Roadblocks in the way of Passion

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Abstract

Free association is the fundamental rule of psychoanalytic psychotherapy. It is through the patient's associations that a glimpse can be had of what has been repressed. But, at least with some patients, this is easier said than done. There appears to be a conundrum in force: the inhibitions which caused the patient's desire to become repressed are precisely those which inhibit "the irruption of copious ideas".

Freud said: "In my opinion the physician has taken upon himself duties not only towards the individual patient but towards science as well" (1905[1901]: 8). In its own way this article is both a clinical and a theoretical matter. It considers free association as a therapeutic problem, giving a case to illustrate grappling with the patient's inability to free associate. The article also speculates on free association as an intellectual puzzle, and proposes a model which encompasses both empty and full speech.

I

In Ray Bradbury's short story 'The Man in the Rorschach Shirt', Simon Wincelaus, the narrator, is riding on a bus in California when, to his amazement, a man in his seventies boards—Dr. Immanuel Brokaw, the famous psychiatrist who ten years before had disappeared from New York. Instead of the familiar sober, dark suit, Brokaw wears a marvellous shirt.

> A wild thing, all lush creeper and live flytrap undergrowth, all Pop-Op dilation and contraction, full-flowered and crammed at every interstice and cross-hatch with mythological beasts and symbols!
>
> Open at the neck, this vast shirt hung wind-whipped like a thousand flags from a parade of united but neurotic nations. (1948: 242-3)

It transpires that Brokaw, disillusioned, has retired from formal psychotherapy only to have taken up informal, ambulatory therapy.[1] Wearing one of his dozen technicolour dream shirts (one was designed by Jackson Pollack) Brokaw does therapy on the go, asking passers-by what they see in the shirt. Now as he

1 The sources of his disillusionment—the two straws that broke his two humps—deserve an article on their own. Suffice to say that Bradbury beautifully and simply shows what it is to encounter the

moves slowly down the aisle, a boy sees dancing horses, a young man sees fleecy sheep clouds, a young woman sees surfers, big waves, and surfboards. Laughter spreads infectiously between the passengers. A woman sees skyscrapers, a man sees crossword puzzles, a child sees zebras. An old woman saw Adams and Eves being driven from Gardens, while a young woman saw them invited back in. Brokaw sewed "all our separateness up in one"; he "asked for, got, and cured us of our hairballs on the spot" (243-244).

The therapeutic point is that there is something healing about simply telling another what your inner eye sees. The sociological point is that there is something unifying about sharing the personal. The epistemological point is that each person sees something different in the shirt, something distinctly personal. We call this projecting, free associating, playing, fantasising, daydreaming.

Now imagine a passenger on that bus who looks at the shirt, opens her mouth to speak, and then catches herself: "Oh how ridiculous. Maybe there is something to this but I can't do it. I feel lost and down and hate myself right now..." and so on, making her way into a horrible, unproductive eddy of despair and self-reproach. This article is about working with such a woman—a woman who couldn't (wouldn't?) daydream.

II

The fundamental rule of psychoanalytic psychotherapy is that the patient should free associate. Freud used the term *freier einfall*—what falls into the mind, what comes to mind, the free irruption of ideas.

> Say whatever goes through your mind. Act as though, for instance, you were a traveller sitting next to the window of a railway carriage and describing to someone inside the carriage the changing views which you see outside. Finally, never forget that you have promised to be absolutely honest, and never to leave anything out because, for some reason or other, it is unpleasant to tell it. (Freud: 1913: 135)

"The first goal of the rule of free association is the elimination of the voluntary selection of thoughts" (Laplache and Pontalis: 1980, 170). The purpose of free association is not to give free rein to primary process itself, but rather it is "a type of communication in which the unconscious determinism is more accessible"

Lacanian Real. Or, rather, what it is to no longer be able to take for granted the Symbolic (what one hears) and the Imaginary (what one sees).

through fresh connections or gaps in the patient's discourse (178). "The pure metal of valuable unconscious thoughts [is to] be extracted from the raw material of the patient's associations" (Freud: 1905[1901]: 112).

The clinical questions, then are: "How do you get people to associate freely?", and "If there is trouble doing this, what is the nature of the trouble, and what can be done about it?" (Will: 1970: vii).

Between primary process and secondary process is a barrier—first censorship, or repression, the unconscious, automatic inhibition of activity. But there is also second censorship, or suppression—conscious, voluntary inhibition. Free association is designed to do away with suppression so that the workings of repression can be encountered.

If the patient must talk in a particular way, on the therapist's side there is an equivalent way of listening. Freud calls it "evenly suspended attention". "The rule for the doctor may be expressed: He should withhold all conscious influences from his capacity to attend, and give himself over completely to his 'unconscious memory'" (1912: 112).

III

Let me introduce my patient. Her presenting problem was whether to sever the relationship with a partner from whom she'd been separated for some years, or to get together with him again. In other words, gridlock from the get-go. My immediate impression was of a chronically worried and puzzled woman. She had generally flat affect and considerable anxiety. To the question, "What do you feel?" she had no response.

It soon became apparent that my patient had an over-developed inner self-critic which strangulated her activities and her talk. For her it was not a case of, "There's something I *could* say but something tells me not to say it". I doubt whether back then she would have been able to say with any confidence that there *was* more to be said. Instead a steady stream of exasperation, self-doubt, and hopelessness simply drowned anything else which might have been brewing. As I understand it, this stream of negativity became a blockage; it simply filled up the part of her mind which she had conscious access to. And yet, as her exasperation showed, part of her was aware that there might be more going on inside her and that she was inhibited.[2]

2 I recall here Charles Rycroft's definition of the defences: "all techniques used by the ego to master, control, canalise, and use forces 'which may lead to neurosis'" (1968: 28).

We spoke of how her niceness meant that she only had easy access to the middle range of feelings: liking, but not loving and hating.[3]

It was quite useless to ask her to put the self-reproaching thoughts aside and to free associate; after all she *was* reporting exactly what was on her mind![4]

The strange thing was that when I was with my patient *I* had no trouble at all free associating. I regularly had very clear visual images and strong feelings. In the very first session I had the distinct image of my patient and me waiting to cross the busy road outside: a little girl of about three, she was holding my hand. The fact that I could so easily free associate led me to think that she was *disowning* her creativity and 'lending' it to me. Consider patients unable to complete dreams. They "may project into the analyst dilemmas that they are unable to dream about in order that the analyst's functioning may transform the dilemmas into ones that can be thought and dreamt about" (Sedlak: 1997: 295). This seemed to fit with the case at hand as the dream is, as Ralph Greenson said it is, the freest of free associations (cited in Barnett: 1998: 624).

Steadily my patient's symptoms improved over the course of the therapy. Her anxiety diminished, and her steady anhedonia developed into a movement between feeling alive and interested to feeling depressed. Along the way she decided to finally end things with her partner. Over time she became better able to identify how she was feeling, or even *that* she was feeling. Now and then she would report feeling a strong "spiritual feeling" in the room; and eventually she began hesitantly to use words like "intimacy" and "love". These moments of deep connection were few and brief; they would be shut off by her characteristic self-critical talk. She would subsequently feel disappointed, hopeless, and sometimes quite depressed.

We might say that thinking which is divorced from feeling is a kind of disorder of thought. Jung had a notion that "the feeling part of the personality is at the opposite pole to the thinking part" (cited in Symington 1993: 24). We see this in the defence of intellectualisation, when an idea is dissociated from feelings. The opposite defence, when feelings are dissociated from thinking Symington calls "sentimentalization". Like the difference between sympathy and empathy,

3 Lacan said that there are three passions: love, hate, and ignorance. Our symptoms keep us ignorant, but there is satisfaction there too. See, for example, the chapter 'Truth Emerges from the Mistake' in Seminar I (1975: 271).

4 Having said that, I know of a woman aged sixtyish who was referred to a psychiatrist by her minister because she felt depressed. This was a woman with no experience of psychotherapy. What she encountered was absolute silence for the full hour; no greeting, no explanation, nothing. The experience was a complete mystery to her—not to say frightening—and, needless to say, she never returned. *Some* explanation is necessary even if we expect that the patient is unlikely to do quite as asked.

sentimental feelings are not genuine: "genuine feeling is backed up by knowledge. The difference between these two is enormous and of crucial importance to psychotherapists" (24). And, conversely, in the case under question, genuine thought is that which is backed up by feeling.

My patient had come to me because she couldn't make up her mind. Theodor Reik tells how one day when out walking he met Freud and told him of a decision he was struggling with. Freud said:

> When making a decision of minor importance, I have always found it advantageous to consider all the pros and cons. In vital matters, however, such as the choice of a mate or a profession, the decision should come from the unconscious, from somewhere within ourselves. In the important decisions of our personal life, we should be governed, I think, by the deep inner needs of our nature. (1948: vii)

My patient's problem was that she didn't know much at all about her "inner nature", about her heart's desire; as a consequence, her thinking did not have an affective motor/compass.

She described her mother in this way. Though she had been good with the children as babies, she was a critical woman who was absolutely sure of what was black and what was white. A woman who did not countenance opposing views. As for her father, he had been an inoffensive drinker who was of little consequence in her life as far as she could see. I had an idea, thus, that my patient had completely internalised the critical aspect of her mother and this demeaning and defeating object would be roused whenever my patient started showing signs of asserting her own wishes and desires.

Though the therapy went well, the blockage I am discussing remained unmoved. No amount of empathy, analysis, or waiting could shift the roadblock's bar once it had been lowered across her path. Gradually it came to seem to be not just an inhibition, but the symptom itself. It is as though the therapy was raising her temperature, yet no sooner did bubbles begin forming than she poured on cold water.

Some time into the therapy I had a thought/image which I subsequently realised was a development of that very first fantasy of crossing the road. I told her that I was understanding things in the following way. She desired to go somewhere (to find the object of her desire), but along the way the road went into a foggy dip (a zone of unfamiliarity), and rather than drive carefully through toward her heart's desire, she assumed the fog to be an impenetrable barrier and so took a deviation,

and meandered about feeling lost (the directionless, critical talk) and increasingly distant from where she wanted to be (i.e. depressed).[5] She took the fog to be an uncrossable road, as in my original fantasy[6]. This story made sense to her but on its own it was not enough to change things. Something else was needed.

IV

The most obvious thing to say might be that my patient was not free associating. Or is it? Another way to think about my work with my patient is that what my patient was doing *was* free associating in the sense that "by revealing our errings [free association] allows us to grasp the truth that is concealed in our hiddeness, by revealing the unconscious secrets contained in our everyday speech" (Thompson: 1994: 68). In my patient's case one might think that this suggested that her hesitancies, exasperated grumblings, and self-critical denunciations were evidence of "unconscious secrets"—they constituted free associations. Resistance, one could say, is a good sign: it means that the unconscious is being touched. However, this would seem to be confusing the roadblock for the vehicle: to extend what counts as free association so as to make it almost meaningless. What is *not* to count as free association in this case? It is not what Thompson means. Free association, he makes clear, is a "technical use of the mind, whose sole aim is to 'reveal the concealed'" (1994: 82).

Just say what comes to mind...this is easier said than done. Indeed, some would say that when one is able to free associate one is cured! This view would have it that what my patient was doing was *not* free associating. To my mind free association is in the same ball park as play, daydreams, fantasies, reveries, creativity, full speech. Lacan contrasts full speech with empty speech. Empty speech "takes its orders from the ego....and demands that the analyst falls in with it." (Benvenuto and Kennedy: 1986: 84) Examples are the demand for reassurance, and the demand to be treated as the patient was treated by his or her parents. Lacan speaks of the danger of:

> the patient's capture in an objectification...of his static state or of his 'statue', in a renewed status of his alienation.
>
> Quite the contrary, the art of the analyst must be to suspend the subject's certainties until their last mirages have been consumed. (1953: 43)

5 The symptom, then, is the turning off the path, not the depressed state which is, rather, a consequence of the defence.

6 Or to use Lacan's metaphor, she mistook a mirage for a certainty (1953: 43).

Or let us think here in terms of play. For Winnicott "*play is an achievement* in individual emotional growth" (undated: 59). Play is primarily "a *creative activity* (as in dream)" (60). When it goes wrong he speaks of "the psychopathology of play"(61); "without play the child is unable to see the world creatively, and in consequence is thrown back on compliance and a sense of futility, or on the exploitation of direct instinctual satisfactions" (60).

For his part, Freud likened free association to the poet when creating. He quoted in this regard from a letter of Schiller. But, as Janet Malcolm points out: "Just as there are few people who can write poems like Schiller, there are few analytic patients who can free associate easily, if at all" (Malcolm: 17).

Then there is the contrary view on the nature of free association. 'Aaron Green'[7] describes the first patient allocated to him when he was a trainee analyst. She gave "vapid, inconsequential answers", talked in an "inane, girlish, monosyllabic way", and complained about his not helping her.

> I found her in every way disappointing. I had expected a patient who would free-associate, and here they had sent me this banal girl who just blathered. I didn't understand—I was so naïve then—that her blathering *was* free association, that blathering is just what free association is....Only after years of terrible and futile struggle did it dawn on me that if I just listened—if I just let her talk, let her blather—things would come out, and this is what would help her, not my pedantic, didactic interpretations. If I could only have learned to shut up! (in Malcolm: 1981: p. 71)

Conversely, as 'Green' found with his second patient—"a refined, cultivated woman, eager to do the analytic work, appreciative of Aaron, extremely pleasant and interesting to be with, and very good-looking" (Malcolm: 1981: 79)—fluent conversation can be something else entirely.

How do we know when a patient's talk is to count as free associating? Sullivan: "When a person keeps on talking about the bees and the flowers, and so on, I may say quite sardonically, 'This seems to be *really* free associating, but I wonder what on earth it pertains to'" (1970: 80). While Sullivan is on to something here, not for the first time his technique doesn't sit well with his theory of the functioning of the mind: "The mind usually does not spend much time on irrelevant and unimportant details" (80). If this is the case, why interrupt and attempt to influence someone who *is* spending much time talking about the bees and the flowers, and so on?

7 The pseudonym which Janet Malcom (1981) gives for the analyst she interviews.

Anything can be defensive. Is there a corollary, anything can be productive and communicative? In the words of Otto Will: "It is this remarkable intermingling of the communicative and defensive aspects of speech which characterises every interview" (1970: xxi). How is one to recognise empty speech? And what then of the patient's speech which is both flowing (in terms of verbiage), but blocked (in terms of content)? In the case of my patient, she had little difficulty using up the time with self-critical, exasperated, hopeless comments. Why do I assert that this was not productive free associating? First, her face would change from lively and radiant to uptight and worried, and she would make her disappointment clear. Second, my countertransference reaction was an exasperation which matched her own; a sense of, "oh no, it's gone again—the stuckness is back".

In any event, there is a theoretical problem here. How are we to schematise speech which holds back, speech which is blocked, and speech which is full? Let us separate out three types of speech here (see Table 1).

Table 1

TYPE A	TYPE B	TYPE C
Consciously selects and omits what comes to mind, i.e. deliberately puts a blockage in place.	Does not consciously select or omit; instead is only aware of the blockage itself and reports this.	*Freier einfalle*, free irruption of copious ideas.

V

The introduction of active intervention into therapeutic passivity is very cautiously accepted in principle in mainstream psychoanalysis. In a paper published in 1953 Kurt Eissler introduced the term 'parameter' meaning the chary use of instructions, directives, and advice to end stalemate. Perhaps the best known adaptation to orthodox technique is that of Jacques Lacan's abbreviated sessions. This practice (along with his novel training methods) resulted in his expulsion from the International Psychoanalytic Association. Lacan would routinely reduce the length of a session to as short as five minutes, sometimes even a single interaction in the waiting room. He is also reported to have eaten meals and counted money during sessions (Roudinesco: 1990). All these were attempts to simply stop the flow of empty speech. "Variable time is valuable," Lacanians believe, "in combating many forms of resistance" (Leader and Groves: 1995: 56).

The question which confronts all technical attempts to unstick therapy stands out starkly here: what about the defence which is thereby being avoided? Is being combated what the resistance needs? Should it not be analysed, understood, worked through? But, all technique—including free association itself—has originated as experimentation. Then, if it works, it has been theorised.

Winnicott, too, was wont to adapt his technique. Winnicott said that either therapy happens in the overlap of two areas of play (that of the therapist and that of the patient), "or else the treatment must be directed towards enabling the [patient] to become able to play" (1964-1968: 300). (So too in the case at hand, free associative playfulness is the goal, not the rule of the therapy.) Margaret Little (1990) reports that when she was his patient Winnicott decided that an hour wasn't enough for her and so extended session to an hour and a half. He also spent these sessions holding her hand in both his hands; during long silences he sometimes fell asleep.

Freud himself, it is well known, was not averse to adapting his practice. Take the case of the Wolf Man (1918). Writing of speeding up the treatment, Freud describes an intervention.

> In the course of a few years it was possible to give him back a large amount of his independence, to awaken his interest in life and to adjust his relations to the people most important to him. But there progress came to a stop. We advanced no further...and it was obvious that the patient found his present position highly comfortable and had no wish to take any step forward which would bring him nearer to the end of his treatment. It was a case of the treatment inhibiting itself: it was in danger of failing as a result of its—partial—success. In this predicament I resorted to the heroic measure of fixing a time-limit for the analysis. At the beginning of a year's work I informed the patient that the coming year was to be the last one of his treatment, no matter what he achieved in the time still left to him. At first he did not believe me, but once he was convinced that I was in deadly earnest, the desired change set in. His resistances shrank up....When he left me...I believed that his cure was radical and permanent. (1937: 217)

Is any practice, then, to be permitted if it seems to work? This is highly doubtful. Never one to accept easy victories, Freud came to realise that he had been mistaken; several times afterwards the Wolf Man needed further therapeutic treatment (with Ruth Mack Brunswick). Though he employed this fixing of a time-limit in other instances, it did not become a standard technique for the following reasons.

> There can only be one verdict about the value of this blackmailing device: it is effective provided that one hits the right time for it. But it cannot guarantee to accomplish the task completely. On the contrary, we may be sure that, while part of the material may become accessible under the pressure of the threat, another part will be kept back and thus become buried, as it were, and lost to our therapeutic efforts....Nor can any general rule be laid down as to the right time for resorting to this forcible technical device; the decision must be left to the analyst's tact. A miscalculation cannot be rectified. The saying that a lion only springs once must apply here. (1937: 218-219)

In the case at hand, too, it would be well to keep these factors in mind: *when* might a "forcible technical device" be implemented? My view is the standard one that one shouldn't be in a hurry to knock down defences. We had been doing productive work for some years. I had some confidence that pushing her would not be destructive. And I was mindful of Freud's warning about what might be lost.

VI

Though the cramped lack of free associating continued in my patient's speech, that is not to say that things were constantly deadly. Indeed, they were often very alive only for that aliveness to be squelched by her criticisms and doubts: sometimes only after 40 minutes, sometimes before the session even started. In what follows I describe how my technique changed for a time with this patient. What I intuitively came to might be taken as standard practice in some therapeutic modalities. Nevertheless, it is always necessary to think deeply about what we do especially when what we do takes a turn. Without auto-critique, supervision, and some agonising, what's to stop a therapist doing any thing?

I have said how I would easily get images and feelings and that I thought that these were to some degree being disowned by my patient. I began handing these back to her. When a session seemed to peter out I'd say something like: "For me the emotional shape of the session has been like this: first there was a strong erotic feeling in the room, then there was a cosy warmth, and then, when we began talking about..., I felt a bit empty. Right now I feel a tenseness in my solar plexus—I don't know what feeling it is". Usually she would respond with some kind of recognition—yes that's right, or no it's a bit wrong in some respect—and then she would be able to talk further. It occurs to me that this is a bit like Winnicott's squiggle game (1964-1966). We'd take turns to add material. (This kind of thing is powerful but obviously demands absolute truthfulness from the therapist. It would be worse that useless to make up something here.)

The erotic nature of our relationship became a charged topic of conversation; my patient wondered aloud whether she had been identifying a spiritual nature in her feelings in order to deny the erotic. And then her father came to the fore in the therapy. It began with my patient saying that she realised that she knew nothing about her father. I got a desolate image of a bright, cold, empty room, followed by a heartbroken feeling—and said so. It occurred to me that here was something which may lie on the other side of the fog—she turned away from the object of desire (father) and then felt lost. She spoke of feeling devastated about what she hadn't got from him, also about her disappointment and anger with me for not realizing how important father material was to her, despite the fact that she had thrown me off the scent several times. (This dynamic has since shown itself to be part of the complex.)

At about this time we decided to meet twice weekly, for two reasons. First, she was spending much of each session filling me in on the week's events and then getting into richer material only towards the end. Also, she seemed not to be able to keep the feelings and ideas generated in one session alive until the next session. (Again, losing touch with her heart's desire, and then meandering.) I agreed to offer a link to the previous week: "You may not want to go there today, but last time we were talking about ...".

As can be seen, I had decided to do all I could to encourage her creative inner work; to find "détours by which repression can be evaded" (Freud: 1905[1901]: 15). I spoke of us needing to pry apart two blocks which jammed together too quickly. What I meant was that when a wish came into view ("I'd like to live in...") this would straight away be confronted with a reason why not ("but I can't do that because..."). I said that it would be good to be able to delay making any judgments and just daydream to see how much emotional and fantasy oomph the idea had. Then and only then should any decisions be made.

And then I found a way to put all of these modifications together into a technique which has worked remarkably well on several occasions.

She reported, for example, that she wondered when driving to the session whether I was really there for her, this was not a real relationship after all, she shouldn't have come because in this mood nothing would happen. I interrupted this flow: "Let's put those thoughts aside for now. Can you say what you can feel in your body?" After a minute she said the word "together". All through this, not wanting to apply even more pressure, I looked out the window into the distance, listening with the third ear. She went on at my prompting to say that it wasn't a localised feeling, but was all over her body. As she concentrated on

noticing her sensations her demeanour relaxed. As before, I said what was going on for me: warmth, and a focused intensity around my heart.

After a few minutes of this I asked: "Staying with this feeling, what comes to mind?" She said: "There's something but I can't say it because it has a double meaning". But remarkably this didn't pull her into the characteristic unproductive cycle. I pressed on and asked, "Can you see anything?" She said: "A mountain". Aha! Here was the internal view I'd been looking for. I asked for details. What kind of mountain was it, a range or a peak? Was it rocky, grassy, or snow-covered? Then, was it a particular mountain? "Yes it's my favourite mountain near X." She described it vividly. Then, "Now it's become another mountain, the one near my father's house where he lived after my parents divorced." By now she was hiking easily through this fantasy/memory.[8] At the end of the session she expressed astonishment that there was so much there. I said: "This is your internal world, it's very precious—we need to take it seriously and not treat it with disdain."

I have described how my patient's speech would repeatedly be of Type B. But in the session just outlined her speech became Type C—a free-floating daydream not unlike Lacan's full speech. Notice the path that her speech took. It didn't go from Type B to Type C, as one might have expected. Instead, her speech moved from Type B which is strictly speaking free association ("I shouldn't have come because in this mood nothing will happen"), to Type A which might be thought of as the least promising form where the patient consciously selects and omits what comes to mind ("There's something but I can't say it because it has a double meaning"[9]), and only then to Type C, the most desirable form (the mountain reverie).

The advantage of Type A, then, is that even though something is being suppressed, the patient knows something about what this is and that it is being held back. This can be overcome. We can speculate that as the enormous barrier was evaded for her she became aware of something embarrassing, a new barrier which she was able to simply drive over to the land which has been her/our goal for so long.

8 "Things that were not in the center of our attention, things that were at the fringe, a passing impression, a fleeting presentiment, now take on importance" (Theodor Reik: 1948: 172).

9 Incidentally, while he does not advocate harassing the patient to disclose a suppressed thought, Freud is adamant that the therapist not collude in keeping certain no-go areas. "It is very remarkable how the whole task becomes impossible if a reservation is allowed in any single place. But we only have to reflect what would happen if the right of asylum existed at any one point in a town; how long would it be before all the riff-raff of the town had collected there?" (1913: 135n-136n).

VII

Why had I waited so long to act? I considered that in this case earlier use of such a technique would not have borne fruit as the patient was not ready for it; for a long time her pooh-poohing would extend to not being able to take seriously my words either. But it is a worthwhile question to keep in mind, not to needlessly extend therapy for its own sake.

Perhaps I should have waited longer. It occurs to me that there is a danger of forcing patients—via free association, the very epitome of freedom—to think in a particular way—namely free association. Perhaps the patient should be allowed to bore her own symptom to death; the stuckness should be seen as an accurate reflection of her inner experience and should simply be followed. Or in Lacan's terms, there are two types of ignorance: the ignorance of the therapist who knows that s/he doesn't know but wishes to know, and the patient who loves his/her ignorance and does not want to know.[10]

In the case of my patient, what about that characteristic defence? Why does she, like all of us, seem not to want what she desires? Most people, says Harry Stack Sullivan, "wish that they could talk things over frankly with somebody, but they also carry with them, practically from childhood, ingrained determinations which block free discussion" (1970: 9). I think of the defence as having been placed there long ago in order to help her to avoid the pain and frustration of disappointed playfulness as a youngster, a playfulness that might have been addressed by father. So, the therapy becomes in part an 'after-parenting'; developing psychic playfulness in part through side-stepping the defence.

But, as Freud warned, one always loses something when introducing a technique, a parameter. What about the transference issues with regard to the emergence of the defence in the therapy, and also with regard to my shunting it aside? "In order to complete the concepts of empty and full speech, one needs to take account of the nature of the person to whom the speech is addressed" (Benvenuto and Kennedy: 1986: 86). This has become clearer. There is oedipal transference, there is erotic transference—the unspoken *double entendre* turned out to be the word "passion", meaning both aliveness, generally, and eroticisation, specifically.[11] Linked to this, no doubt, it has also become evident how great is her fear of dependence and loss.

10 Slavoj Žižek (2001) develops this them is his book titled *Enjoy Your Symptom!*.

11 Interestingly, this spontaneous emergence of a surprising, hard-to-say word (always to do with our relationship) has occurred more frequently in the period subsequent to that described in this article. The obstruction has become that described by Freud in his paper on writers and day-

And, as importantly, what about *counter*transference? Could it be that, as in the cases above of Lacan, Winnicott, and Freud, deviations from standard technique come about when the *therapist* reaches the end of his or her tether, and all the rest is intellectual justification? While I do believe that the argument about the nature of free association is one worth having, it is also true that I find a lot of pleasure in a particular mutual playfulness in therapy. And conversely, I feel some frustration and loss when this is missing for too long. That is what I bring to the situation and must beware of fitting Thomas Szasz's sarcastic definitions:

> Free association: the term the psychoanalyst uses to register his approval of the patient who talks about what the analyst wants him to talk about. The opposite of resistance.
>
> Resistance: the term the psychoanalyst uses to register his disapproval of the patient who talks about what the he himself wants to talk about rather than what the analyst wants him to talk about. (1973: 82)

I have schematised three types of speech: consciously holding something back, not being able to speak freely but neither consciously holding back, and speaking freely. If to free associate is to "speak without thinking" (Rodriguez: 2002), then could my patient said to be free associating? Indeed, she said freely what she thought, which was *that she was thinking*. So there's a type of speech (Type B) which *is* free association in that there is no suppression, but at the same time *is not* free association in that it is restricted and unplayful. In Table 2, the first of these (Type A) is not free associating, indeed, it is precisely what free associat-

Table 2

Not Free Association *Sup*pression (second censorship between Cs and PCs)	**Free Association** *Re*pression (first censorship between PCs and Ucs)	
Consciously selects and omits what comes to mind, i.e. deliberately puts a blockage in place.	Does not consciously select or omit; instead is only aware of the blockage itself and reports this.	*Freier einfalle*, free irruption copious ideas.
(Empty Speech)		(Full Speech)

dreaming: "The opposite of play is not what is serious but what is real" (1908[1907]: 144). Now, though, it has become a simpler matter for both of us to notice the barrier being erected and to hurdle it.

ing is designed to prevent, viz. suppression. The second and third types of speech (B and C) can both be considered free association as they comply with the fundamental rule of saying whatever comes to mind. However, there is something unsatisfactory about the second, blocked type of speech—the characteristic speech of my patient—which is alienated from desire. It is not, in Lacan's terms, full speech.

The contribution here, then, is of a model whereby free association can encompass both empty and full speech.

As for the defences, the reality is that "say whatever goes through your mind" is an instruction which cannot be followed. "Under the dominance of the resistances, obedience [to the rule of free association] weakens, and there comes a time in every analysis when the patient disregards it. We must remember from our own self-analysis how irresistible the temptation is to yield to these pretexts put forward by critical judgement for rejecting certain ideas" (Freud: 1913: 135n). What Freud was able to see was it is *all* of interest, the content of the associations and the defences encountered in the attempt to associate. Not only that, even "the manner in which our patients bring forward their associations during the work of analysis gives us an opportunity for making some interesting observations" (1923: 235). There is something there even with the most stuck of records. Lacan says: "Even if it communicates nothing, the discourse represents the existence of communication; even if it denies the evidence, it affirms that speech constitutes truth; even if it is intended to deceive, the discourse speculates on faith in testimony" (1953: 43).

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