensations of those events, or one may not have any recollection of the experiences, but be overwhelmed by feelings resulting from them. These different patterns are somewhat determined by age and level of psychological maturation. Van der Kolk and van der Hart (1989) have recently summarized the classical thinking of Janet as well as recent research which support the idea that memory is stored in a variety of ways depending on each individual's development and the level of thinking and functioning. When dissociated experiences return into consciousness, their form will be determined by the way they were encoded in memory. Thus, adults who have experienced childhood trauma present differently from adults who have been traumatized in adulthood. In clinical experience, adult trauma tends to result in the ability to recall events (although not the associated affects) while childhood trauma results in more amnesia (Herman & Schatzow, 1987).

Cognitive Awareness with Dissociated Affect

Cognitive awareness of trauma alone can be quite misleading. The patient who is aware of the events, but not conscious of the related affective experience is prone to report the experience in a rather matter-of-fact manner. Such patients often also deny the importance of these events in an understandable effort to keep overwhelmingly dysphoric affects from consciousness. Such a presentation commonly leads therapists to collude with the denial and to ignore the importance of the trauma in the production of emotional disturbance and psychiatric illness. Patients may present with a wide variety of symptoms such as depression, anxiety, substance abuse, eating disorders, self-destructive or dysfunctional behaviors, but deny the importance of traumatic events. Interestingly, if questioned about whether it *feels* as though the events happened to them, they often report that they know it did, but feels as though it happened to somebody else. Therapists ignore this kind of history at their patients' peril. Too much time and effort is spent on fruitless treatment programs to control symptoms such as endless trials of medications, or psychotherapy unrelated to the central issue.

Case Illustration

A woman in her early thirties was admitted to the hospital for treatment of what appeared to be major depression. She underwent a sophisticated biologic work-up and was begun on a series of medication trials which failed to improve the depression. Finally, she was given a course of electroconvulsive treatments which seemed to result in modest improvement. She was discharged from the hospital but was readmitted on the same day following a serious suicide attempt. Following readmission, the patient appeared overtly hostile and irritable as well as depressed. Hospital staff and her therapist were frustrated and angry about her lack of progress and her apparent angry and manipulative stance. Interestingly, it had been known throughout the course of treatment that the patient had undergone a major traumatic incident some years previously: after feeding her infant child a new medication, the child had gone into allergic anaphylaxis and died. Because she was able to report the events, and even denied any persistent feelings about the death, it was assumed that it was no longer a major issue. However, the old traumatic events were painfully explored again and her depressive symptoms began to resolve. She appeared warmer and more engaged with others and was eventually discharged uneventfully.

Affective Experiences without Cognitive Awareness

Situations in which there is actual amnesia (full or partial) for the traumatic events are potentially confusing and produce misinterpretation and clinical errors. Affective experiences that arise from

previously dissociated trauma can be very misleading. Often with minimal stimulus, patients can be flooded with overwhelming affects such as depression, panic, despair, suicidality, or rage. If these affective experiences occur with amnesia about the etiologic trauma, neither patients nor therapists have any way of knowing the source of the feelings. This may be highly frustrating for patients who may realize that they are reacting in an irrational manner, and may feel as though they are somehow inherently disturbed. Patients may also find reasons in the current reality to attach the feelings to, even though the affects are clearly out of proportion to the current situation. Unfortunately, therapists may be equally frustrated and collude with their patients' self-blame. In this way, the presence of affective reliving in the absence of cognitive memory may once again place the patient in the role of victim, reenacting an abusive scenario. However, if the situation can be recognized, therapists can validate the affects as related to previous traumatic events, and can help patients understand their feelings and contain their behavior.

Case Illustration

A young woman, who had previously decompensated while attending college, received intensive treatment over several years. She spent a prolonged period of time in the hospital and gradually transitioned to a half-way house, then an apartment and a full-time job. In her treatment she came to gradually understand how her chaotic and dysfunctional family left her poorly equipped to live independently, to feel normal self-esteem and relate socially. She began to take courses in preparation of returning to college. Over a period of two weeks or so she began to feel increasingy panicked, depressed, and suicidal, much as she had felt when she first entered treatment. She felt alone and trapped, and blamed herself for her inability to function normally. She abused her medication and alcohol, and became involved in a number of highly self-destructive activities, including an automobile accident which could have easily resulted in serious injury or death. She was admitted to the hospital where she continued these activities, much to the frustration of the staff who (as she continued to do) blamed her for her inability to control her regression. After several weeks of intense turmoil for the patient and the staff, her therapist realized that she had never really communicated her old college experiences except in a relatively superficial manner. When he suggested this to her she began to become flooded with the memories of just how victimized she had felt, how isolated, and how despairing and suicidal. In college she also had abused alcohol and had gotten involved in self-destructive activities. At that time she blamed herself for being unable to fit in, in contrast to previous experiences while living at home for which she blamed her family. The return to course work had precipitated the reexperiencing of the affect that went with her unresolved and overwhelming experiences at school. With this understanding the patient and staff were able to work together much more cooperatively and the situation rapidly resolved. Despite continuing fears, the patient was able to go on to take more courses uneventfully and made plans to reapply to college on a full-time basis.

Repetitions of Behaviors

The return of previously dissociated behaviors may be the most confusing of all types of dissociative reliving, since the patient may have the compulsion to repeat the behaviors without any real understanding of either the events or feelings involved in the experience of the original trauma. Unfortunately, these behaviors are often destructive. Without substantive apparent reasons, patients may become engaged in intensely self-destructive behaviors such as self-inflicted cutting, suicidal behaviors, or hurtful behaviors toward others. Understandably, patients are often horrified by their own behavior, or may try to distance themselves from it as if they weren't responsible. The inability of the patients to communicate the true origins of their behavior once again sets them up to be blamed (by themselves and others) for what they are experiencing. Moreover, the usual atmosphere of crisis and panic which surrounds these destructive behaviors further clouds the scene, making it more difficult for even well-meaning therapists to act with empathy and compassion. This is not to suggest that patients are not responsible for their behaviors, but that the behaviors are communications about past realities which need to be understood. In the context of understanding the past, the behaviors can be contained and modified.

Case Illustration

A 32-year-old woman had received a long course of various treatments including hospitalization, individual psychotherapy, medication, and other modalities, but continued to have frequent crises. These included cutting herself severely (usually without much affect or pain), fainting, pseudoseizures, and taking overdoses of her medication (again, usually without much affect). She was repeatedly admitted to the hospital for impulses to hurt herself. Following admission she was typically nearly mute, and would begin some kind of head banging or flailing about which would result in the use of mechanical restraints. Hospital staff became increasingly angry at the patient for what they saw as her unwillingness to take responsibility for her behavior. This was compounded by her claiming not to remember really what happened when she was put into restraints, and by berating the staff for treating her cruelly. Only after dozens of these episodes did an observant nurse comment to the patient's therapist that the patient made very sexualized writhing movements while in restraints. This began an exploration which eventually uncovered a history of incest and repeated violent sexual abuse. The patient continued to struggle with her symptoms and behavior. However, the understanding

of the patient's victimization made it more tolerable for the patient and for the staff who began to see themselves as helping the patient recover the past events.

Reexperiencing Somatic Sensations

Somatic symptoms which are actually dissociated bodily sensations having to do with past trauma are also difficult to understand. The patient who presents with persistent choking experiences, bodily pain, nausea, vomiting, eating, and sleep problems, headaches, etc., may, in some instances, be reexperiencing old trauma in a somatic modality. Of course, a medical evaluation is always warranted to rule out true somatic etiologies, but a post-traumatic etiology should also be considered. Medical interventions are generally fruitless for dissociated somatic symptoms, and may only further harm the patient. Of course, the presence of other dissociative symptoms makes a dissociative diagnosis more likely.

Case Illustration

A 37-year-old man was seen in psychiatric consultation after a full medical evaluation failed to uncover any cause for excruciating abdominal pain and intractable nausea and vomiting. The patient was intolerant of any oral intake including fluids and was in danger of becoming severely dehydrated. After a period of psychiatric hospitalization he became slightly improved and was discharged on a regimen of painkillers and tranquilizers. In psychotherapy over the next two years the patient explored a rather painful childhood and recent disappointments. Although he improved, he continued to have disabling abdominal pain, nausea, and vomiting. Finally, in his third year of treatment, he began to relate an episode which had occurred in his early twenties. As a way of fleeing his difficult home situation he had joined a paramilitary organization and had been part of a mercenary guerrilla movement in Latin America. He described the combat experience in painful detail (along with excruciating abdominal cramping). He had, at one point, shot a comrade in the head when the comrade was mortally wounded but not dead. It was at this point that he experienced the disgust, nausea, and abdominal pain which later came back to trouble him. After several additional months of treatment he was free of somatic symptoms.

Conclusions

Freud's concept of the repetition compulsion has a major application in the treatment of a wide variety of patients with traumatic backgrounds. It is becoming increasingly clear that such patients comprise a large proportion of psychiatric patients with many different kinds of diagnoses. The reexperiencing or reliving of previously dissociated experiences must be recognized, whether in its full-blown form of flashbacks or in many kinds of partial forms. It is only with the recognition of the presence of old trauma and the acknowledgment of the importance of trauma in producing emotional disturbance and psychiatric illness, that these patients can be effectively treated. It is with this understanding that clinicians can effectively deal with symptoms and behaviors which otherwise too often lead to reenactments of unacknowledged past abuse. Understanding of trauma can promote the empathy and patience that clinicians need to join with their patients in what is often a painful and difficult treatment process. It is only with such knowledge that clinicians can provide the necessary interpersonal arena in which old trauma can be explored and neutralized. And it is only with this kind of treatment that such patients can begin to achieve some sense of stability and control in their lives.

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