A patient was recently talking about a conversation with his father. It was a type of conversation he told me about many times. As he was talking I realized he wasn’t telling me about the conversation, rather he was repeating his part of the conversation. His words and tone were apologetic, as if he had to explain why his very existence was a bother to him and those around him. We had seen many times how his sad, repentant feelings were often nostalgically revived with a bittersweet longing. In this he was creating a mood with his words, a mood of sadness, of regret, of self-abasement, a mood designed to have me love him….or hate him….it was all the same to him.

Listening to the patient talk I had questions I’ve had many times before: Why was this conversation being repeated in action? Why, at this moment, couldn’t the patient tell me about the conversation, and his multiple thoughts and feelings about this? After all, he had reported many conversations where he had done that. From what part of the mind is this form of expression coming? It is obviously different than an understanding of a longed for feeling state that we learn about via the patient’s associations.

When Freud introduced the repetition compulsion, he used the phrase “the compulsion to repeat in action”. Why did he need this addition, “in action”? If he were primarily
trying to describe how certain mental events recur, the “compulsion to repeat” would have been sufficient. Since Freud did not use words injudiciously, we have to assume this term “in action” had particular significance for him. However, Freud’s explanation for why the patient’s psychic life is expressed “in action” was, at best unsatisfactory, and seemingly contradictory. Thus, at various points in his 1914 paper we see Freud explaining the in action part of the compulsion to repeat as: a resistance to remembering, and the patient’s only way of remembering. Puzzling is that Freud doesn’t elaborate this paradox, which has been a source of confusion for analysts ever since (Busch, 1995). Whole schools of psychoanalytic thought have been built upon one side of the equation, while the other side has been conveniently ignored.

There are various ways one can approach the question of the Panel, “What is repeated in the compulsion to repeat?” I have chosen to consider it in terms of what can we learn about the patient’s mind in the midst of these repetitions in actions, and what does it tell us about clinical technique in approaching these repetitions.

First let us look at how Freud described these actions.

For instance, the patient does not say that he remembers that he used to be defiant and critical towards his parents’ authority; instead, he behaves in that way to the doctor. He does not remember how he came to a helpless and hopeless deadlock in his infantile sexual researches; but he produces a mass of confused dreams and associations, complains that he cannot succeed in anything and asserts that he is fated never to carry through what he undertakes.

(1914, p.149).
As you see this is a very modern description of what we would now call “action in speech” (Loewald, 1971, 1975), or what I have characterized as “action language” (Busch, 1995, 2004) or what Rizzuto called “speech acts”. These are times when the patient’s verbalizations are meant to do something or bring about something, rather than communicate something. This occurs at an unconscious level (for the most part), while at a conscious level the patient believes he is describing a dream, or telling about an upsetting event, or complaining about his wife. What he communicates to the analyst is that; I don’t believe in dreams; or feel sorry for me; or love me more than any woman. As we’ve gradually learned, the whole range of psychic states can be expressed via action language. Action language is used to ward off anxiety, to repair a self-state, to bring about a response from the analyst that is gratifying, traumatizing, or reinforces a resistance, and to express every other human emotion or fantasy. Loewald captured the significance of action language in psychoanalytic treatment when he stated that, “we take the patient less and less as speaking merely about himself, about his experiences and memories, and more and more as symbolizing action in speech:” (1975, p. 366; italics added).

I don’t think there would be much disagreement with the statement that, within the neurotic to severe character disorder range, the more regressed the patient the more likely he is to communicate via action language. At these times we can no longer listen to the words as associations, and turn our attention to the feeling state conveyed by the words, usually understood best via our countertransference. The Kleinians, who seem to see more regressed patients (Hinshelwood, personal communication) have been writing about this type of communication for years, focusing on projective identifications.
What does this tell us about action language? Based upon the observation that the more regressed the patient, the more likely they are to use action language, it is my conclusion that the closer one comes to expressions of the unconscious in psychoanalytic treatment, the more likely it is to occur as action language. Why is that? As I have indicated elsewhere (Busch, 1989), thought is under the domination of action for a much longer period of time than has generally been recognized in psychoanalysis. It is not until a child is around age seven that one can talk of his having an integrated cognitive system with which he can organize the world relatively free from action referents. Before that time, the child's thinking is heavily influenced by its motoric underpinnings. For example, a five-year-old can successfully walk to school and negotiate a number of school corridors to find his kindergarten class, but he is unable to reproduce this in representational form, as his thinking is of a “doing” type. The younger the child, the more his thinking will be dominated by action. For children capable of higher-level functioning, conflict and regression will heighten the tendency toward thinking based on action.

The reason for this “action” type of thinking has to do, in part, with the way thought processes develop. One of the major characteristics of all intelligence is that it is a matter of action. The main distinction between different stages of intellectual development is the degree to which actions become internalized and behavior is based upon representations rather than overt actions. However, it is important to note that the process of internalization is a very lengthy one [Busch, 1989, p. 538].

What has not been sufficiently emphasized is that actions become increasingly woven into the fabric of the psychoanalytic process, in part, because of the long period of time the child's thinking remains under the influence of action determinants. Central conflicts
and the adaptations to them are first experienced, thought about, and worked out at an action level. Whatever the danger, the original defensive adaptations and compromise formations were undertaken in action terms, and thus may remain unavailable to higher-level ego functioning or remain in waiting as regressive flash points. *Up until the oedipal phase and its crucial importance in shaping psychic development, action-tendencies remain as a primary mode of the child's thought processes.*

So what is earliest and most primitive in the unconscious is stored in action thoughts. That is why so many characteristics Freud identified as “primary process” thinking is similar to the way Piaget described the action determinants of children’s thoughts. Thus, the closer we come to what is unconscious, the more likely the patient will express themselves via the compulsion to repeat in action. The deeper we go into the unconscious, and it is useful to think of gradients in the unconscious, the more evident thought is equated with action. Think of our most disturbed patients where, in areas of their disturbance, thoughts are closer to reflex actions. In English a term has been coined for these repetitive reactions, that captures it’s reflexive nature….a knee jerk response. There are, of course, other important qualities in action language as an expression from the unconscious.

1. The patient is driven to actualize a wish, defense, compromise formation, object relationship, self-object relationship, or repair a self-state. J. Sandler (1974) captured the quality of this way of being as preemptory.

2. There is an implicit insistence that whatever the analysand is attempting to actualize, the analyst must enact it with him. Until the analyst understands the attempt to actualize, there is little he can do to stop the enactment.
3. As the press to actualize is an unconsciously driven communication, it is usually registered first in the analyst’s unconscious. We first respond to this more primitive level of communication via our more primitive form of reception. Thus, we learn first of what is going on via a feeling-state. It is only with the analyst’s beginning awareness of his engagement in an enactment that he can begin, via the use of his countertransference, to understand what he is unconsciously being directed to actualize.

*Implications for Treatment Of the Compulsion to Repeat in Action*

What does all this tell us about technique when analyzing the *compulsion to repeat in action*? As a general principle of technique, my views are akin to Green’s (2005), statement, “*the aim of an interpretation is not to produce insight directly but to facilitate the psychic functioning that is likely to help insight* (p.5), or as Sugarman (2006) put it, the goal of analysis is not insight, but *insightfulness*.

How does this translate into technique when working with action language? As an over-arching theme, we are attempting to translate action language into words as a necessary step in helping patients find increasing degrees of freedom to think and feel. The general principle is we try to engage the patient’s higher-level ego functions to deal with the most regressive parts of the personality. As a first step we need to identify the nature of the action language and communicate this to the patient. *It is my impression this basic step is often bypassed for deeper interpretations.* We too often assume agreed upon meanings before we interpret. It is my experience that unless the patient is in some agreement on what is being talked about, interpretations become authoritative directives. We cannot meaningfully
interpret the patient’s provocative behavior, until he can get a glimpse of this behavior.

A well-respected analyst reports the following vignette. A patient returns from holiday reporting she found romance with an old lover, and waxes rhapsodically about the encounter. She goes on at length about this. The analyst feels pressure from the patient to agree with her view. However, the analyst is highly suspicious of this old lover and detecting an edge in the patient’s voice says, “Aren’t you really angry at him?” The patient gets furious with the analyst, which the analyst sees as confirmation of her anger.

The problem with this intervention, as I understand it, is that the analyst was pointing out exactly what the patient was defending against. Her anger seemed to be the result of a threat to a bypassed defense. The main way I would see bringing the patient’s attempt to have me side with her defense (the action language), would be to see if I could help her begin to explore the defensive nature of her commentary on the week-end…i.e., her need to go over the same material with no room for thought. Once the patient can see this, we have a chance to explore the press to have us both agree to her view of the week-end.

When the analysand communicates primarily in action language we attempt to translate this language into words, in the hopes of forming a new preconscious structure of thoughts (but not yet meaning), while attempting to understand the fears that may keep the patient communicating in action language. The first step is clarification. What is clarified is the action language as a way of helping patients associate at a preconscious level. The purpose of a clarification is to ultimately add
meaning, not causes. Meaning leads to causes. It is the elaboration of a dynamic process viewed via the analysand’s action language. This is not a cognitive process, for without the analyst’s empathic involvement with the analysand’s emotional shadings and the analyst’s psychoanalytic understanding at multiple levels, any communication will detract from a deeper involvement between the analytic pair.

**Clinical Vignette**

Ken is a successful entrepreneur in his early 40’s. He started his own company 20 years earlier. He devoted his twenties and thirties primarily to his work, and then decided it was time to get married. Ken approached the task with the same devotion and energy he used to grow his company. However, he had little success and became increasingly anxious. It was at this time he sought treatment.

What I will report to you is from the time of treatment when Ken was noticing dreams, fleeting moments of day dreams, feelings, etc. In short, he started to notice his inner life, and was no longer exclusively focused on external events, such as the personal deficiencies of the women he dated. Over several months a pattern kept repeating. Ken would recount a dream, or what seemed like a meaningful observation about his inner life. What would happen next was often different, but I would find myself confused, distant, and barely able to remember what had led to his associations. There will be several examples of this in the clinical vignette that follows. While in these examples Ken is seemingly doing what we ask patients to do (i.e., associating), but in his words he is repeating something in action with the analyst.
Ken: I had a dream last night. I got on the plane and there was this game going on.

People would take different seats. I sat down next to an older woman. I thought later it was because I felt safest there. That’s the dream.

Nikki (his wife) has been real angry recently, and maybe that’s why I thought of someone safe. (He then goes over familiar territory of how she feels the relationship has lost its excitement.)

[My impression is he’s telling me this as if he hadn’t been talking about it recently. I find myself increasingly emotionally distant from what he’s saying. I wonder why he doesn’t seem to have registered what we’ve talked about? It is a familiar feeling that while in the sessions Ken seems engaged, but at times there seems to be little carry-over to proceeding sessions. This is the first compulsion to repeat in action in the session...i.e., creating emotional distance between us as a defense. From Ken’s perspective he’s associating to the dream. However the form of the associations (going over old material) and the resulting countertransference is indicative of his words as action language.]

FB: I wonder if you can recall talking about Nikki’s anger with you recently.

[In this I am identifying the form of the action language, and putting it into words. In this way we have a better chance of Ken leading us to the specificity of what this repetition in action is about, by raising it from action language to preconscious thinking. It is only via preconscious thinking we gain access to the associative process.]

Ken (continues): Now that you mention it I do remember. I just thought of another part of the dream. In the plane I saw Allen Blount, my history teacher from college, but didn’t talk to him. When I had him as a teacher I liked him a lot. At the end of the semester he asked my friend Lyle to work as his research assistant. I felt disappointed. I spoke to Lyle
a number of years later and asked him how the work with Allen went. Lyle responded, “He was a real jerk”. My immediate fantasy was that Allen had tried to molest him.

Ken then went through a dizzying description of other elements in the dream, along with an equally dizzying set of details on the day residue. I found myself getting lost in the facts, and not feeling able to reflect more freely on this material. This was a familiar feeling, as Ken often gets lost in the day residue details of the dream.

FB: I wonder if it seems to you that finding all these external circumstances that contribute to the dream, sometimes also take us away from the meaning of the dream.

[Here again I am putting into words the action language as a defense. After identifying the previous repetition we see Ken’s association to homosexual anxiety, and then a defensive repetition. Until we are clear that Ken can see the defensive repetition, there is little utility in interpreting what transference fantasy Ken is defending against.]

Ken I know I have this familiar experience every time I tell a dream. As I go further into the dream there are all these details, and I can’t remember why they even came up. Funny, though, while you were talking I thought of the nickname we had for the history teacher, it was “Big Al”. Once I called him that and he was very upset. I felt really badly about it for a long time.

FB: So when we talk about how you get lost in the details with me, your thoughts go to being disrespectful toward some man who you like, as if there is a conflict about liking a man.

Ken I just remembered I had an odd experience when I first cam in today. For the first time ever, as I was coming in from outside, I started to reach for the glove in my pocket. It was like I was going to put it on to protect myself from any germs that might be on the
door. Well of course, this being wintertime and so many people having colds, it’s a good idea to be careful where you touch. But I’ve never done that before. I was even careful when I went into the waiting room not to touch the doorknob. Of course you may be glad that I don’t touch the doorknob because of all the women I’ve been sleeping with recently. So I guess I’m just concerned about a disease.

FB: You just moved away from the idea that it was sexually transmitted disease that seemed to be associated with our both touching the same doorknob, leading you to feel you needed protection coming in today.

[So here we have a verbal association about an action that more directly reflects Ken’s homosexual anxiety, and then the defense against it….again in words. I am not suggesting this was simply the result of what happened in these moments, as we had worked on getting closer to this issue over many months. However, what I am trying to highlight is the necessity to identify the repetitions in action thoughts, before interpreting the underlying dynamics. If, as I believe, these repetitions in action thoughts are expressions of the more regressed part of the personality, we need to approach them by enlisting the more mature parts of the personality. This is one technique I have found helpful in dealing with repetitions in action thoughts.

Summary

In summary, I have focused on what I believe was Freud’s major contribution…i.e., identifying the compulsion to repeat as a clinical phenomena ubiquitous in psychoanalysis. It had potential importance for clinical technique that was not able to mined at the time. However, it was Freud’s genius to identify what has become a key concept in clinical work some 100 years later.