The American Journal of Psychoanalysis, ***2010, 70,*** *(282–298)*
© 2010 Association for the Advancement of Psychoanalysis 0002-9548/10
www.palgrave-journals.com/ajp/

REPETITIVE MALADAPTIVE BEHAVIOR: BEYOND REPETITION COMPULSION

Brad Bowins

Maladaptive behavior that repeats, typically known as repetition compulsion, is one of the primary reasons that people seek psychotherapy. However, even with psychotherapeutic advances it continues to be extremely difficult to treat. Despite wishes and efforts to the contrary repetition compulsion does not actually achieve mastery, as evidenced by the problem rarely resolving without therapeutic intervention, and the difficulty involved in producing treatment gains. A new framework is proposed, whereby such behavior is divided into behavior of non-traumatic origin and traumatic origin with some overlap occurring. Repetitive maladaptive behavior of non-traumatic origin arises from an evolutionary-based process whereby patterns of behavior frequently displayed by caregivers and compatible with a child's temperament are acquired and repeated. It has a familiarity and ego-syntonic aspect that strongly motivates the person to retain the behavior. Repetitive maladaptive behavior of traumatic origin is characterized by defensive dissociation of the cognitive and emotional components of trauma, making it very difficult for the person to integrate the experience. The strong resistance of repetitive maladaptive behavior to change is based on the influence of both types on personality, and also factors specific to each. Psychotherapy, although very challenging at the best of times, can achieve the mastery wished and strived for, with the aid of several suggestions provided.

KEY WORDS: repetition compulsion; avoidance; dissociation; defense mechanisms; grieving; trauma; maladaptive behavior; therapeutic interventions.

DOI:10.1057/ajp.2010.14

INTRODUCTION

Several theorists have commented on the repetitious nature of behavior, such as Freud (1914a) who proposed that a propensity to repeat past experiences is a fundamental human characteristic. Bibring (1943) indicated that repetition is a tendency of life, including psychological processes. Schur (1966) went one step further expressing that repetitiveness is a ubiquitous phenomenon transmitted in every living organism by the genetic code. Inderbitzin and Levy (1998) suggest that the question is not why we repeat but what stops us from

Brad Bowins, M.D., F.R.C.P.(C), Psychiatrist, University of Toronto; Health Services — Psychiatric Division. Private Practice, Toronto, Canada.

Address correspondence to Brad Bowins, M.D., F.R.C.P.(C), 2200 Yonge Street, Suite 1700, Toronto, Ontario, Canada M4S 2C6; e-mail: brad.bowins@bellnet.ca

repeating. Repetitious behavior can include thoughts, images, flashbacks, dreams, emotions, somatic sensations, and behavioral re-enactments.

Within a psychotherapy context repetitive maladaptive behavior is extremely prevalent, and arguably the main reason people seek psychotherapy. Maladaptive refers to physical, psychological and somatic behavior that favors negative outcomes in terms of resource standing, relationships, functioning, or emotional states. Freud (1914a) described how patients would repeat neurotic conflicts during analysis rather than remember the traumatic origins. Later in "Beyond The Pleasure Principle" (1920, p. 18) Freud expressed "He is obliged to repeat the repressed material as a contemporary experience instead of, as the physician would prefer to see, remembering it as something belonging to the past." Feelings that cannot be remembered or expressed in words will be manifested in actions. Freud applied the term repetition compulsion to this phenomenon.

Freud (1920, 1926) believed that repetition of traumatic experiences in dreams, behavior, and fate neurosis are in the service of mastery rather than the pleasure principle. Psychoanalysts typically emphasize a mastery aspect to traumatic re-experiencing and wish fulfillment to non-traumatic. Bibring (1943) believed that the repetition of traumatic experiences leads to mastery, at least partly because of the restorative tendencies of the ego. Janet (1925) indicated that there is a need to relive a traumatic event to master it. Horowitz (1976) suggested that a traumatic event is repeated to align the traumatic experience and a person's view of it, a so-called completion tendency. Cohen (1980) explained that repetition occurs because the ego has not organized the conflict or wish. The repetition proceeds so that the unconscious trauma can be retrospectively mastered. Loewald (1971) indicated that the compulsion to repeat unconscious conflicts, wishes and experiences passively is primarily because of their having remained under repression and not exposed to the organizing influence of the ego, an occurrence that would lead to re-creative repetition and mastery.

Looking at Post-Traumatic Stress Disorder (PTSD) however, where the re-experiencing of trauma is a central symptom, repetition causes ongoing suffering and no mastery (Inderbitzin and Levy, 1998; Kriegman and Slavin, 1989; Keane, 1985). Considering repetition compulsion behavior beyond PTSD mastery is rarely achieved despite any wish or effort in this regard, and the repetitive behavior actually reduces the likelihood of mastery (Levy, 2000; Chu, 1991; Van Der Kolk and Greenberg, 1987; Van Der Kolk, 1989; Keane 1985). Of course, if repetitive maladaptive behavior in and of itself actually succeeded in achieving mastery the suffering would frequently resolve without the need for psychotherapy.

In the grieving process, repetition, in contrast to repetition compulsion, typically achieves some semblance of control or mastery (Levy, 2000).

Factors that might account for the discrepancy include: First, the grieving process is activated immediately following a loss. Second, there are other components to grieving that assist in the progression to mastery, such as bargaining and reevaluating the loss, working through emotions linked to the loss, and eventual acceptance of the loss. Third, the cognitive components of the loss and emotional suffering are fully conscious and hence more accessible to mental processes designed to facilitate mastery and control.

Psychotherapy is expected to bring about change, instead of the frustrating scenario of extreme resistance even when the person is made consciously aware of the problem. Given the conceptual confusion, evidence that repetition compulsion does not succeed in achieving mastery despite the wish for it, and tremendous burden of suffering exacted by repetitive maladaptive behavior, a need exists to simplify the framework for such behavior making it more accessible to clinicians. Addressing these concerns I propose that repetitive maladaptive behavior be divided into that of non-traumatic and traumatic origin. Repetitive maladaptive behavior of non-traumatic origin is proposed to arise from an evolutionary process, which facilitates the acquisition of adaptive behavior patterns during the early years of development. Prominent patterns of behavior in the child's environment are acquired through this process, and repeated over time assuming that they are in some way compatible with the child's genetically based temperament/personality. While this mechanism enhances evolutionary fitness through absorption of adaptive patterns of behavior, maladaptive patterns displayed by caregivers and compatible with a child's genetically based temperament/personality are also acquired.

Repetitive maladaptive behavior of traumatic origin functions as a dissociation-based defense. Conscious linking of the cognitive components of a traumatic occurrence and the adverse emotions arising from it is avoided. This defense acts either by repetition of trauma-related behavior, or the application of specific defenses in an overly intense and rigid fashion. Although consciously approaching and addressing disturbing psychological states, as in psychotherapy, represents an attempt at mastery and often succeeds in achieving this goal, the opposite—avoidance via dissociation—ensures that there is no mastery frustrating the usual wish for it. Consistent with these two mechanisms Reiser (1984) argued for a dual track with biological and psychological realms.

REPETITIVE MALADAPTIVE BEHAVIOR OF NON-TRAUMATIC ORIGIN

Repetition of behaviors is a characteristic of life. In cognitively simple organisms natural selection over time produces changes in behavior. For

example, bees that demonstrate a somewhat more effective defensive behavior to a new type of invader become more numerous in succeeding generations. The evolution of intelligence enables behavior change free of genetic coding. For example, chimpanzees can learn to apply a different type of tool to search for insects. With humans representing the extreme in the evolution of intelligence, why does behavior tend to repeat?

A rule in ecology is that an organism cannot expend more energy than what it consumes (Barish, 1982). Repeating patterns of behavior that have proven advantageous helps to conserve energy, as opposed to generating new behaviors each time for the same basic type of task. During our hunting-gathering evolution, trial and error learning and teaching would have proven very energy intensive given the complex array of behaviors required to function well in the social setting and survive in harsh environments. It is proposed that to conserve energy resources, patterns of behavior displayed by caregivers are unconsciously acquired during primarily the childhood years. Behavioral patterns refer to general modes of interacting with the social and physical environments, such as showing affection towards others and approaching the physical environment in an open exploratory fashion.

In an evolutionary context acquiring patterns of behavior would have been energy efficient and adaptive for the following reasons: First, caregivers having survived in a harsh physical environment with very real predators and not infrequent food shortages, and in a social environment where individuals had to secure resources, act in accordance with debts and entitlements, and manage the political realities, would likely display adaptive ways of interacting with the physical and social environment that the child could benefit from. Second, in a hunting/gathering context several people were involved in the rearing of children, thereby exposing a child to a broad range of adaptive patterns of behavior. Those patterns frequently demonstrated by several individuals were almost certainly very adaptive for the particular physical and social environment. Third, the extended caregiver network would often have opposed highly maladaptive patterns of behavior including abuse and neglect, and even if such patterns were to persist their influence would be lessened when weighted against the broad range of adaptive patterns demonstrated (Glantz and Pearce, 1989). Of course there would be exceptions where the entire group demonstrated maladaptive behavior such as we see in modern day cults. However, if too maladaptive, these very groups might have been as short lived as most cults are.

With agricultural and later industrial forms of social organization people typically lived in smaller units where the potential for maladaptive patterns to remain unopposed would be greater. Although debatable, the

modern day scenario of two or even one caregiver raising a child is a historical anomaly when considered in an evolutionary context, and one that allows deviant patterns of behavior to be over-represented and go unopposed. For example, a neurotic parent raising a child herself or himself can present predominately maladaptive ways of interacting with the social environment.

Acquired patterns of behavior must be represented in memory. Memory is an essential property of all biologically adaptive systems (Edelman, 1992). Emotional and history dependent context is laid down at the level of the amygdala, hippocampus, and other substrates of learning and memory (Post and Weiss, 1997). Memory at a biological level can be divided into representational and habit forms (Meunier *et al.*, 1996; Mishkin and Appenzeller, 1987; Squire and Zola-Morgan, 1991). Representational memory is conscious and achievable in a single episode framework. Habit memory is implicit, relatively automatic, and functions on an unconscious basis.

Patterns of behavior displayed by caregivers are predominately acquired via habit memory. Acquisition of these patterns does not involve conscious learning and progresses with repeated exposure to the given pattern. A pattern displayed very infrequently would then be unlikely to successfully lay down a persistent memory trace, unless perhaps the circumstances elevated the pattern to a highly salient level. Exposure to caregivers fleeing a predator would be such an instance. In most cases, though, memory for the pattern of behavior builds in a gradual and subtle fashion. Behavior generated in accordance with these patterns then feels automatic and does not require conscious thought. For example, exposure to a caregiver that repeatedly withdraws from any stressor will lay down this pattern in memory, and the person will automatically act in this way when faced with a challenge. It is feasible that representational memory can modify habit memory. For example, the person discovers that approaching the opposite sex produces a rewarding response, resulting in the habit memory being modified such that the opposite sex is not to be withdrawn from.

Acting in accordance with such patterns of behavior represents a path of familiarity in producing behavior. However, absorbing a particular behavioral pattern from a caregiver is not a given because the fit with the child's genetically based temperament/personality will largely determine the patterns that are absorbed. Personality factors based on popular assessment instruments include introversion/extroversion, neuroticism/emotional stability, openness to experience, agreeableness, conscientiousness, harm avoidance, novelty seeking, reward dependence, and persistence (Costa and McCrae, 1992; Cloninger *et al.*, 1993). Temperament represents the

very early genetically based expression of personality factors. If a person ranks high on novelty-seeking an exploratory pattern of interacting with the world is highly likely to be adopted, while a withdrawal pattern is much less likely to be encoded.

From a psychoanalytic framework Karen Horney identified three neurotic personality styles consisting of moving towards, against, or away from people (Horney, 1945). Interestingly, the mechanism for acquiring these three personality styles might be the evolution-based patterns of behavior process described here. Early life interactions with caregivers results in the development of these neurotic personality styles (Horney, 1945; Feiring, 1984). For example, a moving towards style involves a parent-child experience of so-called lovable goodness to acquire affection. The moving against style arises from parents who combine neglect with criticisms and humiliation. In the case of the moving away style parents are inconsistent, moody, and egocentric, and hence will not have bonded with others instead likely moving apart. Essentially, parents display behavior integral to the three neurotic personality styles described by Horney, raising the distinct possibility that in part or full these neurotic personality styles are acquired by the patterns of behavior mechanism described here, although most psychoanalytic theorists would use the term, internalization (Ferenczi, 1952[1909]; Freud, 1914b; Fairbairn, 1952; Schafer, 1968).

In general, frequency of exposure to a pattern of behavior is probably the major factor assuring that highly adaptive patterns for the particular environment are internalized. Much like with language acquisition, this mechanism facilitates acquisition of the predominant patterns of behavior within the child's environment. If a behavior repeats even when disadvantageous, such as a person abusing his or her children, it is often the case that the pattern of behavior has been internalized from caregivers and feels familiar. Alternative behavior, such as showing love and affection for children, is much more challenging as there is no habit memory for this behavior. In the case of child abuse the abused often finds it easier to abuse than to resist this pattern. To unlearn a maladaptive pattern of behavior typically requires over-learning of adaptive patterns to compensate for the absence of an encoded template. For example, a person abused as a child must resist striking out at his own child and consciously apply constructive patterns of disciplining and interacting.

Treating repetitive maladaptive behavior generally is a formidable process, and that derived from this evolutionary process presents some unique treatment challenges—the internalization of these patterns from caregivers in early life, reasonable fit with the person's genetically based temperament/personality, and memory encoding make these repetitious maladaptive behaviors somewhat resilient to change. It is ego-syntonic and

comfortable at some deep level because of it becoming a distinct aspect of personality derived from the repetitiveness, early start in life, and fit with temperament. Standard definitions of personality emphasizing enduring and characteristic ways of acting and reacting highlight how these patterns of behavior comprise an aspect of personality. As Karen Horney (1950) so accurately pointed out, aspects of character are formed from ongoing interactions with the environment and come to form a character armor (Reich, 1945). What all this means is that in the absence of sufficient motivation and guidance the maladaptive pattern of behavior will persist. Even with psychotherapy the repetitive behavior often persists given that it is personality based and ego-syntonic. To modify these patterns of behavior there are some helpful steps that the therapist may take, including:

Explain the nature of patterns of behavior such as their acquisition from caregivers and how they represent a familiar and ironically comfortable way to interact with others. Also explain the concept that behaviors adaptive in an earlier context might no longer be so in another context, and shifting behavior to meet current needs represents optimal adaptation.

Clarify what patterns of behavior are maladaptive and describe them in detail so that the patient is clear regarding the behaviors that need to be changed. For example, when a significant challenge is present withdrawal behavior occurs. Accurate identification of maladaptive behavior patterns playing out in therapy is crucial. For example, the patient raises a supposed concern about the therapist's style and uses it to rationalize leaving therapy. The pattern of withdrawing from a stressor is surfacing in therapy.

Identify triggers for the maladaptive pattern of behavior, and emphasize how these triggers must be addressed to prevent ongoing repetitions. For example, a stressful work assignment might be a key trigger for withdrawal behavior leading to days off work.

Provide reasons for altering the pattern/s of behavior in question to increase motivation. For example, it can be explained that even though withdrawing from challenges is safer in the short run, this pattern of behavior blocks gains in the moderate to long run, such as finding a desirable partner.

As a therapist appreciate and communicate to the patient that to unlearn a maladaptive pattern of behavior it is necessary to over-learn alternative more adaptive patterns through conscious repetition and practice, until the new behavior becomes automatic. As an example, facing every reasonable challenge will set into place a pattern of approach rather than withdrawal.

Treat any conditions that maintain maladaptive patterns of behavior, such as social anxiety maintaining withdrawal behavior.

Assist the patient in devising adaptive patterns of behavior to replace maladaptive ones.

Provide support and reinforcement for new more adaptive patterns of behavior. For example, describe how by completing work tasks and not taking days off the employer and fellow employees seem more interested and supportive. Likewise, persevering in therapy and working through perceived conflicts is producing a stable relationship.

Framing the process in the language of biological memory, conscious representational memory is applied to modify, negate, and replace habit memory. Repetition of the more adaptive pattern of behavior in different contexts will heighten familiarity so that it is no longer unnatural. As the underlying neural encoding for the new more adaptive pattern of behavior progresses it feels increasingly natural, and automatic. At some point it will constitute an unconscious habit memory. This transition from maladaptive to adaptive patterns of behavior will proceed gradually over time even with solid psychotherapeutic support.

REPETITIVE MALADAPTIVE BEHAVIOR OF TRAUMATIC ORIGIN

Trauma plays a major role in repetitive maladaptive behavior (Chu, 1991). Of course, there are different ways of viewing and defining trauma. In the narrowest sense, it can be taken as objectively damaging occurrences such as sexual or physical abuse. However, this misses a great deal of what might actually traumatize a person (Levy, 2000). In addition, children are more sensitive to trauma given their less developed cognitive structures, global undifferentiated thinking, and great dependence on parental figures (Levy, 2000). "Even objectively harmless events can become major traumas in the absence of ways to cope with them. Traumatization depends so much on the child's view of the event" (Angyal, 1965, pp. 118-119). Although children might be more vulnerable to trauma, adults can also experience it, and very subjective factors can play an instrumental role. For example, the perception that death is a possibility during stressful events can produce greater trauma in healthy adults (Morgan *et al.*, 2001). Based on the diverse and subjective nature of trauma, the position will be taken here that any event producing significant emotional distress at any point in life can be conceptualized as traumatic.

Trauma-related emotions and cognitions naturally enter consciousness, based on the evolutionary fitness benefits of attending consciously to traumatic events, and the fitness reducing consequences of failing to do so. To any event there are cognitive and emotional aspects, and these two components are automatically forged together into a psychological program based on a biologically based learning process (Kutz, 1989; Bowlby, 1988; Van Der Kolk, 1987). However, in the case of traumatic events this linkage is often not tolerated at a conscious level, providing a potent negative

reinforcement framework for a dissociative defense. Conscious linking of the adverse emotions and cognitive components of a traumatic experience is avoided via dissociation. Avoidance behavior in adulthood has been associated with traumatic childhood social experiences such as rejection and isolation (Meyer and Carver, 2000; Stravynski *et al.*, 1989). Avoidance is also more common in those with low tolerance of negative emotions, elevated responsiveness to threats, and sensory processing sensitivity, characteristics that make a person more vulnerable to interpreting adverse events in a traumatic fashion (Millon, 1967; Meyer, 2002; Meyer and Carver, 2000). Beck and Freeman (1990) suggest that people who use avoidance chronically hold a belief that unpleasant emotions and cognitions are intolerable and overwhelming, motivating them to continue the cognitive-emotional avoidance. Avoidance also constitutes the main ingredient of the moving away personality style described by Karen Horney (1945, 1950) highlighting the power of this mechanism.

Given that trauma-related negative emotions and cognitions remain disconnected at a conscious level, dissociation is integral to the avoidance response—dissociation produces and sustains the avoidance. Both the distressing emotions and the cognitions involved in the traumatic experience can achieve conscious awareness but they are not consciously linked to one another, instead persisting in a dissociated state. Freud (1894) described how dissociation dislocates affect from ideas. Vaillant (1977) indicated that dissociation permits the ego to alter the internal state so that the pain of conflict seems irrelevant. Dissociation plays an instrumental role in how a person emotionally and cognitively processes trauma (Bromberg, 1998; Stern, 1997). Research indicates (Ross *et al.*, 1990, 1991) that dissociation constitutes a spectrum ranging from mild variants of absorption and imaginative involvement commonly experienced by virtually everyone, to more moderate depersonalization and derealization still quite frequently encountered, to more severe amnesia and identity fragmentation.

In prior papers (Bowins, 2004, 2006) I posit that dissociation serves as one of two main psychological defense templates, the other being positive cognitive distortions, both protecting us from negative emotional states in much the same way as our immune system defends against pathogens. Specific types of dissociation are derived from the general template, one being the emotional detachment factor characterizing antisocial personality disorder, favoring enhanced resource acquisition in an evolutionary context via more successful deceit and coping with violent settings (Bowins, 2004). Avoidance reduces or prevents contact with a distressing object, situation, or emotional state, and as such represents a form of dissociation. For example, a person who fears intimacy walls off any non-professional contact with a potential partner.

The dissociative function of repetitive maladaptive behavior of traumatic origins works either by re-experiencing feelings, beliefs, sensations, or behavior from the traumatic event, or over-utilization of typically less mature, or what I have referred to as more cognitively distorting psychological defenses such as repression, isolation and identification with an aggressor (Bowins, 2004, 2006). Levy (2000) conceptualized repetition compulsion as including these two components. Re-experiencing of a traumatic event can include thoughts, images, flashbacks, dreams, emotions, somatic sensations, and behavioral re-enactments (Levy, 2000; Chu, 1991). In a general sense psychopathology itself might even be defined on the basis of how the past intrudes on the present (Pine, 1985).

Re-experiencing aspects of past trauma can deflect from consciously linking the cognitive components of a traumatic event to the adverse emotional states produced by it. For example, a woman who was sexually abused as a child sexualizes her relationships with men, having multiple casual encounters and no emotional investment from her partners. Her sexual behavior repeats the trauma in a behavioral sense while preventing emotions from surfacing during sexual encounters, thereby avoiding conscious awareness of the link between her past abuse and the distressing emotions arising from the abuse. If she developed a caring relationship, the more emotionally charged sexual experience would trigger the disturbing emotions while linking them to the sexual abuse, given that they surfaced during the sexual encounter. Even when feelings associated with the trauma are re-experienced they are not consciously linked to the cognitive components of the trauma that has given rise to them.

Trauma frequently results in re-experiencing, but how this transpires determines whether or not mastery is achieved. Owing to the evolutionary fitness benefits of attending to traumatic occurrences, the cognitive components and emotions arising from trauma will enter consciousness and be fused. However, when this occurrence is experienced as too painful, defenses will activate, foremost avoidance via dissociation. Both the cognitive and emotional components can be present in consciousness but not linked, or the emotional component only present (repression) or the cognitive component only present (isolation). It is also possible for both to be kept out of consciousness. In the case of the grieving process, emotional pain arising from a traumatic loss is consciously linked to the cognitive components and repeated as a fused unit, resulting in mastery over the event. With the avoidance via dissociation defense there is never any conscious linking of the cognitive components of the traumatic experience to the disturbing emotions arising from it, so there is no mastery. Re-experiencing of thoughts, images, flashbacks, dreams, emotions, somatic sensations, and

behavioral re-enactments occur with the cognitive and emotional components of the traumatic experience remaining dissociated. Not surprisingly, when the grieving process is delayed mastery over the feelings is less successful and suffering commonly persists.

In the case of PTSD the grieving process fails to engage properly, resulting in intrusive re-experiencing of the traumatic occurrence. The other major symptom clusters of PTSD, namely avoidance of trauma-related stimuli and heightened physiological arousal, are understandable within an evolutionary context, based on the defensive value of avoiding agents, and anything associated with them, that have proven highly damaging, plus being hyper-vigilant for threats. However, the largely dissociated repetition of traumatic cognitions and emotions, and failure to fully fuse them undoubtedly maintains these additional PTSD symptoms longer than would be expected if a successful grieving process transpired.

The grieving process represents an evolved defense enabling us to come to terms with major losses without incurring a fitness-reducing decline in functioning (Bowins, 2004). Trauma invariably involves a loss of some sort, such as a loss of control, freedom, mental or physical wellbeing, relationship, trust, or a valued object. The loss aspect of trauma contributes greatly to an event being experienced as traumatic. By extension the grieving process might well be designed to enable us to cope with, and master, trauma. When it engages and progresses unimpeded right after a traumatic occurrence the disturbing feelings are consciously linked to the cognitive components of the trauma and resolution of the distress progresses. When the grieving process fails to engage, re-experiencing shifts to the avoidance via dissociation defensive strategy.

Extreme avoidance defenses are commonly utilized following trauma to block the feelings arising from the experience (Krystal, 1988; Terr, 1990). Rigid defenses are often applied to avoid feared states (Levy, 2000). It is the rigid use of more cognitively distorting defenses and not the utilization *per se* that creates difficulties (Reich, 1945). In contrast to achieving mastery, rigid use of defenses ensures that the person does not consciously link emotional pain to the cognitive components of the traumatic experience. The defenses applied entail a more intense degree of cognitive distortion, in that the cognitive components of the trauma are completely disconnected from the adverse emotions arising from it. For example, identification with the aggressor (Ferenczi, 1980[1933]) greatly distorts the experience such that some positive emotional reactions are linked to the trauma, as opposed to emotions like fear, shame, guilt and sadness that actually arose from the trauma. Extensive isolation leaves memories and ideation associated with the trauma intact but blocks awareness of any affect associated with it.

Considering the dissociated re-experiencing and/or extreme avoidance defenses present in repetitive maladaptive behavior of traumatic origin, it is not surprising that resistance is commonly encountered when attempting to analyze a repetition compulsion. Freud (1923) indicated that there exists a demonic aspect derived from id resistance. He viewed the compulsion to repeat as exemplifying the typical resistance of the unconscious (Freud, 1926). Freud (1923, 1926) and Ferenczi and Rank (1924) believed that the repetitions often represent insurmountable resistances. Repetition compulsion is said to have an aura of unanalyzability offering a protective shield (Inderbitzin and Levy 1998). Negative transference itself can be viewed as a specialized form of repetition compulsion (Gill, 1979; Schafer, 1979; Corradi, 2006). Clearly, from the therapist's perspective repetition compulsion represents a path of resistance.

Repetitive maladaptive behavior of traumatic origin is extremely challenging to treat because of treatment resistance, its dissociated nature, and how the re-experienced events and rigidly applied defenses can come to constitute aspects of personality. Frustration is a common reaction with even highly experienced therapists, and progress can be painstaking for both the patient and therapist. To assist in the treatment of repetitive maladaptive behavior of traumatic origin here are some suggestions:

Indicate to the patient how the repetitive behavior is maladaptive in regards to relationships, general functioning, or emotional states. For example, a woman allows men to repeatedly take advantage of her.

Explain to the patient how he or she is not linking distressing feelings arising from a traumatic occurrence to the cognitive components of the trauma.

To optimize motivation indicate that as a general rule conscious processing of fear and other disturbing emotions diminishes the pain, even though in the very short run the pain might seem worse.

Identify the relevant traumatic occurrence/s. In the case of the woman in the above example, her father failed to look out for her needs and aggressively criticized her as a child.

Clearly identify re-experiencing of the trauma, including thoughts, images, flashbacks, dreams, emotions, somatic sensations, and behavioral re-enactments. For example, the woman repeatedly perceives that she cannot have an impact on men and responds in a very passive way to any violation.

Identify specific avoidance defenses, such as identification with the aggressor or extreme isolation.

Work cautiously with the specific avoidance defenses as opposed to dismantling them right away. Remember that these defenses are a form of self-protection and must be relinquished gradually in a safe setting.

Help the patient clarify adverse trauma-related emotions. The woman in our example feels sad at the losses encountered in her relationship with her father, and powerless to change a man's behavior when it impacts negatively on her.

Focus on emotional suffering even though the patient will initially not understand at a feeling level how the pain is linked to the cognitive components of the traumatic experience. The patient might understand intellectually how this makes sense, but it will take time for the understanding to be felt.

Link these adverse emotions to the cognitive components of the traumatic occurrence. The woman needs to see how the treatment by her father left her feeling sad and powerless, and how these feelings contribute both to her perception that she is ineffectual and her passive response to violations.

Explain the grieving process with it's various components, such as consciously re-experiencing the loss in terms of thoughts and emotions.

Help the patient identify trauma-related losses. In the woman's case how she lost out on a close supportive relationship with her father.

Encourage the patient to grieve these losses within the safety of the therapeutic environment.

When the patient has progressed to the common endpoint of grieving—acceptance—the repetitive maladaptive behavior, whether it take the form of re-experiencing or extreme avoidance defenses, should be significantly diminished or ended. Encouraging patients to immediately process disturbing feelings helps prevent a return of any repetitive maladaptive behavior and will make them less vulnerable to future trauma. Emphasize how grieving traumatic losses while somewhat painful in the present greatly diminishes suffering over time. Although psychoanalytic therapy can be highly effective at overcoming the resistance inherent in repetition compulsion, incorporating some or all of the therapeutic suggestions outlined here will foster still greater success in treating repetitive maladaptive behavior of traumatic origin.

OVERLAP OF NON-TRAUMATIC AND TRAUMATIC REPETITIVE MALADAPTIVE BEHAVIOR

Although distinct mechanisms, there is significant overlap between repetitive maladaptive behavior of non-traumatic and traumatic origin. The overlap occurs when there is internalization of trauma-related patterns of behavior. For example, a parent yells at the child in a very derogatory fashion and the child internalizes this pattern of behavior, in addition to developing repetitive maladaptive behaviors of traumatic origin type. The essential difference, though, is that in the case of the former, the trauma is incidental

while with the latter it is essential. To elaborate, if the child witnesses over time the parent yelling at others the pattern can be acquired despite no trauma occurring to the child. For the avoidance via dissociation form of repetitive maladaptive behavior, traumatic experiences to the self are involved.

CONCLUSION

Repetitive maladaptive behavior represents one of the most common and certainly most challenging psychotherapeutic problems. Given this scenario repetition compulsion in and of itself cannot result in mastery and actually sabotages the person's wishes and efforts to achieve it. Any attempt at mastery requires psychotherapy, typically longer term and conducted by a highly skilled therapist. Even then progress is often frustratingly slow and can be limited, but the person's wish for mastery can be satisfied because psychotherapy is capable of mobilizing constructive behaviors (Horney, 1950) to achieve the sought after mastery. Moving beyond classic formulations of repetition compulsion affords the possibility of improving our understanding and psychotherapeutic approaches. Dividing repetitive maladaptive behavior into non-traumatic and traumatic origin types encompasses the range of such behavior, and has a high degree of face validity.

Patterns of behavior internalized from caregivers represent a non-traumatic source of repetitive maladaptive behavior. Traumatic origin repetitive maladaptive behavior involves avoidance via dissociation, such that the distressing emotions and cognitive components of a traumatic experience are not linked at a conscious level. Overlap between the two types of repetitive maladaptive behavior can occur with trauma, although in the case of internalized patterns of behavior trauma is incidental and not essential.

Faced with repetitive maladaptive behavior, psychotherapists are advised first to attempt to distinguish between a non-traumatic, traumatic, or combined source. Obviously, repetitive maladaptive behavior without an identifiable source of objective or subjective trauma will represent that of non-traumatic origin. However, given the subjective nature of trauma this distinction can be difficult at times. A guiding principle is that to the person seeking treatment repetitive maladaptive behavior of non-traumatic origin is largely ego-syntonic, while that of traumatic origin is mainly ego-dystonic. By adopting the conceptual framework outlined here and applying the therapy suggestions described for both types of repetitive maladaptive behavior, treatment for this most challenging and frustrating of psychotherapy problems will be enhanced.

ACKNOWLEDGMENTS

Dr. Irwin Kleinman, Private practice, Toronto, Ontario, for his feedback on earlier drafts.

REFERENCES

Angyal, A. (1965). *Neurosis and treatment: A holistic theory*. New York: Wiley.
Barish, D.P. (1982). *Sociobiology and behavior*. New York: Elsevier.
Beck, A.T. & Freeman, A. (1990). *Cognitive therapy of personality disorders*. New York: Guilford.
Bibring, E. (1943). The conception of the repetition compulsion. *Psychoanalytic Quarterly, 12,* 486–519.
Bowins, B.E. (2004). Psychological defense mechanisms: A new perspective. *American Journal of Psychoanalysis, 64*(1), 1–26.
Bowins, B.E. (2006). How psychiatric treatments can enhance psychological defense mechanisms. *American Journal of Psychoanalysis, 66*(2), 173–194.
Bowlby, J. (1988). Developmental psychiatry comes of age. *American Journal of Psychiatry, 145,* 1–10.
Bromberg, P.M. (1998). *Standing in the spaces: Essays on clinical process, trauma, and dissociation*. Hillsdale, NJ: Analytic Press.
Chu, J. (1991). The repetition compulsion revisited: Reliving dissociated trauma. *Psychotherapy, 28,* 327–332.
Cloninger, C.R., Svrakic, D.M. & Pryzbeck, T.R. (1993). A psychobiological model of temperament and character. *Archives of General Psychiatry, 50,* 975–990.
Cohen, J. (1980). Structural consequences of psychic trauma: A new look at "Beyond the pleasure principle". *International Journal of Psychoanalysis, 61,* 421–432.
Corradi, R.B. (2006). Psychodynamic psychotherapy: A core conceptual model and its application. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 34*(1), 93–116.
Costa, P.T. & McCrae, R.R. (1992). Revised NEO Personality (NEO-PI-R) and NEO Five Factor Inventory (NEO-FFI) professional journal manual. Odessa Florida: Psychological Assessment Resources.
Edelman, G. (1992). *Bright air, brilliant fire*. New York: Basic Books.
Fairbairn, W.R.D. (1952). *Psychoanalytic studies of the personality*. London: Routledge & Kegan Paul.
Feiring, C. (1984). Behavioral styles in infancy and adulthood: The work of Karen Horney and attachment theorists collaterally considered. *American Journal of Psychoanalysis, 44*(2), 197–208.
Ferenczi, S. (1952[1909]). Introjection and transference. In E. Jones (Ed.) *First Contributions to Psychoanalysis* (pp. 35–93) London: Karnac Books.
Ferenczi, S. (1980[1933]). Confusion of tongues between adults and the child. In M. Balint (Ed.) *Final Contributions to Psychoanalysis* (pp. 156–167) London: Karnac Books.
Ferenczi, S. & Rank, O. (1924). *The development of psychoanalysis*. New York: Nervous and Mental Disorder Publishers.
Freud, S. (1894). The neuro-psychosis of defense. *Standard Edition, 3,* 43–61.

Freud, S. (1914a). Remembering, repeating and working-through. (Further recommendations on the technique of psycho-analysis II.). *Standard Edition, 12,* 145–156.
Freud, S. (1914b). On narcissism: An introduction. *Standard Edition, 14,* 67–102.
Freud, S. (1920). Beyond the pleasure principle. *Standard Edition, 18,* 1–64.
Freud, S. (1923). The ego and the id. *Standard Edition, 19,* 1–66.
Freud, S. (1926). Inhibitions, symptoms and anxiety. *Standard Edition, 20,* 75–175.
Gill, M.M. (1979). The analysis of the transference. *Journal of the American Psychoanalytic Association, 27*(S), 263–288.
Glantz, K. & Pearce, J. (1989). *Exiles from Eden: Psychotherapy from an evolutionary perspective*. Markham, Ontario: Penguin Books Canada.
Horney, K. (1945). *Our inner conflicts*. New York: W.W. Norton.
Horney, K. (1950). *Neurosis and human growth*. New York: W.W. Norton.
Horowitz, M.J. (1976). *Stress response syndrome*. New York: Jason Aronson.
Inderbitzin, L. & Levy, S. (1998). Repetition compulsion revisited: Implications for technique. *Psychoanalytic Quarterly, 67,* 32–53.
Janet, P. (1925). *Psychological healing* (Vol. 1). New York: Macmillan.
Keane, T. (1985). A behavioral approach to assessing and treating post-traumatic stress disorders in Vietnam veterans. In C. Figley (Ed.) *Trauma and its wake* (pp. 107–135) New York: Brunner Mazel.
Kriegman, D. & Slavin, M.O. (1989). The myth of the repetition compulsion and the negative therapeutic reaction: An evolutionary biological analysis. *Progress in Self Psychology, 5,* 209–253.
Krystal, H. (1988). *Integration and self-healing*. New York: Analytic Press.
Kutz, I. (1989). Samson's complex: The compulsion to re-enact betrayal and rage. *British Journal of Medical Psychology, 62,* 123–134.
Levy, M. (2000). A conceptualization of the repetition compulsion. *Psychiatry, 63,* 45–53.
Loewald, H.W. (1971). Some considerations on repetition and repetition compulsion. *International Journal of Psychoanalysis, 52,* 59–66.
Meunier, M., Hadfield, W., Bachevalier, J. & Murray, E.A. (1996). Effects of rhinal cortex lesions combined with hippocampectomy on visual recognition memory in rhesus monkeys. *Journal of Neurophysiology, 75,* 1190–1205.
Meyer, B. (2002). Personality and mood correlates of avoidant personality disorder. *Journal of Personality Disorders, 16*(2), 174–188.
Meyer, B. & Carver, C.S. (2000). Negative childhood accounts, sensitivity, and pessimism: A study of avoidant personality disorder features in college students. *Journal of Personality Disorders, 14,* 233–248.
Millon, T. (1967). *Modern psychopathology: A biosocial approach to maladaptive learning and functioning*. Philadelphia, PA: W.B. Saunders.
Mishkin, M. & Appenzeller, T. (1987). The anatomy of memory. *Scientific American, 256,* 80–89.
Morgan, C.A., Hazlett, G., Wang, S., Richardson, E., Schnurr, P. & Southwick, S.M. (2001). Symptoms of dissociation in humans experiencing acute, uncontrollable stress: A prospective investigation. *The American Journal of Psychiatry, 158*(8), 1239–1247.
Pine, F. (1985). *Developmental theory and clinical process*. New Haven, CT: Yale University Press.
Post, R.M. & Weiss, S.R. (1997). Emergent properties of neural systems: How focal molecular neurobiological alterations can affect behavior. *Development and Psychopathology, 9,* 907–929.

Reich, W. (1945). *Character analysis*. New York: Touchstone.
Reiser, M.F. (1984). *Mind, brain, body: Toward a convergence of psychoanalysis and neurobiology*. New York: Basic Books.
Ross, C., Joshi, S. & Currie, R. (1990). Dissociative experiences in the general population. *American Journal of Psychiatry, 147*(11), 1547–1552.
Ross, C., Joshi, S. & Currie, R. (1991). Dissociative experiences in the general population: A factor analysis. *Hospital and Community Psychiatry, 42*(3), 297–301.
Schafer, R. (1968). *Aspects of internalization*. New York: International University Press.
Schafer, R. (1979). Character, ego-syntonicity, and character change. *Journal of the American Psychoanalytic Association, 27*(4), 867–891.
Schur, M. (1966). *The id and the regulatory principles of mental functioning*. New York: International University Press.
Squire, L.R. & Zola-Morgan, S. (1991). The medial temporal lobe memory system. *Science, 253,* 1380–1386.
Stern, D.B. (1997). *Unformulated experience: From dissociation to imagination in psychoanalysis*. Hillsdale, NJ: Analytic Press.
Stravynski, A., Elie, R. & Franche, R.L. (1989). Perception of early parenting by patients diagnosed with avoidant personality disorder: A test of the overprotection hypothesis. *Acta Psychiatrica Scandinavica, 80,* 415–420.
Terr, L. (1990). *Too scared to cry*. New York: Harper and Row.
Vaillant, G. (1977). *Adaptation to life*. Boston, MA: Little, Brown and Company.
Van Der Kolk, B.A. (1987). *The separation cry and the trauma response: Developmental issues in the psychology of attachment and separation in psychological trauma*. Washington, DC: American Psychological Press.
Van Der Kolk, B.A. (1989). The compulsion to repeat the trauma. *Psychiatric Clinics of North America, 12,* 389–411.
Van Der Kolk, B.A. & Greenberg, M.S. (1987). The psychobiology of the trauma response: Hyperarousal, constriction, and addiction to traumatic reexposure. In B.A. Van Der Kolk (Ed.) *Psychological trauma* (pp. 63–78) New York: American Psychiatric Press.