Paul Russell and Repetition

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Abstract

In Boston in the 1980's and 1990's Paul Russell wrote and taught about psychotherapy in a way that conveyed a lively engagement with the experience of the therapist or analyst as well as that of the patient. He foreshadowed ideas that would be elaborated by later relational thinkers. This paper seeks to introduce the reader to his thinking about the repetition compulsion and to bring it to bear on two clinical cases, one where the repetition extended over a long period and another where it was swift and pivotal. In this way I show how Russell's ideas have power to sharpen and enliven the way therapists might work with repetition – with both its difficulty and its potency.

I began this paper after attending a workshop led by Barbara and Stuart Pizer, introducing the work of Paul Russell. Both workshop presenters had been students of Paul Russell and they spoke very warmly of him as a generous teacher. Prior to his death in 1996, he used to give presentations in local programmes in the Boston area. These were very popular but almost none of these papers were published. Ten years after his death a number of his papers were gathered in the Smith College Journal of Social Work and two were printed in Contemporary Psychoanalysis. They were published 'as is' in both journals. Grounded in Freud, Russell espouses, however, Kohut's advocacy of an empathic stance and, relatively rarely for an American writer of his time, he is also influenced by Winnicott. He is valued by relational thinkers as he thinks always from the standpoint of two people in the room. He wants a therapist to feel, to be real and to be able to think about what he or she is going through in the session. He believes that the particularities of this will be a 'royal road' to understanding what the client is bringing.

Repetition

Russell speaks of repetition in the Freudian sense but we can also see him moving towards an understanding that the repetition does not belong to the client alone but comes into being between both client and therapist. Sometimes he talks of the way the therapist needs to contain the pressure under which he is placed at these times in order to be able to contain what was not originally contained (2006 a, p.76). At other times he comes very close to acknowledging what relational thinkers would come to openly embrace, that the therapist will be drawn in so that the original experience will be recreated. This is evident when, in the same paper, he presents a rare clinical vignette, showing how his feelings and those of his client captured exactly "what the reality must have been like for her" (p.79). As well as the term "repetition compulsion", he uses the word "repetition" alone, which is not quite, but near to, what relational theorists will call "enactment". I will use both terms with a degree of overlap.

Russell's most cited paper is called 'The Theory of the Crunch' (2006c). In this he considers the experience, when working with a borderline client, of being caught in a crisis. He describes something that will probably be familiar: when the therapy reaches a point where the therapy itself is under threat, when the therapy relationship is under intense strain, when both therapist and client feel confused and possibly overwhelmed:

> These crises have a way of generating so much affect and consuming so much energy that one of the major problems in the treatment situation is the disorientation of the therapist. The feeling is, that if only the storm would clear the treatment could begin. Take this point, when the confusion is at its greatest, when the therapist's anxiety, helplessness and sweat are at new levels, not before thought possible, and call it the crunch. (2006c p. 10)

This quotation gives a flavour of why Paul Russell has a particular appeal: he speaks in direct and real language of the therapist's experience. When I read this passage I felt I knew exactly what he was talking about, and that he knew precisely what I had been going through with a particular client. Realness has a central place both in his style of writing and in his theory.

In 'The Theory of the Crunch', Russell is equally direct and real about the client's experience. The borderline client, he says, has suffered trauma in the area of attachment. In the therapy, attachment arises and so the client will render into the therapy precisely what is his or her greatest difficulty:

> It is as if the patient chooses the treatment crisis - the potential rupture of the therapy relationship – to try to convey that which is most important to him. And worse yet, he does so not in words, but by recreating the anguish for which he came to treatment to begin with. (p. 10)

Russell understands this crisis as a repetition. The particular individual configuration of the early trauma, of the "primary developmental failure...in the area of the capacity to form human relationships" (op. cit. p.11) is repeated in the therapy. And both client and therapist experience it - the client as desperation, franticness or rage, the therapist, Russell says, as "urgency". In fact, he says that when therapists feel this sense of urgency, the powerful feeling that "I must do something", it is the surest indicator that we are dealing with repetition or with the crunch. Possibly one reason why this particular paper was so popular was because it offers the beleaguered therapist a thought that enables him to hold to the work. For Russell believes that the crunch can offer an opportunity for the therapist to step outside the old and offer something new - containment and a chance to experience feelings that were otherwise not available to conversation, relationship or thought. This, of course is not a single experience, but one repeated over and over, rather like a spiral staircase with each repeated turn giving a slightly higher view (2006c, pp. 14-15).

Russell wrote about the repetition compulsion more broadly than as it applied to the borderline experience. He developed his thoughts about it in a number of papers, notably one called 'Trauma, repetition and affect' which he delivered in a symposium in 1991. Repetitions occur compulsively outside therapy. Therapists will recognise this in the client who repeatedly gets herself into exactly the same sort of bother with exactly the same sort of person, for instance. But what interests Russell more are the repetitions that occur within the therapy relationship itself. These are manifested in the large scale configuration of the relationship and in the finest details of verbal exchange. They are one of the principal tools of our work.
Russell says, "The concept of the repetition compulsion I take to be the most important concept Freud left to us" (2006d, p.604). He says that in therapy repetition is experienced as unavoidable, like a fate or doom:

> ...despite the apparent wish to avoid the pain, the cost, the injury of the repetition, one finds oneself repeating nevertheless, as if drawn to some fatal flame, as if governed by some malignant attraction which one does not know and cannot comprehend or control. It has, in other words, all the external earmarks of a volitional act, and yet the person is unaware of wishing any such thing. In fact... quite the contrary; he or she would wish to avoid it. (2006d, p.605)

Russell believes that the repetition compulsion and trauma are intimately connected. The trauma may be a specific injury or it may be "the traumatising effect of a family system" (2006d, p. 602). Trauma has the effect of narrowing the range of affect available to a person:

> The more adverse the early experience, the more severe the early injury, the more limited, the more intense and more constricted is the emotional grid. (2006c, p.15)

By repeating over and over again the known path of the familiar trauma, the person, paradoxically is trying to remain safe and avoid risk. Part of the risk is of feeling affect that is outside the familiar repetitive range. The person does not know what the affect is: it is the unknown terror, and all the more terrifying because unknown. Another part of the risk involves giving up "the safety of aloneness" (2006d, p.613). Aloneness enables the person to hold on to familiar feelings, painful as they may be, and not to open to the emotion that might emerge in relationship, especially shame, sadness and grief. "The real risk", says Russell, "consists in genuinely giving up the repetition and all that this involves" (2006d, p.614).

On the other hand repetition also has a "task unsolved aspect" (2006c, p.15). Russell believes that the person may reproduce the original trauma in some way or may reproduce the disruption of relationship (attachment) which is a feature of it. Either way, Russell says, "we can be sure... that what is reproduced is what the person needs to feel in order to repair the injury" (2006d, p. 614).

Let me illustrate this through considering a case. It involves a child of nine. I will call him Dylan. Dylan was brought to therapy by his grandmother with whom he was living and in whose house he was refusing to eat; he was taking breakfast at school. It soon became clear that he was making every effort to render living with grandmother untenable so that he could be returned to the care of his mother. When this occurred his behaviour would be so uncontrollable that his mother would send him back to grandmother again – and so it was going on and on. The trauma was around a failure of holding and he was repeating it over and over.

After introductions in the waiting room he came willingly with me into the playroom. It felt as if I had barely taken in his bright blue eyes, well-built body, spiked hair and sharp look before he immediately tossed the central emotional problem into the room. In the twinkling of an eye he was sitting cross-legged on top of a tall cupboard, looking down like a bright-eyes seagull at his startled therapist. Immediately there was the central issue: I was thinking with considerable urgency, one clear thought – what if he falls? A second, what if he brings the whole cupboard down? And a third, what if he is injured?

The issue was right there – falling, holding, potential calamity and collapse, potential falling to pieces of the relationship. Naturally I experienced urgency to act – and I did act, getting him safely down. This was just sensible. But on another level from 'sensible', I was from the first moment being tested in precisely the area of the trauma.

This became even clearer to me when I contacted his school. He had well intentioned teachers, genuinely concerned for his wellbeing. They were aware of the way he boomeranged between his mother's home and his grandmother's. But he was not in the classroom the day I called. He was in the next door room where he would be sent when his behaviour became intolerable. So he was going back and forth between two classrooms as he went back and forth between two homes. The teachers were doing the very last thing they would have wanted - repeating the trauma.

And in the course of therapy this determined and creative child repeated over and over the central area of difficulty. He would perch a small batman figure on the top of the curtains, door frame, any high place from which falling would be calamitous. Or I would be engaged in endless games of throw and catch, in which, despite my best efforts, I would inevitably at times drop or fail to catch the small hero being thrown at me. Being inside the repetition was inescapable and I experienced it painfully – feeling despair, failure, helplessness, what it is like to be the one who drops and the one who is dropped.

I consider that what was going on here was primarily a traumatic repetition, an endless rehearsal of the same events. For Dylan it seemed to hold an excitement,

perhaps a kind of addictive fascination. At times it was like riding a roller-coaster; the thrill lay in getting as close to terror as possible without being destroyed by it. In this repetition there was also enormous pressure on the other person to act. In his actual life the child was trying to enforce change; he was absolutely bent on getting back to his mother and his behaviour was directed to this end. There was also a mental component. As Dylan refused to eat at his grandmother's house, to accept her food, he also fought mentally to refuse her interpretation of his mother's life, her feelings towards his mother, her daughter – he was adamant in holding to his belief that he belonged with his own mother and siblings. In this mental representation of events, he was unable to hold or fit his experiences of being sent away by his mother too, or that he was causing this to happen. These experiences needed to be excluded, repressed. The truth itself was unspeakable and unhearable to him. In fact, when I attempted to put things into words, he would literally cover his ears. The original traumatic failure of holding emerged in family, at school and in his therapy, but in exact repetitions, unchanging. Relationship was excluded and replaced by repetition; I felt squeezed into acting a role in his tightly scripted drama. We were in the same room but he remained isolated. There was no place to think of past hurts – there was only the present. The range of affect was narrow: excitement, fear, rage, triumph, on his side, despair, sadness, helplessness and shame on mine.

In a paper entitled 'Our appointment in Thebes: acknowledgement by the analyst in the context of repetition and dissociation', Jessica Benjamin (2008) describes how in an enactment the therapist will find herself locked into a restricted way of experiencing the other, as freedom and flexibility of response break down into what she calls 'twoness'. In 'twoness' there is a back and forth dynamic of 'doer and done to'. In this dynamic both therapist and client can find themselves hurtling down a path that leads to a recreating of precisely the wound that both client and therapist are seeking to heal, and in a normal self state would wish above all not to repeat. They become like Oedipus, fleeing to Thebes so as not to fulfil the terrible fate prophesied for him - and running directly towards that fate. So for Dylan, I and his teachers became his abandoning mother, failing over and over again to hold him.

Russell speaks of such a repetition in one of his better-known but rather dense statements:

> The repetition compulsion represents the scar tissue of interruptions of attachment, attachments the person needed in the service of emotional growth. Interruptions, therefore, in the development of the capacity to feel. The repetition compulsion, much as does an addiction, operates in lieu of a relationship. It is its own kind of history in the subjunctive. The repetition compulsion is paradoxically both an invitation to a relationship and an invitation to repeat the interruption of some important earlier relationship. It is both adaptive and suicidal because, in this context, relatedness is what the person most needs and yet cannot feel. (2006d, p.612)

Like scar tissue, the repetitions experienced in this therapy prevented any closeness. Like thickened skin, they kept us from touching. The repetition kept away unbearable feelings and unthinkable thoughts. It rewrote the history of the past, deleting the child's loss, grief and shame, offering instead a "history in the subjunctive", a "what if", or "if only" story in which the child was in charge of his fate, his mother had not truly failed to hold him, he did not lack a father, and excitement and power replaced sadness, impotence and shame. Both inviting relationship and keeping it at bay, it was as Russell says, "both adaptive and suicidal", enabling survival and killing off real relationship.

Negotiation of Affect

How then can therapy help? Russell believes that it is through what he calls the "negotiation of affect".

Russell holds that understanding alone will not make for a giving up of the repetition compulsion. This rings true to me as I think of clients who come to understand why they do a certain thing over and over again and continue to do it, even with this understanding. At times like this the therapist can find herself repeating the same interpretation like a frozen dinner pulled out of the freezer. Giving up the repetition compulsion, Russell says, is possible only in a relationship, and a real relationship at that. The repetition compulsion is given up only in the repetition compulsion itself.

I will try to explain my understanding of this process, as described in 'Trauma, Repetition and Affect' (2006b) and in another paper called 'The Negotiation of Affect' (2006d). As the repetition is brought into the therapy, it engages both therapist and client. And it does this in such a way that the engagement is real. The therapist is feeling intensely and so is the client. The client is trying to go down the old, well-worn path with the therapist. But he or she is also, at some level, engaging in therapy, in an intimate relationship that has already survived some testing, and so has also a hope that, with this person, things might possibly be different.

Battered in the 'crunch', or repetition, the therapist, Russell believes, is first of all required to contain things – the client's feelings, but even more her own feelings and the pressure to act. What does not happen is crucial – significantly, retaliation or severance of the connection. Sometimes what occurs is primarily holding. Sometimes in the earlier stages of a therapy that is all that can occur until a degree of safety is established and affect is less overwhelming. When there is enough experience of containment to outweigh the intensity of the emotions clustered around the trauma that is enacted, something new can begin to occur.

Benjamin reminds us, however, that therapists will inevitably get caught up in the enactment – some rupture will occur. It is not only in containment but in the process of rupture and repair that safety is gradually established. She stresses the

therapeutic value of the therapist's acknowledgement of what has occurred and her own part in it.

With containment, acknowledgement and reflection, gradually there is an experience that the relationship survives. There is a gradual shift from the safety of isolation to safety within the relationship. Disavowed feelings and unthinkable thoughts are gradually allowed into the therapeutic space. Symbolisation begins to be possible. Affects can be worked with – who owns what feelings, to whom they have been passed, what feelings are there, what feelings come to be. A sense of something stereotyped is replaced by a sense of liveliness. Bit by bit safety is found less in aloneness than in a relationship. This is what I think Russell means by "the negotiation of affect". It is the therapist's affect that is negotiated as much as the client's.

Typically, Russell says, perception follows, as well as rage and then grief for how things were and "all the ways in which one has not been who one might have been" (2006d, p. 615). The repetition compulsion delivers the traumatic memory not as a conscious memory but as a present event. In the rendering of the repetition, the trauma can become a memory, Russell says, "in another part of the mind receiving the same input" (2006d, p.620). I would understand this as an implicit memory, residing in sensory and affective experience, becoming available to the processes of explicit memory, to relationship, to language.

Let me illustrate with another example. D is a woman in her late 40's, a supermarket worker, whose inner world feels fragmented and at times incoherent. She says she is dyslexic: she confuses numbers and will stumble through the syllables of a word like a child learning to read and checking, "Is that right?" She came to therapy haunted by a lifelong dream of houses that are not separate from one other and is terrified at the thought of her mother's taking over her mind. She tells me at the start that she was born to a mother who believed that she was carrying a dead baby, and who, when she delivered a live infant said she was like a pixie. She walks with a stiff-legged gait that reminds me of nothing so much as a walky-talky doll. Her doll was a nexus of childhood distress. She came to therapy like an excited and frightened child. Now she is faced with feelings that are almost impossible to bear – anger, terror, "pain".

It happens towards the end of a session where she has been feeling intensely. Suddenly she looks at me intently and asks, "Do you get affected by my pain? Are you all right?" I say that she is afraid she will damage me. I say this does not happen. I am all right. I want to help her to some understanding so after a hesitation I add, but Mum was not all right. As I add this last remark I am aware that I am showing that I am thinking about Mum. D goes with me. She talks of her mother:

> *"Her mother didn't look after her. Her father was violent to her. She would show me the scars on her legs and back where he hit her with the jug cord."*
> *"And her mother?" I ask.*
> *"She added to it. She would hit her with the hearth broom. What's a hearth broom?"*

D lapses into a failure of words and silence. Something has happened between us.

The session seems to end normally enough but I feel something of significance has happened. I record the above interaction in detail. Then D cancels the next session. I experience powerful feelings – shame, remorse, fear of having damaged my client or destroyed the therapy. It has all the hallmarks of an enactment, the emotional impact of a 'crunch'. I begin to process it in Russell's way, seeing my experience as a tracing of an earlier trauma. I negotiate to be both mother and not-mother.

This is where it takes me: When D asked if I was all right, she was bringing into the therapy the trauma, what went wrong. It was about her and Mum. In the moment I was Mum – Mum who could be destroyed by her distress. As she was afraid of damaging or destroying Mum, her therapist 'Mum' became afraid of damaging or destroying her. I stepped back. Consciously I was trying to bring calm and insight. I hoped that I could help her to begin to make some sense of what she had experienced with Mum. Unconsciously I refused to stay with her and be for the moment the Mum who could be damaged. I moved to separate myself from this fragile mother and assert my steadiness. I did exactly what Mum had done – I refused the invitation to enter the distress with her. I stepped back from her chaos and my own. She had told me how when she was distressed as a child Mum would send her to the basement to tear up boxes. I sent her back to the basement. In Russell's terms, I acted. Whatever my conscious intention, the impact of my acting was to recreate the trauma. The trauma had to do with a stepping back, a crucial failure in attachment.

I began to understand why this mother might have stepped back. This was a woman who believed that she had killed the baby inside her. The primary mother-infant interactions were infused with the feel of the dead baby being carried and terror of the murderous maternal insides. I was the mother who was trying to prevent her baby from being killed, who sent her away so as not to destroy her. I was escaping my own feelings as much as my client's.

Backing away from the destructive therapeutic moment, I took the road to Thebes. In this context Benjamin quotes Ferenczi:

> … the analyst, although he may behave as he will … take kindness … as far as he possibly can … will have to repeat with his own hands the act of murder previously perpetrated against the patient. (2008, p. 31)

Russell says something similar:

> It is as if things cannot be real, and the patient will not feel psychotherapy means anything, until the treatment situation becomes so much like a dangerous part of the patient's past, that there is in fact a real risk of a repeat of the past. (2006b, p.631)

While I am processing in this way, my client, as she later told me, is overwhelmed by her emotions. The rage is so great that she could not trust herself to come to the next session. She also feared that she will kill me or the relationship. A week later she returned.

> *She came in saying, "I haven't been to work today. I rang in and said I was sick and had my period. I know I'll get punished tomorrow for taking the day off but I am owed 137 sick days." I registered the impossibility of this number and her struggle to come to therapy.*
> *"I want to ask you something. Are you sympathetic to my mother?"*
> *I said, "I will answer your question but tell me what you are thinking. I've been thinking about what happened at the end of the last session"*
> *"I felt you got interested in Mum's story. That you were thinking more about Mum. Feeling sorry for her. I've been very, very angry. I needed to stay away last week because I was so angry with you. I had to take the time to get it straight in myself. I put you under a glass jar for a while."*

D then recounted two dreams: one which had been repeated over four nights. Both dreams were accompanied by intense affect. "I am in a car being driven through a forest. Other people are in the car. I have to get to work. That feeling is very strong in the dream. Then in the dream I have this thought- it's very clear –'This is not my dream.' In the second dream I am in a long house on my own. It's my house. I go upstairs and there is a man there eating a meal. He does not belong in my house. I get very angry and want to get him out. But he manhandles me, he throws me about. I feel very upset that I cannot use my martial arts against him. I desperately want to dial for help but cannot recall the number. In the end I ring 123 and get Telecom."

There had been times before in this therapy where the client had become enraged with me and visibly struggled in the chair not to fight with me or "rip off your face". Up until this point, I had been unable to have thoughts about why these feelings might have come about at a particular point; my response had been to hold and survive. But this time, in the enactment, the trouble was brought into the room by both of us and we were able to begin the conversation that may eventually relieve and demystify.

Brought into the therapeutic conversation, the dream of the car driving her to work might be seen as her own experience of being "driven", compelled to work when her dream was to be elsewhere – at therapy. It brings into the room the experience

that while she missed a session doing the work of mastering her anger, she also longed to be present. I felt as well that the clear assertion that this was not her dream might represent her experience of the therapeutic disjunction, and in the strength of the tone with which it was asserted, a beginning of separating from her mother. Interestingly in subsequent sessions she spoke of stepping back from Mum, a space opening up, like the space between the cushions in my room: "I can start to feel for Mum."

The second dream has been less spoken of and it seems important to let the meaning emerge between us. I wonder who will be the intruder eating in her house, what has disempowered her and throws her around like a doll. Certainly in turning my attention to the mother and my own needs to soothe or clarify I experienced being the intruder who broke into her mental "going on being". It does seem clear, however, that she was in her own house and that while help was not easy to get, it was available.

These sessions signalled a significant shift in the therapeutic relationship, in the client's relationships outside therapy and in her inner equilibrium. I believe that the reason for this lies not just in our bringing to consciousness the content of the dreams but more significantly in the fact of being able to talk about them, to stand aside from the joined houses of the maternal/therapist mind and the client's mind, to find a space for thought and conversation. In Benjamin's terms we might think of achieving the presence of a 'third'. In Russell's we might think about the affective repetition of the original trauma to attachment being replaced by a mutual remaining in relationship while the affects are negotiated: in this case, who feels destructive, who feels they could be damaged, where the fear lies and the anger. Who is being protected? What feels dead and why?

To transform the repetition, the therapist needs to be available for negotiation, says Russell, "must- negotiate to be both the person(s) with whom the initial negotiation failed, and the person with whom it might possibly be different" (2006b, p. 635).
In the processing what the client was later to call "the thing" or "the day you felt sorry for my mother", both client and therapist had to enter new territory. There was no theory for me to reproduce, no past for D to rehearse – there was only this new moment of both staying present and seeking words instead of the dyslexic. The conversation was alive. We were interacting with feeling. I think this is at least part of what Russell means when he talks of the negotiation of affect and "truth...accomplished in dialogue". The language becomes fresh, lively and metaphorical. At the end of the session the client said she felt "washed". The language was evocative. I pictured her emerging from water, from a stream or a womb, new born, alive. The affectively charged repetition made movement possible. Negotiation of those affects effected it.

When he considers repetition or enactment Russell reminds therapists of the client's desire to bring her trouble to where it might be held and understood and the

opposing pressure to repeat without giving up on the old defences or aloneness. Russell also draws attention to therapists' experience of 'urgency', a pressure to act; Benjamin underlines the way this pressure inevitably draws the therapist into the action that will repeat the trauma but is also the only place where the trauma can be healed. The repetition is healed only in the repetition. Russell highlights the way the therapist must be both affectively inside the enactment (in the city of Thebes) and outside it (on a hill looking down) so as to be able to see what it happening. The role of the theorist and therapeutic writing is to give a map, a guide to the city that enables us to recognise down what streets we are walking, when we are on a roundabout and when we stand at a crossroads. On this journey Paul Russell is a lively and engaged companion.

Conclusion

I have outlined Paul Russell's thinking in the area of repetition and used it to consider two clinical cases. I hope I have been able to share the pleasure and benefit I have taken from engaging with this writer.

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