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AN EMPIRICAL STUDY OF THE FUNDAMENTAL RULE OF FREE ASSOCIATION

SHERI HEATHER JACOBSON

A thesis submitted in partial fulfilment
of the Doctor of Philosophy in
Psychotherapy and Counselling
at the School of Psychotherapy and Counselling
at Regent's College
validated by
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ABSTRACT

Freud devised the fundamental rule - the order given to patients to free associate - over a century ago. He considered it to be a pivotal and explicit part of psychoanalytic treatment, but the literature reveals contrasting views. This study seeks to clarify the debate by examining current psychoanalysts' views and approaches to the rule.

Forty practising psychoanalysts took part in semi-structured interviews – twenty from the American Psychoanalytic Association and twenty from the British Psychoanalytical Society. Grounded theory methods and statistical calculations were used to analyse the data.

The study found that free association is still an important part of psychoanalysis. Most participants give an initial introduction to free association at the outset of treatment. There seems to be two main approaches to the fundamental rule. Followers of approach A tend to accept the idea of free association as a 'rule', give lengthy or extensive introductions with many elaborations, use a firm tone, assist patients, and are motivated to offer clarity or to provide a framework. Followers of approach B reject the idea of free association as a 'rule', give a brief introduction with few elaborations (or give no introduction at all), use a gentle tone, give little assistance, and are motivated to create a spirit of mutuality or to avoid the authoritarian impact. American participants tend to adopt more elements from approach A than B and British participants adopt more elements from approach B than A.

In some ways the introduction has changed since Freud's conception: it is less authoritarian in tone, it may encourage self-reflection about resistances and may include references to dreams and images. The fundamental rule can be viewed as

‘ongoing’; it is frequently alluded to via repetition, prompts and the work of resistance analysis. In some cases free association entails a degree of education.

CHAPTER ONE: INTRODUCTION

1.1 CHAPTER OVERVIEW

This chapter explains the context in which the research study is situated. It outlines the research problem and justifies why this area deserves attention. It summarises the chosen theoretical paradigm and methodology. It delimits the study's scope and provides definitions that are central to the topic. It lists the research questions that guide the project and the hypotheses to be tested. Finally, it outlines the next five chapters.

1.2 BACKGROUND OF RESEARCH

Ernest Jones regarded the devising of the free association method as one of the most significant accomplishments of Freud's scientific life (1953: 265). Since 1901, Freud developed and refined the fundamental rule - the injunction on patients to submit to free association to the best of their ability. In his papers on 'Recommendations to Physicians Practising Psycho-analysis' (1912b) and 'On Beginning the Treatment' (1913), Freud established the fundamental rule as part of the psychoanalytic contract. In these sources, he recommends that analysts should come to an understanding with their patients on the use of the couch, the frequency and duration of sessions, holidays, payment and the fundamental rule.

Since its conception, the fundamental rule has been subject to much discussion. The most comprehensive accounts of free association include Loewenstein's article 'Some Considerations on Free Association' (1963), a panel discussion of 'The Basic Rule: Free Association – A Reconsideration' (Seidenberg 1971), Mahony's 'Boundaries of Free Association' (1979), Anton Kris' '*Free*

Association: Method and Process' (1982), as well as contributions by Bellak (1961), Kanzer (1972), Gray (1982), Busch (1994) and Bollas (2002). Added to these are theoretical and technical reconsiderations of the rule, for example by Thompson (1998) and Green (2000). Finally, the literature contains countless side references to the theory and practice of free association.

Contributors to the literature express varying opinions of the rule. Most continue to uphold it as an indispensable technical precept of the psychoanalytic encounter and the chief method of psychoanalysis. Some even believe it is an unchallenged and static fixture. However, the concept of free association is sometimes put into question. For example, at the 2002 conference of the International Psychoanalytical Association, a panel discussed the question: 'Is Free Association still Fundamental?' (McDermott 2003). At the 2004 conference, the question on the agenda was less contentious but nonetheless up for debate: 'Is Free Association still at the core of Psychoanalysis?' (Hoffer & Youngren 2005).

The literature reveals that there are many different ways of handling the fundamental rule. Some think that certain patients should be exempt from free association. Some have suggested alternatives to free association in accordance with their theoretical orientations. Some prefer not to announce the fundamental rule, even though they use free association in sessions. Some authors propose modifications to the rule: to reduce its authoritarian tone, to incorporate fully resistance analysis or to be updated to include associations other than thoughts, memories and feelings.

Taken together, these contributions represent conflicting conceptions of the fundamental rule and show that it can be approached in many ways. Although some contributors have taken informal surveys of colleagues on this matter, the outcomes are sometimes impressionistic, often inconsistent and almost always difficult to verify.

1.3 RESEARCH PROBLEM AND JUSTIFICATION

The motivation for this research stems from an interest in discussions on the fundamental rule in psychoanalytic literature and conferences. Although both forums are not short of descriptions and justifications for use of the fundamental rule, views often conflict; it is difficult to get a clear picture of how mainstream psychoanalysts think of the fundamental rule and how they use it. This study seeks to fill that knowledge gap.

The research thus concerns itself with an empirical investigation of views and practices on free association. Empirical testing in psychoanalysis is not nearly as widespread as clinical research. This seems to have begun with Freud's contempt for empirical testing and continues because of analysts' reluctance to engage in such research (Cooper 1993: 383). Empirical studies are not without complications; an important downside is that it can neither capture analysts' inner experiences while they work analytically, nor can it reveal unconscious motivation (Arlow 1993: 144).

The empirical studies that have been published tend to measure analytic outcome and efficacy of treatment (Cooper 1993: 385), or are concerned with developmental studies. However, there are others which measure psychoanalysts' views and which have received positive attention. Examples include Kirsner's '*Unfree Associations: Inside Psychoanalytic Institutes*' (2000) which assessed organisational conflicts of institutions, and Hamilton's '*The Analyst's Preconscious*' (1996) which assessed analyst's attitudes and practices on the subject of transference. There have also been two empirical surveys on the fundamental rule: Glover's questionnaire (1932-1938) and Lichtenberg & Galler's postal survey (1982-1987). This study recognises the contributions of both, and draws heavily from the latter.

Glover sent questionnaires to experienced members of the British Psychoanalytical Society in 1932 asking 'What do you actually do in analysis?' He devised five specific questions on the fundamental rule. From twenty-four replies, he

discovered that psychoanalysts have relaxed their use of the fundamental rule; in Glover's words, they are not 'slavish in obedience to their own general rules' (1955: 302). Lichtenberg & Galler conducted a survey on forty-nine psychoanalysts, all of whom were eminent thinkers in the field (mostly members of editorial boards). They asked analysts how they presented the fundamental rule and what considerations guided them. The results point to wide variation in timing, phrasing and frequency of use of the fundamental rule. They also point to a tension between conservativism (17% of psychoanalysts routinely followed Freud's recommendations) and innovation (some preferred to experiment with the rule) (1987: 60).

This study hopes to build on these contributions in five respects. First, it aims to update the findings. In the seventeen years since Lichtenberg & Galler published their study, psychoanalytic thought and practice has developed in ways that might impact on attitudes towards the fundamental rule.

Secondly, this study aims to pose the question in a wider context. The sample will include mainstream psychoanalysts who may not have contributed to the literature. By sampling from a roster of psychoanalysts, a more balanced outcome may emerge than in Lichtenberg & Galler's investigation of 'eminent thinkers'.

Thirdly, this study employs different research methods to the previous surveys. There are disadvantages of self-reporting questionnaires, including the possibility that written answers are tailored to appear technically competent or to meet the researcher's interest. This may have introduced biases in the results, and it is hoped that one-to-one interviews might reduce this effect.

Fourthly, this study adopts elements from a formal methodology - grounded theory - with an attendant interpretive paradigm. Grounded theory is an inductive methodology which can produce descriptions, hypotheses or theories that are empirically grounded in the data. Grounded theory allows greater scope for discovery than deductive methods (which seek to test existing theories). Given that there is no

formal theory on the use of the fundamental rule, many of its methods are suitable for this inquiry. In the spirit of grounded theory, the primary research questions derive from debates in the literature and recent conferences.

Fifthly, formal statistics will be applied to data analysis. Statistical calculations were avoided by Glover because 'owing to the smallness of the numbers involved, it was scarcely worthwhile' (1955: 267). Although Lichtenberg & Galler's sample was considerably larger, they too eschewed statistics in favour of outlining general tendencies. In this study it is thought that discussion of themes obtained from grounded theory methods can be enhanced with statistics; it allows for greater clarity and accuracy. The methodology chapter will discuss the implications of a mixed methodology.

Lastly, the study will take a different sample of psychoanalysts to the ones in the previous surveys. Glover's sample (Britain) seems to constitute a small proportion of international psychoanalysts and makes for a uniform investigation. On the other hand Lichtenberg & Galler's study had a mixed sample population (U.S., Canada, France and England), yet the theoretical and cultural differences among members were not accounted for in their findings. This study proposes to draw a sample from the U.K. and the U.S. (roughly equivalent to the British Psychoanalytical Society and the American Psychoanalytic Association). This would increase the degree of cultural and theoretical variation amongst research participants which can be incorporated into the findings as part of a comparative study. It would also preserve a degree of uniformity so that cultural differences do not become the focus of the study.

There are three further reasons for choosing the U.K. and the U.S. as the sample population. The American Psychoanalytic Association (APsaA) has been selected because with 3,200 members, it is the largest group of the International Psychoanalytical Association (which has 11,000 members) and thus offers a good representation of international psychoanalysts. However, 84% of the APsaA's graduate psychoanalysts are medically trained, and this is not representative of the

IPA. The British Psychoanalytical Society offers a good contrast because its 417 members have wide variation of orientation and occupational background. Secondly, the British Psychoanalytical Society and the American Psychoanalytic Society were founded in 1919[1] and 1911 respectively, and were two of the earliest psychoanalytical societies to form. This is suitable for a study which has as one of its subsidiary aims, the framing of fundamental rule into a historical perspective. Finally, after reviewing the literature on the fundamental rule, it is apparent that most of the contributions are made by American and British psychoanalysts. By sampling the same nationalities, we can legitimately make comparisons between accounts in the literature and the study's findings.

1.4 DEFINITIONS

'Free association' and the 'fundamental rule' are closely linked and are sometimes used interchangeably. Laplanche & Pontalis, among others, define the two concepts in a similar way (1973: 169, 178) but in fact, a subtle distinction can be made. **Free association** can be defined as 'a psychoanalytic technique for the investigation of the logical mind, in which a relaxed subject reports all passing thoughts without reservation' (New Oxford Dictionary of English 1999). It is a mistranslation of the German term '*freier Einfall*' which contains the words 'free' and 'irruption' and roughly means 'a thought that spontaneously comes to mind as it erupts into consciousness' (Thompson 1998: 699). The **fundamental rule**, or **basic rule,** is the agreement that patients are asked to accept which is to submit to free association to the best of their ability. As Freud conceived it, it was a pledge to be candid during each analytic session (Thomspon 1998: 698-699). Thus, this study makes a distinction between the fundamental rule - a promise to comply with free association - and the act of free association itself.

[1] Ernest Jones formed the London Psycho-Analytical Society in October 1913. He dissolved the organisation and reconstituted it as the British Psychoanalytical Society in February 1919 (King & Steiner 1991: 10-11)

Free association can be distinguished from other similar techniques. Although free association has influenced the surrealist movement in art through the form of disconnected images that are unconsciously linked, they are not the same; rather, what links them is a similar form of creativity (Bollas 2002: 72). Free association also differs from the 'stream of consciousness', daydreams, and thinking aloud, which may be grouped as 'unanalytic associations' (Lewin 1955: 190). They differ in that free association is not wish-fulfilling or goal-reaching (Loewenstein 1963: 458) and it is not a solitary activity (Bollas 2002: 63). Free association also differs from narrative, which implies coherence of a beginning, middle, end, and plot (Hanly 1996: 451, Holmes 1998: 230). Finally, free association has even less in common with 'word association tests'; in the latter, the patient responds to a given word stimulus whereas in free association, the patient says whatever comes to mind.

In sum, free association is unique to psychoanalysis, which with the couch, frequency of sessions and exclusion of distractions (Olinick 1954: 57-58), has no equivalent in adult life (Spiegel 1975: 380, Balter & Spencer 1991: 362, Chasseguet-Smirgel 1992: 6).

1.5 DELIMITATIONS

The research is subject to a number of restrictions. One is that the study is limited in scope. It samples from only two institutions - The American Psychoanalytic Association (predominantly Freudian and ego psychology) and the British Psychoanalytical Society (mostly Kleinian and Independent). It therefore fails to capture the diverse views of analysts from different orientations (for example the Lacanian tradition) and different countries (for example France, Brazil or Israel).

The study is also limited to practising analysts who work psychoanalytically with adult patients for fifty-minute sessions. The fifty-minute session is in line with the American Psychoanalytic Association's description of psychoanalysis. Children

are excluded since their mode of communication is play rather than free association. Although it is assumed that participants work with patients four or five times a week, the study does not exclude those who work with three or fewer sessions. This is because many psychoanalysts still consider the work to be psychoanalytic even if it takes place over fewer weekly sessions. (Sabbadini personal communication 21/7/03).

Another limitation applies to the literature review. The literature review is not an acceptable guide of how current psychoanalysts practise; it encompasses a wider set of views since some accounts are not written by psychoanalysts from the two selected organisations. However, this project aims to produce an empirical assessment and a literature review is a useful starting point. The literature is reviewed up to the period January 2004. Subsequent accounts have not been considered. A cut-off point has been established so that the research results can be focussed on exclusively.

1.6 RESEARCH QUESTIONS

The observations in the literature point to four **hypotheses**:

1. Psychoanalysts consider free association to be ‘fundamental’.
2. Psychoanalysts no longer consider free association to be a ‘rule’.
3. Psychoanalysts still introduce free association to patients.
4. The introductions that psychoanalysts give to patients have been modified:
    a) to reduce the authoritarian tone.
    b) to include a reference to resistance analysis.
    c) to include associations other than ‘thoughts’.

Main questions:

1. How, if at all, do psychoanalysts introduce to patients the fundamental rule?

2. What are their considerations for approaching the matter in this way?

Subsidiary questions:

3. How have the presentation and conception of the fundamental rule changed since Freud?
4. Do British and American psychoanalysts differ in the way they present and regard the fundamental rule?

By asking these four questions, the above hypotheses can be tested and we can get an understanding of how some psychoanalysts view the fundamental rule and how they work with it. The answers will help place this psychoanalytic technique into an historical context, thereby assessing the legacy of Freud's formulation a century since it was developed. In addition, through the window of free association, we will be able to catch a glimpse of the general psychoanalytic practice of a group of analysts.

1.7 OVERVIEW OF THESIS

The next chapter reviews the literature. It traces the historical development of free association and charts how Freud formulated the fundamental rule. It reviews the theoretical arguments that have been posited for and against use of the rule; this includes the cases that have been made for its modification. Two important research contributions are then examined, and arguments are advanced for why these studies should be extended.

Chapter three discusses the research design. It outlines the theoretical paradigm of interpretivism and explains the uses and limitations of qualitative

methods. Data collection and recording techniques are described including convenience sampling, semi-structured interviews and audio-recording equipment. Data analysis procedures, based on Strauss and Corbin's grounded theory methods, are explained. The use of statistical calculations is justified, as is the use of computer software (NVivo) to manage data. Criteria to evaluate trustworthiness and authenticity are listed, and ethical principles that bind the research are discussed.

Chapter four analyses the data produced by the aforementioned methodology. It presents the results thematically, beginning with the definition of free association and ending with the considerations and influences on the approach to the fundamental rule. Data are presented via participants' quotes and statistical tabulations. Synthesizing the overall results, it proposes a new hypothesis of how the fundamental rule is approached.

Chapter five discusses these findings relative to Freud, the literature review, and past surveys. It highlights the many results that are in concert with the literature, and points to those that are not. It shows to what extent the four hypotheses have been supported, and it comments on Freud's legacy. It also contains a summary of participant feedback.

Chapter six summarises the research and its findings. It discusses the results' limitations, indicates the study's potential relevance, and suggests areas of further research. Lastly, it lists the contributions made by the study.

1.8 CHAPTER SUMMARY

This introductory chapter explained the background of the research study, including the mixed accounts of the fundamental rule in the literature. We saw that from such debates, a research problem suggests itself: What do current psychoanalysts think of the rule of free association and how do they work with it in practice? The aims of this research are to produce an updated assessment of the fundamental rule, and to help chart its historical change. It hopes to build on previous studies by conducting one-to-one interviews with a sample of practising psychoanalysts, and analysing the data with grounded theory methods. Justification was provided for the why this topic should be investigated and why the sample should incorporate American and British psychoanalysts. Definitions of the key concepts used in this study have been given. Some limitations of the study have been outlined, as well as the research hypotheses and questions. Finally, an overview of the thesis was presented.

CHAPTER TWO: LITERATURE REVIEW

2.1 CHAPTER OVERVIEW

This chapter begins by inspecting the evolution of free association to situate the research within a historical context. It then examines free association as a method and considers its assumptions, conditions, and processes. It describes some of the positive views about the fundamental rule and some of the difficulties associated with it, namely its paradoxical nature and numerous forms of resistance. It charts the changes to the fundamental rule, including exceptions to the rule for patients with ego distortions, and three proposals for modification to the rule. It reviews two important research contributions that have surveyed the way in which analysts regard, and make use of, the fundamental rule. Lastly, it highlights the path for further research in light of this literature review.

2.2 EARLY HISTORY OF FREE ASSOCIATION

2.2.1 Hypnosis with suggestion[1]

Freud set up private practice in April 1886 employing the accepted treatment method of electrotherapy (Jones 1953: 285). A year and a half later, he was working clinically with hypnotic suggestion (ibid: 258), a technique he had learnt from Charcot at the Salpêtrière in Paris (Freud 1886: 13, 1924: 192). In *Psychical Treatment* (1890) and in an 1891 contribution to Anton Bum's *Medical Handbook,* Freud explains the technique of hypnosis as follows: the physician sits the patient in a comfortable chair and requests silence, as talking would inhibit falling asleep. Any

[1] The following distinctions can be made: **Hypnosis** is 'the induction of a state of consciousness in which a person apparently loses the power of voluntary action and is highly responsive to suggestion or direction', **hypnotherapy** is 'the use of hypnosis as a therapeutic technique', and **suggestion** refers to 'the influencing of a person to accept an idea, belief, or impulse uncritically, especially as a technique in hypnosis or other therapies'. (*New Oxford English Dictionary* 1999).

tight clothing is removed and the room is darkened. The physician sits opposite the patient and can bring about hypnosis through many ways, most commonly by getting the patient to look into the hypnotist's eyes (1921: 125). Once hypnosis has been induced, the therapeutic work, via suggestion, begins. The physician denies the illness from which the patient claims to suffer: 'you no longer have any pains in this place' (1891: 111), or assures the patient that it can be overcome. The patient is then woken up with a comment such as 'wake up' (1890: 297) or 'that is enough for the present' (1891: 112). Freud says that we can expect either an instant result or a delayed effect (post-hypnotic suggestion) (ibid).

2.2.2 Hypnosis with cathartic method

Freud was soon using hypnosis in the service of uncovering patient's recollections of their traumatic experiences (remembering), and the cathartic method of releasing strangulated affect (abreacting) (Freud 1914b: 147, A. Kris 1982: xiv, Joseph 1990: 92). Freud claimed to have learnt the method of investigation under hypnosis from Breuer (1914a: 9). Instead of making 'forcible-prohibitions' by suggestion (ibid, 1917: 449), the physician, under this method, asks hypnotised patients questions to reveal 'pathogenic recollections' (Freud & Breuer 1895: 268). Breuer's patient Anna O mostly spoke in soliloquy and she labelled the process 'chimney sweeping' or 'the talking cure' (ibid: 30).

Freud first used the cathartic method in May 1889 with Fräulein Emmy von N (1895: 48). He found that as well as her hypnosis, during massage, she was using their 'conversation, apparently unconstrained and guided by chance' (ibid: 56). He observed that though she changed topics, her speech was not meaningless. He seemed surprised to see that she unburdened herself of pathogenic memories without being instructed to do so (ibid). Emmy von N also reproved Freud for interrupting her flow of thought with his questioning (ibid: 49, Jones 1953: 268). Freud took cue and made another step towards free association (ibid, Fossi 1989: 399).

2.2.3 Abandonment of hypnosis

Freud became aware of the difficulties of hypnosis as early as in 1890, and he began to search for alternative procedures (1890: 302). There are several explanations for why Freud abandoned hypnosis. First, Freud discovered that not all patients were hypnotizable (1890: 299, 1895: 267, 1924: 195). He was not certain why this is so, and thus he could not know in advance which patients would be suitable for hypnotic treatment (1895: 267-268, 1917: 449). Lagache believes this is the main reason for giving up hypnosis, noting that 'if all the patients had been hypnotizable, there would have been no psychoanalysis' (1952: 7).

Secondly, Freud discovered that even if subjects were suitable for hypnosis, it could not guarantee success (1895: 100n). He thought that patients risked becoming addicted to hypnosis as a therapy (1917: 449). He also found that the cures produced by hypnosis were often temporary (1917: 449, 1924: 195).

Thirdly, Freud thought that the physician did not have any influence over transference (1917: 451, 1921: 126). Good results from hypnotic suggestion often arise from the patient's determination to please the hypnotist, which diminishes when contact ends (Freud 1923: 237, Jones 1953: 264). Thus, transference possibly caused transient results (Freud 1895: 301). Freud recounts an episode where a patient awoke to throw her arms around him, which motivated him to discard hypnosis (1925: 27). Jones too believes that transference was the principal motive for discarding hypnosis (1953: 266).

Finally, hypnosis masks resistance, which means that the analyst is denied insight into the mental phenomena (Freud 1904: 252, 1917: 292). This may have caused a difficulty given that Freud thought that the physician was entitled to learn about the source of the illness that he was aiming to treat (1925: 19).

Freud's new opinion on hypnosis was clear: 'It was hackwork and not a scientific activity, and it recalled magic, incantations and hocus-pocus' (1917: 449). He considered hypnosis' abandonment 'the most momentous step' in the movement from the cathartic method to psycho-analysis' (1924: 195).

2.2.4 The pressure technique

Freud, inspired by Bernheim's observation that memory of what took place during hypnosis could be recalled by a gentle command and application of hand pressure, devised a 'pressure' or 'concentration' technique (1895: 110). Freud used this method with Miss Lucy R who could not fall into hypnosis. He encouraged her to lie down and close her eyes, to concentrate. He asked questions such as 'How long have you had this symptom?' or 'What was its origin?' (ibid: 109-110). When no memories of the symptom or its origins were stirred, Freud pressed her forehead with his hands and assured her that recollection would arise (ibid: 107, Jones 1953: 267). Freud observed that patients would resist producing ideas under this method, claiming, for example, 'nothing has occurred to me' (1895: 111). He was persuaded that resistances are offered as a defence, which successfully push disagreeable thoughts (repressed material) out of consciousness through censorship (ibid: 269). He would insist that patients relay their thoughts: 'of course you know it' (ibid: 270), or 'You have at this moment come up against something that you had rather not say. It won't do any good. Go on thinking about it' (ibid: 278-9).

2.2.5 Early appearance of free association

In response to observations of resistance, Freud requested patients to say whatever comes to their mind 'without selecting and without being influenced by criticism or affect' (1895: 279). Jones highlights this reference to relaxing the critical faculty as the first move towards free association (1953: 268). Indeed, an early version of the fundamental rule appeared in *Studies on Hysteria*: 'He [the patient] is not to keep it [his thoughts] to himself because he may happen to think it not wanted,

not the right thing, or because it would be too disagreeable for him to say it.' (1895: 270).

As Freud grew confident that removing conscious censorship (relaxing the critical faculty) would eventually yield unconscious memories, he had less need for the pressure technique. By 1904 he no longer insisted, pressed on the forehead, or asked patients to shut their eyes (1904: 250). He writes of 'the "associations" of his patients - involuntary thoughts (most frequently regarded as disturbing elements and therefore ordinarily pushed aside) which so often break across the continuity of a consecutive narrative' (ibid: 251). He asks the patient to '"let himself go" in what he says, "as you would do in a conversation in which you were rambling on quite disconnectedly and at random"' (ibid).

The exact time at which free association substituted hypnosis is not clear. Jones says it has evolved gradually between 1892 and 1896, refined from the preceding methods of hypnosis, suggestion, pressing and questioning (1953: 266). Schur surmises that the birth of free association was on July 24 1895, the date on which Freud analysed his Irma dream (1966: 48); Freud seems to have free associated to every part of his dream until a meaningful pattern emerged (Freud 1900a: 107-121, Schur 1966: 48). However, the associations were not 'free' since they were produced in a systematized format (Barchilon 1964: 268). This event alone is unlikely to have symbolised the invention of free association, though Freud's employment of 'controlled association' (asking for further associations to particular details) may have contributed to the eventual design of free association (L. Spiegel 1975: 379).

2.2.6 Historical development of free association

Trosman regards Freud's method as a product of a historical continuum rather than as an innovation (1969: 497). Several thinkers may have influenced Freud. Aristotle was the first to discuss associations and to state laws guiding the interplay of associative elements (Bellak 1961: 9) and Freud was familiar with his works. Freud

has also referred to Hobbes, Berkeley, Spencer, Brentano, Herbart, and Lipps, all of whom contributed ideas to associationism.

Freud read much German literature (E. Ticho 1986: 228) and was familiar with the works of author and playwright Schnitzler (Jones 1953: 380). In his novella *Lieutenant Gustl* (1901), Schnitzler develops a 'stream of consciousness' technique which consists of the protagonist's internal monologue of intimate thoughts as they arise. To an extent this narrative form resembles free association (Beharriell 1962: 728). Freud wrote to Schnitzler in 1922 that he considered him his double ('*Doppelgänger*'). He wrote: 'I have thus gained the impression that you have learned through intuition...everything that I have had to unearth by laborious work on other persons' (letter in Kupper & Rollman-Branch 1959: 109-110). It is difficult to ascertain the direction of influence, since Schnitzler read Freud's works too. It is possible that both methods developed simultaneously (ibid: 125).

Freud reflects that Börne, German-Jewish essayist and political journalist, had influenced him (1920: 264-265). In a brief essay on *The Art of Becoming an Original Writer in Three Days* (1823), Börne advises: 'Take a few sheets of paper and for three days on end write down, without fabrication or hypocrisy, everything that comes into your head' (in Freud 1920: 265). Although Freud did not recall reading this article, he was given Börne's works as a gift when he was fourteen, and it was the only book he kept from his youth fifty years later (ibid). Yet, Zilboorg challenges this source of influence, arguing that Börne's work, deals with a stream of consciousness, not associations (1952: 492). A stream of consciousness, Loewenstein states, is characterised by wish-fulfilling patterns that aim at a specific goal, and are solitary in character while free association, occurring in a psychoanalytic setting, eliminates both wish-fulfilment and solitary thought (1963: 458). Instead, Zilboorg (1952: 492) believes that Galton is the likely influence on Freud's free association.

In *Psychometric Experiments* (1879), Galton describes a method aimed at gaining insight into the mind, in which he records the ideas that have emerged while

letting the mind 'play freely' (1879: 150). His findings match the properties of free association in several ways (Zilboorg 1952: 493), for example, Galton found associations to be involuntary ('fleeting and obscure') (1879: 150) and affected by early education (ibid: 159). He also found the process 'trying and irksome', which may approximate resistance (ibid: 151). Zilboorg cannot confirm whether Freud read this article, but he insists that Freud owned a copy of the journal in which it featured (1952: 494).

Galton's method seems to be a precursor to Jung's 'word association test' (Friedman & Goldstein 1964: 221). Jung published his article *Psychoanalysis and Association Experiments* in 1906 (Fischer 1990: 490) and he sent Freud a copy. However, Jung's method differs from Freud's; word association involves response to given stimulus words, and tension around specific words are taken to signal the area of the patient's difficulties (Samuels 1983: 434, Jung 1906: 410-417).

Janet experimented with hypnosis and proposed, 'automatic talking'' which seems to have been his equivalent model of free association (Kalinich 1993: 210). Ellenberger believes that 'the methods and concepts of Freud were modelled after those of Janet' (1970: 539-540), but does not suggest that this was the direct influence on Freud. Perhaps both methods were a product of the intellectual climate of the era. This seems likely if we consider that ideas are often inextricable from the social and cultural milieu in which they arise. Thus, Freud's discovery of free association may have been an outgrowth of the *zeitgeist* of his time (Zilboorg 1952: 495, Aron 1996: 101).

2.3 EARLY REFERENCES TO THE FUNDAMENTAL RULE

By 1898, the year Freud began drafting *The Interpretation of Dreams* (E. Kris 1950: 114) the free association method was given the status as the chief method of investigation (A. Kris 1982: xiv), and inextricably linked with psychoanalysis (Panel

1971: 99). Freud titled this method the 'fundamental rule of psycho-analysis' in 1912 (1912b: 115). A year later, Freud provided readers with a full description of the rule as he might phrase it to a patient:

> *One more thing before you start. What you tell me must differ in one respect from an ordinary conversation. Ordinarily you rightly try to keep a connecting thread running through your remarks and you exclude any intrusive ideas that may occur to you and any side-issues, so as not to wander too far from the point. But in this case, you must proceed differently. You will notice that as you relate things various thoughts will occur to you which you would like to put aside on the ground of certain criticisms and objections. You will be tempted to say to yourself that this or that is irrelevant here, or is quite unimportant, or nonsensical, so that there is no need to say it. You must never give in to these criticisms, but must say it in spite of them – indeed, you must say it precisely because you feel an aversion to doing so. Later on you will find out and learn to understand the reason for this injunction, which is really the only one you have to follow. So 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 leave anything out because, for some reason or other, it is unpleasant to tell it. (1913: 134-135).*

Perhaps his clearest and most succinct description of free association contained in the following statement:

> *We instruct the patient to put himself into a state of quiet, unreflecting self-observation, and to report to us whatever internal perceptions he is able to make - feelings, thoughts, memories – in the order in which they occur to him. At the same time we warn him expressly against giving way to any motive which would lead him to exclude any of them whether on the ground that it is too disagreeable or too indiscreet to say, or that it is*

too unimportant or irrelevant, or that it is nonsensical and need not be said. (1917: 287).

Freud discovered that patients failed to comply with this order since the ego intervenes in the flow of associations by one of its defence mechanisms – resistance (1917: 288, A. Freud 1937: 13). These resistances are unwanted obstacles in the smooth operation of free association (Freud 1925: 42), and are overcome by interpretation once a positive transference has been established (1913: 139).

2.4 ASSUMPTIONS AND CONDITIONS OF FREE ASSOCIATION

The assumptions and conditions are now outlined to help contextualise appraisals of the method. Although they are treated here as separate factors, in practice they overlap.

2.4.1 Assumption: psychic determinism

The method of free association stems from a theoretical assumption of 'psychic determinism' – the belief that some agency determines the course of wandering thoughts. What appear to be arbitrary accidents are in fact intelligible (Freud 1901: 239, 1910: 38), and by implication, the analyst can elicit meaning from the patient's chain of associations (L. Spiegel 1975: 387). Freud adhered to this view in his work, and he found that patients' haphazard utterances are often elucidated by subsequent comments (Jones 1953: 269-270). Spencer & Balter claim that most analysts believe in psychic determinism (1990: 397), although some have challenged it (see Waelder 1963: 15-42).

2.4.2 Assumption: unconscious mental activity

Free association is based on a related belief in unconscious mental activity (Bachrach 1989: 286, 1996: Beres 1960: 265) - the idea that neurotic symptoms derive from unconscious, defended internal and external conditions in the patient's past. The spontaneous thoughts and feelings uncovered via free association thus represent derivatives of unconscious urges, attitudes, identifications, prohibitions, and ideals (Lichtenberg & Galler 1987: 48). This happens in many ways including unintentional choice of themes, sets of verbalizations revealing unconscious connections between them, and the emergence of more detailed descriptions and unvoiced thoughts (Panel 1971: 99-101). Free association is therefore a tool for making unconscious, as well as conscious, material available to the patient and analyst for examination (Alexander 1935: 604, Laforgue 1936: 369, Richards 1990: 356, Busch 1995a: 453).

However, as Fossi discusses, the notion that the analyst is an objective scientist trying, via free association, to arrive at the hidden truths contained in an absolute unconscious, has been challenged (1989: 399). From a social-constructivist perspective (for example Hoffman 1991, 1992 and Stern 1992) the concept of the unconscious is a relative one; the analysts' view of the patient's unconscious is subjective. It implies that a different analyst with the same patient might discover different aspects of the unconscious (Schafer 1983: 205). Under this view, what is discovered is a construction (Levenson 1983), a storyline (Schafer 1983) or a narrative (Spence 1982), that fits with both analyst and patient, as opposed to an objective truth or reconstructed memory (Hirsch 1995: 274).

2.4.3 Assumption: intrapsychic activity

Under the topographic notion of lifting repression, the analyst employed free association to make the unconscious drives and derivatives, conscious (id-analysis) (A. Kris 1983: 407, Joseph 1990: 96,). Under the structural model, the value of free

association shifted towards revealing the patient's intrapsychic conflicts - to bring to light shifts in ego, superego and id, and their relation to one other (A. Freud 1937: 15, A. Kris 1983: 407, Rangell 1987: 234). Intrapsychic processes can be observed through the content and organisation of free associations, and through changes in the patient's mood and behaviour (L. Spiegel 1975: 380). Loewenstein argues that compliance with the fundamental rule enables intrapsychic shifts in ego and superego functions, and the analyst takes over these roles making possible the processes occurring in an analysis (1963: 454, 466).

2.4.4 Condition: altered state of consciousness

Free association also relies on achieving a psychical state that is similar to the state of mind before falling asleep, and one resembling that in hypnosis (Freud 1900a: 102). Free association is also seen as an intermediary between dreaming and waking activity (Evans 1961: 91, Kanzer 1961: 348) or as entailing shifts in states of consciousness (Grand & Pardes 1974: 62). This is achieved with the help of the reclined position on the couch.

2.4.5 Condition: the couch

The couch is a feature retained from hypnosis (Freud 1913: 133-134, Jones 1953: 268). Freud asked patients to lie on the couch, with the analyst out of the patient's view. He reasoned that this helps the patient 'concentrate his attention on his self-observation' (1900a: 101), and that it helps him to surrender to the flow of his unconscious thoughts (1913: 134). He added that he disliked being stared at by others (ibid). Many analysts continue to believe that the couch plays a role in free association. The couch facilitates an altered state of consciousness in the patient through the recumbent position, relaxation, and relative lack of sensory stimulus, (G. Ticho 1967: 310, Pulver 1995a: 11, Greenacre 1959: 496). It also reproduces the infantile situation (Lewin 1955: 195-196, Spitz 1956: 382, Stamm 1962: 775) since the couch is similar to the cot (Bollas 1987: 258-259).

Others, Pulver remarks, do not find the couch essential (1995a: 11), and some including Macalpine (1950: 522-523) find it unhelpful. However, most analysts who have written on the subject (for example Fenichel, 1941; Glover, 1955; Greenacre, 1959; Stone, 1961; Greenson, 1967; Sabbadini 1985; Rothstein, 1990; Goldberger, 1995) recommend handling responses to the couch with flexibility.

2.4.6 Condition: free-floating attention

Freud introduced an equivalent pledge for the analyst: to adopt the position of 'evenly suspended attention' (1912b: 111-112). The analyst is advised not to 'fix anything that he heard particularly in his memory, and... catch the drift of the patient's unconscious with his own unconscious' (Freud 1923: 239). Gardner prefers the term 'free attention' (1991: 865) and Reik's concept of listening with the 'third ear' (1948: 144) seems to be a variation of this (Bergmann 1997: 80). Sandler dislikes the term 'evenly suspended attention' because its connotations of banishing everything from the mind seems an insupportable burden on the analyst. He prefers to describe it as 'free-floating attention', which he defines as: 'the capacity to allow all sorts of thoughts, daydreams and associations to enter the analyst's consciousness while he is at the same time listening to and observing the patient.' (1976: 44). Pulver describes it as associating to the patient's free associations (1995a: 13), and indeed for A. Kris, free association delineates both the patient's and the analyst's associations (1992: 212). Balter, Lothane & Spencer argue that collectively, free association and free-floating attention serve as an analysing 'instrument' (Spencer & Balter 1990: 397).

Free-floating attention is occasionally seen as corresponding with the patient's fundamental rule (Meissner 1971: 280, Duncan 1989: 696). Others view free-floating attention as complementary to, but different from, free association (for example Rosenblatt & Thickstun 1984: 75 and Sandbank 1993: 725). They are similar in that the associations are psychically determined (Balter, Lothane & Spencer 1991: 369).

Yet they differ because free-floating attention is intended as a specific response to the patient's communications whereas the patient's free associations are more widely determined (Olinick 1954: 58, W. Grossman 1995:895).

Many analysts believe that free-floating attention is an imperative in the analytic process, and a necessary condition to allow free associations to develop (Sandler & Sandler 1978: 289, Gill 1984: 384, Williams 2002: 471). Free-floating attention represents a position of 'open-ended' acceptance of the patient (Gitelson 1962: 198), promotes a mutual identification between analyst and patient (since both adopt related attitudes towards psychoanalytic material), and aids empathic understanding towards the patient (L. Spiegel 1975: 383-384). It can promote regression in analysts, freeing them from secondary-process thinking (Spencer & Balter 1990: 411). It also enables analysts to notice connections between the associations and to experience emotional responses to the patient's communications which otherwise may not have been possible (ibid).

Calef & Weinshel also consider free-floating attention as an altered state of consciousness (1980: 290), which is compatible with techniques of mindfulness. Mindfulness derives from meditation skills of Buddhist philosophy and suggests 'moment-to-moment attention to thoughts, feelings, images, or sensations as they arise and pass away within the field of awareness.' (M. Epstein 1990: 160). However, free-floating attention, unlike meditation, occurs within the presence of another. The concept of 'reverie' developed by Bion – 'a state of mind which is open to the reception of any "objects" from the loved object' (1962: 36) - may be a more apt description of what occurs in free-floating attention. On the other hand, L. Friedman views free-floating attention as distinct from reverie as well as from meditation (1983: 212).

Some have criticised Freud's notion of 'evenly suspended attention'. Spence finds it flawed since it is not the 'impartial instrument' (Freud 1927:36) that Freud spoke of, but can be experienced by the patient as an intrusive process (1988: 597). In

addition, free-floating attention does not guarantee that the analyst can tune into the full scope of meaning residing in the patient's communications (Spence 1995: 708). Fromm says that while free-floating attention is accurate as a description, it is insufficient; deep concentration is also necessary to bring about a feeling of 'interest and vitality in the session' (Biancioli 1992: 719-720). Despite this critique, free-floating attention is generally considered an important part of free association.

Other features enhance free association too; the conditions of confidentiality, analytic neutrality, and abstinence, serve to ensure that the patient free associates in response to internal or external stimuli without influence from the analyst (Kasin 1977: 364, Lichtenberg 1999: 726). The frequency and regularity of couch sessions are also thought to promote free association (Ticho 1967: 311).

2.5 PROCESS OF FREE ASSOCIATION

The form, content, and style of free associations are said to be particular to each patient (A. Kris 1982: 12, Rangell 1987: 234). In addition, cultural and personal factors influence how patients learn to adhere to the fundamental rule (Loewenstein 1958: 205). Despite this, some generalisations of the mechanisms of free association can be made. In the process of free association, a thought presents itself to the patient that triggers a series of further linked thoughts (Rosner 1973: 558). The thoughts move from the more conscious to the less conscious, primitive or naive (Ferenczi 1931: 470, Rangell 1968: 23, Rosner 1973: 558). This occurs by an attenuation of the ego and superego. In this section, we examine the determinants of free association, and the processes of ego and superego regression.

2.5.1 Process: determinants of free association

There are many determinants of free association (A. Kris 1982: 11). Patients may produce a comment based on internal stimuli such as their own bodily sensations,

affective mood, day residues, past experience, dreams, and insights arising from the associative process (Rosner 1973: 560). External stimuli to free associations include the patient's everyday 'reality' (an event at work, at home or on the journey to the session), the contents of previous sessions, extensions of the associative process (dreams or insights) and the analyst's productions (interpretations, bodily or vocal signals) (A. Kris 1983: 409).

Many authors underline this last element - the analyst as a determinant of free associations. Freud's formulation of the fundamental rule in 1925 (p. 40) shows that he is aware that free association is not a unilateral process but involves the impact of two individuals on one another (Kanzer 1972: 249). Similarly, working within an interpersonal framework, Sullivan views the analyst as a 'participant observer', not a detached observer. For him, free associations are not elements of the patient's experience that naturally unfurl, but are to some extent shaped out of the patient-analyst interaction (1954: 3). Thus, the patient associates differently with different analysts (Mitchell 1988: 484). Many writers including A. Kris (1982: 13), Gill (1984: 171) and Spence (1995: 710) confirm that analysts play a role in shaping associations. Each intervention – analysts' nonverbal cues, their choice of when to ask for further associations, and their decisions when to stay silent (Edelson 1983: 74) - suggest a direction for the patient to follow.

Similarly, for many working with intersubjectivity theories (Stolorow et al. 1978: 248, Gill 1984: 171, Hoffman 1996: 113, Aron 1997: 891), psychoanalytic data including free associations, are jointly constructed by the patient and the analyst. Mutual generation of data can be a common and helpful construction, (Goldberg 1997: 492) but analysts are advised to be aware of the impact of their interventions on the patient's free association (Gill 1984: 171, Hoffman 1996: 112).

2.5.2 Process: suspension of ego controls

Adherence to the fundamental rule implies that the ego temporarily suspends part of its cognitive function; censorship, moral judgement, logic, concentration, and goal-directed thinking are avoided (Moore 1974: 506-7, Blum 1981: 549). This allows a partial and reversible regression (A Freud 1937: 12, 15, E. Kris 1956: 540, Calder 1958: 557).

Ego regression, through relaxation of the critical faculty, allows unconscious and preconscious ideas (id and id derivatives A. Freud 1937: 12) to surface (Nunberg 1951: 8). During the period of ego regression, the analyst exercises the cognitive functions on behalf of the patient (Loewenstein 1963: 463, Blum 1981: 549, Gray 1982: 623). The level of ego regression varies among patients (Balter, Lothane & Spencer 1980: 481). A 1958 Panel report concluded that in psychoanalytic treatment, there is an optimum level of ego regression to permit free association (Calder 1958: 552), a view that Busch believes still holds (1997a: 41). However, for Busch, the optimal level of regression is obtained by analysing resistances (1997a: 43) which, as we will see, is a view that is not unanimously accepted.

2.5.3 Process: observing ego and oscillating function

Many contributors such as A. Freud (1937: 8), E. Kris (1956: 452), Greenson (1965: 158) and Gray (1973: 492) stress that the development of an observing ego is important for a successful outcome of analysis. It encourages patients' eventual interest in the intellectual process including their free associations as well as improving their capacity for self-analysis (Stone 1981: 92-3). The observing ego is reminiscent of Freud's description of the ego's capacity to take itself as an object and observe itself (1933: 58). However, this was not embedded in Freud's technique and he seemed to discourage the use of intellect or widening curiosity (Busch 1994: 373).

Sterba claimed that 'dissociation' between an id-dominated 'experiencing ego' and a reality-dominated 'observing ego', is essential to a successful analysis (1934: 120). Bellak claims that free association relies on an ability to move smoothly between these two parts, terming it the 'oscillating function of the ego' (1955: 375, 1961: 17). Patients relax their critical faculties to an experiencing mode to allow unconscious material to surface, but reign back these functions when reflecting on interpretations (Needles 1978: 62, Bellak & Meyers 1975: 416). Many confirm that the ability to move between the two positions is a requirement of the fundamental rule (Calder 1958: 558, Arlow 1963: 581, G. Ticho 1967: 310, Thompson 1998: 699) and is a prerequisite for participation in analysis (Greenson 1965: 174, Aron 1993: 309). Indeed, an inability to move smoothly between ego regression and heightened acuity of self-observation is sometimes the cause for disturbances to free association, which will be addressed later.

This view is not without its critics. Fromm, for example, believes that rational thought is not part of free association: "If I invite the patient to join me in reasonable thought about an object matter, then this is thinking, and not free association" (1955: 3). Kanzer on the other hand finds the separation between 'experiencing' and 'critical' egos artificial and undesirable since he believes there is a continuum between them (1972: 252, 256, 1981: 73). Noy (1969, 1979), Horowitz (1972), Fosshage (1983) and Bucci (1985) have challenged the idea of oscillation between progressive and regressive shifts (Aron & Bushra 1998: 390). These authors doubt that primary process precedes secondary process, finding it preferable to assume that they are integrated (ibid). Bucci adds to this a 'referential activity', which correlates primary and secondary processes and engenders emotional insight (Bucci 1997a: 161, 1997b: 160). Despite these challenges, many accounts in the literature assume a separation between experiencing and observing egos.

2.5.4 Process: suspension of superego function

Besides suspension in the observing ego, the fundamental rule entails a relaxation of the patient's observing superego (Burke in A. Freud 1949: 200, Zilboorg 1952: 490, Blum 1981: 549-550), for which the analyst's superego temporarily stands in (Olds 1992: 441). Several commentators have found the superego aspects inherent in the fundamental rule to be a source of contention because of the authoritarian connotations. We will see that this has led to a modification in the fundamental rule.

2.6 SUPPORT FOR THE FUNDAMENTAL RULE

There are mixed views about the fundamental rule's status. Some insist that the fundamental rule is a fixed technical precept, which has varied little (Kanzer 1981: 71). Many continue to regard it as the cornerstone of analysis – the oldest and most consistent technical precept in psychoanalysis (Schafer 1976, Mahony 1979). Moore & Fine's description of the rule eighty-five years later is essentially the same as Freud's (1990: 78). In his appraisal of the fundamental rule, Ogden remarked that it 'is often treated as a static unexamined fixture in the analytic landscape carrying all the stifling power of Freud's 1913...description' (1996: 889).

We will summarize the positive appraisals of the fundamental rule, before turning to the other side of the debate.

For Eissler, the invention of free association was significant:

> *Just as the invention of a new musical instrument, like the trumpet, or the introduction of a new medium - like oil into painting - leads to the creation of a new style, so technological advances often introduce new phases of scientific development. Freud's method of free association was just such an advance, in that it made psychoanalysis possible (1969: 470).*

Free association has been called the 'cornerstone' or 'hallmark' of the psychoanalytic process by many observers such as Reich (1933: 4), Blum (1981: 550), Kanzer (1971: 104), A. Freud (1972: 152), Joseph (1990: 88), (Rangell 1992: 419), Busch (1995a: 450) and Mawson (2002: 515). Additionally, A. Kris (1990: 26) and Williams (2002:471), think that the fundamental rule is central regardless of the analyst's theoretical orientation.

Accounts in the literature show how free association promotes psychoanalysis in different ways. Many authors express the benefit of free association in terms of the purpose that it serves in the psychoanalytic process. As we have seen, free association is a tool that produces thoughts and feelings representative of the unconscious – id derivatives, ego defences, and superego demands – that forms the raw data of analysis.

Further benefits are well-documented in the literature. Newton claims that the free association method gives the patient leadership for the agenda (1989: 40). It enlists and strengthens the patient's autonomous ego in the work, so that patients can overcome their inhibitions and punitive impulses (ibid, Adler & Bachant 1996: 1028). It frees analysts to observe, associate, and think, and the patients' continual supply of associations allows analysts to develop, confirm, and refute clinical hypotheses (Newton 1989: 44). Presenting the fundamental rule solves patients' problems of how they must proceed, and reduces confusion in embarking on an oblique and sometimes frightening experience (Lichtenberg & Galler 1987: 48, 73). Finally, free association helps the patient to acquire tools of insight (Steele 1979: 397, Schwartz 1984: 569, Gedo 1995: 351) and self-analysis (G. Ticho 1967: 310, Kanzer 1981: 85, Wilson & Weinstein 1992: 753, Bergmann 1993: 382).

Free association, by way of regression, also facilitates transference and the creation of a transference neurosis (Wilson & Weinstein 1992: 751). Many authors, including Glover (1928: 183), Gill (1954: 778), Rangell (1954: 740) and Stone (1981: 91-92), find transference and transference neurosis crucial to the analytic process.

Joseph further argues that the way in which the analyst conceptualises and presents the fundamental rule has vital consequences for the development of transference, and the learning that takes place in the analysis (1990: 88-89). For A. Kris, the development of transference reactions is not the goal of psychoanalysis, but the chief result of the free association method (1982: 36). However, a panel on *Concepts and Controversies about the Transference Neurosis* (Abend & Shaw 1991: 234) summarised that many writers do not find the transference neurosis to be essential to psychoanalytic treatment. Contrarily, Reed's conclusion from her survey on members of the American Psychoanalytic Association is that a successful analysis does indeed rely on resolving a transference neurosis (1994: 56).

Some writers have explored why the fundamental rule might be considered as an established and static principle in analytic technique. Any lack of change might be explained by the tacit obligation analysts feel towards the institutional standard on the fundamental rule. Kanzer claims that psychoanalytic rules 'constitute a common group ideal, obviously represented by Freud himself' and that 'Psychoanalytic training and professional standards have in fact become a social medium for inculcating and maintaining institutionalized forms of such ideals'. (1972: 260). R. Spiegel detects an underlying assumption among analysts that modification to the classical situation of free association on the couch detracts from psychoanalysis and alters its nature (1970: 50).

Other authors have commented that free association is taken for granted. A chief exponent of this view is Bollas who in two publications '*The Mystery of Things*' (1999) and '*Free Association*' (2002) argues that it has been 'marginalised' (1999: 70). He argues that free association, is rooted in the maternal order because it entails speaking without scrutiny, focus or fear and the patient is contained by a supportive and silent analyst (ibid: 183). He finds that in the current analytic world, the paternal order dominates. Thus, free association might be taken for granted because it lies in the maternal sphere. Bollas implies that the way out of this imbalance is for the analyst to use more silence and curtail excessive use of interpretation (since insight

belongs to the paternal sphere). Goldberg criticises Bollas' application of Lacanian concepts as 'arbitrary, and typecast, as well as concretized and oversimplified' (2001: 882). Nevertheless, many others share Bollas' underlying point– that free association is essential.

2.7 DIFFICULTIES IN ADHERING TO THE RULE

On the other side of the debate, many authors refer to the complications of a fixed technical rule. There are extensive references in the literature to 'disturbances', 'distortions', 'difficulties', 'interferences', 'interruptions', 'obstacles' and 'impossibilities' of observing the fundamental rule. We now discuss the paradoxical nature of the fundamental rule, and examine its major impediments - resistances and ego distortions - in an attempt to appreciate the criticisms that have led to modifications.

2.7.1 Paradox

The fundamental rule is paradoxical in many ways. Associations are expected to be free, yet they are produced under the assumption of strict determinism (Zilboorg 1952: 491) and additionally, under an obligation to do so (Stone 1981:92, Caruth 1985: 559). Thus, associational freedom is juxtaposed with determinism and obligation. Stolorow prefers to use the term 'unfree associations' given that associations are required by an injunction (1997: 861). We have also seen that some such as Spence (1982) and Schafer (1983) infer that free association is a joint construction or narrative developed by the patient and the analyst. Thus, the patient's productions are not free but influenced in part by the analyst's 'unwittingly communicated theoretical bias' (Hirsch 1998: 83, see also Fonagy in McDermott 2003: 1353).

Another contradiction within free association is that it is not always possible to verbalise thoughts and feelings; Loewenstein doubts that the patient can obey the fundamental rule 'in the sense of telling everything that occurs to him' (1963: 453). Spence (1982) maintains that free associations are not 'free' since they conform to rules of grammar, and since secondary thinking is used to fill in gaps (Martin 1991: 290).

A further paradox is that the ability to free associate signals that a patient has been successfully analysed and is ready to end (Brenner 1985: 226, Modell 1988: 592, Gedo 1995: 351). This suggests that beginning patients will fail to comply with the fundamental rule, a point underscored by many including Reich (1933: 9) and G. Ticho (1967: 310).

Freud seems to acknowledge the paradoxical nature by appreciating that free association is never 'free' (1925: 40-41). He understands that associations are influenced by unconscious material (1924: 195) including the transference (1912a: 103). Freud also understands that difficulties are bound to arise: 'later, under the dominance of the resistances, obedience to it [the fundamental rule] weakens, and there comes a time in every analysis when the patient disregards it' (1913: 135fn).

Rangell (1968: 22) and Bronstein (2002: 479) offer a different solution to the paradox of free associations being 'unfree'; they conceive the concept of freedom in relative terms. Bronstein says it is unhelpful to speak of absolute freedom because it evokes an 'ideal' state of mind, which is contradictory to the concept of psychopathology. She prefers to say that a patient's associations are freer on certain occasions, and less free on others (2002: 479). She goes on to argue that the goal of analysis is to discover why a patient cannot associate more freely (ibid: 488). This is similar to A. Kris, for whom the goal of analysis is the promotion of associational freedom, by which he means relative freedom from unconscious obstacles (1982: 3-4, 1983: 408, 1992: 212). Spence et al (1993) likewise find that 'associational freedom' can be beneficial (Meares & Joseph 1995: 57). Furthermore, associations are free in

the sense that they derive from the individual rather than through an 'artificial set of quasi-scientific experimental rules' (Zilboorg 1952: 491) and that they communicate the state of the patient's internal world (Bronstein 2002: 482).

Despite its paradoxes, a consensus emerges in the literature that the fundamental rule should be viewed as an ideal which is seldom reached (Weigert 1954: 705, L. Spiegel 1975: 380, Gedo 1995: 350, Adler & Bachant 1996: 1027). It is also viewed as a useful tool for the conflicts it produces rather than as an end in itself (A Freud 1937: 15, Aruffo 1995: 384, Bronstein 2002: 479). Lichtenberg & Galler claim that all analysts understand that patients are not able to follow fully the fundamental rule (1987: 48). To some, it is fortunate that the ideal is rarely attained, since following it strictly would require exclusive focus on the id (A. Freud 1937: 13) with the material resembling an incoherent 'word salad' (Makari & Shapiro 1993: 998). Etchegoyen among others, takes the view that the rule is put forward not to seek compliance but to see how patients behave in the face of it. To him, its use lies in acting as a baseline reference since it is only once the analyst has formulated the rule that non-compliance be analysed (1991: 61, 67). In this line of thinking, the paradoxical nature of the fundamental rule is not a hindrance.

2.7.2 Resistance

That the fundamental rule evokes resistance is universally understood (Stone 1981: 92, Modell 1991: 733). Indeed resistances can explain most of the obstacles to following the fundamental rule (Loewenstein in Pumpian-Mindlin 1967: 162). Resistance can be defined in a broad sense as a defence against insight, occurring within and outside analysis (Rangell 1983: 148, 156). Typically, the term resistance denotes opposition to the analytic setting, particularly to the treatment and to the analyst (Freud 1900b: 517, 1926: 157, Loewenstein 1963: 462). Resistance can be explained in terms of a counter-cathexis of the ego opposing the emergence of unconscious material (Freud 1926: 159; Reich 1933: 4, Major 1974: 390). This makes it difficult for the patient to abide by the fundamental rule (Fenichel 1932: 615, Reich

1933: 4), given that lability of cathexis is required for free association (Furman & Furman 1984: 430).

A. Kris defines resistance more narrowly, as an unconscious opposition to the fundamental rule, and distinguishes it from 'reluctance', a conscious form of opposition. Examples of reluctance include verbal criticism and the wish to quit the analysis (1982: 31-38). Klufi also adopts this distinction (1992: 149). However, most authors do not separate conscious from unconscious resistance to the rule. Hoch, for example, finds the term 'reluctance' unhelpful since it encourages analysts to be less watchful; he prefers to think of reluctance as a subdivision of resistance, which manifests itself differently (1983: 610). In the following discussion, resistance will signify 'a conflict about verbally expressing something in the analytic situation' (Davison, Pray & Bristol 1990: 601), be it conscious or unconscious.

2.7.3 Types of resistance

Freud observed that resistance can take on different forms and that it is often difficult to detect (1917: 287). A. Freud explained that patients' psychopathology determines their difficulty in following the fundamental rule and reflects specific defence mechanisms in their symptom formations (1937: 36).

Common examples of blockages in the free associative flow include pausing, hesitation, repetition, incomplete thoughts, rambling, obscurities, expressions such as 'I can't remember', 'my mind is a blank', and changes in affective tone (Freud 1917: 288, Bryan 1920: 61, Weigert 1954: 705, A. Kris 1982: 35, Busch 1997b: 410). Some patients resist against the fundamental rule by selecting which associations to articulate and which to omit (Ferenczi 1931: 470, Riviere 1936: 309, E. Kris 1956: 450, L. Spiegel 1975: 384, A. Kris 1982: 35). This occurs because patients cannot tolerate expression of thoughts and feelings they deem inappropriate (Kernberg 1979: 233). Bellak ascribes such 'shallow associations' to the inability to achieve a level of ego regression (1961: 17).

Some patients pay 'lip service' to free association (Kernberg 1974: 234) by following the rule '*ad absurdum*' (Freud 1917: 289). In furnishing the analyst with a mass of detail, patients demonstrate passive compliance and deny the analyst access to disturbing unconscious elements such that the associations are barely visible or are disjointed (Freud 1917: 289, A. Freud 1937: 38, Seidenberg 1971: 100, G. Epstein 1976, Busch 1994: 368-9). These associations may also be devoid of affective content (A. Freud 1937: 38). In Bellak's scheme of oscillation (1961: 17), such patients achieve ego regression, but are unable to switch to the observing, cognitive function.

The notion of a 'pseudo-free association' is also used to denote a communication which initially appears to be a free association but on closer inspection turns out to been 'engineered' – a result of applying too much self-reflection (Mawson 2002: 521). A. Freud refers to various ways in which free association can be misused, including for exhibitionism or dramatization (1954: 59). Loewenstein points out that free association, itself, could be used as a resistance, as a means of turning away from important material (Seidenberg 1971: 100). He illustrates this with a patients' comment: 'I was going to free associate, but I'd better tell you what really is on my mind.' (ibid). Treurniet states that free association itself can become a resistance in the case of regressive states (1993: 885). Schafer (1983) has shown that patients can resist by trying to be 'good' patients (Inderbitzin 1988: 677) which concurs with Fogel's position in his paper 'Psychological Mindedness as a Defence' (1995: 808-814).

Silence is often regarded as a manifestation of resistance to the fundamental rule (for example Freud 1912a: 101, Levy 1958: 57, Greenson 1961: 79-80, Brockbank 1970: 457, Inderbitzen 1988: 677). Calogeras' response to a patient resisting through silence was to allow her to withhold her associations. He told her: 'If you are unable to talk about these things now, it's all right if you remain silent. When you are able to, then you can speak about them.' (1967: 546). He found that by not

holding her to the rule she became more trusting, was able to gain ego-integrity and autonomy and her resistive silences were reduced (ibid).

However, silence seems to play other roles besides resistance. Sabbadini writes that silence may be a barrier, but it can also be a meaningful expression that cannot be conveyed by words (1991: 409). He explains that a discourse without silences would make a parody of free association, and, before interpreting a silence, an analyst is advised to embrace silences and their multiple characteristics and meanings (ibid: 407). Other authors have referred to silence as a form of communication (Arlow 1961: 50, Gill 1994: 95), in particular as a form of speech (Loewenstein 1961: 3) or as a re-enactment of a historical event (Greenson 1961: 80).

The argument that silence is important lends support to the idea that free association is a necessary, but not sufficient, criterion for analytic work. In addition to free association, there must be room for pauses to reflect (Stone 1981: 92). A sound relationship between the analyst and patient is also important (Ferenczi 1932: 169, Kernberg 1983: 463). Finally, to achieve good therapeutic effects, the patient should internalize the process encountered during free association (Bergmann 1993: 944, Stone 1981: 92).

Acting out (or enactment), like silence, is often considered an example of resistance to free association (Inderbitzen 1988: 677). This includes events such as forgotten appointments, walking out of sessions or deciding to quit the analysis (Roughton 1993: 446), whistling, removing shoes, lateness (Paniagua 1991: 676), falling asleep (Kanzer 1958: 466, Eissler 1958: 231), smoking, sucking, (Ticho & Richards 1980: 624), bringing a pillow (Myers 1982: 471) or exaggerated movement (Myers 1987: 646-650, Waugaman 1987: 861). These seem to be precluded from free association; as Harris and Aron have commented, the fundamental rule contains the explicit message to 'say everything' together with the implicit message 'do not act out' (1997: 533). Although acting out is sometimes thought to be a resistance to free

association, it is sometimes considered a communication (Freud 1913: 138, 1914b: 150) and part of free association (Treurniet 1997: 606-607).

2.7.4 Resistance analysis

Resistance, in its various forms, is responsible for failure to comply with the fundamental rule, yet paradoxically some such as Loewenstein (1961: 2) and Boesky (1990: 574), believe there could be no psychoanalytic process without analysis of resistance.

Initially, under the topographical model, Freud emphasised helping patients to comply with the fundamental rule by overcoming resistances through interpretation (1912a: 101). In the later structural model, free association was geared towards understanding resistances (Erard 1983: 64). Freud says that the technique evolved to one where the analyst uses interpretation 'mainly for recognizing the resistances which appear there, and making them conscious to the patient' (1914b: 147). Freud emphasised the need to 'overcome' resistances (ibid) but simultaneously wrote that the analyst must 'allow the patient time to become more conversant with the resistance, to work through it' (1914b: 155). This seems to foreshadow the work of resistance analysis, advocated by ego psychologists such as A. Kris, Gray and Busch.

Many such writers (Hartmann 1951, Gray 1982, Apfelbaum & Gill 1989, Busch 1992) think that in his later technique, Freud continued to focus on overcoming resistances, rather than analysing or investigating them (understanding the way the patient avoids compliance with the rule and the reasons for this). The following statement by Freud shows this to be the case: 'we bring forward logical arguments against it [resistance]; we promise the ego rewards and advantages if it will give up its resistance' (1926: 159). Busch believes that Freud implies 'working through' only in the sense that resistances were not entirely by-passed, and thinks that Freud left it to others to highlight the importance of resistance analysis (1992: 1094). Brenner takes a different position, claiming that Freud's 'working through' is actually analysis of the

transference, which is a form of resistance (1987: 102). Davison, Pray & Bristol build on this; 'working through' implies understanding resistances, and not overcoming them (1990: 602-603). However, the past two decades have seen a rise in interpersonal theories, which place less emphasis on resistance analysis (H. Friedman 1998: 1266). Despite the debate over Freud's position, we will later see how the general trend of resistance analysis has led to proposals for changes in the fundamental rule.

2.7.5 Ego distortions

Some of the difficulties in complying with the fundamental rule arise because of patient's ego or developmental distortions (S. Abrams 1981: 268). Isay gives us an example from the speech of a patient with obsessional character structure: 'I am thinking how, you know, that uh ... like my extreme behavior ... and then there... here... like... that, uh ... people sort of... that come around have.' (1977: 441). This shows that some patients with ego distortions cannot free associate in a manner that is understandable and communicative of affect. This view is consistent with R. Spiegel's comment that modification to free association often arises in response to a wider range of patient-difficulties (1970: 50).

In a paper 'The Central Phobic Position: A New Formulation of the Free Association Method' (2000), Green argues that distortion in free association is in some cases due to fear of an excess of associations rather than due to resistance (2000: 431). He gives a clinical example of a chronically anxious patient, Gabriel, who avoided spontaneous thinking because he dreaded the prospect of where his associations might lead to (2000: 431-435).

2.8 EXCEPTIONS TO THE FUNDAMENTAL RULE

Many analysts have argued that the rule should be waived for some patients. Laforgue observes that if forcefully applied, the rule may lead to a premature termination of the analysis or the use of the rule as a pretext for offering complex resistances (1936: 369). Therefore, in working with patients suffering from obsessional, character, or masochistic neuroses, the rule should be suspended (ibid). Levy advocates excluding the rule for severe obsessionals (1958: 50) and Federn omitted the rule at the onset of psychotic depression and mania (1934: 210). Shapiro suspended a patient's use of free association when he discovered she was 'in the throes of a psychotic depression' (1984: 13). Eissler writes that the rule cannot be used with 'the schizophrenias' since it might induce a premature regression, or with 'the delinquencies' since the patient will refuse to obey it (1953: 113). Fromm-Reichmann omits the rule with 'psychoneurotics' and borderline patients since it poses the risk of disintegrated thinking (Eisenstein 1951: 302). She does not ask the patient to lie down or free associate, but such patients should feel free to sit or lie wherever they feel sufficiently secure to abandon 'defensive narcissistic isolation' (Fromm-Reichmann 1939: 421). R. Spiegel believes that free association is not suitable to depressive patients (1965: 35, 1980b: 329). She is concerned that free association promotes an intellectualized evasion of feeling (1980a: 612-3); her method is to inquire into the nuances of feeling states - the patient's 'marginal thoughts' - particularly with obsessional patients (1977: 375).

Notwithstanding the analysts who make exceptions to the rule, there are others such as Volkan (in Porder 1993: 290) and Green (2000) who continue to apply the fundamental rule with borderline patients.

2.9 REJECTION OF THE FUNDAMENTAL RULE

While some analysts use the rule flexibly and sometimes waive it, others reject it entirely. Some have considered substituting free association for other techniques because of its difficulties or because it is inconsistent with their theoretical perspectives.

Jung, despite an early use of Freud's free association in the case of Sabina Spielrein, came to rule it out as a technique (Hoffer 2001: 122). By the time of their split in 1913, Jung came to view Freud's free association in the analysis of personal complexes as reductive, limiting, and backward looking, and thought that it imperils the patient by creating confusion and a regressive dependency on the analyst (ibid: 124). However, Jung did not remain in the psychoanalytic mainstream, and analytical psychologists have adopted the technique of 'amplification' [2] (P. Friedman & Goldstein 1964: 206; Aron 1989: 117).

Zetzel (1966) and Greenson (1967) have put forward concepts of the working and therapeutic alliances, which necessitates deviation from the fundamental rule (Kanzer 1981: 79). Zetzel's 'therapeutic alliance' stresses early aspects of development and the mother-child dyad (1956: 169-171). This inclines towards a maternalizing intervention – supportive measures akin to a good parent (Curtis 1979: 188) - which substitutes for the fundamental rule (Blum & Simons 1981: 647-8). Greenson's 'working alliance' focuses on the realistic aspects of the analytic relationship, and his interventions 'alternate' between these realistic aspects and the fundamental rule (ibid). On the other hand, Curtis implies that the fundamental rule need not be substituted since free association is the channel of intrapsychic phantasy, of transference material (as in Zetzel's system) and of 'meanings and motives' in the real relationship (1979: 188). A. Kris (1982: 26) and Kern (1995: 409), who believe

[2] Amplification is not a connected chain of associations but an expansion of dream content. It is distinct from free association since the associations are given by the physician as well as the patient (Jacobi 1959: 80-81).

that the therapeutic alliance is a joint effort, echo this; they are concerned to expand the patient's free associations rather than oppose them.

Spence (1982) argues that real free association and free-floating attention are impossible, and it may be analytically ineffective since patients cannot convey the images and perceptual experiences through words (Shengold 1985: 240-241, Sass & Woolfolk 1988: 432, Siegert 1990: 163). He believes that free association, thought to help reconstruct the past, is non-existent given that the past is constructed in the here and now (Kermode 1985: 9). Although he recommends that free-floating attention be dropped in favour of active, expectant listening (Shengold 1985: 240-241), he does not seem to propose an alternative to free association.

Hoffman argues that free association applies to the traditional paradigm; the patient could report whatever came to mind as the analyst was 'not really a person' (1998: 796). In his model of social constructivism, he replaces, to a degree, free association with the 'free emergence of multiple transference-countertransference scenarios', which are reflected on and interpreted as the analysis proceeds. Fosshage also proposes an abandonment of free association since 'persistent attempts to isolate elements in the patient's waking mentation for associational purposes would detour and disrupt the patient's waking communication' (1987: 306). Kohut, originator of self-psychology, was led away from the free association method, with his focus on empathy and introspection (Aron 1989: 117). Kohut continued to employ free association, although as an 'auxiliary' tool, in the service of his method of empathic observation (1959: 462-464). Balter & Spencer claim that Kohut may not have intended to devalue free association, but this is in fact the outcome (1991: 361, 367, 391).

Sullivan's 'detailed inquiry' (1954: 81) is considered another alternative to free association to collecting material. It entails unfocused questioning about the patient's interaction with others, past and present and in reality, phantasy, and dreams (Levenson 1987: 208, 1996: 640). Variations of Sullivan's detailed inquiry include

Levenson's 'detailed deconstructive inquiry' (1991: 182) - viewed as the interpersonal equivalent of free association (Gill 1993: 402, 1994: 100) - and Chrzanowski's 'collaborative inquiry' (1980: 354) in which the analyst is as free to provide data as the patient.

Inquiry as a technique seems antithetical to the spirit of the fundamental rule since questioning introduces outside influences into the free association process. Freud (1909) indicates that he obtains details through questions, which he uses to expand on the patient's free associations (Moses 1992: 305). However, questioning seems to tamper with the fundamental rule since the analyst uses it as a technical intervention which can influence the patient's associations (Curtis 1996: 572, Olinick 1954: 62). As Levenson notes: 'Even the most parsimonious request for 'what does that bring to mind?' reveals the therapist, who must choose when to ask even that presumably neutral inquiry' (1996: 640-1). Glover remarks that 'If analysts made a fetich [sic] of the association rule it would be inconsistent of them to ask questions.' (1955: 302).

Some (Olinick 1954: 57, 62; Moses 1992: 301, Lionells 1992: 320) generally omit questioning. Others like Eissler (1953: 109) and Boesky (1989: 602) regard the question as a type of communication and as a central analytical tool. They believe it is complementary to free association since it can help expand and explore the patient's associations (ibid, Moses 1992: 302, 305). Some analysts imply that although questions interrupt free association, they use them sparingly when certain conditions apply. This includes instances when the patient misuses free association (Loewenstein 1958: 206), and when free association has not provided sufficient detail as in the case with patients who are not analytically minded (Stern 1992: 328). Olinick finds limited questions to be suitable in cases of inarticulate borderlines, anxiety states, obsessionals, and psychotics (1980: 107-108), which is consistent with the belief that these groups are unable to free associate.

Questioning, however, does not seem to have replaced free association as the chief psychoanalytic method. Even Sullivan, for whom the 'detailed inquiry' holds importance, does not eschew free association (1954: 85); in the next section we will see how he explains free association to his patients.

It seems that in spite of the arguments for suspending or replacing free association, most writers in the literature find free association to be very important to the analytic process. This view will be tested empirically in the chapters to come.

2.10 MODIFICATIONS TO THE FUNDAMENTAL RULE

In addition to these infrequent proposals of alternatives to free association, there appears to be three types of modification to the fundamental rule. One proposal for change is that the rule should be more flexible because of its authoritarian tone, and that free association should not be presented as a strict rule. Another appeal is that the rule should incorporate resistance analysis, which means that patients should be instructed to observe their resistances to free association. Thirdly, it has been argued that the scope should be widened beyond 'thoughts, feelings and memories' to include other associations and different types of communication such as drawing and bodily movements.

2.10.1 Modification: reduce authoritarian impact

Many have observed the authoritarian (Kanzer 1972: 260, Blum 1981: 548, Busch 1995a: 463, Havens 1997: 525) and obligatory (Havens 1980: 53; Joseph 1990: 95) nature of the fundamental rule as it was first formulated. Freud's writings on this topic contain numerous injunctions: 'he must', 'it is necessary to insist', 'we instruct the patient', 'warn him', 'pledge him to obey', 'we urge him always to follow', and 'you have promised to be absolutely honest' (1900a: 101, 1913: 134, 1917: 287, 1924: 196, 1940: 174). The authoritarian tone is evident in a passage where he requests a

patient 'to account for having broken the sacred rule' (1917: 288). Thompson believes that it is the 'promise' to be candid that characterises the fundamental rule; Freud believed that a rule was necessary for the analytic experience because non-compliance revealed transference resistance (1998: 706). However, A. Freud remarks that the fundamental rule has occasionally been criticised for being a needless authoritarian signal and a coercion on patients to express what they would prefer to keep private (1972: 152). Busch believes that free association continues to be dogged by its authoritarian origins (1995a: 463).

We have seen that the fundamental rule entails a relaxation of the patient's observing superego with the analyst taking over that role (Blum 1981: 549-550, Olds 1992: 441). Freud explains that analysts lend themselves as models of superego operation in the service of strengthening patients in their quest to analyse fears of their drives and of their own, more primitive, superegos (1940: 172-175, 181). Freud also warns against the temptation of analysts to misuse their superego's power over patient's ego; he advises analysts to respect the patient's individuality (ibid: 175). Despite Freud's note of caution, Burke believes that anxiety is provoked when analysts lend themselves as superego models, increasing the patients need for defences, and resulting in acting out (A. Freud 1949: 200). The fundamental rule, Burke claims, cripples and may even ruin the process of analysis. It is contrary to the natural law according to which psychic material is continually repressed; the rule arises not out of a real necessity, but from counter-transference that would better be avoided (ibid).

Kanzer observes that the enforcement of the rule invokes appeals to the superego insidiously by substituting the 'external figure of the infallible analyst' with the patient's own responsibility and conscience (Kanzer 1972: 257-8). Breaking the fundamental rule, through failures in free association, can become a source of guilt (L. Spiegel 1975: 380) and threatens continued illness as punishment for breaking it (Kanzer 1972: 258). Blum perceives Freud's words 'never forget that you have promised to be absolutely honest, and never leave anything out' (1913: 135) as

suggestive of a court oath (1981: 548). Gill implies that a 'rule' is antithetical to the analyst's goal of neutrality (1994: 79). Epstein finds that the fundamental rule addresses the superego and provokes its resistance. He proposes an alternative label – the 'fundamental condition' - which is aimed at addressing the ego and enlisting cooperation (in Mahony 1979: 157).

Some authors argue that the fundamental rule is detrimental to the patient's rights. In Stone's view, the injunction deprives patients of the 'civil right' to withhold their thoughts (1961:21, 1981:92). A. Freud finds that several analysts echo this is complaint (Sandler & A. Freud 1985: 8). Joseph maintains that the fundamental rule inhibits the development of autonomy and subsequent capacity for self-analysis (1990: 98). Modell (1988: 592) believes that it is irreconcilable with the need to protect the privacy of self. Blass has also argued that it is sometimes appropriate for the patient not to speak (2003: 1283). Ogden similarly thinks that it is essential for patients to realise that their freedom to be silent is as great as their freedom to speak, and believes that the rule risks provoking a pathological relationship if it is imposed strictly (1996: 889). Little recommends flexibility in the rule. She gives patients 'permission' to speak or to withhold thoughts freely (1951: 39). In a reciprocal way, she thinks that the patient should allow the analyst to say some things but should be free to reject the analyst's views. She comments that overall, this mitigates the 'didactic' or 'authoritarian attitude' (ibid).

Laforgue also advises against strict enforcement of the fundamental rule, demonstrating that analysis can proceed successfully without the analyst knowing everything (1937: 40). For certain patients, the rule might cause difficulty, and overall, Laforgue conceives the rule as an elastic formula, to be interpreted liberally and not as an orthodox rule (ibid). J. Spiegel adds that it is neither necessary nor often feasible to impose the rule, since patients will mostly speak freely without an order, and they would not have to worry about being 'good' patients (1988: 386). However, like Laforgue, he does not explain whether, or how, he presents this to the patient.

Brenner (1985: 266) and Pulver (1995b: 646) note that many analysts have adjusted their presentation of the fundamental rule in keeping with their objection to the authoritarian tone, and do not announce the fundamental rule in the traditional sense. Aron does not invoke the fundamental rule in the traditional, authoritarian way, but does employ free association: 'Although I do not tell my patients that I require them to say everything that comes to mind, I do nevertheless expect them to do just that to whatever degree they can.' (1995: 223-4). Similarly, Boesky finds that few analysts still announce to patients the fundamental rule; instead, he indicates to patients that they should say whatever comes to mind, and draws their attention to subjects they have omitted (1990: 574).

Greenson adjusts his presentation of the rule in view of its authoritarian undertone. He offers a simple description of free association (he reasons that very lengthy explanations can overprotect the patient) at an appropriate time, explains its purpose (that it provides important clues to early experiences) and then takes questions. He tell patients that free association entails

> *trying to let your thoughts drift and to say to the best of your ability whatever comes into your mind. This is not easy because that means saying things which may be illogical or embarrassing or trivial or seemingly irrelevant (Seidenberg 1971: 102).*

Although he finds that it does not eradicate all difficulties of the fundamental rule, he contends that this curbs patients' anxiety, and reduces the extent to which the analyst is regarded as omnipotent. Flexibility and experimentation are encouraged, and if patients have doubts about this procedure, Greenson waits until they are ready (ibid: 103).

Ogden is also against framing the rule in an authoritarian way. His solution is to put across the following version:

> *I view our meetings as a time for you to say what you want to say, when you want to say it, and for me to respond in my own way. At the same time, there must always be a place for privacy for both of us (1996: 889-890).*

Similarly, Altman informs the patients that they may 'say anything' (1976: 58-59), and Gill, who objects to giving instructions, simply declares: 'I would like to hear what's on your mind' (1994: 99). Lichtenberg prefers the patient to follow a general 'working principle' as opposed to a 'basic rule' because it is less likely to bring on feelings of failure or guilt at not complying and it might prevent rebellious resistance (1985: 48). As part of the working principle, Lichtenberg explains to patients what is required of them, arguing that the benefit of patients' relative clarity about the procedure outweighs the loss of spontaneity (Lichtenberg & Galler 1987: 72).

Clarification of the rule, implicit in Lichtenberg and Greenson's approach, has become important to some analysts. According to Pulver, the degree to which analysts spell out the fundamental rule to the patient in practice varies greatly (1995a: 11). He hints that there is some controversy over how extensively the analyst should explain free association, but that analysts generally find some explanation to be helpful (1995a: 12). Demystification of the rule for patients implies that analysts give a formal explanation of the rule as opposed to no instructions at all, and typically, this is done in a way to avoid an authoritarian impact. As an example, Busch emphasises the need for presenting the purpose and guidelines of free association for effective work, since: 'Analysands do not come into analysis spontaneously attempting to use the method of free association' (1997a: 42). He implies that there is a way of presenting the rule in a way that enlists the help of the patient instead of appearing doctrinaire. He puts this to patients in the following way: 'If we listen carefully to your associations in a variety of ways, we can learn about the conflicts that brought you into analysis' (1995a: 455). This, he believes, is not to be confused with intellectualization of the analysis; rather, as Gray (1994) points out, making free association explicit helps to enlist the patient as a co-participant (Busch 1997a: 43).

Busch dislikes how some analysts do not give instructions (ibid: 42). He also finds that demonstration of free association - listening to patient's verbalizations and asking them to expand on certain associations - inadvertently encourages a regressive relationship, thus perpetuating an authoritarian tone that it sought to avoid (ibid: 44). The technique he criticises is used by Sullivan; he discusses free association only once the patient has had the experience of speaking at random: 'the psychiatrist should try to get something to happen, that he can then refer to as having happened, instead of telling the patient to say every littlest thing that comes to his mind' (1954: 85).

In the spirit of clarification, some (for example Joseph 1990: 102 and Pulver 1995a: 11) explain to patients the purpose of the couch, and some, like Greenson illustrate free association with a metaphor (Seidenberg 1971: 102). Joseph also chooses to clarify the method to patients. He tells them: 'your treatment will be most helpful if you try to put into words whatever you experience of whatever come to mind' (1990: 102) and also explains to them how the frequency of sessions, use of the couch and free association help to lift unconscious material into the foreground to permit analytic understanding, insight and growth (ibid). Etchegoyen also likes to be unambiguous and precise about the contract (1991: 64, 67, 68). He presents the fundamental rule in few words and phrases it as a possibility rather than an obligation: the patient 'can say everything he thinks; at the same time, he should know that the analyst hopes that he will not keep things to himself, that he will speak without reserve' (1991: 68). He thinks that it is democratic to be explicit about the work so that both parties have a clear idea of the treatment (1991: 61). At the same time, he recognises that the contract implies great responsibility. Thus, he feels a statement such as 'you can say everything you think, and you have the right to remain silent' gives the patient too much freedom (1991: 68).

Some analysts, including Greenson (1971: 102) and Etchgoyen (1991: 68), quoted above, think that the rule should mention that it is difficult to follow. This seems to be consonant with clarification of the method to patients and with the

practice of resistance analysis. It is thought that phrases such as 'I understand that the task of saying everything that comes to mind is a difficult (or impossible one)' can eradicate the patient's sense of failure (Lichtenberg & Galler 1987: 74, Newton 1989: 41, Busch 1994: 367) and reduce the authoritative, guilt-inducing tone (Lichtenberg & Galler 1987: 74).

Schafer worries about the risk of the analyst as a corrupt superego and argues that the analyst's choice of words is important. He tries to convey a sense of responsibility on the patient, so he avoids the expression 'what comes to mind?' which presumes passivity. He is also intent on bringing resistance to the fore. He reformulates the rule with these considerations in mind:

> *I shall expect you to talk to me each time you come. As you talk, you will notice that you refrain from saying certain things. You may do so because you want to avoid being trivial, irrelevant, embarrassed, tactless, or otherwise disruptive. It is essential to our work that you do this as little as possible. I urge you to tell me of those instances of selection or omission no matter what their content may be (1976: 147-148).*

Pulver, describing the technique employed by most contemporary American practitioners, indicates that the presentation of the rule serves to inform patients of the likelihood of difficulty:

> *He is alerted to the fact that while this may seems easy, in fact it will turn out to be difficult. Inevitably he will feel that some things are irrelevant or embarrassing or trivial and will be tempted not to talk about them. He should do his best to talk about them anyway but should also realize that free association, while it is called the fundamental rule, is not in any way a moral imperative. It is simply the best way to begin in the attempt to get the job done...no one is able to free-associate continually and constantly. (1995a: 11).*

However, Ogden believes that whilst it is important to introduce the patient to the peculiarities of the analytic dialogue, a softened version, informing patients about the impending difficulty, is unhelpful (1996: 889). He prefers to open a session by saying nothing or by asking the patient 'Where should we begin?' (ibid).

2.10.2 Critique of modification to reduce authoritarian impact

Gill too, avoids an authoritarian presentation by not giving explicit instructions to patients. However, he believes that most of the attempts at circumventing authoritarianism reflect the misconception that an individual's experience can be influenced by altering the rule's wording. He argues that the 'underlying attitude' of the analyst is what is most important; if the analyst behaves democratically, the patient will experience the analyst as such. He believes that if patients regard the fundamental rule as an authoritarian demand, then the analyst should respond by interpretation rather than by relaxing the fundamental rule or insisting on it (1994: 95, 99).

Other analysts have no difficulty with the authority inherent in the fundamental rule. Kernberg is a case in point, arguing that analysts exercise a legitimate authority in establishing a frame for psychoanalytic treatment including free association; their training and knowledge are validated by psychoanalytic education, and by the recognition of the scientific status of psychoanalysis (1996: 142). L. Grossman takes a similar stance, asserting that it is reasonable for analysts to make suggestions about the fundamental rule and the couch, given their expertise in these procedures. He believes that although analysts do not dictate conditions, they should hope that their 'authoritative (not authoritarian) statements' have some influence (1996: 688). Equally, Newton contends that authoritatively assigning the patient a task can enhance effective collaboration, rather than alienate the patient (1989: 32). E. Kris also opposes modification to the rule in the direction of permissiveness, arguing that it would not produce a useful organization of associations (1956: 445).

Overall, the literature reveals numerous solutions to the problem of the authoritarian impact. The different approaches range from not introducing the rule, to giving a full explanation in the name of clarity. It is difficult to get a sense of which approach prevails amongst analysts today.

2.10.3 Modification: incorporate resistance analysis

Another view, propounded by many ego psychologists, is that the rule should be modified to incorporate resistance analysis. Many thinkers insist on the value of resistance analysis to the analytic process (for example Reich 1933: 27, Fenichel 1941: 43, Hartmann 1951: 39, Loewenstein 1967: 801, Spruiell 1983: 18, Weinshel 1984: 74, Lichtenberg & Galler 1987: 48). Resistance analysis involves two processes: the analyst interprets resistance before content, and patients reflect on their resistances to following the fundamental rule. Loewenstein comments that the need for the patient and analyst to observe the patient's resistance to verbalise thoughts has resulted in amendments to the way that analysts present the fundamental rule (Seidenberg 1971: 102).

Gray (1982, 1986), Busch (1992, 1994, 1995a) and A. Kris (1992) think that ego psychology has not been fully integrated into the fundamental rule, and call for resistances to be brought to centre stage in the associative process. They believe that the focus of free association remains on circumventing patients' resistances - lifting repression or removing the ancillary defences that supported repression - rather than understanding them (A. Kris 1992: 214). They think the analyst should, in consequence, observe the process of free association including the form of speech, sequencing of thoughts, and pauses (where resistance is in operation), in addition to the content which traditionally has been the focus. These ego psychologists are not alone on this matter, since others (Gedo 1981, Bucci 1988) find attention to the form of the patient's communications including vocal intonation (Mawson 2002: 511) to be of great value.

Some analysts call for the rule to be presented to convey an understanding of resistances. This is a departure from Freud whose instructions on free association were not orientated to self-reflection (Busch 1994: 372). Loewenstein (1963: 455), Busch (1994: 368) and Newton (1989: 41) expect patients to observe their ambivalence towards perceiving or voicing the emerging thoughts. Gray helps patients to observe their resistances in action (for example, when they pause after voicing a disturbing thought), and to get them to understand the causes for the resistances (1990: 1092).

Some make self-reflection explicit, like Pressman, who proposes a 'fundamental rule amended' (1969: 190). This means stating to patients the rule of free association ('Say everything that occurs to your mind without criticism') plus the cognitive rule ('and reflect on it, using it to enlarge your knowledge of yourself and of your problems') (1969a: 189, 190). Busch deems resistance analysis to be a necessary addition to the basic rule, put across in whatever language and in whatever timing is felt appropriate (1994: 370-1). Lichtenberg & Galler (and A. Kris 1982) recommend explaining to the patient that they will invariably experience reluctance to reveal their associations but that these actually provide the opportunity for psychoanalytic explorations (1987: 72). Such explanations simultaneously demystify the analytic process. Davison, Pray & Bristol convey to patients in initial instructions that sensing resistance is an important function since it shows the patients the area needing attention (1990: 612). They justify their approach as 'pragmatic, congruent with analytic theory, and finds correspondence in our analytic work' (ibid).

2.10.4 Critique of modification to incorporate resistance analysis

Two significant criticisms have been lodged against the incorporation of resistance analysis into the fundamental rule. First, the self-observing function has been criticised. It is difficult to relay what is on one's mind and simultaneously observe oneself resist. As Busch informs us, most patients in the beginning of analysis

have limited abilities for self-reflection (1995a: 455). Secondly, the consideration of the free association in light of resistance analysis takes place within an ego psychological framework that is one-person and objective (H. Friedman 1998: 1262). Freidman believes that despite their prolific writings on the subject of the fundamental rule, Busch's and Gray's positions do not resonate with many contemporary analysts who focus on the interpersonal and subjective quality of the psychoanalytic dyad (ibid).

On the other hand, Pulver, claiming to represent the average American analyst, acknowledges the importance of resistance analysis. Pulver believes that the patient should be informed that:

> *Everyone, usually sooner rather than later, avoids saying what comes to mind. An understanding of the ways he avoids doing so and the reasons for that avoidance is as important a part of the analysis as the content of the thought itself. (1995a: 11).*

Thus, there are conflicting views about whether analysts' presentation of the fundamental rule incorporates resistance analysis or not.

2.10.5 Modification: widen types of associations

There has been another direction of change in the fundamental rule towards expanding associations. Freud lists three types of associations that patients are encouraged to verbalise - thoughts, feelings, and memories (1917:287). An increasing trend has been to suggest the patient verbalise wishes, phantasies, sensations, and images (for example A. Kris 1990: 26). Feigelson finds it important for the patient to report all mental experiences including emotions or lack of emotions, daydreams, night dreams, bodily sensations, and visual images (1978: 365). Rather than instructing patients to say 'whatever comes to your mind', his formal presentation of the fundamental rule includes the instruction to report all mental experiences: 'He [the

patient] should be told that he is to tell about all those types of mental experience as he observes or experiences them.' (ibid).

In a general summary of technique employed by mainstream American analysts, Pulver lists the following as possible free associations: 'early memories, dreams, bodily sensations, traumas, motivations, phantasies, thoughts, imagery, and characterological ways of behaving' (1995a: 11). This hints that American analysts have indeed widened their scope of associations, but it is uncertain whether they explicitly state this to patients.

Many references to the scope of free association, whilst not explicitly requesting different types associations, do not preclude them. As an example, Lewin writes about associations 'no matter from what source, or what the form or content' (1955: 185). It is possible, that Freud too has made allowance for these types of associations, indicated by his remark that 'it must theoretically always be possible to have an association, provided that no conditions are made as to its character' (1925: 42).

Some arguments have been put forward for including nonverbal material as free association, for example noise, body movement and drawing. Wimer Brakel in a paper *Shall Drawing Become Part of Free Association?: Proposal for a Modification in Psychoanalytic Technique* argues a case for pictorial representation to be included as an association (1993: 359-394). For her, a session would proceed in the standard way except that paper and pencil are available and the opening instruction to free associate would be 'to communicate whatever comes to mind' (1993: 374). Others (Ferenczi 1931: 474, Erickson & Kubie 1938: 463, Shane 1977: 97, Karp 1997: 267) have also referred to drawing as a part of free association. Scott thinks that the rule should be changed sometimes so that noises from patients may be accepted (1958: 111). He has experimented with a new rule: 'Try to talk, etcetera, and if you can't talk, try to make some kind of noise, and if you don't know what kind of noise to make just guess.' (ibid: 108). Mahony believes that current formulas using 'say',

preclude the possibility of sounds. He suggests that instead the rule should be worded in this way: 'The progress of your analysis depends on how much you give voice to (express) all that comes to you" (1979: 183-184).

In other examples of widened associations, Lichtenberg encourages bodily activity and nonverbal signs (1985: 49), Gedo believes whistling is suitable for particular patients (1981), and Balint entreated a patient to perform a somersault (1968: 128-131). However, in some of these instances, such nonverbal communication is used when free association fails, as with acute obsessional depression (Erickson & Kubie 1938: 463), schizoid traits (Kernberg 1983: 263), or chronically psychotic patients (McLaughlin 1975: 372).

It has been observed that modern British analysts are increasingly giving space to nonverbal associations (Garland 2002:507, Mawson 2002:511, 515), even though, as we have seen, some analysts would label these as resistance. Analysts commonly note the form, as well as the content, of the associations including rhythm, force, and silences (Bronstein 2002:479). O'Shaughnessy says it is widely accepted that patients relay their mental states beyond verbal associations; feelings such as anxiety, hate, excitement or tiredness (1983: 281) can be conveyed by projection, introjection, identification, symbolism and transference (Garland 2002: 492). Examples of nonverbal material are abundant in the literature. They include: body language (Reich 1933, Deutsch 1952: 196-214), the manner of associating such as tone of voice (Balint 1950: 118, Brenner 1985: 226), motoric actions such as sitting up, changing position on couch (Balint 1950: 118, Brenner 1985: 226, Busch 1995b: 63), and change of mood and affect (Loewald 1975: 292, Ticho & Richards 1980: 624, Brenner 1985: 226).

Yet, these authors appear to conceive free association as both verbal and nonverbal material. They do not seem to incorporate this into the fundamental rule; they do not instruct the patient to produce material such as body language or transference. However, it remains the case that some analysts have widened the scope

of the rule to include associations such as dreams, images and sensations. Indeed, Lichtenberg & Galler recommend this addition to their readers (1987: 73). It is of interest to discover to what extent analysts today take this approach.

2.11 RESEARCH CONTRIBUTIONS

So far, we have seen the conflicting views of the fundamental rule and the variations in how it is presented. We now turn to the studies that have shed empirical light on this matter. Research into actual analytic practice regarding the fundamental rule is limited to two investigations – Glover (1955), and Lichtenberg & Galler (1987).

2.11.1 Glover

Glover conducted empirical research between 1932 and 1938 on the topic of analysts' actual practice. He sent out questionnaires to twenty-nine practicing analysts on various aspects of their technique, and received twenty-four replies. He did not find the absence of five replies to have distorted his results. He did find, however, that some questions were left blank and some questions were supplemented with justifying statements, which to him, indicate the operation of 'guilt' and 'timidity' (1955: 266).

With the small number of replies, Glover reasons that formal statistics could be omitted in favour of noting general trends. Thus, agreement in at least two-thirds of replies was taken to signal a 'general habit, tendency or practice', a minority of at least one-third represented a 'strong body of opinion', and strongly expressed opinions were given 'special consideration' (1955: 267). He adds that the results may hold for the period until 1946, as he believes no new advances had been made since (1955: 266n).

He devised five questions intended to elicit information on the fundamental rule, the first of which was ‘Do you keep strictly to the free association rule or permit (advise) relaxations of it?’ (1955: 300). He found that a ‘majority’ permit relaxation of the rule, and several answers showed that it is impossible to prevent relaxation. A ‘minority’ adhered unswervingly to the rule, but said that it sometimes has to be relaxed. A few respondents hint that they mainly abide by the rule, but relax it for specific reasons such as when they find it to be of ‘special difficulty’. Two analysts never advise relaxation, and two both permit and recommend it. One respondent believed that it was unnecessary to recommend the rule to the patient at all (1955: 300).

Closely linked to this was the question: ‘Do you abandon the association rule in certain instances, holding the patient to one thread until you have constructed a phantasy piece-meal?’ He found that half of those surveyed sometimes abandon the rule, and one-third encourage expansion of phantasies. These replies, Glover says, are congruent with the preceding question that analysts relax their use of the rule (1955: 301).

A third question asked whether analysts interpret based on ‘isolated’ words or actions or whether they wait for confirmation from associations. The results showed that a ‘majority’ occasionally interpret from details without waiting, while one-third claim they always wait for confirming associations (Glover 1955: 301). Again, this illustrates a tendency for analysts to relax their use of the fundamental rule.

A related question was ‘Do you ask direct questions: (a) about matters of fact, e.g. family history; (b) about matters of phantasy; (c) about emotional reactions?’ Glover believes that this question is another way of discovering how strictly analysts obey their own rules, since questioning is inconsistent with the fundamental rule (1955: 302). The findings were that a ‘majority’ ask questions freely, while others do so only occasionally. Some report that they never ask questions in the beginning of analysis (1955: 302). Glover concludes that analysts are not slaves to the rule.

A final question was 'Do you favour adopting any form of play technique in adult analysis (e.g. providing paper and pencil, etc.)?' This is the only question that seems to measure, in a roundabout way, modification to the way the rule is expressed. Glover discovered that a 'majority' did not object to doing this although only one-third believed this necessary or did so in practice, and limited it to measures such as writing, drawing and producing diagrams (1955: 303). Glover has remarked that 'in earlier times' the fundamental rule would be strictly adhered to, and that there would be a 'conservative reaction' against changes such as providing paper and pencil for writing, drawing, and diagrammatic illustrations since this widens the scope of expression from merely the verbal to include the affective (1955: 303). Yet his findings imply that analysts have accepted the wider scope of free association, even if they do not themselves use these techniques.

Glover's five questions show that as early as in 1938, analysts were not keeping strictly to the letter of the fundamental rule. Glover's findings of 'relaxation' seem to include the fact that analysts suspend their use of the fundamental rule (for example to construct a phantasy or to give interpretations), make exceptions for certain patients, and modify the rule to include play technique such as drawing.

2.11.2 Lichtenberg & Galler

The most significant research to date on the current usage of the fundamental rule is Lichtenberg & Galler's survey of forty-nine analysts ('eminent teachers' all of whom contributed to psychoanalytic journals) by questionnaire between 1982 and 1983. They sought to discover how analysts present the rule to their patients and what considerations led them to handle this issue to way they do. They found great variation in the wording, the form (fixed or flexible) and the timing[3] of the rule.

[3] six analysts addressed it in consultation period, seven just before the couch session and eight presented it in the consultation and then elaborated upon it later. Thirteen analysts spoke of the rule whilst addressing the goal of psychoanalysis with the patient, sixteen presented it separately from the

Respondents were either interested in developing a basic framework from which the emergence of resistances could be observed, or in creating a spirit of cooperation and mutuality. Within this division, some preferred minimal explanations, for example, 'say whatever comes into your mind', and some preferred more lengthy instructions. Eleven analysts use a consistent presentation, and nineteen tailor the presentation to the individual patient. Only five respondents took Freud's words as the optimal model[4], while twelve expanded on Freud's words ('thoughts, feelings and memories' 1917: 287) to include body sensations, images and dreams as part of the associations, or to encourage patients to notice difficulties that they encounter in producing thoughts. This indicates that the rule has been widened to include nonverbal associations.

They write that 'many' analysts hint to their patients of the difficulty in free-associating, which may indicate a move in the direction of resistance analysis. Yet Lichtenberg & Galler do not specify how many conceived the fundamental rule in this last manner, which would show the extent to which suggestions by Busch and Gray to integrate ego psychology are reflected in practice.

Lichtenberg & Galler summarise that over the past fifty years there has been a trend in modification of the rule's presentation to mitigate the bias towards authority. They find that this change has been shaped by personal experiences and experimentation, or reading contemporary psychoanalytic literature (1987: 69). They discovered that the predominant tone of the fundamental rule is one of 'gentle exhortation' (1987:63) as opposed to applying strict rules. Respondents are prone to putting the rule across in the following ways: 'I want you to try', 'attempt to be as frank as you can' or 'I hope you will be able to express yourself as freely as possible' (1987: 63). This matches the trend in the literature of modification to the rule to reduce the authoritarian impact.

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description of psychoanalysis, and only three demonstrated the rule instead of giving a distinct explanation.

[4] six used metaphors, although only three of them chose Freud's metaphor of a passenger observing on a train.

Finally, Lichtenberg & Galler detect that analysts are torn between wanting to introduce new approaches in their practice and wanting to preserve psychoanalytic tradition and their own experience. This insight does not seem to be conveyed in the literature.

2.11.3 Critique of previous research

Glover's results, although revealing, suffer from two main drawbacks. The first is that his survey covered many topics and aimed to produce a general summary of analytic practice at the time. The small number of replies and the brief outlines of the findings do not make for a definitive picture of free association. Secondly, the questions, he admits were not optimally worded and may have been cause for misunderstanding (1955: 300).

Lichtenberg & Galler's survey offers an illuminating account of the use and views on the fundamental rule. Their findings seem to tally with the themes contained in journal articles and informal surveys presented in the literature. Busch, for example, discovers from his informal investigation of American colleagues that there are subtle changes in both the content and tone of the instructions given to patients since Freud's original description (1994: 364). He finds that many of his colleagues do not offer instructions to the patient in free association. He finds a philosophy of 'Let patients do what they will, and the analyst will work with whatever comes up.' (1997a: 42). These observations are congruent with Lichtenberg and Galler's results that there are changes to the way the rule is used, and that many analysts prefer flexible approaches to presenting the method of free association.

However, Busch is critical of Lichtenberg & Galler's survey methodology, referring to its 'skewed sample, giving variable responses (in terms of detail), [which] can only give one an impressionistic view of some analyst's current perception of how they practice' (1994: 364). In view of Busch's criticism, it seems possible to

provide a more comprehensive account of the fundamental rule. Although Glover and Lichtenberg & Galler's survey show changes in analysts' attitudes towards the fundamental rule, more work can be done to measure the shift. The two questions posed by Lichtenberg & Galler are the central ones guiding this research since they are suitable for investigating the current views of and use of the fundamental rule:

1. How, if at all, do psychoanalysts introduce to patients the fundamental rule?

2. What are their considerations for approaching the matter in this way?

By posing the questions not only to leading analysts, but also to all members of a psychoanalytic organisation, the fundamental rule can be assessed on a more representative basis. The postal questionnaires used by Glover and Lichtenberg & Galler can be replaced by the interview method which promises more accurate data. The responses to the questions can be analysed more rigorously by adopting a formal methodology; grounded theory methods combined with quantitative data analysis are ideal for this task. Finally, the sample population can be modified to account for differences in cultural factors. The literature would suggest that American and British psychoanalytical organisations are an appropriate sample population since their members are at the forefront of the debate.

In addition, the observations in the literature and previous two studies point to four hypotheses that will be tested:

1. Psychoanalysts consider free association to be 'fundamental'.
2. Psychoanalysts no longer consider free association to be a 'rule'.
3. Psychoanalysts still introduce free association to patients.
4. The introductions that psychoanalysts give to patients have been modified:

   a) to reduce the authoritarian tone.

   b) to include a reference to resistance analysis.

   c) to include associations other than 'thoughts'.

2.12 CHAPTER SUMMARY

This chapter described how Freud became acquainted with hypnotism and how he employed it therapeutically initially with suggestion, and later in the service of the cathartic method. It explained why Freud replaced hypnosis with the 'pressure' technique, and how that in turn evolved into a method resembling free association. It addressed the historical antecedents of the method, highlighting the thinkers who might have influenced Freud.

We have seen that free association rests on assumptions of psychic determinism, unconscious mental processes and, after the arrival of the structural model, intrapsychic activities. Free association also is conditional on an altered state of consciousness, the couch, and free-floating attention. Its process entails a suspension of ego controls, an oscillation between experiencing and observing portions of the ego, and a relaxation of superego functions.

Many accounts of free association regard it to be the cornerstone of the psychoanalytic process, and some believe that its importance transcends theoretical orientation. Most consider it a tool – a method of extracting raw data of analysis - which derives from, and points to, unconscious material. A few have drawn attention to the role of free association in promoting self-observation and in establishing

conditions for insight. Many also believe that it facilitates the development of transference, another crucial factor in psychoanalytic treatment.

Many observers have commented on the paradoxical nature of free association, and many more have drawn attention to the types of resistance to the fundamental rule. This chapter has explored areas of change to the rule in light of some of its difficulties. Some analysts exempt certain patients from following the rule because of their psychopathology. Others reject the rule altogether. Three main modifications have been advanced: to reduce the authoritarian implications, to incorporate resistance analysis, and to encompass different types of associations. However, the extent of this change remains uncertain.

We have reviewed two surveys conducted on this topic. Glover's investigation between 1932 and 1938 discovered that analysts take a relaxed approach to using the fundamental rule. Lichtenberg & Galler's survey (1982 to 1983) also revealed that the fundamental rule has been altered. Analysts, they discovered, have expanded the rule to include different types of associations and are increasingly using a tone of 'gentle exhortation' rather than setting absolute rules. These two studies resonate with accounts in the literature, although there are several ways to reach results that are more comprehensive. The hope is that by adopting different data collection methods and techniques for analysis, and by pooling from a different sampling frame, the current use of the fundamental rule can be assessed thoroughly. In the next chapter, we outline the methodological components in detail.

CHAPTER THREE: METHODOLOGY

3.1 CHAPTER OVERVIEW

This chapter explains all aspects of the research design including the assumptions brought to the research, the strategies for collecting and analysing the data, and the steps taken to legitimize the project. It also shows how a pilot study helped shape the eventual methodology. Table 3.1 below gives an outline of the components used in this research study.

RESEARCH COMPONENT	COMPONENT USED IN THIS RESEARCH
Theoretical framework	Interpretivism & psychoanalysis
Methodology	Qualitative and quantitative research
Method for data collection	Semi-structured interviews
Procedures for data analysis	Grounded theory methods (Strauss & Corbin) Statistical analysis
CADQA (computer-assisted data for qualitative analysis)	NVivo
Quality evaluation	Lincoln & Guba
Ethical principles	The British Psychological Society

Table 3.1 Structure of the research project

3.2 THEORETICAL FRAMEWORK

The research is mainly framed by an **interpretive** paradigm. Interpretivism is concerned with how the social world is perceived, interpreted or understood (Mason 1996: 4). Its underlying ontology is **relativism** which holds that there are multiple

realities and that each individual's way of making sense of the world is as valid as any other (Crotty 1998: 58, Denzin & Lincoln 1998: 27). Its underlying epistemology is **constructivism** which holds that knowledge and understanding are mutually created (ibid).

An interpretive perspective has some methodological implications which this study tries to incorporate:

- People and their interpretations, perceptions and reasoning processes are taken to be the primary data source.
- As far as is possible, a researcher needs to take the standpoint of those studied; the researcher must try to use the participant's own categories to capture their world of meaning.
- Non-directive interviews and participant observation are ideal methods because they are conducive to capturing perceptions and understandings.

(Denzin 1978: 99, Crotty: 1998: 75-76, Mason 2002:56).

In this study I assume that each psychoanalyst's way of perceiving, experiencing and interpreting is unique. I do not believe that as a researcher I can act as an unbiased, detached observer to discover the 'truth' about how analysts work with the fundamental rule; rather, I believe that my own expectations and biases will influence the results. I assume that there are several possible interpretations of analysts' behaviour and that the participants and I will mutually shape the research outcome. I also assume that participants react to the knowledge that they are being studied and may present a different version of their practice from that which actually takes place.

There is a significant problem with adopting interpretivism as a theoretical framework, namely that it is not a perfect match for the research question. For example, it is inconsistent with statistical analysis (Denscombe 22: 2002) which I

believe is helpful to the study. Also, although interpretivism takes into account internal stimuli, it does not place much emphasis on unconscious processes of behaviour and interaction (Brittan 1973: 190). This poses a difficulty since the research subject falls within psychoanalysis, and as a researcher in the field I find it difficult to ignore its basic tenets. For example, during the interviews I observed what appeared to be the mechanisms of defence, transference and counter-transference occurring between myself and participants.

The solution to this problem seems to lie in tailoring the paradigm to fit the research needs. Crotty finds such adaptation acceptable: 'every piece of research is unique and calls for a unique methodology. We, as the researcher, have to develop it.' (Crotty 1998: 13-14). Therefore, as well as taking a partly interpretive perspective, I have also viewed the participants and research process through the lens of psychoanalysis. Also, since I wish to apply statistical calculations and assume that data can be counted and measured, my perspective contains a measure of positivism.

3.3 QUALITATIVE METHODOLOGY

Although some quantitative procedures are used, this study mainly adopts a qualitative methodology for data collection and analysis. There are several features of qualitative research that make it suitable for the study:

- It is aimed at discovering the meaning that things have for the individuals who experience them, and the interpretations of those meanings by the researcher.
- The researcher is interested in process, meaning, and understanding acquired through words. Often quotes from participants are used in support of the study's findings.

- Data are mediated through the researcher rather than through inventories or questionnaires.

(Bogdan & Biklen 1998: 4, Merriam 2002: 5).

The study's aim is to describe psychoanalysts' thought processes and action - how they conceive of, and present the fundamental rule. The research questions seem best answered by rich description which a qualitative methodology can provide since its methods allow us to get close to participants' perspectives.

3.3.1 Grounded theory methods

There are five common types of qualitative research: biography, ethnography, case study, phenomenology, and grounded theory (Creswell 1998: 4). A biography or a case study would not be relevant since I wish to examine several participants rather than focus on a few. The research project does not merit phenomenological research, which closely examines the subjective experience of individuals, since it would offer greater depth than was needed. Ethnography is not suitable since confidentiality prevents a researcher from entering the 'field' to engage with analysts and patients during sessions.

A **grounded theory** is a theory that has been 'derived from data, systematically gathered and analysed through the research process' (Strauss & Corbin 1998: 12). This is to be distinguished from **grounded theory methods** which are the procedures followed to produce a grounded theory. This study adopts the latter (grounded theory methods) because it consists of a useful set of tools for understanding empirical worlds (Charmaz 2000: 510). Grounded theory methods can help answer the question of 'what is going on in an area?', a question that I wish to raise about the views and use of the fundamental rule.

Two main strands of grounded theory have evolved since its inception. For this research, three reasons make Strauss & Corbin's procedures preferable to those of Glaser. First, Glaser uses the methodology to develop theory, an aim which is not intended for this research. Strauss & Corbin, on the other hand, authorize the use of grounded theory procedures for description or for the discovery of categories (1998: 9, 288). They explain that 'description is needed to convey what was (or is) going on, what the setting looks like, what the people involved are doing, and so on' (ibid: 16). This is precisely the aim of the present study - to produce a description of psychoanalysts' perception and use of the fundamental rule by uncovering categories and recurring themes.

Secondly, in Glaser's approach, the research problem itself is discovered through the emerging data and begins with 'abstract wonderment' (1992: 22). This is not useful for the current study, in which a set of questions and hypotheses, based on the literature, has already been developed. Strauss & Corbin, on the other hand, allow for research questions to be decided before data collection (1998: 40-42), which is a suitable path for this study.

Thirdly, Strauss & Corbin's position can be squared with interpretivism. Indeed, grounded theory evolved from the symbolic interactionist approach to the study of human behaviour – a branch of interpretivism (Crotty 1998: 78). Glaser, on the other hand, recommends distance and independence from phenomena studied (Locke 1996: 239), which seems to echo the tenets of positivism.

However, Strauss & Corbin's grounded theory methods need to be adjusted to fit the study's needs. Charmaz says that 'we can use grounded theory methods as flexible, heuristic strategies rather than as formulaic procedures' (2000: 510), and the present research intends to do just that. Later, I will highlight the procedures of Strauss & Corbin that are relevant, and those are omitted because they are meant for generating theory.

3.3.2 Limitations of grounded theory

There are some limitations of grounded theory to consider. One is that grounded theory aims for analysis through fracturing data (by creating codes and categories) instead of portraying the subjects' experience (Conrad 1990 and Riessman 1990 in Charmaz 2000: 521). However, this does not pose a challenge to the study since it attempts to do both – to convey participants' experiences and to fracture the data for statistical analysis and hypothesis-testing.

Another criticism is that Strauss & Corbin 'force' data through preconceived questions, categories, and hypotheses (Glaser 2002). This is a valid objection, and to mitigate this I avoid using predetermined categories; I allow categories to emerge from interview material, and use participant's terminology ('invivo codes') where possible. However, a certain amount of bias exists given that I am likely to have been influenced by the literature and by conference discussions.

A further problem is that there are potentially limitless options for coding (Flick 2002: 185). In practice, I did find this to be a limitation. All categories could be endlessly elaborated, and although further refinement was possible, I found it necessary to restrict the number of times I re-coded each transcript.

3.4 DATA COLLECTION

3.4.1 Semi-structured interviews

Of the three general sources of data – observations, documents and interviews (Merriam 2002: 12) - the latter seems best suited to the research study.

The first research question - 'how do psychoanalysts present the fundamental rule?' - could be answered by observing and recording what psychoanalysts say to their patients during sessions. However, direct observation is not feasible because the

psychoanalytic meeting is confidential. It might be possible to interview patients for their recollection of how the analyst presented the fundamental rule, but this too intrudes on the contract of confidentiality.

Questionnaires are not considered suitable since they are unlikely to yield in-depth responses (Strauss & Corbin 1998: 205). Glover noted the limitations of questionnaires: 'Obviously a certain amount of objectivity and goodwill had to be taken for granted. Nothing is easier to sabotage than a psychological questionnaire.' (Glover 1955: 266). Respondents might be inclined to give answers that they think are required by the researcher, or that are desirable by the standards of their profession. Although there is a risk of this occurring during interviews, it is hoped that it will be mitigated by establishing rapport.

Another method is the focus group, whereby a group of psychoanalysts collectively discuss their use of the rule. However, there is a risk that psychoanalysts would hide their true practices for fear of judgement from others in the group. Also, it would be difficult to set up a group given psychoanalysts' fixed time commitments.

Semi-structured, one-to-one interviews are an appropriate method for this study. They are useful when research is exploratory and when the researcher does not want to use pre-determined codes (Mathers et al 1998: 2). Also, they would help answer the second research question - 'what are the psychoanalysts' considerations in approaching the fundamental rule in the way they do?' This is because there are no other ways to study analyst's attitudes other than have them communicate their views. Overall, interviews are less invasive than direct observation, and yield more depth than questionnaires.

A significant limitation of self-reporting is that during an interview, participants might have difficulty in recollecting events. More likely, participants may withhold information, or give answers that they believe the researcher wants (Lincoln & Guba 1985 in Robson 2002: 172). Spence comments that we can never know what

really happens during an analytic session, and we must assume that most of the analyst's memories are geared toward what is approved by standard theory and orthodox technique (2001: 454). This is what Glover recognized in his own study as 'cautiousness, conservatism, or even timidity' (1955: 267). Hopefully this is partially solved by offering participants a guarantee of anonymity and confidentiality.

3.4.2 Sampling procedures

The sample for this study is limited in advance by certain criteria: the participants should be associate members or full members (not candidates) of the APsaA or BPaS, they should be currently practicing psychoanalysis, and they should be working with adults (not exclusively children). Table 3.2 displays the sampling strategy.

Theoretical Population:	American & British psychoanalysts
Study Population:	APsaA & BPaS
Sampling Frame:	Rosters of APsaA & BPaS
Sample Size:	20 APsaA psychoanalysts, 20 BPaS psychoanalysts.
Type of Sampling:	Convenience sampling

Table 3.2 Details of Sampling Strategy

The labels 'American' and 'British' here refer to psychoanalysts who have trained in, and currently practice in, the U.S. and the U.K. respectively. The sampling frame used to identify the study population will be the rosters of the American Psychoanalytic Association (APsaA) and the British Psychoanalytical Society (BPaS)[1]. APsaA has 3200 members and the BPaS has 417 members (source: online rosters, 2003).

[1] It must be noted, however, that the APsaA and the BPaS are not exactly synonymous with American and British psychoanalysts, for example not all members of APsaA practice in the U.S.

Several difficulties arise when trying to access a research area (Flick 2002: 56). Research can be a disruptive factor for the organisations under investigation, and they can react defensively since the limitations of its own activities may be disclosed to the researcher. Also, a research study rarely offers an immediate or long-term pay-off for the organisation and its members. Finally, there is a conflict for the researcher between the need to protect data and the need to be open about all stages of the research process.

I aimed to avoid disruption to psychoanalysts and the two organisations by collecting the data as quickly as possible, and by being transparent about the research. I first wrote to Joseph Lichtenberg & Floyd Galler whose 1982-1987 study I was seeking to replicate, informing them of my research plans. Dr. Lichtenberg responded with his approval. I then contacted the American Psychoanalytic Association (APsaA) and the British Psychoanalytical Society (BPaS) for permission to access its members. I explained the purpose of the study to both organisations over the telephone and sent written details of the research plans. I then devised sampling techniques to invite members to participate. I decided on an initial sample size of forty. This number seemed large enough to cover multiple perspectives, and small enough to permit a thorough analysis of the data.

Non-proportionate stratified sampling was used in the pilot study and proved unfruitful. It involved dividing the population into homogenous groups (U.S. and U.K.) and taking a random sample from each organisation. From the APsaA membership list I selected every tenth analyst and sent by email a request for participation. Of the twenty-four analysts emailed, only one replied and he did not follow up my invitation to set up an interview time.

I had to rethink the sampling strategies. I consulted with some conference panellists about how to enlist participants. Eventually, I was able to post a note on the electronic message board which circulates to over 1500 members of APsaA. From this, a number of participants came forward, and I set up twenty interviews. To gain

twenty British participants, I wrote to every tenth member of the BPaS with a note from my supervisor to verify my authenticity. I wrote a total of 67 letters to get the required number of participants. The information sent to participants is reproduced in Appendices I and II.

One limitation of this type of 'convenience' sampling is that participants are self-selecting. This raises the question of whether those who did not participate represent a certain body of opinion (Glover 1955: 266) and whether their views would have contributed something new to the findings. We can speculate about why some declined to take part. These analysts might have unorthodox approaches to the fundamental rule which they are reluctant to share. Or they might use the rule conventionally and so feel that they have nothing noteworthy to talk about. Alternatively, they might have been unavailable.

Another limitation of convenience sampling is that participants cannot be said to represent the two organisations. For example, the email sent to American participants excluded from the study those participants who do not have access to email. Although the results of the study may not be representative of the organisations' members, they do offer an insight into the ideas and practices of a limited group.

In my letters, I explained that I was not a psychoanalyst but a student and part-time counsellor. My status as an 'outsider' may have been a disadvantage since it could have placed a distance between us. This might be a problem since Adler & Adler observe that social groups have 'two sets of realities about their activities: one presented to outsiders and the other reserved for insiders' (1987: 21). On the other hand, my position as an outsider can reduce potential bias in the data analysis and results since I had no vested interest in discovering one particular set of results.

3.4.3 Payment

I offered participants payment for their time. I felt that since analysts organise their practice on an hourly basis, I wished to respect their time constraints and fee-structure. I thought that I would be more likely to get analysts to speak with me openly and unhurriedly if they allocated some time in exchange for hourly compensation.

It is difficult to determine the effect of payment on the participants' involvement. Payment became a feature of the interview insofar as it was discussed over the phone or by email. I acknowledge that it may have acted as an incentive to participate. Equally, I acknowledge that the supporting letter from my supervisor may have encouraged participation.

3.4.4 Telephone interviews

Telephone interviews were chosen in favour of face-to-face meetings. As Mathers et al state: 'Telephone interviewing can be ideally suited to busy professional respondents, such as general practitioners [...and] are also particularly useful when the respondents to be interviewed are widely geographically distributed' (1998: 3-4).

The pilot study confirmed that this method had several advantages. First, interviews could be arranged at a late stage or re-scheduled. Such flexibility meant that the interview was organised at a convenient time to the analyst. For example, US.A made a tentative date over the Christmas break which turned out to be inconvenient for him. At short-notice we re-arranged the interview for New Year's Day. This may not have been possible with a face-to-face meeting. It was hoped that by organising a time to suit both parties, we would be in a receptive frame of mind.

Secondly, telephone interviewing eliminated the need to arrange transportation and accommodation for each meeting, saving time and cost. It also meant that time

spent navigating the way to the psychoanalyst's office could instead be used to prepare for the interview and to write-up reflections immediately after it ended.

Also, telephone interviewing created an atmosphere of anonymity and neutrality. Dialogue was the main focus instead of physical aspects, and this seemed to set both parties at ease; I was able to focus on the direction of the interview, on understanding and making notes, and participants could focus on putting across their opinions. This arrangement parallels the analytic situation where often the patient lies on the couch unable to see the analyst. In analysis, the purpose of the neutrality and anonymity is to facilitate free associations of the patient. The interview situation is similar since a neutral environment is generated, and participants can feel at ease to talk about their experiences without being influenced by the interviewer. Indeed, the interviews often seemed to run in a free associative way. Some participants made comments to this effect:

> *you are trying to find out about free association by using the tool of free association. Which is why I imagine you have chosen an interview rather than a survey or structured questions (UK.E para 14).*

However, lack of visual cues in telephone interviews also acted as a disadvantage; I was not able to capture participants' body language. Such signs may have given me an additional layer of information beyond verbal responses. Whilst physical features could not be read, I felt that I could sense non-verbal communication transmitted through tone, voice, pitch, and silences. I could often detect the participants' mood such as confusion, contentedness, disapproval, interest, or boredom. I could sometimes detect the meaning of silences – whether it was a reflective pause or a silence indicating the end of a point. I tried to incorporate these into the transcript in square brackets – for example the expression of hesitation, laughter or mimicry. However, I recognise that these were my personal constructions, and I may have misinterpreted the cues. Overall, it must be considered that the results would have been different had the interviews been conducted face-to-face.

A closely related disadvantage was that the opportunity to develop a strong rapport was lost. We can speculate that if the meetings were held in person, there would have been more of chance to develop trust, and for participants to be more frank about their views.

3.4.5 Time scale and duration

The interviews took place over one year (2004), since the aim was to describe the way analysts currently conceive of, and present, the fundamental rule.

Mathers et al suggest that 'It can be difficult to establish a rapport in too short a time but conversely taking too much time is unfair to the interviewee' (1998: 9). I established from the pilot study that interviews would vary in duration but would not run significantly over one hour. The pilot study of three analysts revealed different styles of communicating. For example, US.A took a long time to express a view point, whereas US.B conveyed her ideas concisely. Additionally, some participants seemed to be more time-constrained than others. For example US.B only had thirty minutes over lunch to spare, whereas UK.K approached the interview leisurely and let the interview run over an hour. Where possible, before the interview questions began, I confirmed how much time the participant had available. Overall, interviews varied in length from 24 minutes to 63 minutes; the average was 40 minutes.

3.4.6 Interview protocol

I used an interview protocol sheet that referred to key issues, questions, and interview probes. These issues were derived from the literature and were aimed at answering the research questions. Table 3.3 lists the interview questions on the protocol sheet. I found several principles to be important in establishing the questions. First, I formulated them so that they should be brief, easy to understand, and jargon-free (Kvale 1996: 130). I aimed to ask open-ended questions, since they do not pre-determine the answers and allow space for respondents to reply in their own terms

(Patton 1987: 122-123). Laddering (Price 2002: 277) (or question sequencing) was also used whereby questions moved from general or broad issues to specific and narrow ones. Also, Patton says that talking about their behaviour helps establish a context for the respondents to express their views (1987: 115). I agree that it was useful to ask about experience and action before asking about opinions.

1. What role does free association play in your practice?
2. How would you define free association?
3. How important is free association?
4. What makes it so important for you?
5. What is your listening stance?
6. How do you conceive of the fundamental rule? Do you regard free association as a rule? Do you introduce the idea of free association to patients? If so, how do you introduce it? How would you phrase it to patients? When would you introduce it?
7. What considerations have led you to handle free association in this way?

Table 3.3 Interview questions

The pilot study showed that the initial questions and probes required little modification. I thought that the data produced for the three participants US.A, US.B, and US.C was of sufficient quality and value to merit inclusion as part of the study.

At the start of each interview I checked that participants gave their consent to be recorded and I thanked them for taking part. My approach was to begin with the statement 'I am interested in finding out about your views of the fundamental rule of free association and how you work with it'. Several participants proceeded to discuss their opinion and practices. I allowed them to develop their ideas until they came to a clear stop. While they spoke, I listened and noted down areas they had not addressed or that needed further discussion. My interaction at this stage was limited to brief

acknowledgements such as 'uh huh' or 'I see'. When they stopped speaking, I picked up on various points, asking them to clarify or elaborate further. If participants strayed from the subject, I would attempt to bring them back to the topic. My questions often took the form of 'can you say more about X?' or 'you talked about doing X, can you share some of your considerations for that?'

Other participants did not respond to my opening statement, and preferred to be asked questions. In those cases, I asked them questions from table 3.3 beginning with 'what role does free association play in your practice?' Often, this was open-ended enough to prompt participants to explore the topic. I found that many participants spoke in a free-flowing way and answered most of the points in table 3.3. If they missed out areas, then I would introduce them as a question, at a relevant time so as not to make the interview disjointed.

At the end of the interview, I collected some supplementary data including details of the psychoanalyst's training institute, years in clinical practice, and theoretical orientation. In the pilot interviews I asked for more details than were necessary (such as how they viewed psychoanalysis in terms of frequency of sessions, and their use of the couch). In subsequent interviews I simplified the attribute sheet to the one displayed in table 3.4. The purpose in noting down these attributes is twofold. They were developed to allow comparisons, for example, to see if certain attributes are relevant to the findings. They also helped me to build a picture of the analyst and to recall them and our interview.

Date of the interview:
Place of the interview:
Identifier for the interviewee:
Gender of the interviewee:
Training institute:
Working as psychoanalyst since:
Theoretical orientation:
Impressions of the interview:

Table 3.4 Attribute sheet for interviews.

I followed up the interview with a note thanking the participants and confirming that I would contact them in due course with a summary of the results. Once the interview was over, I wrote down my reflections. This included my thoughts on my role as interviewer, my impressions of the analyst, and my reflection of the dynamic between us. The interplay of transference and counter-transference was unique on each occasion, but often took one of two configurations: 1) Student-teacher. I felt intimidated, less knowledgeable than them, or perceived them as a 'lecturer' (see Appendix III for an example) 2) Co-researcher. I felt at ease and the participant seemed to be interested in pursuing the research goals together (see Appendix IV for an example). Within these modes of relating, the participants and I had different levels of defensiveness. I also found that my interviewing technique improved over time as I gained confidence. I was quicker at spotting which areas were not addressed, and formulated my questions more clearly and succinctly. This meant that the quality of data varied over the course of interviews. In my reflections I tried to speculate about the effect this may have had.

3.4.7 Recording and transcription

Interviews were audio-recorded to have accurate records of the conversations. This allowed the discussion to flow without the interruption of note-taking. A Sony Recorder with high grade cassettes was connected to the telephone. There are some

drawbacks of audio-recording, including that it might induce nervousness given that there will be an exact reproduction of comments. This seemed to occur for a few participants who seemed to hesitate at the start of the interview. Another problem is that as an interviewer, I felt I could rely on the recording; this occasionally prevented me from asking to repeat something I had misheard.

On average it took several hours to transcribe each interview, but with practice it became quicker. Although time-consuming, personally transcribing the interviews allowed me to uphold confidentiality, and to become familiar with the material. I found it helpful to transcribe the data within hours of the interview, and to write down my impressions while still fresh.

In the pilot study I transcribed all sounds including 'um's', 'ah's, and 'er's. This made the transcript difficult to read, so in subsequent interviews I tried to reduce this by following a simple transcription convention outlined by Lewins which was compatible with the NVivo computer package (1998: 58). This entailed marking down notable aspects of non-verbal communication in square brackets as mentioned. A full transcript is reproduced in Appendix V. Where I have supplied quotes in chapter four, I have removed repetition or expressions such as 'you know' to simplify the passage for the reader, though the context of the quote remains unchanged.

Participants were assigned code letters - US or UK and a letter A to T. Transcripts were password-protected on the computer. From the pilot study, I found it helpful to listen to the recordings twice after transcribing to check for accuracy. Also, one participant, UK.I, was sent a copy of his transcript to ensure that transcription standards did justice to the interview; he confirmed that it was accurate except for a spelling error.

3.5 DATA ANALYSIS

Strategies for data analysis of interview material include: conversational analysis, discourse analysis, narrative analysis, objective hermeuntics and content analysis. However, the first four methods prioritise the text and are unsuitable in a project that is concerned above all with portraying participants' meanings. Content analysis, although it entails a useful process of coding, applies pre-determined codes (Ryan & Bernard 785: 2000), whereas this study seeks to discover codes from the data.

In the pilot study I trialled Strauss & Corbin's data analysis procedures, and found many to be useful. Table 3.5 shows which steps were subsequently followed in the research, and which were avoided. Selective coding was omitted, because the aim was not to find a core category but to answer a set of research questions. Theoretical comparisons, the coding paradigm, the conditional matrix, and theoretical sampling were excluded from the research because they are explicitly aimed at theory building. In another deviation from Strauss & Corbin's procedures, I did not use the literature as data. This is required by the design of the project since it seeks to compare actual experiences of psychoanalysts with those reported in the literature. As such, it is important that the literature as data is kept separate from interviews as data.

STRAUSS & CORBIN'S PROCEDURES	USED IN THIS RESEARCH?
Open Coding	✓
Axial Coding	✓
Simultaneous Data Collection & Analysis	✓
Constant Comparative Analysis	✓
Memos and Diagrams	✓
Saturation	✓
Selective Coding	×
Theoretical Comparison	×
Coding Paradigm	×
Conditional Matrix	×
Theoretical Sampling	×
Literature as Data	×

Table 3.5 Data analysis strategies of Strauss & Corbin

3.5.1 Open coding

Open coding is a process of reading a text line-by-line or word-by-word to reveal the thoughts and ideas it contains. These ideas are then labelled (Strauss & Corbin 1998: 106). Coding in this way is useful because it prevents us from applying our own ideas on to the data: 'This form of coding helps us to remain attuned to our subjects' views of their realities, rather than assume that we share the same views and worlds.' (Charmaz 2000: 515). The drawbacks of coding at this level are that it is time-consuming, and that the researcher can become lost in the minutia of the data (Allan 2003: 2).

For this stage, I read each transcript twice and extracted ideas inherent in the interview into 'codes'. Some of these were 'in vivo' codes (Glaser & Strauss 1967), taken from participants' words. Other codes were invented 'sociological constructs'

(Strauss 1987: 33), and others were taken from the literature (Strauss & Corbin 1998: 115).

By comparing incident to incident, codes that share common characteristics (in events, objects, actions or interactions) were grouped under a higher order concept called a **category** (Strauss & Corbin 1998: 102). This allows reduction of the number of units with which to work (ibid: 113). For example in the study, codes such as 'free association introduced in the consultation' and 'free association introduced in second session' are grouped under the category 'timing'.

Next, within each category, **subcategories** were identified and placed on a continuum to show its properties and dimensions (Strauss & Corbin 1998: 116). For example, the category of 'tone' has subcategories 'gentle', 'moderate' 'firm', 'task-oriented' and 'positive value'.

3.5.2 Axial coding

The purpose of 'axial coding' is to reassemble the data that became fractured during open coding (Robson 2002: 494). In this stage, intensive analysis is done around the 'axis' of each category (Strauss 1987: 32). Categories are related to their subcategories to form a more complete description about phenomena (Strauss & Corbin 1998: 124, 143).

This process resulted in many changes to the codes. At one stage there were over 600 codes, but as codes were merged, deleted, renamed and re-organised, they were eventually reduced to 335. I read through each of these 'codes' to ensure that the comments were appropriately placed. Finally, I re-read the 40 transcripts to check that ideas were placed into relevant codes. I recognize that due to my subjectivities, another researcher coding the same forty interviews is unlikely to produce an identical coding scheme; there are some points, due to my own limitations, I will continue to

overlook. Figure 3.1 shows part of a transcript that has undergone open and axial coding.

TranscriptUKF5Aug 4 - Document Browser

SJ: One area that I've been particularly interested in is how you might let patients know about free association, if you introduce it all?
UK.F: It's very rare that I don't actually introduce it, and I say 'this is how I work' and I use the phrase 'free association'. Sometimes people nod knowledgeable 'oh yes I've heard of that' other people look quite blank. And I then go on to elaborate a bit of what Freud said originally 'to try and speak as freely as possible without censorship even if what comes to mind seems trivial or embarrassing or irrelevant'. [4 sec pause] And I don't think there's another way to do that. I and I have heard, and I don't know if this is apocryphal, I have heard of analysts who say absolutely nothing from the very start. And to me that would be an incredibly frightening kind of encounter for a new patient. And, again, I think it connects with management of anxiety that if you say a bit to the patient, they'll hear a bit and gradually they'll begin to get a sense of what the process is about. Just before you phoned I finished with a patient, and this is now something - I'm seeing her once a week and something like our forth or fifth session. And in each session she has tried to ask me very direct questions, within what is free association. And I've answered that in terms of 'I wonder why you need to ask these questions just now?' And so, the frequency of her asking these questions has gone done, and her capacity to let her mind flow freely has gone up.
SJ: So you would introduce it in order to not make it a frightening experience?
UK.F: Yeah, I think that you have to respect people's defenses and when you meet someone initially, you don't actually know an awful lot about what's going on in their mind. And I think to push someone's head under water as it were without explanation is unlikely to be helpful in the long run.
SJ: Can I ask you when you would introduce it and why you would do it at that point?
UK.F: When I would introduce it? At the very start. The way I work, I have an initial consultation. Mostly I have a one-off consultation, very occasionally I've seen people more than that. But towards the end of that initial consultation, I will have some idea about whether I think I can work with them and whether the stuff they're talking about is stuff that might be processed analytically. I would then ask them what they know about psychotherapy and or psychoanalysis, and I would then say 'well this is how I work'.

SJ: And then you'd go on to explain, as you said before.
UK.F: Yeah, I would say to them, if we've agreed that the person is going to come and see me, when they came for that next session I would say 'from now on, this is the way I will work', and I would repeat the fundamental

Task - oriented tone; Familiarise analysis; FR - Use term 'FA'; New to analysis; Influence of Freud; Clear introduction at outset; FR - avoid censorship; No references; Mid-length statement; Views of FR; To provide containment; Improves over time; Trust, safety; Draw attention & get pt to reflect; FA promoted; To avoid deprivation; Timing - consultation; Clear introduction at outset; First person singular, Task - oriented tone; Repeat the fundamental rule; First person singular

Figure 3.1 A segment of UK.F's transcript with coding.

3.5.3 Simultaneous data collection and analysis

Wherever possible, I began to analyse the data immediately after the interview. Simultaneous collection and analysis allows the researcher to become sensitive to the data, and helps to pace the data analysis by preventing an unmanageable build-up of transcripts (Merriam 2002: 14). It is also a requirement for constant comparative analysis.

3.5.4 Constant comparative analysis

The basic strategy of the constant comparative method is to compare continuously the data for similarities and differences (Glaser & Strauss 1967:101-116). This ongoing process of looking for comparisons in the data, leads to creating and modifying categories. (Charmaz 1983, 1995, Strauss & Corbin 1998). This technique was used to refine the ideas, and eventually produced the coding structure displayed in figure 3.2.

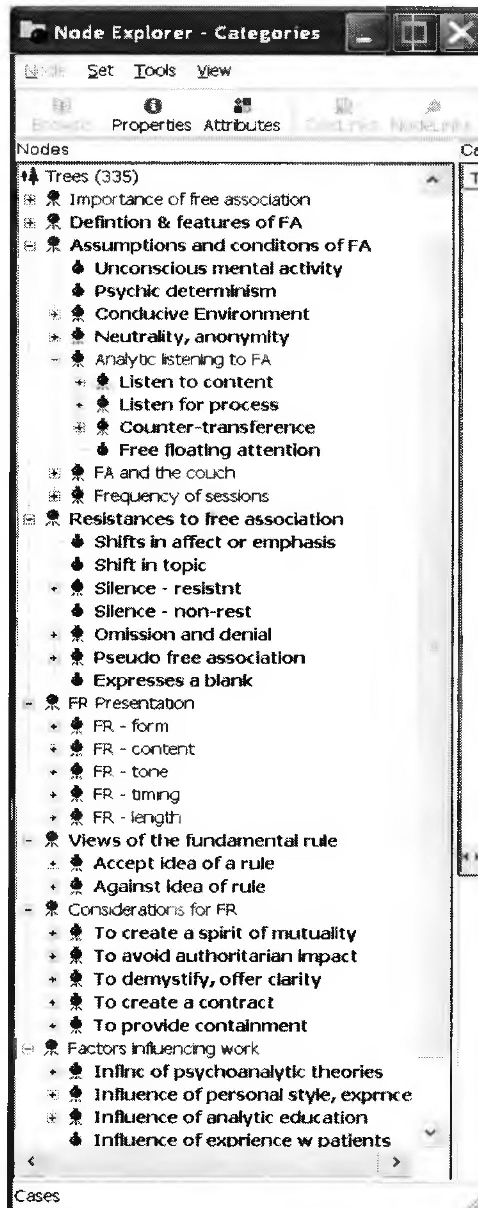

Figure 3.2 Categories and sub-categories linked in a tree structure

3.5.5 Memos and databites

Throughout the coding procedure, I wrote **databites** which are comments about the interview material, and **memos** which record thoughts, interpretations and questions relating to the data analysis (Strauss & Corbin 1998: 110). These were consulted regularly; they served as an aide-memoir of thoughts formed about the data,

and helped to stimulate further ideas. The databite in figure 3.3 was written relating to US.F's comment: 'In other words, the notion for me is free association, but then to get to parts that seem to be important to pick up on.' (para 45).

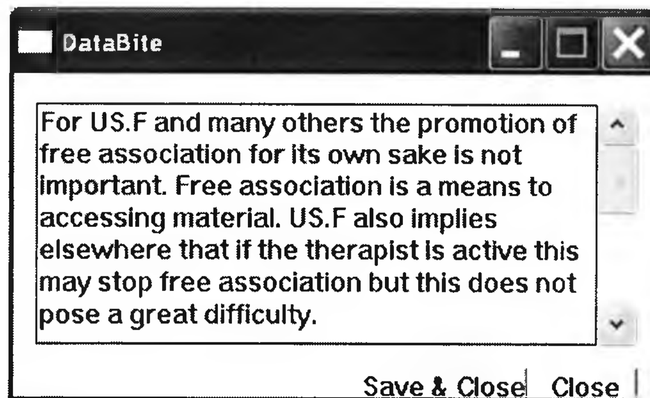

Figure 3.3 Example of a databite

Figure 3.4 gives an example of a memo on 'education/teaching to free associate' stimulated by UK.D's interview.

I am thinking about the lack of education in free association with the British analysts so far. I wonder why this was missing? Perhaps because their previous experience/qualifications are arts-based, although some were GPS so this may not be a good theory. Or perhaps it is because they are more interested in the object relations and therefore want to impose themselves as little as possible i.e. give minimal instructions. The Americans, on the other hand on the whole regard defence analysis as key and they also seem to give more explicit instructions to patients. I'm not sure if there is a causal link, I need to investigate further. Another explanation for placing less emphasis on education may be the expectations of the patient group, and this might be cultural too, the Americans wanting quicker results, more talk and guidance. I must be careful not to make this too many assumptions, and I will stay alert to new information from future interviews.

Figure 3.4 Example of a memo

3.5.6 Saturation

Strauss and Corbin tell us that interviewing should stop when new data does not add significantly to major patterns discovered (1998: 136, 292); the analysis will

have accounted for much of the possible variation (1998: 158). In this study, saturation seemed to be reached before the forty interviews were complete. However further interviews were already arranged, and it seemed preferable to complete them.

3.5.7 Quantitative data analysis

Some methodologists have pointed to the falsity of the qualitative-quantitative distinction, and have claimed that the two methodologies are not always mutually exclusive (Pidgeon & Henwood 1997: 253). Some believe that there are ways in which they can be combined (Lincoln & Guba 1985: 198, Bryman 1988: 131-152, Punch 1998: 247). Indeed, for this study, I thought that verbal data (in the form of interviews) could be usefully broken into discrete variables to enable themes to be measured against one another. Thus, measurement through quantification is used as a supplement to qualitative strategies.

In analysing the data I looked for the possible influence of:

a) gender
b) orientation
c) years of experience
d) nationality (U.S. v. U.K.).

Statistical results are only presented where a significant relationship is found.

Three main equations have been used to enhance the qualitative findings (see Appendix VI for the formulae):

1. **Chi-squared**. Used to determine whether two proportions could have occurred by chance.
2. **t-test**. Used to determine whether the mean scores of two groups are significantly different.

3. **Pearson's correlation co-efficient**. Used to determine the amount and significance of a correlation between two variables.

(Hinton 2004: 89, 250, 264)

An important limitation of using quantitative analysis on qualitative data is that the data moves away from its raw state as it is shaped by the researcher (Denscombe 2003: 241). For example, to categorise the length of the fundamental rule, I created groups: 0-30 words = 'brief introduction', 31-60 words= 'mid-length', and so on. This can be seen as imposing on the data. Hopefully this disadvantage is outweighed by the advantages of easier data-management and reader-friendly results.

3.6 COMPUTER PROGRAM

CAQDAs (Computer-assisted qualitative data analysis) are software packages that have been developed to facilitate data analysis. Their main advantage is speed at handling large volumes of data, and rigour in filing and retrieving codes, categories, and memos (Strauss & Corbin 1998: 219, Searle 2000: 155). However, some express concern that computer software homogenises the method of data analysis and distances researchers from their data. Other researchers have found this to be unfounded. Barry, for example, believes this concern is often expressed by those who have not used CAQDAs, and furthermore, that CAQDAs do not remove the need to be familiar with the data (1998: 2.1)

In the pilot study, I tried two methods - coding the data manually, and coding within a program called NVivo – before deciding which strategy to use:

1) Hand coding: I made several copies of the transcript, manually cut out relevant sections, and placed them into piles with code names. The results left me with a proliferation of strips of paper. They decreased as I noticed connections

between the codes and attached them to coloured index cards. Still, I found the paperwork difficult to manage and disorientating when searching for codes. Overall, I felt disorganised using this manual method, and was worried that I had no back-up should I lose the index cards.

2) NVivo: After trying demonstrations with two other qualitative packages – Nudist and Atlas - I selected NVivo because of its user-friendly interface and compatibility with grounded theory methods. NVivo allowed me to code quickly, search for previously coded material, rename, and regroup codes and categories. I found it easier to code interviews on screen than to cut and paste pieces of paper on to cards. However, working on the computer, limited creative thinking. This problem was managed by printing out transcripts, and working on paper when I wished to make manual notes.

Overall, then, the computer program was used for storing and managing the data, for indexing, and for retrieval. I went on a training course at the Institute of Education on NVivo to learn how to exploit fully its functions. NVivo, I believe, enhanced efficiency of data analysis, and freed up time otherwise spent on manual retrieval. One limitation is that the computer program was unable to analyse the data, which in any case is inconsistent with the interpretivist goal of searching for meaning.

3.7 EVALUATION CRITERIA

Certain steps have been taken to help evaluate the study's trustworthiness. Guba & Lincoln's (1989) criteria were followed since they are consistent with the interpretivist assumptions of the study (Baptiste 2001: 19). Alternative criteria are available for quantitative research, but are not used, since this study draws more heavily from qualitative research.

Table 3.6 shows the strategies that are associated with each criterion of trustworthiness (Guba & Lincoln 1989), and shows whether they are followed.

CRITERIA	STRATEGIES	USED IN THIS RESEARCH?
Credibility	Peer Debriefing	✓
	Member Checks	✓
	Investigator Responsiveness	✓
	Prolonged Engagement	×
Transferability	Thick Description	✓
Dependability	Dependability Audit	✓
Confirmability	Confirmability Audit	✓
	Reflexivity	✓

Table 3.6 Evaluation strategies

3.7.1 Credibility

Credibility refers to the accuracy with which the account has represented the views of the participants. A study is credible when participants or others reading the study can recognise the descriptions and interpretations. Although many methodologists question whether researchers can ever capture lived experience, various strategies may be used to strive for credibility (Guba & Lincoln 1989: 237-239, Merriam 1998).

One helpful strategy is **peer debriefing,** where individuals outside the study are asked to review the steps taken during data analysis. To do this, I presented the results of the pilot study to a PhD study group who gave feedback and suggestions on the methods, findings, and shortcomings. I have incorporated their comments to improve credibility.

Another strategy is **member checks,** which entails asking research participants to review data records, and results. To do this, I invited participants to verify the findings. Each participant was sent a two-paragraph summary of the results (see Appendix VII). I also created a website with fifteen pages of detail on the study, and sent participants a link to this site (see Appendix VIII). Fourteen participants communicated their feedback - whether their perspectives have been adequately represented, and whether the conclusions are credible - and I present their comments in chapter five.

Morse et al propose another strategy of **investigator responsiveness** (2002: 10-11) – the researcher should be open, sensitive to the data, creative, and flexible. I tried to keep this in mind throughout the data analysis, and was willing to relinquish ideas or categories that were poorly supported.

Another strategy is **prolonged engagement,** but it was not used. It entails a long presence in the site to build trust and to overcome distortions caused by the presence of the researcher. In this study, repeated interviews with psychoanalysts were not needed, since all the necessary information was conveyed in one interview, and I wished to minimize disruption to participants. Thus, I have attempted to reach credibility through the other strategies discussed above.

3.7.2 Transferability

Transferability is the extent to which the results are applicable to similar contexts. With transferability, audiences of the study are given the opportunity to decide if the findings, such as categories and themes, are applicable to other cases. Transferability is made possible by clear and rich descriptions of the participants, procedures and interactions. Geertz terms this ‘thick description’ (1973). This study makes no claims to apply to analysts in other organizations or other countries. Yet, having specified the parameters of the study, I hope that the reader is equipped to decide if the interpretation is relevant in other contexts.

3.7.3 Dependability

Dependability is the extent to which if the research was reproduced with similar participants in a similar context, its findings would be repeated (Erlandson et al 1993: 33). This is a difficult criterion to meet since it is unlikely that if replicated, similar results would emerge. This is due to uncontrollable changes such as the participant's or the researcher's mood. For example, I noticed that US.B seemed more tired and rushed during her interview than when I first spoke to her to arrange the interview. Perhaps if the interview took place at a different time, the resulting data would also be different.

3.7.4 Confirmability

Confirmability is the process of checking interpretations and conclusions for researcher bias (Lincoln & Guba 1985: 320-321, Erlandson, et al. 1993: 34). It is partly achieved when the results can be traced to their origin. For this reason, I have included paragraph numbers for all quotes in the findings; the source of the quote can be traced to its place in the transcript. Participant feedback, discussed earlier as 'member checks', also helps meet this criterion.

There will be an inevitable amount of subjectivity in an interpretivist study. Biases can never fully be removed; however, an awareness of them will improve confirmability of the study. Various steps are taken to monitor, and contain, reflexivity. Epistemological assumptions have already been announced. Memoing in grounded theory can help achieve reflection (Strauss 1987). I have kept notes with my impressions of the interview, and have kept a research journal detailing the research process. Although memoing and journaling took time, and sometimes seemed to distract from the work of coding, it was important in keeping track of the development of ideas.

3.7.5 Ethical criteria

The research abided by the principles of the British Psychological Society - *Ethical Principles for Conducting Research with Human Participants* (2000). Participants were explained about the nature of the research, and their informed consent was obtained (principle 3.1). Participants were paid their hourly fee, and payment abided with principle 3.7 - 'The payment of participants must not be used to induce them to risk harm beyond that which they risk without payment in their normal lifestyle'.

Disruption to participants was minimised by completing the interview in one meeting. They were given contact details should they wish to raise any questions or concerns after the interview (principle 8.2). Anonymity was guaranteed, and they were referred to by letter in the transcripts and in the findings. Confidentiality was also assured in line with principle 7.1, and to achieve this, tape-recordings were securely stored, were not distributed, and will be destroyed once the study is complete.

3.8 CHAPTER SUMMARY

This chapter has described all parts of the research design. Although psychoanalytic principles partly underlie the research, the main theoretical paradigm is interpretivism. Grounded theory methods are shown to be suitable for the research questions and they are congruent with interpretivism. Strauss & Corbin's (1998) procedures are adopted for analysing data, including coding strategies, simultaneous data collection and analysis, constant comparative analysis, and memoing. The variations and limitations of grounded theory were discussed, along with a justification for why some procedures are not applicable, and why quantitative methods are a helpful supplement. We discussed the nature of the sample and sampling techniques. We saw why the semi-structured interview is more suitable than

direct observation, questionnaires, or focus groups. We described the procedures used for data recording, and the use of NVivo as a software package for managing data. We outlined Guba & Lincoln's (1989) criteria which evaluate the study's trustworthiness and authenticity. Finally, we showed how this research abides by ethical principles set out by the British Psychological Society (2000). It is hoped that the research design devised and explicated in this chapter is sufficient to answer the research questions in a manner that is rigorous and ethical. In the next chapter, we turn to the results produced under this methodological framework.

CHAPTER FOUR: FINDINGS

4.1 CHAPTER OVERVIEW

In this section, the study's results are presented qualitatively by way of verbatim quotes, and quantitatively through charts and statistics. We see how participants define and describe free association, how important they consider it, and what they believe are its benefits. We take an in-depth look at the introduction of free association. We see whether analysts choose to give an introduction, and if so, the timing and length in which it is done. We examine the content of the introductions such as whether they specify types of associations, and whether they include comments about resistance analysis. We also see the tone in which introductions are given. We see that the fundamental rule is considered as 'ongoing', in the respect that many participants repeat, or indirectly refer to, the rule after it has been introduced. We review some evidence that there is an 'educative' aspect to free association. We see how participants justify the way they handle the introduction of free association, and we see some of the sources of influence on their approach. Finally, we link various significance tests together to form a new hypothesis about the fundamental rule.

4.2 DEMOGRAPHIC DETAILS

To provide a context for the research findings, some information on participants is outlined. Table 4.1 shows the gender composition, qualifications, years of experience and activities engaged in, by the forty participants.

	AMERICAN	BRITISH	TOTAL
NUMBER OF PARTICIPANTS	20	20	40
GENDER			
Male	11	14	25
Female	9	6	15
MAIN QUALIFICATION			
Medicine	10	10	20
Psychology	6	2	8
Social work	3	3	6
Academia	0	4	6
Other	1	1	2
AVERAGE YEARS QUALIFIED	14	18	16
ACTIVITIES IN THE FIELD			
Publish	14	14	28
Lecture/Teach	14	14	28
Training analyst	8	8	16

Table 4.1 Details of participants

Gender. There were more male participants than female, and among the British participants the ratio was more than 2:1. This is not representative of the British Psychoanalytic Society as a whole, and in a later section 'limitations' we will consider the possible impact of this on the results.

Main qualification. Participants were asked to state their previous qualifications and work experience, and they are grouped under their main qualification before training as a psychoanalyst. Half of all participants trained in medicine and are qualified doctors (including psychiatrists, general practitioners, and paediatricians). The other major fields are psychology, social work, and academia (teaching and researching).

Years qualified. On average, participants have been qualified for 16 years. On average, the British participants have been qualified for four years more than the Americans. The participants, in general, are therefore very experienced. Experience varied from newly qualified (2004) to 48 years of practice (1957). This high variation in length of experience offers good range and breadth to the study.

Activities in the field. Almost three-quarters of the participants publish articles or books, and three-quarters do some form of teaching. Of the twenty-eight participants who teach, sixteen are training or supervising analysts. This further suggests that many of the participants are very active in the field, over and above their work with patients.

Orientation. Participants were asked about the theoretical orientation to which they felt most aligned. Each of the British participants were affiliated to a group – 'Contemporary Freudian', 'Kleinian', or 'Independent'. Several participants were reluctant to describe their orientation, claiming that such classification is the cause of unnecessary divisions in the psychoanalytic community. Many American participants expressing this opinion have described themselves as 'eclectic' or 'not exclusively anything'. This has made links between the findings and orientation difficult, and this limitation is discussed in the final chapter. Tables 4.2 and 4.3 display the theories that

participants have found important. The total exceeds forty since each participant often nominated more than one set of ideas. From this, it appears that the American participants are mainly committed to an ego psychological framework, though some are interested in other ideas such as object relations, classical drive theory, and relational theories (such as intersubjectivity). On the British side, most 'votes' went to the Independent tradition, followed closely by Kleinian thinking; only a handful went to Contemporary Freudian theories. In other words, among this sample, there is a significant difference in orientation between countries. This difference offers breadth to the study, and again, the possible impact on the results will be watched.

PREFERRED THEORIES	Number of participants
Ego psychology	17
Classical drive theory	5
Object relations	5
Relational theories	3
Self psychology	2
Communicative	2

Table 4.2 Preferred theoretical approaches of American participants

PREFERRED THEORIES	Number of participants
Independent	12
Kleinian	10
Freudian	4

Table 4.3 Preferred theoretical approaches of British participants

The American participants are affiliated with a range of societies including from New York, Boston, San Francisco, Chicago, Philadelphia, Columbia, Washington, Cincinnati and Seattle. Again, this range adds variety to the types of participants included in the study.

4.3 DEFINITIONS AND FEATURES

The following definition and description of free association is an aggregate of participants' responses:

In the presence of the analyst, thoughts, feelings, sensations and other mental content arise spontaneously in the patient's mind. These are reported, and may be unordered or seemingly unconnected. The patient and/or analyst reflect on these 'free associations', often finding them surprising or illuminating. Free association best occurs when patients allow themselves to feel relaxed and relatively free of distractions. This is aided by a trusting relationship, the analyst's position of neutrality, anonymity and relative silence, the patient's recumbent position on the couch, and a continuity of sessions. As a method, free association is a vital route to revealing the unconscious. It is subject to a variety of resistances, and total free association is therefore impossible or an ideal. Free association is a paradox since it is an 'order' to be 'free'. Some patients are better able to free associate than others, and lower-functioning people are sometimes thought to be less capable of free associating. The ability to free associate can improve over time.

In defining the fundamental rule, each analyst highlighted different aspects. The most emphasised aspects in order are: free association is subject to resistances, it entails freedom and relaxation, it requires a trusting relationship, it requires the analyst's silence, and it entails self-observation and reflection.

RESULTS (≠40): (Participants' comments are counted under several headings if appropriate. The numbers in brackets refer to the number of participants who have raised this point.)

Definitions:

Spontaneous	(17)
Presence of another	(8)
Reported	(7)
Haphazard	(13)
Surprising or exciting	(19)
Reflected upon	(24)

Assumptions:

Psychic determinism	(15)
Unconscious mental activity	(14)

Conditions:

Freedom and relaxation	(31)
Trusting relationship	(26)
Neutrality and anonymity	(15)
Analyst's silence	(25)
The couch	(16)
High frequency of sessions	(12)

Other features:

Paradoxical	(10)
Subject to resistance	(40)
Ability varies	(25)
Best for high functioning patients	(16)
Improves over time	(19)
Broad definition	(18)

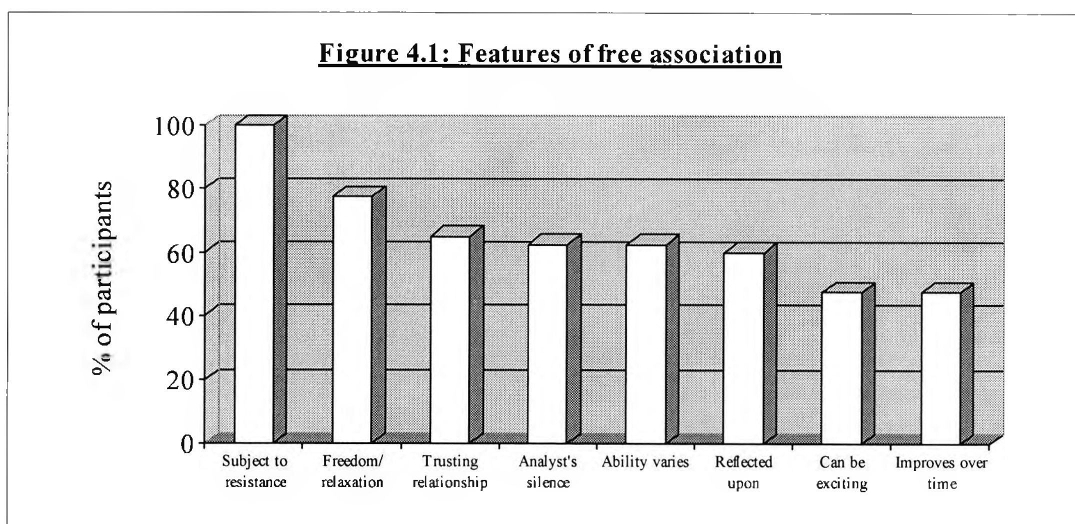

Figure 4.1 above displays the most frequently cited definitions and features of free association. All participants described free association as being subject to resistances, and over three-quarters defined it as a state of freedom and relaxation.

4.3.1 Ideas arise spontaneously (17)[1]

42.5 percent of participants pointed out that in free association, thoughts, feelings, and other mental content are believed to occur spontaneously to the patient. One participant, UK.I, says that regrettably 'association' is a very clichéd term which

[1] UK.A (para 12), UK.C (para 11), UK.D (para 4) UK.F (para 5), UK.I (para 18), UK.L (para 35), UK.Q (para 30), UK.S (para 11), UK.T (para 20), US.D (para 44), US.F (para 10), US.H (para 44), US.I (para 23), US.J (para 15), US.N (para 43), US.P (para 17), US.R (para 10).

inaccurately describes the process. She says that the German term '*einfall'* is closer to what actually takes place – which is an 'irruption' of an idea, or an idea that 'suddenly shoots' or 'falls into the mind' (paragraph 18). Several other participants mention in passing the spontaneous quality of free association, and indeed the notion of spontaneity is implicit in the request 'say **what comes** to mind'.

4.3.2 Occurs in presence of another (8)[2]

It is obvious that another person (the analyst) is required for analytical free association to occur. However, in defining free association, 20 percent of participants have chosen to highlight this aspect. For example UK.F says 'it's not just a question of being able to free associate, you have to be able to free associate in the presence of another.' (para 15). This is also part of how US.B defines free association: 'For me free association is whatever comes to mind and the ability to say it in the presence of another' (para 16).

4.3.3 Free associations are reported (7)[3]

That free associations are reported is also obvious, but 17.5 percent drew attention to this feature. US.R for example clarifies that there is a difference between having an idea arise, and expressing this idea verbally: 'allowing ideas to flow as they enter the mind and to speak what ideas come to mind is a different matter than having those ideas come up.' (para 10). US.Q also makes this distinction: 'the patient has been instructed to pay attention to his or her associations, and in the course of talking the patient will realise that he or she has had a thought and will articulate the thought' (para 3).

[2] UK.A (para 38), UK.F (para 15), UK.H (para 33), UK.I (para 14), UK.J (para 23), US.B (para 16), US.H (para 34), US.J (para 15).
[3] US.C (para 5), US.H (para 10), US.I (para 23), US.J (para 15), US.L (para 20), US.Q (para 3), US.R (para 10).

4.3.4 Free associations might be haphazard (13)[4]

32.5 percent of participants have remarked how free associations often are seemingly random, irrational and non-linear. UK.B calls the associations 'apparently consciously disconnected' (para 22), and US.R says that they aren't 'necessarily linked in some logical way.' (para 14). US.T discusses this with patients:

> *people say all the time "I'm afraid that I'm not going to make sense" or "I'm afraid that I'm rambling". And I say "that's quite your job to be able to do that if you wish. We don't have to know in advance where you're going to go". And that's really the sine qua non of a psychoanalytic treatment, that's what distinguishes it from all others (para 8).*

4.3.5 Free associations can be surprising or exciting (19)[5]

Just under half of all participants have referred to the 'new', 'powerful', 'revealing', 'exciting' or 'enjoyable' aspects that can be brought up by free association. UK.F illustrates how a patient might be surprised by material that has come up. A patient might say "you know that's really odd, I've just thought of something that I haven't remembered for twenty, thirty years" (para 5). He also compares the experience of understanding associations to a 'eureka experience for a lot of people. They'll say "Oh my God! I never thought of it like that".' (para 10). US.S speaks of the gratification for both patient and analyst: 'once people get it, it's really exciting to them, and they like it. I think there's a lot of pleasure - I think Kris talks about this - about libidinal gratification that goes with free association' (para 22).

[4] UK.A (para 12), UK.B (para 14), UK.C (para 9), UK.D (para 9), UK.F (para 10), UK.I (para 14) UK.P (para 25), US.D (para 7), US.F (para 10), US.N (para 45), US.Q (para 9), US.S (para 12), US.T (para 8).
[5] UK.C (para 9), UK.D (para 4), UK.F (para 5, 10), UK.G (para 19), UK.H (para 49), UK.I (para 18, 28), UK.J (para 27), UK.K (para 10), UK.L (para 10), UK.O (para 16, 24), UK.S (para 11), US.C (para 20), US.G (para 37), US.H (para 10), US.I (para 27), US.N (para 43,105) US.Q (para 9), US.R (para 12), US.S (para 22, 24, 28).

4.3.6 Free associations are reflected upon (24)[6]

60 percent of participants have emphasised the patient's self-reflective or self-observing function; not only do free associations have to be reported, but the content has to be reflected upon. UK.F says that 'at some point they have to develop a capacity not just to free associate but to think about the associations which are coming up.' (para 5). UK.C suggests that they need to switch between the two modes: 'what we're really asking for is for people to adopt a freely moving, alternation between reporting a mental content and then thinking about it.' (para 23). US.I also infers an alternation between reporting and self-observation: 'they're training their mind in that therapeutic split, that they are producing the utterances on the one hand and then looking and watching and seeing what they can pick up at the same time.' (para 25). Some participants, like US.M, say that it is the resistance which needs to be reflected upon, not just the content. Being 'heavily influenced by the structural theory and modern ego psychology', his method 'is to foster the patient's observing capacity to observe their own defensive activity.' (para 18).

Some analysts discourage reflective activity and a small number of participants[7] have shown that they prefer if patients do not to reflect too much or self-observe, arguing that that is the analyst's role; the patient should concentrate on free association alone. UK.Q, for example, is weary when patients are 'rushing to the role of being the analyst, interpreting their material all the time [...] rather than allowing the material to develop by being the patient and free associating to it' (para 22). All five of these participants who discourage reflective activity are British. We will see that more American participants than British are committed to resistance analysis and self-observation.

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[6] UK.C (para 23), UK.D (para 6), UK.F (para 5), UK.G (para 19),UK.H* (para 49), UK.I* (para 14, 28), UK.J (para 15), UK.K* (para 12) UK.L (para 15), UK.M (para 39), UK.O* (para 24), UK.S (para 11), UK.T (para 26), US.D (para 7), US.G (para 37), US.H (para 26), US.I (para 25), US.J* (para 11, 13, 19), US.L (para 16), US.M (para 18), US.O (para 30), US.N (para 57), US.P (para 35), US.T (para 22).* refers to those who speak of a therapeutic split.

[7] UK.D (para 14), UK.H (para 37), UK.I (para 18), UK.J (para 29), UK.Q (para 22).

4.3.7 Psychic determinism and unconscious mental activity (20) [8]

The assumptions of psychic determinism or unconscious mental activity are implied in half of the participant's comments. US.A spells out these 'basic postulates':

One is that there is a great deal of mental activity of which you are not conscious, and secondly what is called psychic determinism, that basically the past determines the present. If you are listening to a stream of thought, you may not know how A and B are related to each other, but you make the assumption that they are. (para 40).

4.3.8 Freedom and relaxation (31) [9]

The majority of participants – over three-quarters – have remarked that a degree of relaxation is involved in free association. They refer to the 'absence of censorship', 'lack of conscious monitoring', 'removing inhibitions', 'relaxing superego functioning', and becoming 'open' and 'receptive'. US.I defines free association as 'relaxing and letting one thought follow another the way a poet does, letting thoughts spill out into the air or on to the page' (para 27). US.N thinks it should be 'effortless': 'you don't exert a conscious effort to go into this direction or another, but you let it come in, and let yourself be surprised by it.' (para 43). US.S says it entails associating with as little inhibition or social control as possible, and 'without trying to maintain a narrative or a conversation' (para 18).

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[8] UK.B (para 8, 20), UK.C (para 9), UK.D (para 4), UK.E (para 20),UK.G (para 19), UK.I (para 22, 24), UK.O (para 10), UK.P (para 25), UK.Q (para 6), UK.S (para 11), US.A (para 40), US.H (para 8, 10), US.J (para 13), US.K (para 45), US.N (para 45, 47), US.P (para 25), US.Q (para 7, 11*) US.R (para 14), US.S (para 12, 24) US.T (para 8).

[9] UK.A (para 10, 38), UK.C (para 11), UK.B (para 20), UK.D (para 4, 24), UK.E (para 12), UK.F (para 5), UK.G (para 19), UK.H (para 31), UK.I (para 18), UK.J (para 23), UK.K (para 12), UK.L (para 53), UK.M (para 39), UK.P (para 13, 25), UK.R (para 11), UK.S (para 11), UK.T (para 62), US.A (para 38), US.C (para 5), US.D (para 13), US.H (para 30), US.I (para 27), US.J (para 15), US.L (para 12), US.M (para 18), US.N (para 43), US.O (para 38), US.Q (para 29), US.R (para 10), US.S (para 12, 18), US.T (para 8).

4.3.9 Trusting relationship (26) [10]

A large number of participants (65 percent) say it is important that the analyst offers trust and empathy to patients. US.K shows how such qualities can encourage free association: 'if I'm able to develop a more of an emotional connection and feel more of a relationship with them [patients], the repressed material that comes forward is more rather than less.' (para 31). For US.J, these qualities help define free association:

> *free association is a process by which, in the safety and security of a trusting relationship, within a holding space, the client has the opportunity [to free associate]. But that it has to occur in a very safe environment - I want to emphasise that. (para 15).*

This point is sometimes expressed in an object relations framework. For example UK.D comments that 'to actually free associate one really has to be at ease with oneself and to be trustful of one's object - who you're talking to.' (para 6).

4.3.10 Neutrality and anonymity (15) [11]

37.5 percent of participants comment on how neutrality and anonymity are conducive to free association. These conditions offer the patient the necessary space, free from interference, to be able to get on with the task. UK.E finds free association is 'greatly facilitated by the rule of abstinence, where the patient knows little or nothing about the analyst, and doesn't see the analyst, and has no distractions or interruptions' (para 30).

A few others (four) [12] seem to challenge the notion of a 'blank screen' and have revealed in the interview that they self-disclose. US.K rather than conventionally

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[10] UK.A (para 10), UK.B (para 32), UK.D (para 6), UK.F (Para 5, 7), UK.G (para 27, 31), UK.H (para 25), UK.I (para 14), UK.J (para 19, 27), UK.K (para 16), UK.L (para 9, 13), UK.M (para 7), UK.N (para 17), UK.O (para 40), UK.P (11, 21), UK.R (para 13), UK.S (para 11, 15), UK.T (para 20), US.C (para 41), US.D (para 37), US.E (para 8), US.I (para 39), US.J (para 15), US.K (para 31), US.N (para 73), US.P (para 9, 13), US.T (para 20).

[11] UK.A (para 20), UK.B (para 34), UK.C (para 37), UK.D (para 20), UK.E (para 30), UK.G (para 31), UK.N (para 5), UK.R (para 10), UK.S (15), US.F (para 46), US.H (para 10), US.M (para 66), US.O (para 40), US.P (para 23), US.Q (para 41).

asking for guided associations to a dream might show enthusiasm for it: "that's quite a dream!" (para 25). In the 'pure' sense of free association, such a comment is directive and leaning, as it imparts the analyst's personal response to the patient's material.

4.3.11 Relative silence (25) [13]

62.5 percent of participants show that they use silence to encourage the production of free association. US.B says that although there 'may be long periods of silence, sometimes just allowing that silence will stimulate thoughts, and the person will just go with it' (para 8). UK.K would rather not interpret at all if it would interrupt the associations: 'patients sometimes say "Oh god I'm talking, I don't know where I'm going with this". I'll think, "Ok, fine, great!" but I won't say so, because that will spoil the flow.' (para 10). US.J implies that it can be experienced by the patient as containing: 'I find myself using a lot of silence and trying to create this kind of space where a client can to the best of their ability free associate' (para 13).

4.3.12 The couch (16) [14]

Not all participants believe that the recumbent position is essential for analysis, and indeed two participants prefer to conduct analysis face-to-face. However, 40 percent stated that the couch will facilitate free association. UK.N comments that 'it is really powerful to be on the couch not to be seeing your analyst or your therapist. It allows you the space to be able to more easily get in touch with your own thoughts and therefore free associate properly.' (para 33). US.F infers that the couch promotes anonymity which in turn helps free association. She says that 'when they go to the couch, it feels more for me as if the free association will occur

[12] US.I (para 11), US.K (para 25, 31, 33), US.P (para 7, 35), US.T (para 28).
[13] UK.B (para 8, 16, 54), UK.C (para 9), UK.D (para 16), UK.F (para 29), UK.H (para 41, 49), UK.I (para 18, 26), UK.J (para 27, 35), UK.K (para 10), UK.L (37), UK.O (para 16, 20), UK.R (para 27), UK.S (para 17), UK.T (para 42), US.A (para 36), US.B (para 8), US.C (para 18, 21), US.D (para 37), US.F (para 20), US.H (para 16), US.J (para 13), US.M (para 46), US.O (para 30, 32), US.R (para 32), US.S (para 38), US.T (32).
[14] UK.A (para 54), UK.D (para 22), UK.E (para 30), UK.F (para 39), UK.I (para 14), UK.M (para 17-19), UK.N (para 33), UK.P (para 7), UK.Q (para 30), UK.S (para 27, 29), UK.T (para 12), US.C (para 33), US.D (para 11), US.F (para 12), US.N (para 101), US.R (para 33).

[...] because they are not looking at my face and they are not getting feedback' (para 12).

4.3.13 High frequency (12) [15]

30 percent of participants imply that a high frequency of regular sessions aids free association. UK.Q makes a direct link: 'more frequency, more continuity, more likelihood of a freer free association.' (para 32).

4.3.14 The fundamental rule is paradoxical (10) [16]

There are different ways in which participants conceive the fundamental rule as paradoxical, but in total 25 percent do so. The most quoted view is that the fundamental rule is paradoxical because it is an 'order' to freedom. UK.S announces that 'there's a strange paradox within it - namely "I'm instructing you to be completely free with your thoughts" [laughs] and that in some sense undoes freedom' (para 23). US.T points out the paradox by asking 'how can association be free if it's a rule? In other words, you say "the fundamental rule", well that immediately takes the freedom out of it' (para 4). Participants also find it paradoxical because the associations are not free, but unconsciously determined as US.N comments: 'it's misleading to call them "free associations" because they are determined by the contents and the ideas, the thoughts and the emotions within the individual.' (para 43).

[15] UK.A (para 52), UK.D (para 18), UK.E (para 32), UK.F (para 5), UK.H (para 55), UK.K (para 26), UK.L (para 11), UK.M (para 21), UK.Q (para 32), UK.R (para 33), US.A (para 82), US.D (para 17).
[16] UK.B (para 22), UK.I (para 26), UK.O (para 10, 34), UK.R (para 5), UK.S (para 23), US.C (para 29), US.K (para 33,39), US.N (para 43), US.S (para 18), US.T (para 4).

4.3.15 Free association is subject to resistances (40) [17]

Every participant made some reference to the difficulties involved in free associating. Many of them referred to this point several times. These difficulties are described primarily as 'resistances' (by 72.5 percent of participants) but also in an array of other names: 'blocks', 'obstacles', 'impasses', 'impediments', 'problems', 'struggles', and 'interferences'. Some participants describe the process of how resistance comes about. An individual feels anxiety, shame, uncertainty, or guilt of allowing their minds (or a sensitive area of it) to be revealed to themselves or to the analyst. They then defend themselves from this via resistance. UK.H highlights the universal operation of resistance: 'nobody even at the end of a full analysis can completely free associate, there always will be difficulties in completely free associating.' (para 37). UK.R says that 'free association isn't something that [chuckles] comes easily to anybody.' (para 17). He will try to understand what the patient's defences are and what they are protecting the patient from for example, 'it might be an issue of conscious guilt about betraying parents or something of that sort, or the family, [or] the fear of loss of control.' (para 23).

UK.Q defines free association in terms of its difficulty: 'one might use the term in the sense of something that is only rarely achieved, in other words, where there aren't interruptions, diversions, twisting of one's associations, inhibitions of them, for defensive reasons.' (para 36). This is also part of how US.K defines free association: 'part of the definition is that we're giving the patient an impossible task. Due to the nature of repression, shame, guilt, it's an idealized notion to say whatever one's mental contents are' (para 39). In total, 30 percent of participants stressed that free association is impossible or an ideal. US.M talks about how it is impossible because 'everyone exhibits and employs defensive functioning' (para 18). He says: 'I

[17] UK.A (para 10, 26), UK.B (para 8, 26, 30, 32, 34^), UK.C (para 13), UK.D (para 4, 6*), UK.E (para 16, 18, 22), UK.F (para 5, 35), UK.G (para 19), UK.H (para 25*, 37, 51*), UK.I (para 14, 18, 28), UK.J (para 11, 15*, 23, 35), UK.K (para 8*), UK.L (7*, 9^, 11, 33), UK.M (para 5, 11), UK.N (para 5*^), UK.O (para 22*), UK.P (para 13*^, 29), UK.Q (para 20, 24, 36, 38), UK.R (8, 11^, 17, 23), UK.S (para 21), UK.T (para 48), US.A (para 18*, 28, 30^), US.B (para 12, 14*?), US.C (para 8, 20), US.D (para 7*, 27), US.E (para 42), US.F (para 50, 60), US.G (para 13*), US.H (para 32, 38*^), US.I (para 11*, 25), US.J (para 11, 13, 19*) US.K (para 21*, 39^), US.L (para 12*, 16^, 20), US.M (para 16*, 18^, 36), US.N (para 57), US.O (para 30, 36^), ?US.P (para 27), US.Q (para 29*^), US.R (para 8), US.S (para 12, 34*), US.T (para 8*, 22). ^=free association is impossible or ideal (12 participants)*=understanding resistance more important than free association (21 participants).

think that it's a term that has a history of great significance, but it was a fiction really. No one can associate freely unless they're manic or something.' (para 36).

Of all the comments on definition, the nature of difficulty with free association is referred to the most. We will see later what kinds of resistances participants have worked with, as well as the techniques that analysts apply to them. We will also see that half of participants believe that understanding the resistances to free association is equally or more important than getting the patient to fully free associate.

4.3.16 Ability to free associate varies (25) [18]

Another common observation, made by 62.5 percent of participants is that some patients are better at free associating than others. UK.F believes that 'people's capacity to use it varies quite widely [...] There are some people who can free associate from the word go, whose level of inhibition is so low that you get a flood of stuff' (para 5). On the other hand he has seen patients who have not been able too free associate because 'they're too defensive, they're too cut off from their feelings' (para 35). US.M adds that the ability to free associate can vary across time:

> *there's the whole class of patients who can't talk readily, that's part of their difficulty and part of their character structure [...] and it might be variable, they might be able to talk more freely sometimes, and then not able to talk at all at other times. (para 32).*

US.M's observation that varying ability to free associate might reflect varying personality structures is echoed by a further fifteen analysts (40 percent in total). They hint that lower functioning patients, or those who are internally insecure, unstable or disturbed, are less suited to the method of free association. UK.F thinks that 'it's that level of emotional security which is underneath which dictates how well someone is able to use that process of free association.' (para 5). US.P thinks so too: 'you have to

[18] UK.A (para 10), UK.E (para 16, 18, 22), UK.F (para 5, 35), UK.G (para 19, 37, 43), UK.H (para 21, 49), UK.I (para 14) UK.K (para 8, 323), UK.M (para 21), UK.P (para 31), UK.R (para 27), UK.S (para 11), UK.T (para 8, 10), US.A (para 82), US.B (para 4), US.C (para 31, 33-35), US.G para (20, 31), US.H (para 32), US.I (para 11, 27), US.J (para 11), US.M (para 32), US.N (para 45), US.O (para 30), US.P (para 13, 15, 17), US.R (para 8), US.S (para 44).

have a level of safety to tolerate the open-endedness of your own free associations.' (para 15). UK.A remarks that:

> *patients very often find it very difficult to be free. That may be part of their personality structure - they're very obsessional schizoid patients, it's very hard for them to allow themselves to have the sort of freedom to go with free association. Their associations tend to be very stilted, and very rigid. (para 10).*

UK.K talks of borderline or 'near-psychotic' patients suggesting they are not suitable to the method: 'I think the nature of really serious disturbance by definition means that somebody can't free associate easily. If they could, they wouldn't be highly disturbed in that way.' (para 30, 32).

Some participants prefer not to treat disturbed patients because it is likely that they will be unable to free associate. UK.G says of psychotic patients: 'they go through phases where it becomes absolutely stark and the associations can be quite dangerous.' (para 43). He finds the treatment of psychotic patients difficult and ideally would not work with them, but admits that sometimes their psychotic tendencies are not picked up at assessment stage. Three participants[19] additionally give examples where they have abandoned free association because the associations were becoming too disturbing. US.C for example might find a patient getting 'more and more anxious, they might get tightened up, they might start unravelling in ways that are undesirable. Over time they might come up with greater symptoms - they might become depressed or become schizoidal' (para 35). In such cases, she will 'abandon it. It's not what they need to do' (para 33). On the other hand, 10 percent of participants[20] use free association regardless of personality structure. UK.H, for example, recognises that 'more manic patients' may produce 'more pathological free associations' (para 49), but he still uses the method.

[19] US.C (para 33, 35), US.G (para 29, 31), US.P (para 15).
[20] UK.H (para 49), UK.I (para 14), US.D (para 29), US.E (para 48).

4.3.17 Free association tends to improve over time (20)[21]

Another common observation is that the patient's ability to free associate will improve over time. UK.F comments that 'over a period of time they might begin to open up and loosen up and then they begin to free associate' (para 5). UK.M believes that 'it's a skill that one develops during the analysis' (para 39). US.R thinks that the ability to free associate 'tends to get better as time goes on and patients learn a little bit more about the analyst and about what is fair game to talk about.' (para 8).

4.3.18 Free association broadly defined (18)[22]

Free associations can be viewed in the narrow sense (free associations occur in the analytic setting and do not include transference or resistance) or in the broad sense (free association is anything the patient says or does). In discussing free association in the interview, most participants conceived of free association in the narrow sense. However, they noted that it can be viewed more widely as well. Free association can occur in daily life, say 12.5 percent of participants. UK.E for instance, says that analysis is not only context in which free association occurs:

> *sometimes when I go into the supermarket and see the gentleman who serves me fish, he frequently free associates. I don't interpret it, I don't use it. But I am aware that that's what he's doing. Because he's just saying what comes into his head. (para 12).*

Also, 37.5 percent of participants mention that free association can be used in psychotherapy and psychiatric practice. US.M encourages it in all his work:

> *I always encourage patients even in the most supportive therapy, to say what's on their mind, [...] So I guess that implies that I rely on this notion*

[21] UK.A (para 12), UK.D (para 6), UK.F (para 5), UK.G (para 19), UK.I (para 28), UK.J (para 17), UK.L (para 13), UK.M (para 39), UK.O (para 20), UK.R (para 27), UK.S (para 11), UK.T (para 8), US.C (para 37), US.H (para 34, 44), US.I (para 23), US.J (para 13), US.N (para 57), US.R (para 8), US.S (para 22), US.T (para 22).
[22] UK.A (para 34*), UK.B (para 56*), UK.E (para 12^, 30^), UK.H (para 7*, 31^), UK.N (para 5*, 13^, 33*), UK.O (para 20*), UK.R (para 5^), UK.S (para 11^), US.A (para 82*), US.F (para 4*), US.G (para 29*), US.H (para 8*), US.I (para 11*), US.J (para 7*, 17*), US.K (para 19*), US.M (para 16*, 40*), US.N (para 31*, 99*), US.Q (para 29*). *= free association occurs in psychotherapy/psychiatry (15 participants), ^= occurs in everyday life (5 participants).

of speaking freely as a primary method in just about all of my psychiatric work. (para 40).

4.3.19 Section Summary

This section has outlined the various definitions, assumptions, conditions, and features of free association discussed by participants. Although they raised numerous points, the most frequently mentioned aspects were that it is subject to resistances, that it is characterised by freedom and relaxation, that it requires a trusting relationship and the analyst's silence, that the ability to free associate varies from person to person, that it tends to improve over time, and that free associations are not just reported, but reflected upon. Next we review the question of whether participants believe free association is important.

4.4 IMPORTANCE OF FREE ASSOCIATION

There seems to be a continuum ranging from views of free association as 'fundamental' to 'not especially important'. Those regarding it as 'fundamental' stress that it is the cornerstone of the analysis and the driving force of analytic treatment. Free association is 'important' when participants value the role that it plays in the work, but think it is not an exclusive feature, and that other aspects such as transference play an equally important role. A handful of participants who find free association 'not especially important' feel that free association is to be used flexibly. A single participant believed that the rule of free association is important but not enough; it is also necessary for the patient to follow a second rule of making up a story. Another finding is that thirteen participants[23] take the ability to associate freely as a good indicator that an analysis has been beneficial, and that for four[24] participants, free association is taken to be a goal in itself.

[23] UK.A (para 26), UK.D (para 5), UK.F (para 5), UK.H (para 37), UK.L (para 9), UK.N (para 29), UK.O (para 20), UK.P (para 7, 13), UK.Q (para 36), US.H (para 32-34), US.K (para 11), US.S (para 10, 26), US.T (para 22).
[24] UK.K (para 8, 10), UK.R (para 5, 11, 29), UK.S (para 11), US.M (para 20).

RESULTS (=40):

Free association is:

Fundamental	(7)
Important	(27)
Important but not enough	(1)
Not especially important	(5)

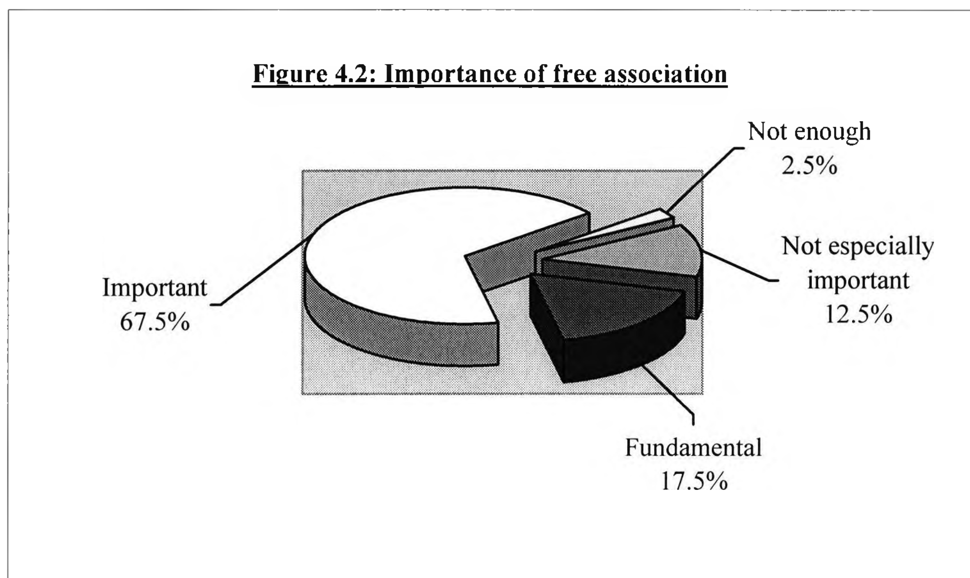

Figure 4.2: Importance of free association

Figure 4.2 shows that the bulk of participants (87.5 percent) find free association to be 'important', 'fundamental' or 'important but not enough'. The remainder (12.5 percent) of participants do not find free association especially important. The average participant (based on mode and median measurements) finds free association to be 'important'. We can assert that significantly more participants find free association to be 'important' or 'fundamental' than 'not especially important' ('extremely significant': chi-squared=22.50, df=1, p=0.0001).

4.4.1 Fundamental (7) [25]

17.5 percent of participants emphasise how vital free association is to psychoanalysis. UK.E says that it is a prerequisite in analysis to be able to free associate and implies that there is no alternative. She remarks that:

> *given that I work as a psychoanalyst I would say it is the only rule that I feel is absolutely critical for the work. [...] If the patient can't free associate, well there's not much we can do to help them. (para 28).*

Similarly, UK.F's view is that 'it is fundamental to a psychoanalytic way of working' (para 5) and finds it difficult to work with patients who can't free associate. UK.O finds it 'essential to psychoanalysis' (para 8). She also thinks that the ability to associate freely is an indicator of a successful treatment: 'when the patient can free associate, we can start thinking of ending analysis' (para 20). US.N notes that 'lip-service is paid to it, but people really no longer understand how crucial and how basic it is.' (para 15) and US.T says 'The analysis depends upon it – it's the life blood' (para 28).

Some of these analysts think that in recent analytic thinking, free association has been upstaged by other aspects such as interpretation, transference, and counter-transference. They believe these aspects should in fact be secondary to free association. UK.R comments that 'of course one is always listening out for transference and counter-transference but they are essentially a means to an end, and the end, in a sense is associative freedom' (para 5). He is one participant who views associational freedom as an outright value. UK.K also views free association as a goal in itself:

> *people often think of free association as a means to an end; it's the thing which reveals unconscious connections [...] But I think that free*

[25] UK.E (para 8), UK.F (para 5), UK.K (para 8), UK.O (para 8), UK.R (para 5), US.N (para 15), US.T (para 28).

association is a vehicle in its own right for internal psychic growth and development (paras 8 & 10).

He also finds that it can be a criterion for ending analysis: 'when somebody comes to the point of actually being able to free associate, then their analysis has done what it needs to for them and they don't need their analysis any longer' (para 8).

4.4.2 Important (27) [26]

67.5 percent of participants think that free association is important, but they are not emphatic about its centrality. For example, US.J finds that 'free association is a major component of my own practice' (para 7). US.B is not always conscious of it but does find it important: 'it's not something I talk about, but certainly, it's a guide for me and it keeps me grounded in the work.' (para 24). US.R finds that 'in theory it's a wonderful method.' (para 12), but questions whether it is 'the bulk of what goes on' (para 8). UK.T finds it to be one of many important aspects: 'It is important. And free association, transference, my counter-transference, dreams, all of that stuff, are the building blocks or the bedrock of what I want to work with.' (para 36) UK.G recognises that the treatment would be 'dead' without free association (para 17), but counter-transference takes centre stage:

free association does lead somewhere and it's a very useful tool. I wouldn't say it's central to my work; I think central to my work is counter-transference and trying to work out what this person is doing and what he's feeling towards the setting and me. (para 11).

[26] UK.A (para 6), UK.B (para 8, 44), UK.C (para 7), UK.D (para 14), UK.G (para 11, 17), UK.H (para 7), UK.I (para 14), UK.J (para 41), UK.L (para 15), UK.M (para 5), UK.N (para 5), UK.P (para 7), UK.Q (para 6), UK.T (para 36), US.A (para 36), US.B (para 24), US.C (para 41), US.D (para 7), US.F (para 50), US.H (para 8), US.I (para 11), US.J (para 7), US.L (para 12), US.M (para 16), US.P (para 7), US.R (para 8), US.S (para 18).

4.4.3 Not especially important (5)[27]

12.5 percent of participants say they use free association flexibly. US.K for instance, who has become 'more relational' in his work, prefers to be 'conversational' with patients. He finds that analyses where he has 'that freedom with the patient to not be stuck and stilted in free association', progress better than analyses using conventional and 'conservative' techniques (para 33). He says that he allows himself to be 'spontaneous' with patients and 'may engage in a little bit more of a here-and-now conversation with the patient, that isn't entirely a sterile free association.' (para 23). Another participant, UK.S, is somewhat critical of free association. He shows that it can be a tool, but what is important is the understanding of the personality rather than what the patient says. He comments about free association:

> *I don't think in the end that's what happens, it's not how people operate [laughs] as it were. They can do it for a short while, but it's not that useful. So it's not the nature of the enterprise as we understand it these days (para 9).*

4.4.4 Important but not enough (1)

Only one participant, US.O, found free association to be insufficient for the task. He practices what he terms 'communicative psychoanalysis' whose method deviates from traditional psychoanalysis. He finds it necessary to ask patients to narrate a dream or story, as well as free associate (para 30). He remarks: 'the fundamental rule of free association remains fundamental, but [...] it has to be supplemented with the rule of guided associations' (para 30). He justifies that stories and dreams are more helpful in accessing the unconscious than free association alone: 'free association takes you to an intellectualised world unless you introduce the need and the requisite for narrative.' (para 36).

[27] UK.S (para 9), US.E (para 70), US.G (para 35, 39), US.K (para 23, 33), US.Q (para 3).

4.4.5 Section summary

Overall, we have seen that the bulk of participants believe free association is important or fundamental to their work. Only a handful of participants challenged this. No participant argued vehemently against free association, so it seems that it is important for all participants but to different degrees. We now examine the aspects that make free association important.

4.5 BENEFITS OF FREE ASSOCIATION

Free association can be useful in a number of ways. Most participants spoke about the role it plays in giving them and the patient access to unconscious material. Other ways in which it is helpful are: to help understand dreams (via guided association), to understand resistances, and to provide evidence for the analyst's hypotheses.

RESULTS (≠40)

Useful for revealing the unconscious	(36)
Useful for understanding dreams	(11)
Useful for confirming hypotheses	(6)
Useful for understanding resistance	(27)

Figure 4.3: Uses of free association

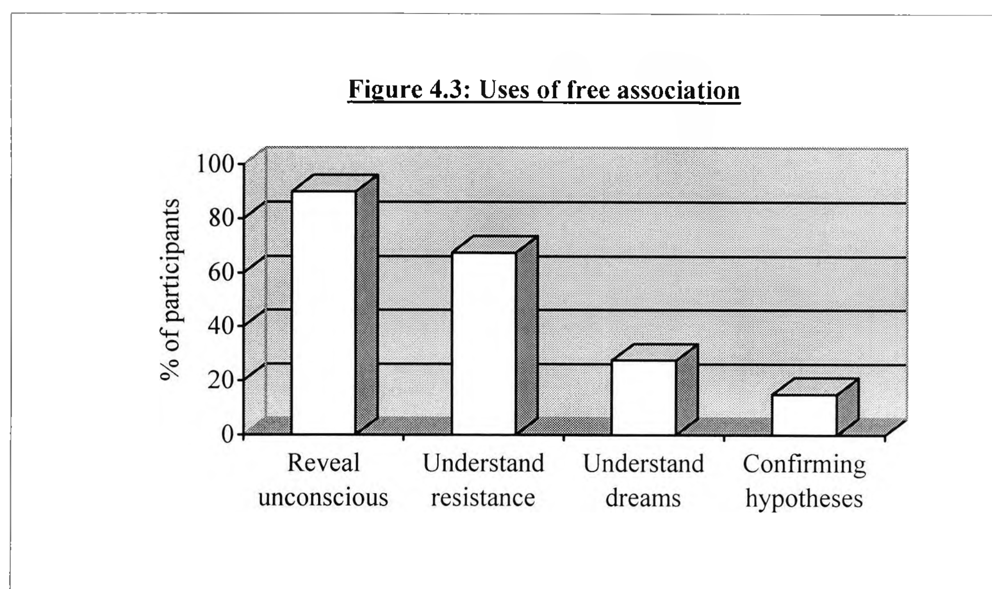

Figure 4.3 displays the finding that free association is most useful because it reveals the unconscious, but also because it helps to understand resistances.

4.5.1 Tool for revealing the unconscious (36) [28]

Nearly all participants – 90 percent - comment that free association gives the analyst access to the mind's content and its levels, most of which are unconscious. UK.E refers to this historic benefit: 'free association is the means whereby we get an insight into the unconscious, that's what it was for Freud, that's how I understand it, and that's how I use it.' (para 10). UK.A explains why free association is important: 'I think it's essential because it gives you such an excellent entrée into the patient's thoughts, feelings, motivations, defences, which you don't get if you're just going to ask questions of the patient.' (para 34). He shows how it might uncover issues from childhood or 'traumatic areas' which have hitherto remained unconscious. UK.N notes that 'if the patient can put those thoughts into words, then we have a direct communication from the unconscious.' (para 13). This is helpful because it provides the data for analysis: 'what will take place in the room will be as near as I can make it,

[28] UK.A (para 10, 34), UK.B (para 20, 22), UK.C (para 9), UK.D (para 4, 6), UK.E (para 10, 12), UK.F (para 5), UK.G (para 11), UK.H (para 47), UK.I (para 14), UK.J (para 15), UK.K (para 8), UK.M (para 5, 13), UK.N (5, 13), UK.O (para 34), UK.Q (para 6), UK.R (para 23), UK.S (para 11), US.A (para 38), US.B (para 16), US.C (para 5), US.D (para 7, 9), US.F (para 54), US.G (para 27), US.H (para 10), US.I (para 11), US.J (para 7), US.K (para 21), US.L (para 12), US.M (para 36), US.N (para 57), US.O (para 38), US.P (para 7, 25), US.Q (para 3), US.R (para 14), US.S (para 10, 18), US.T (para 8).

a reflection of the patient's unconscious only, and that's what we will explore.' (para 5).

4.5.2 Useful for understanding dreams (11)[29]

27.5 percent of participants say that associations to dreams can be helpful in revealing unconscious meanings, in contrast to examining the manifest content alone. For example, UK.H states that 'It's not the dreams in themselves that are crucial, it's the free associations to the dreams that are yet another crucial, or very useful tool' (para 39). UK.Q says something similar: 'someone may free associate to a dream and that may be as helpful in understanding a dream as anything in the dream itself.' (para 6). UK.O agrees, saying that:

> *with dreams I think there is an unfortunate tendency to analyse or understand the manifest content [...] But the problem is that if one doesn't listen to the associations it just gets stuck at the manifest content. (para 10).*

4.5.3 Useful in providing evidence to confirm/disprove hypotheses (6)[30]

15 percent of participants show that free association can provide evidence for a hypothesis that the analyst has formed. They find free associations to be more instructive than rational discussion or conscious agreement by the patient. UK.D raises this point:

> *that's the other vital thing about free association, it's "what is a patient's association to an interpretation?" That tells us so much about whether we're right or wrong. And it's so much better when one does get a free association to an interpretation rather than an intellectual response (para 14).*

[29] UK.G (para 29), UK.H (para 39), UK.O (para 10), UK.Q (para 6), US.B (para 44), US.D (para 17), US.I (para 19), US.K (para 25), US.M (para 34), US.R (para 36), US.S (para 48).
[30] UK.C (para 29), UK.D (para 14, 20), US.A (para 36) US.O (para 30), US.P (para 9), US.R (14, 42).

4.5.4 Useful for examining resistances (27)[31]

67.5 percent of participants find the absence of free association to be important. In other words, free association is not useful in its own right, but as a means of revealing resistances. In turn, the understanding of these resistances (resistance analysis) is a route to understanding the individual. US.A says that it is in its 'absence' that 'its value really comes up.' (para 18). Resistance analysis is his guiding principle: 'defence analysis to me is the hallmark of analysis.' (para 36). US.S echoes this in saying that he is 'just as interested in what stops them as what allows them to continue.' (para 34). UK.D states that 'to struggle' with free association is 'the gist of analysis' (para 6). Similarly, UK.O takes resistance not as the obstacle to analysis, but the 'bread and butter of it' (para 22). UK.K also finds that 'It's how people find that they can't follow the fundamental rule that is the stuff of analysis.' (para 8).

Although many of participants adopting this view affirm the ego psychological approach (63% do so), a substantial number - 37% - describe their leanings as Kleinian, Independent, or eclectic. More American participants (60%) find free association to be useful for revealing resistances than British (40%), but this result is statistically insignificant (chi-squared=0.926, df=1, p=0.3359).

4.5.5 Section summary

The main purpose of free association is to provide access to the patient's mind and its various levels, especially the unconscious. Another important use is that it helps the understanding of resistances. We turn now to examining what kinds of resistances analysts work with.

[31] UK.A (para 14), UK.B (para 8), UK.D (para 6), UK.H (para 25, 51), UK.J (para 15), UK.K (para 8), UK.L (para 7), UK.M (para 23), UK.N (para 5, 33), UK.O (para 22), UK.P (para 13), US.A (para 18, 36), US.B (para 14), US.C (para 21), US.D (para 7), US.E (para 46), US.F (para 50), US.G (para 13), US.H (para 36), US.I (para 11), US.J (para 19), US.K (para 21), US.L (para 16), US.N (para 57), US.Q (para 29), US.S (para 34), US.T (para 8).

4.6 FORMS OF RESISTANCE

Resistance here is taken to mean a manifestation of defence that occurs towards the analytic setting, and towards free association in particular. We have seen that all participants agree that free association will be subject to resistance. Participants spent much time discussing the resistances since they operate against speaking freely, and are an integral part of free association. As one participant says 'you can't understand free association and the fundamental rule outside a whole network of related concepts, so that free association is inseparable from resistance'(UK.J para 11).

Participants gave examples of the types of resistances to which free association is subject. The first group – mainly examples of conscious resistance - includes omissions, denial, and lying and collectively are cited by 40 percent of participants. The second group – mostly unconscious resistance - includes silence, switching of subject matter, and shifts in mood or affect. Three-quarters of participants described instances of 'pseudo-free association' - when what appears to be free associative on the surface, is in fact used for defensive purposes.

RESULTS (≠40)

Omissions, denial or lying	(16)
Silence	(26)
Claims to have a blank mind	(10)
Shift in topic	(20)
Shifts in mood or affect	(17)
Pseudo-free association	(31)
Caricature	(11)
Generalisation/intellectualisation	(14)
Preparing material/reporting events/repetition	(17)

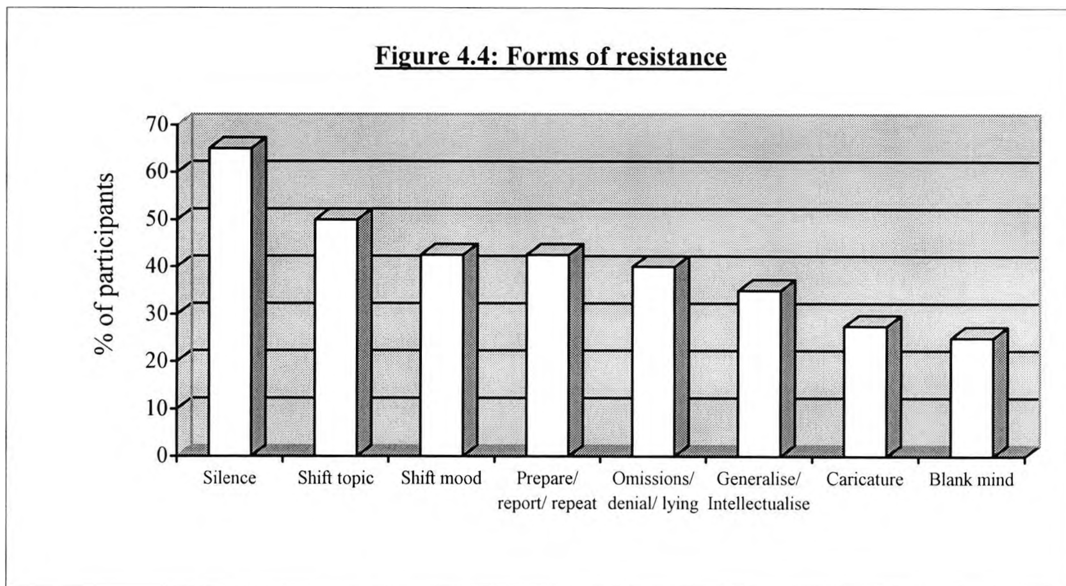

Figure 4.4 illustrates the most common forms of resistance. Silence has been quoted by 65 percent of participants, more than all other types of resistance.

4.6.1 Omissions, denial, lying (16)[32]

40 percent of participants gave examples where the patient is aware of having thoughts, but is uncertain of sharing them with the analyst. Participants labelled this as 'denial', 'disavowal', 'holding back', 'reluctant to go down a particular route', 'communicating with deletions', 'lying to your face', or 'withholding a major reservation'. UK.D has observed conscious objections from the patient such as: "ooh, there are certain things I could never tell you". He recounts how a patient of his, despite several interpretations, refused to talk about what was on his mind because they were about activities in the Freemason's lodge to which the patient belonged. UK.D reflects: 'I thought he legitimised resistance', and the treatment broke down after a year (para 24). However, UK.D hints that this form of resistance is less common than unconscious censoring. US.A encounters many cases of conscious resistance, perhaps because he sees several young patients. He says that 'you see this most really in adolescents, when they would say "well this is not something I intend

[32] UK.D (para 24), UK.H (para 43), UK.I (para 14), UK.M (para 5), UK.N (para 5), UK.R (para 15), US.A (para 18, 20, 28), US.D (para 27), US.E (para 10), US.G (para 27), US.H (para 38), US.M (para 26), US.N (para 61, 69), US.O (para 30), US.Q (para 13), US.T (para 8, 30).

to talk to you about, I only talk to my friends about that"' (para 18). He also finds that it is typical for his patients to say, for example, "there is no way that I can tell you about my sex life, it's just too personal" (para 18).

4.6.2 Silence (26) [33]

Around two-thirds of participants talk about how the patient is silent in ways that are resistant. These are known variously as 'pauses', 'hesitations', 'blocks', and 'breaks'. UK.S illustrates: 'a lot of people are a lot of the time, very tense or stiff, or they don't know what to think, or their mind freezes' (para 21). US.J explains how this happens:

> *all that's going on in the patient's unconscious associations is triggering some kind of emotional experience that they cannot hold in their mind, or that they cannot articulate. So that's what leads them to [...] become stuck, where they're not able to say anything (para 13).*

Participants often distinguish between a 'resistant silence', in which the patient conceals thoughts, and 'productive pauses', in which the patient is having a reflective private moment or pause. US.C, for example, finds some silences to be useful for the patient: 'there are lots of productive pauses - I mean, I sit for long silences with my patients, and the material moves along, and that's a little bit different.' (para 18).

4.6.3 Express a blank mind (10) [34]

A quarter of participants described instances where the patient claims to have nothing to say. Rather than let a silence pass, the patient will express difficulty. Examples are: "I don't know what's on my mind" (US.B para 10), "I can't think of

[33] UK.A (para 22), UK.B (para 14), UK.C (para 23), UK.D (para 8), UK.E (para 22), UK.H (para 45), UK.I (para 14, 18), UK.M (para 11), UK.N (para 19), UK.P (para 27), UK.Q (para 12), UK.S (para 11, 21), US.B (para 30), US.D (para 27), US.E (para 10), US.F (para 50), US.G (para 13), US.H (paras 10, 16), US.I (para 11), US.J (para 11, 13, 19), US.L (para 18), US.M (para 26, 32), US.N (para 59), US.O (paras 34, 36), US.R (paras 16, 18, 34), US.S (para 16).

[34] UK.B (para 32), UK.C (para 9), UK.S (para 21), US.B (para 10), US.C (para 8), US.E (para 10), US.F (para 14), US.G (para 13), US.J (para 17), US.R (para 20).

anything" (US.E para 10), "well nothing's on my mind today' (US.R para 20), and "I really have nothing more to say" (US.C para 8).

4.6.4 Shift in topic (20) [35]

Strictly speaking, free association would allow for topic changes - it entails saying whatever comes to mind, no matter how disconnected - and as such shifts in topic are not necessarily resistant. Yet half of all participants imply that they take such shifts to be a sign of resistance. They spoke of 'discontinuities', 'disruptions', 'diversions', 'changing direction', 'rapid change of subject', 'small shifts in the patient's flow of talk', 'a turning away', or 'changes in the ordinary narrative flow'. UK.Q explains that patients 'might suddenly change position' (para 12). Such a change, he says, 'represents an escape from what went on before' (para 38) and goes on to give an example: 'if someone's talking about something extremely painful, and then suddenly thinks of something pornographic or explicitly sexual, then one might think well this is a very clear defensive jump' (para 38). US.J explains how such a shift in topic comes about: 'it would be a matter of certain memories, or certain associations to me, are creating anxiety in the moment - then the patient has to shift focus to something else.' (para 13).

4.6.5 Change in mood or affect (17) [36]

42.5 percent of participants raised examples of changes in affect, which sometimes accompany changes in topic. Participants describe how they are alert to 'changes in mood' such as anger, anxiety, elation, or depression. They are also aware of 'changes in physical comfort level or position' such as 'breathing', 'facial expressions', and 'eye contact'. Finally, they are aware of shifts in how the patient is communicating - 'odd use of language', 'vivid words', or 'rhythm of speech'. These

[35] UK.A (para 22), UK.B (para 14), UK.C (para 23), UK.D (para 8), UK.G (para 19), UK.J (para 19), UK.Q (para 38, 40), UK.R (para 15), UK.S (para 11), US.A (para 18), US.B (para 18), US.F (para 52), US.H (para 10, 16, 44), US.I (para 11), US.J (para 13), US.L (para 18), US.M (para 20), US.Q (para 13), US.R (para 15), US.S (para 12).

[36] UK.B (para 16), UK.D (para 4), UK.I (para 14), UK.J (para 27), UK.N (para 19), UK.J (para 27), UK.Q (para 24), UK.R (para 15), UK.S (para 11), UK.T (para 38), US.A (para 17), US.D (para 27), US.H (para 10, 44), US.J (para 11), US.N (para 59, 61, 63), US.Q (para 13), US.R (para 16).

nonverbal elements are not necessarily resistant, yet many participants took shifts in affect to signal just that. UK.I looks for bodily cues when patients fall silent (para 14). This is enforced by her underlying belief that all patients 'not just the regressed patients but the more sophisticated, more language-able patients' are 'humanly gesturing' and 'communicating with their bodies' such as through 'eye contact and everything about their physicality' (para 14). US.N is alert to resistance if 'the person will go silent and stop talking, or he'll look embarrassed and ashamed' (para 59).

4.6.6 Pseudo-free association (31)

It is possible, according to 77.5 percent participants, for patients to use free association itself as a defence. This is given the invivo term 'pseudo free association' as UK.J (para 23) has called it. There are several ways of using free association defensively. For example it might be a 'caricature' (free association is too free), or it might be 'stilted' (associations are not free enough - this includes generalisation, intellectualisation, preparing material, reporting, or repetition). In all cases, true free association is absent, even though the patient is talking. Frequently an emotional element is absent, and access to important issues is blocked.

4.6.6.1 Caricature (11)[37]

27.5 percent of participants have described instances of 'paying lip-service to free association', 'talking too much', 'having too few inhibitions', 'making a fetish out of free association', 'a strange stream of consciousness, sort of Joycian free association', or even 'misusing the fundamental rule to punish the analyst'.

US.K was surprised at his patient's hyperbolic interpretation of free association when the patient began by saying:

[37] UK.B (para 14), UK.C (para 23, 25), UK.F (para 13), UK.H (para 49), UK.J (para 35), UK.L (para 19), UK.P (para 25), UK.R (para 27), UK.S (para 11, 17), US.K (para 35), US.N (para 61).

> *I notice you've got a new picture on the wall, and by the way there are birds flying outside, and you know, you seem kind of upset to me today, are you disappointed? And I was speaking to my wife last night and she was upset too. But then I had to get gas this morning for my car.... (para 35).*

US.K concludes that 'this guy would use free association defensively - it was not free association - to avoid talking about anything that would deepen his relationship with me, and anything about himself.' (para 35). Similarly, one of UK.C's new patients followed a literal interpretation of free association. His associations went as follows: "I see a chicken, then I'm thinking of getting a train to Paddington, then I'm thinking of something else" (para 23). UK.C notes that 'although they'd be doing exactly what you'd asked them to do, I think you'd end up feeling that there was something the matter. It would be certainly frustrating' (para 25). Although this 'odd thing' happens 'occasionally', he is surprised that it does not occur more often, given that this is what patients have been instructed to do (para 23).

UK.S similarly finds that there is a 'bowdlerised, sort of misunderstanding of free association'. This is where 'you say whatever comes into your mind [...] as if you were the sensing device of a tape-recorder [chuckles] and you just let the tape roll and you just say what comes through.' He finds this 'usually very unrevealing and a little bit silly.' (para 11). He also notices that some patients 'tell you rather too much about some of the things that they do, and maybe to do with disturbing or perverse material'. In this case, the patient's exposing themselves to the analyst might need to be examined (para 17). UK.F also finds that some patients 'talk too much'. He observes of one patient that in the initial stages of analysis, 'free association for him was more of a process of letting go of everything, in an almost incontinent way' (para 13). In a similar vein, UK.H says there are instances of 'pathological free associations [...] in manic patients, for instance, where they're really in love with their own sound and noises, and actually something quite central is being avoided.'(para 49).

4.6.6.2 Stilted (26) [38]

Another subset of pseudo-free association is where the patient's material is stilted. 35 percent of participants spoke about generalisation, intellectualisation, and 42.5 percent of participants mentioned material that has been pre-planned, reported, or repeated.

UK.F notes how intellectualising speech can be viewed as an impediment:

> *I saw an academic last year for example, who is very highly qualified in his particular field and quoted proverbs in a foreign language, expecting me to understand them. Being provocative, unconsciously, but thinking that what he was saying was free and open and actually it was very controlled and defensive. (para 5).*

UK.L mentions a similar case, describing her patient's speech as a 'kind of soliloquy' with a 'precocious use of language'. She says, 'I wouldn't really see it as free association, but as a kind of pseudo-free association. I suppose he's actually enamoured of his own use of language [...] so perhaps what he's really doing is showing off to me' (para 19).

US.I finds generalisation to be a resistance. When 'a person's talking along and they're saying stuff that's really personal and then they make a generalizing statement' (para 11), then the patient might be using 'a defensive intellectualizing and generalizing to put up a barrier between him and me.' (para 11).

UK.C gives an example of rigidity in free association with patients who arrive with pre-prepared material. He has had 'patients who bring a large folded sheet of paper which they produce from an inside pocket and say "I've had seven dreams last

[38] UK.A (para 10#), UK.C (para 17^), UK.D (para 6*, 8#), UK.F (para 5*), UK.H (para 27^), UK.I (para 18^), UK.J (para 17*, 23*), UK.K (para 26*), UK.L (para 13^, 19*), UK.N (para 31*), UK.O (para 24~), UK.Q (para 24*), UK.R (para 27*), UK.T (para 10*, 12*, 22^), US.C (para 39~), US.F (para 10*?^, 60^), US.G (para 13~, 15~, 49~), US.H (para 30^, 44^), US.I (para 11*), US.J (para 13#, 19~), US.M (para 26*), US.N (para 61*), US.O (para 30*, para 32#), US.Q (para 31~), US.R (para 8^, 20#), US.S (para 12#). Key: *= Intellectualisation/generalisation (15 participants) ^= Preparing (8 participants), #= Reporting (5 participants), ~= Repetition (5 participants).

night" and they tell you all seven dreams in detail, and that isn't the most useful thing.' (para 17). US.F also finds that some patients use mental check-lists. She has found that 'many think about their sessions and what they're going to say beforehand and so there isn't that kind of spontaneity' (para 10). She also describes such 'rehearsed' material as signifying 'tremendous resistance' (para 60).

UK.A recounts instances of patients reporting: 'I've even had patients who sound as if they are dictating a business letter when they are talking to you about their experiences.' (para 10).

US.Q reflects on how repetition of material can be resistant: 'For instance the seriously anxious depressed patient who is obsessing continuously about some worry or other [...] that person is associating freely but it's not very useful, they're just going around in circles.' His hope would be to move to a position where 'we're getting to something that's new and interesting rather than going around the same tree over and over again.' (para 31).

4.6.7 Section summary

There are many forms of resistance, as this section has detailed, but the most quoted are: silence, change of topic, change in affect, and free association itself being used in defensive ways. Next, we see to what extent analysts listen out for such resistances and what the alternative listening stances are.

4.7 LISTENING TO FREE ASSOCIATION

Participants revealed four main listening stances. They might focus on the **content** of the patient's narrative. They might pay attention to the **process** or form of the associations including the mechanisms of resistance and transference. They might attend to their own **counter-transference**, or they might adopt a stance of **free-**

floating attention. In practice these four listening stances occur to different degrees, in different combinations, and at different times.

Listen to content	(40)
Listen for process	(38)
For resistance	(29)
For transference	(26)
For mood	(19)
Free-floating attention	(23)
Listen to own counter-transference	(22)

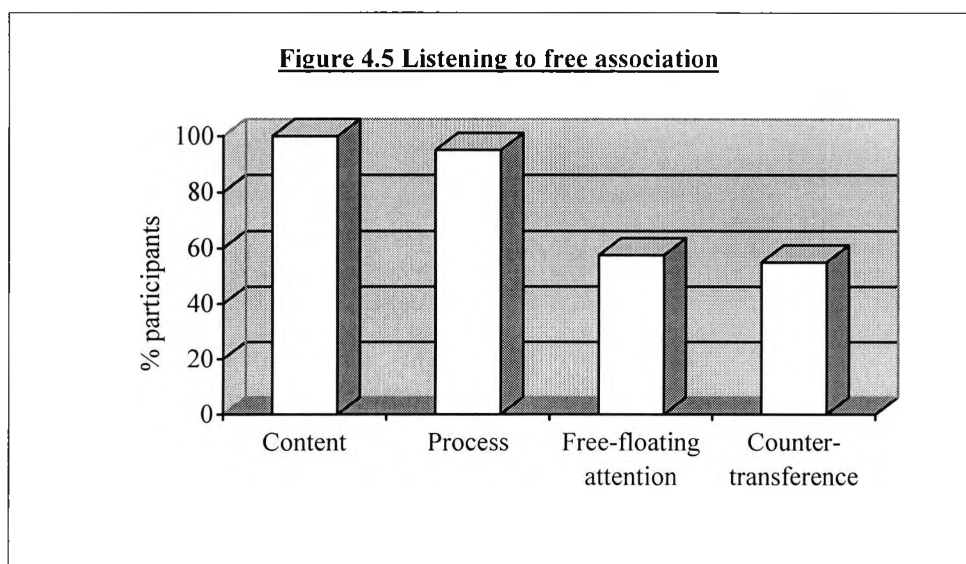

Figure 4.5 Listening to free association

Figure 4.5 illustrates that all participants pay attention to the content of free association and that 95 percent listen for process.

4.7.1 Listen to content (40) [39]

All participants showed that they are alert to the content of the patient's utterances – both to manifest and latent content. UK.E outlines this stance: 'I'm listening to the narrative that is unfolding. So I think that's what goes on. And I'm also trying to linking things together, understand the process, sometimes even just digest what is being said.' (para 24). US.S will listen to a string of associations 'to try to pick up what the connections are, and to show my patients "you know, you said this and then you said this, and that makes me think they're somehow linked in your mind".' (para 12). US.T also looks for connections: 'we're going to remain attentive, listen to that thread, listen for it if we can ferret out the meaning.' (para 8).

4.7.2 Listen for process (38) [40]

All participants listen to the 'process' or what they call the 'pattern', 'shape', 'form', 'structure', 'character', or 'flow' of the free associations. They listen not only to 'what' the patient says, but 'how' the patient says it. This includes listening for resistance (72.5 percent of participants), for transference (65 percent), and for body language, mood or enactment (47.5 percent).

Some analysts such as US.R seem to think that examining process takes preference over content. Rather than take the position 'let's go down to this information inside your head' (para 32), she says 'I am interested in the work of Paul Gray and his close process - paying attention to these very small shifts in the patient's

[39] UK.A (para 16), UK.B (para 8, 36), UK.C (para 9), UK.D (para 8), UK.E (para 24, 26), UK.F (para 5, 11, 13, 19), UK.G (para 25), UK.H (para 33), UK.I (para 14, 18), UK.J (para 15, 17, 27), UK.K (para 8), UK.L (para 22-23, 39), UK.M (para 25), UK.N (para 17), UK.O (para 10, 16, 18), UK.P (para 27), UK.Q (para 26), UK.R (para 15), UK.S (para 11), UK.S (para 62), US.A (para 18, 40), US.B (para 18*), US.C (para 12, 16*), US.D (para 7, 40-42) US.E (para 56), US.F (para 46), US.G (para 37), US.H (para 8, 16, 26), US.I (para 11, 31), US.J (para 11), US.K (para 45), US.L (para 12, 16), US.M (para 26), US.N (para 37), US.O (para 30), US.P (para 25), US.Q (para 13), US.R (para 14,16), US.S (para 12), US.T (para 8). * = listen for wider content.

[40] UK.A (para 11^,16, 52*), UK.B (para 8^, 10, 34*, 40*#), UK.C (para 12-14, 29#, 37*), UK.D (para 12-14#, 20*, 22*), UK.E (para 18^*~, 22*, 24#), UK.F (para 9#, 19#), UK.H (para 33*, 41, 49^~, 51*), UK.I (para 14*#, 26*), UK.J (para 15^#, 17#, 23*, 27#, 59*), UK.K (para 8^~, 14*, 20#, 27~), UK.L (para 11*, 19*, 23#), UK.M (para 11*, 25), UK.N (para 5^*, 13#), UK.O (para 18*, 22^), UK.P (para 25*#, 27#,. 31#, 33*), UK.Q (para 26*#), UK.R (para 5*~, 11^*#, 15*#), 27~), UK.S (para 11^#, 15*#), UK.T (para 12*#, 38#, 44#), US.A (para 17^), US.B (para 18^), US.C (para 16^, 39*), US.D (para 7^), US.E (para 10, 33^), US.F (para 50^), US.G (para 15^, ~37, 47*), US.H (para 30, 44^), US.I (para 11^~,19*, 25, 3*1#), US.J (para 11^*~, 13*#), US.K (para 21^), US.L (para 16^, 18*), US.M (para 16^~, 26~), US.N (para 61*, 63^), US.O (para 30^), US.Q (para 9^, 13^, 35*), US.R (para 16^, 32#), US.S (para 10^~, 12, 18#, 42*), US.T (para 12^). ^= listen for resistance (29), * = listen for transference (26) #= listen for mood (19).

flow of talk, or even in the patient's physical comfort level or position.' (para 16). US.L also claims to have been influenced by Paul Gray's defence analysis and looks out for 'change in the ordinary narrative flow' and for 'interferences or shifts or changes within the patient's association.' (para 18). He adds that he does not listen as 'self-consciously' and 'specifically' as Gray does (para 18), but it remains a useful guide. UK.M also adopts this stance. He says that 'obviously you are listening to the content, but to all the other communications and voice intonation and it depends on the patient; some patients gesticulate a lot which in a sense is quite informative' (para 25)

UK.J says that more than content, he listens 'for points of resistance in the free association and then looking at the defences which are in operation at those points.' (para 15). He says he is sensitive to 'changes in the metabolism of the patient - breathing changes, changes in perspiration, movement, and so on. All those things are part of what one's tuning into.' (para 27). In the same way, US.N listens to the 'characterological aspects of the communication and how the transference relationship is being shaped.' (para 61). He pays 'close attention to how the patient speaks, and what attitudes, and what emotions, and what appearance he presents.'(para 61).

UK.Q adopts a wide listening stance. He recognises the importance of listening to content but equally looks for the manner of communication, including transference:

> *there always needs to be half an ear, half a mind open to how is this content being conveyed to me? Who am I in this conveyance and who is the patient? What roles am I being pulled into, or invited to take, or assumed to have in relation to the patient? (para 26).*

UK.P is always alert to the transference and finds it useful to listen with the question in mind: 'who is talking to whom, in what time and place?' So the point about free association is not just the content, but it's what is the nature of the

relationship at any given moment.' (para 25). Equally, UK.O focuses on transference: 'the one listening stance that is in the back of my mind all the time is what is this patient saying about the relationship here?' (para 18).

Some analysts (22.5 percent of participants) say that they listen out for how freely the patient is communicating. For example, US.J listens with one question in mind: 'to what extent are the free associations in a sense free?' (para 11). In the same way, UK.K listens for the freedom of the associations: 'I've got one ear open just to try and pick up how freely the person is being able to associate and how blocked it is.' (para 8). This position makes sense given his belief that associative freedom is not a means but the goal (para 27). US.M does similarly: 'what I listen for focuses heavily on the freedom of the patient's speaking.' (para 16) and 'the pattern of associations is the primary focus of my attention' (para 26). US.G does this as well: 'there are number of important ways to listen to what's happening in the session, and one question that I can always ask is "does it feel like we're developing more free association?"' (para 39).

Three British participants listen for the 'selected fact', a concept developed by Bion and elaborated by Ron Britton and John Steiner, which involves establishing the mood of a session (UK.D para 12, 14). UK.C follows this approach and tries to:

> *attune to the feeling of what's happening, and then with any luck they'll be some element in what the patient's saying that will illuminate that or be concordant [...] with this emotional mood or be very radically different from it. (para 29).*

UK.I sees this idea from an infant development framework. She does not discount the importance of content, but says:

> *it's actually the infant/baby/primary/regressed unconscious stuff that comes through in the way they enter the room, lie down, move around,*

look at you, everything to do with their physicality that I'm interested in. And I see that as part of free association. (para 14).

4.7.3 Free-floating attention (23) [41]

57.5 percent of participants adopt a state of free-floating attention, also called 'evenly suspended attention', 'open-mindedness', 'abandoning assumptions', or 'listening in a free associative way'. US.N shows that free-floating attention has similar qualities to the patient's free association. He defines it as:

not trying to make an effort to remember - you let it come into you. You don't try to force a thought, you go with the thoughts that occur to you in a free-floating way, and you don't fix your attention on anything in particular, but you are open-minded [...] and take in anything that comes in. (para 35).

UK.E takes this listening stance too:

I just try to surrender myself to the associations of the patient. I don't try to keep things out of my mind. Freud's catch-phrase is "free-floating attention", and I think it is a wonderful way of describing what is going on inside me. (para 24).

UK.D also uses his own free associations. He finds Bion's dictum - 'to abandon memory and desire' - useful to describe this. In other words, 'don't think about what was happening yesterday, or read your notes before the patient comes, and don't have the desire to cure the patient, just take the patient as they come [and be] open to any ideas that come from the patient' (para 14). UK.R ranks listening in a free associative way above listening of transference, defence, and mood. He finds that 'associative freedom' applies to both patient and analyst, and defines it as:

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[41] UK.A (para 16), UK.C (para 29), UK.D (para 14), UK.E (para 24), UK.F (para 17), UK.J (para 15, 25, 27), UK.L (para 21), UK.M (para 23, 25), UK.N (para 13), UK.O (para 49-50), UK.R (para 11), UK.S (para 11, 15), US.A (para 18, 36), US.B (para 22), US.D (para 17), US.G (para 29), US.J (para 11), US.K (para 43, 49), US.L (para 18), US.N (para 35), US.O (para 30), US.S (para 14), US.T (para 24).

trying to free oneself of any kind of assumption about what might emerge in a session. So although I would be listening out for issues of defence and transference and so on, and for the underlying anxiety [...] they would be secondary to [...] the essential position of encouraging in myself and in the patient an openness to what might emerge (para 11).

4.7.4 Listen to counter-transference (22) [42]

Over half of participants show that while listening for content and form of the patient's associations, they also monitor their counter-transference. UK.B says that 'one of the things I'd certainly be looking for is the counter-transference feeling it evokes in me, and the effect of what the patient says has on me.' (para 36). US.T also includes attention to counter-transference as part of his listening stance:

I'm actively listening, I'm constructing hypotheses, letting my own free association go on using of course, as most analysts do these day, their own counter-transference, to get other indicators as to what's going on beneath the surface. So using my body, my mind, as a receiver. (para 24).

UK.A shows that various listening stances can be amalgamated:

I like to sit back and relax, and listen to what they're saying, and how they are saying it, the sort of language that they're using, the facts that they're telling me, whether it conjures up images in me of various thoughts or fantasies, what emotions it arouses in me, in terms of my counter-transference. (para 16).

More British participants (68%) use this listening stance than American participants (32%). Although this is 'not quite' statistically significant (chi-squared=2.909, df=1, p=0.0881), it is often said that British analysts give more weight to counter-transference than Americans. One participant mentions this: 'I sometimes

[42] UK.A (para 16, 24), UK.B (para 36), UK.D (para 8, 20), UK.E (para 24), UK.F (para 19), UK.G (para 17), UK.I (para 14), UK.J (para 17), UK.M (para 25), UK.N (para 5), UK.O (para 18), UK.P (para 25, 33), UK.R (para 5, 13), UK.S (para 11), UK.T (para 10, 36, 38, 41-42), US.A (para 36), US.B (para 22), US.I (para 13), US.K (para 45), US.O (para 32), US.S (para 18), US.T (para 24).

get the impression, certainly within the British Society [...] it's almost as if transference and counter-transference have replaced free association as the fundamental organising principle' (UK.R para 5).

4.7.5 Section summary

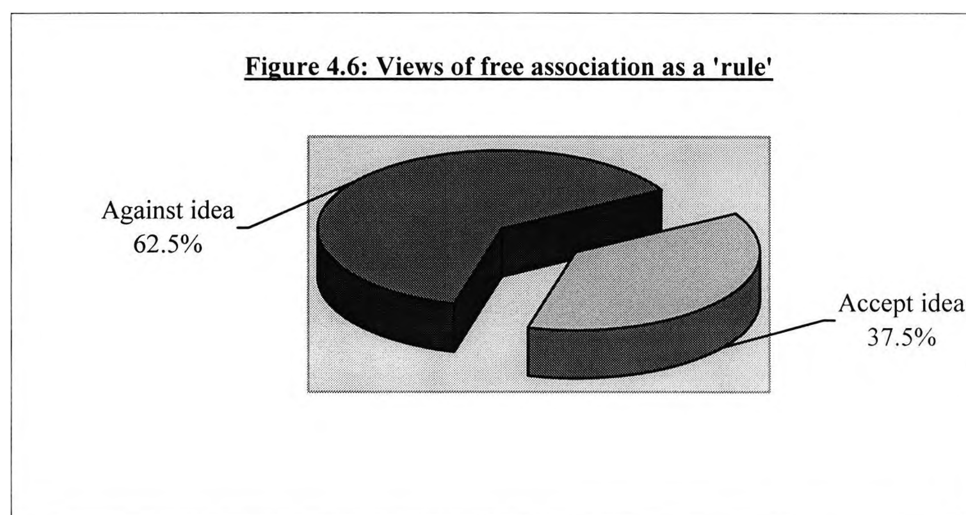
We have seen that the two most typical listening stances involve focussing on content, and on process. But two other stances are also important – listening with free-floating attention, and with counter-transference in mind. In the following section we turn to participants' views towards the idea of free association as a 'rule'.

4.8 VIEWS OF THE FUNDAMENTAL 'RULE'

More participants are against the notion of free association as a 'rule', than those who accept it. However it appears that very few of those who 'accept' the idea, would insist, enforce, or take a heavy-handed approach to the observance of free association; they view free association as a rule but one which patients will be unable to follow at all times. A few participants were ambivalent - they saw free association as a rule in some respects but not in others - but they have been grouped according to their overarching view.

RESULTS (=40): (Each participant is only counted once.)

Against idea of free association as a 'rule'	(25)
Accept idea of free association as a 'rule'	(15)



From figure 4.6 we see that 17.5 percent more participants are against the idea of free association as a 'rule' than those who accept it. However, this difference is statistically insignificant, so we cannot state with any confidence that more participants are against the rule than accept it (chi-squared=1.6, degrees of freedom=1, p=0.2059, two-tailed test.)

4.8.1 Accept idea (15) [43]

37.5 percent of participants accept the general idea of free association as a 'rule'. They view it as an 'instruction', an 'expectation', or a 'technical injunction'. At the same time, many of them recognise that it is impossible to observe; it is not an absolute rule, but a rule in spirit.

US.D has no difficulty with the concept of free association as a rule: 'Many of the people who come to me know the quote fundamental rule already, and for some it has been a rather authoritarian structure, which it is not for me at all.' (para 7). UK.M also accepts the notion of a rule:

[43] UK.B (para 28), UK.D (para 4), UK.E (para 28), UK.I (para 10), UK.L (para 25, 33, 53), UK.M (para 35), UK.N (para 29, 31), UK.T (para 26), US.A (para 50), US.B (para 4), US.D (para 7), US.F (para 22), US.N (para 55), US.O (para 30, 34), US.Q (para 3, 7, 25, 29).

I don't have particular difficulties with the term because [...] it's not a bad idea to start with the patient thinking that you are offering a treatment and that there is a rationale, and there are certain, not many, but certain rules, that are there to make it more likely to work. (para 35).

UK.N shows that although free association is an ideal, it is still a rule:

I qualify it when I tell patients about it, I always say "this is your side of the contract", I don't actually use the word "rule" when I talk to them about it, but I do say, "this is all you're required to do". But by implication it's a kind of rule. (para 29).

4.8.2 Against idea (24) [44]

Three-fifths of participants do not view free association as a rule. Some of them find free association to be a 'suggestion', an 'encouragement', a 'guideline', or an 'opportunity'. Many participants were keen to stress this point of view, and did so in much stronger terms than those who accept the idea of a 'rule'. For example, UK.A does not find the idea of 'rules' to be helpful: 'it's not a rule by the way, I don't believe in rules' (para 6). UK.F says of free association, 'I don't see it as an instruction, I see it more as an invitation.' (para 35). US.K believes that 'It's a guiding principle, but it's not an absolute rule.' (para 35). UK.H similarly says, 'I don't like rules'; he prefers to call it 'guiding principles' (para 7).

For UK.O, rules do not convey a good impression: 'to put it into rules I don't think is helpful. It gives the wrong impression.' (para 34). US.E demonstrates flexibility in her use of free association and claims: 'I am mostly not a rule-oriented person in general, and that the fundamental rule, like all other rules, to me is to be attended to if it's useful, and not when it isn't.' (para 70). UK.K sees free association as a possibility for exploration:

[44] UK.A (para 6, 22), UK.C (para 13), UK.F (para 35), UK.G (para 11), UK.H (para 7, 19, 29), UK.J (para 41), UK.K (para 38), UK.O (para 34), UK.P (para 11, 13, 17), UK.Q (para 20). UK.R (para 17, 25), UK.S (para 19, 21), US.C (para 27, 29), US.E (para 8, 70), US.G (para 31, 35), US.H (para 44), US.I (para 11), US.J (para 17, 19, 21), US.K (para 35), US.L (para 12, 20), US.M (para 16, 34, 44), US.P (para 22-25), US.R (para 8), US.S (para 30, 36), US.T (para 6).

I'm not in favour of rules, I don't use the fundamental rule in that way [...] I'll be implicitly trying to convey what the fundamental rule is getting at, but as a possibility for them; an opportunity rather than an expectation. (para 38).

US.P says something similar stating: 'I'm not a rule person. What I would try to do is to share the thinking behind the rule' (para 23).

US.C does not view free association as a rule, and finds such a view out-of-date:

the term comes from an era where the parlance of language and how we relate to patients is different. I mean this is Freud right? Saying "I'm inventing this new method and here is rule number one. And you have to do what I say because it's my experiment". And I guess I don't view it like that. (para 29).

Instead she uses it to offer patients 'guidance' and to offer them a suggestion: 'I want to hear it in whatever way that you can give it to me. But here's one way, here's something new, here's some other approach for you to consider.' (para 27).

Some of those who are against the idea of it as an injunction have concerns about the 'superego' effects. US.M comments: 'I present it as a guideline, and I don't use the word 'rule', for reasons of its superego connotation.' (para 16). US.L says so too: 'Incidentally, I don't think of it as the "rule" - I don't like the idea of it being a rule, because that's too superegoish.' (para 12). UK.J dislikes rules for the same reason: 'I don't like the notion of a rule. The danger of making it a rule is that you set up a resistance unnaturally, and there's resistance enough without doing that' (para 41). US.T is also weary of the effects on the patients' superego. He finds rules to be contrary to the spirit of analysis, and he 'encourages' his patients, rather than instruct them (para 6).

UK.Q expresses ambivalence about the idea of a 'rule', which is summarised in the following sentence: 'I have a slight unease about the use of the word rule. Because I suppose it is a sort of rule, it's like a rule that stands beyond any other rules.' (para 20). Yet overall he seems uncomfortable with the notion. UK.P also expresses ambivalent views. In some of his comments he hints that free association is a rule, stressing the ethical quality of free association - the 'expectation of truthfulness' (para 7). However, in several other comments, he seems to regard it as a suggestion or opportunity (para 11, 13).

4.8.3 Section summary

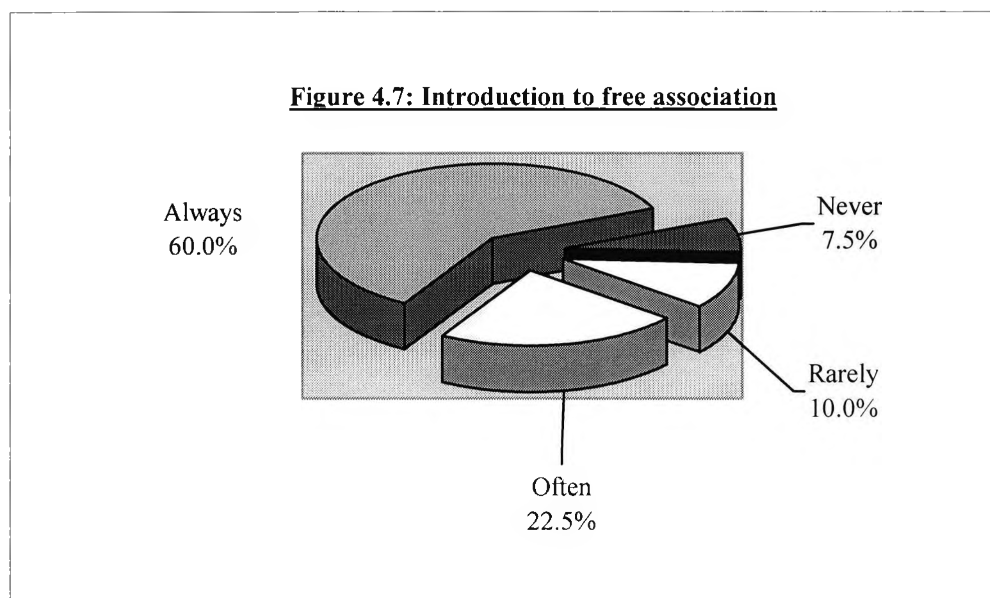
We have seen that more participants reject the idea of free association as a rule than those that accept it, but that this difference is not statistically significant. We now look at whether the concept of free association is introduced at all.

4.9 INTRODUCTION TO FREE ASSOCIATION

Many participants 'always' give clear introductions to free association regardless of who the patient is. Some participants will 'often' give instruction when the patient is new to analysis or asks questions. A few give an introduction in similar circumstances when the patient is naïve about analysis or shows confusion, though this happens 'rarely'. A few participants say they do not introduce free association at all.

RESULTS (=40)

Always give an introduction	(24)
Often give an introduction	(9)
Rarely give an introduction	(4)
Never give an introduction	(3)



The majority of participants (82.5 percent) always, or often, give a clear instruction, while 17.5 percent rarely, or never, give instructions. This shows that introduction is very common among participants, and significantly more give an introduction than not (chi-squared=16.9, df=1, p=0.0001).

4.9.1 Always give an introduction (24) [45]

60 percent of participants almost always give an introduction – they will make a comment about free association as a matter of practice. How much is said will depend on the patient; many participants say that they will elaborate on the initial comment if patients seem unfamiliar with the method, appear anxious, or ask

[45] UK.A (para 6), UK.C (para 11, 13, 49), UK.D (para 4, 22), UK.F (para 21), UK.I (para 10), UK.J (para 15, 35), UK.L (para 25, 29, 33, 49, 51), UK.M (para 13, 37), UK.N (para 5, 31), UK.T (para 24, 52, 62), US.B (para 4-6, 8, 22), US.D (para 7, 9), US.F (para 12, 22), US.G (para 5), US.I (para 11), US.J (para 17, 21), US.K (para 19), US.L (para 12), US.M (para 16. 44), US.N (para 49, 57, 75,. 77), US.O (para 30), US.R (para 8, 24, 30), US.S (para 22, 36), US.T (para 6).

questions about it. With candidates, the introduction tends to be brief and to serve as a reminder of what they already know. Participants here give a 'clear' introduction, in the sense that it is a discrete and unambiguous remark about the method of free association. However, it is not always a 'fixed' remark, since it is often phrased differently.

This group includes UK.I who says 'I tell my patients about the fundamental rule as a given in a preliminary meeting' (para 10), US.I who claims 'I do state the fundamental rule' (para 11) and UK.D who says: 'I always suggest that they do' (para 22). UK.F comments that 'It's very rare that I don't actually introduce it' (para 21), and he will extend his introduction if a patient seems unfamiliar with the concept. US.N shows how there might be some variation in how it is phrased: 'basically, you convey the same message, maybe worded slightly differently in a situation depending on the flow between you and them.' (para 75). UK.J acknowledges that 'there's a big debate about this whether one should say it or not, but I choose to.' (para 35). UK.N always introduces it, and additionally gives patients a leaflet which includes details about free association (para 9).

4.9.2 Often give an introduction (9) [46]

22.5 percent of participants show that they do not automatically give a clear, stand-alone comment about free association, but will do so if the need arises and that this occurs often. Participants say they are likely to talk about free association in the following situations: if patients are new to analysis, if they ask questions or if they are having difficulty/resisting. If the patient is a candidate, it is likely that participants will omit the introduction.

US.Q tends to give an introduction, but not to 'analytically sophisticated' patients (para 27). UK.E echoes that for patients who have already been assessed, she will not need to give an instruction 'because the patient has already had some kind of

[46] UK.B (para 22, 24), UK.E (para 20), UK.H (para 7, 9, 21), US.A (para 41, 48), US.C (para 27), US.E (para 8), US.H (para 10, 30, 38), US.P (para 35, 39), US.Q (para 25, 27).

contact of a psychoanalytic nature.' (para 20). Some participants like US.H will introduce free association if patients ask questions, which occurs often:

> *people have come and lain down and said "I don't know what to do". And under those circumstances I have sometimes said "well, one thing you could do is just say whatever is most coming to mind at any particular moment..." (para 30).*

US.C also usually gives an introduction because most patients are uncertain or ask questions: 'it almost always comes up at the very first meeting. People don't have any idea of what to say or do or what you want to hear from them.' (para 27).

US.A will introduce the idea at the sign of a resistance. He will introduce free association with most patients because resistances inevitably surface: 'if the patient is expressing something and then there's some kind of shift away then that might be a very good time to make some comment about how this works' (para 48). US.E also takes this stance: 'it depends very much on the patient - there are some patients with whom I would introduce it immediately, especially with the ones who have some difficulty talking.' (para 8).

4.9.3 Rarely give an introduction (4) [47]

Four participants present free association in special circumstances. For example, UK.O once used to introduce free association, but no longer does so unless patients ask a question or if they feel anxious (para 29-32). UK.Q is also reluctant to give the rule and does so only occasionally - if the patient asks about it or if the patient is new to analysis:

[47] UK.G (para 11, 13, 21), UK.O (para 29-32), UK.P (para 11), UK.Q (para 18, 20).

> *I wouldn't say it automatically in a consultation before analysis or therapy starts. I might say to someone who either is naïve about analysis, or who's asking about what he's supposed to do, "well, there's one thing that you could try to do, and that is to say what comes into your mind". (para 18).*

For UK.P as well, it is common practice not to introduce free association, though he makes exceptions. He believes that patients come expecting to speak, and they do not need to be explained about free association:

> *I wouldn't make a rule of telling the patient that's what was expected. I would bring it in to the preliminary consultation if there was a particular reason. It might come into it if the patient was anxious about what they were expected to do, for example. (para 11).*

UK.G feels there is no need to give a rule if the patient has been talking freely in the assessment; he just asks them to continue. He has the unusual method of referring to free association for the first time only when it arises relative to a dream, or if the patient says something striking. He finds Freud's introduction too stern. He implies that the discussion of free association is effortless: 'it doesn't seem to me something that has to be blazoned out; it comes very naturally in the work' (para 13).

4.9.4 Never give an introduction (3) [48]

Three participants do not believe in introducing free association. UK.R used to present it formally, but now avoids making any comments: 'I no longer use an introductory phrase or anything like that - I leave it absolutely open. I don't instruct the patient in any way, though I used to for many years.' (para 17). UK.S also used to at times give an introduction, but stopped doing so. He says 'I wouldn't introduce the idea at all.' (para 18). He doesn't find free association useful, and says 'as a therapeutic instruction it doesn't really have much, if any, part to play in the way I work' (para 21). He will occasionally give a prompt if there is a pragmatic need for it,

[48] UK.K (para 14), UK.R (para 17), UK.S (para 11, 18, 21).

> *particularly in an assessment where patients are often looking for [...] some kind of template about how they are supposed to approach this consultation, what they're supposed to speak about or will you ask questions and things like that. And every so often then, one might occasionally, if a patient seems a bit stuck, you might say "well I wonder what you're thinking about?" But, not as a central part of the theoretical method. (para 11).*

Thus, like many other analysts, he demonstrates flexibility in use of technique, and there may be special circumstances in which he will introduce free association, but his preference is to avoid this.

UK.K is also very reluctant to introduce free association: 'I wouldn't try and explain to him what it was or try and get him to do it. That would be the last thing that I'd do' (para 14). He would not even introduce it indirectly through an interpretation:

> *I think to say "there is a different way of doing it, try and do it like this" or even to give any interpretation that might have that connotation that I was looking for something different from them, I would certainly try and avoid. (para 14).*

Of the seven participants who tend not to introduce free association, five have reservations about the concept of a 'rule', and the other two are ambivalent about it. This is to be expected since if you oppose a rule, you are unlikely to state it to patients. Another observation is that these seven are all British. However, these two claims cannot be generalised as the sample is too small to be tested statistically.

4.9.5 Section summary

Overall, most participants give clear introductions, and a small number of participants do so rarely, or never. In total thirty-three participants normally give a clear introduction, four do so in special circumstances, and three never do. In the next

four sections we examine the features of the thirty-seven introductions, beginning with the timing of delivery.

4.10 TIMING OF INTRODUCTION

Free association may be presented at different times of the treatment, but in practice nearly all participants prefer to give the introduction at the outset of treatment – either in the consultation/evaluation stage, or within the first two sessions on the couch. Three participants give introductions at a later stage; two make a comment about free association when resistance occurs, and one brings it in when the patient talks about a dream.

RESULTS (=37)

Introduction at outset	(34)
During consultation	(27)
During first or second session	(7)
Introduction given later	(3)

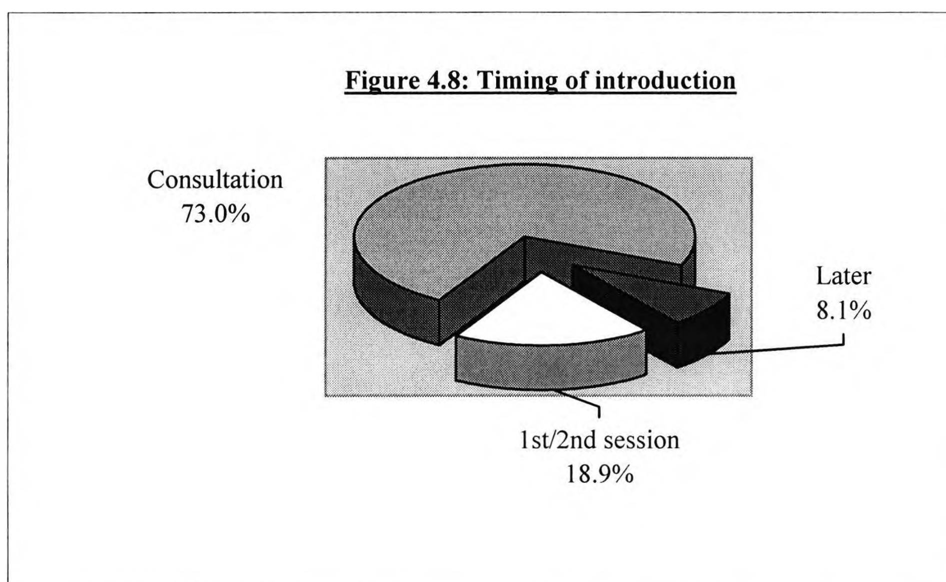


Figure 4.8: Timing of introduction

4.10.1 Introduction at the outset (34)

Figure 4.8 shows that of those participants who offer an introduction, the majority (91.9 percent) do so at the beginning of analysis – either in consultation, or in the first two sessions.

4.10.1.1 Consultation (27) [49]

73 percent of participants giving an introduction say that they raise free association in the 'initial consultation', 'preliminary meeting', 'assessment stage', 'evaluation', or as 'part of the contract', which takes place before patients go on the couch.

For some participants the introduction is given at an early stage of the consultation. For example, UK.A introduces free association 'right at the beginning, when I have the initial consultation with the patient, even before the patient is lying down on the couch' (para 22). UK.D says that 'at the beginning, I do spell out the fundamental rule. Usually in a consultation when I get round to talking about [...] the various parameters, using the couch, times and fees etcetera' (para 4). UK.I says 'I tell my patients about the fundamental rule as a given in a preliminary meeting when they come to see me for a vacancy' (para 10).

Other participants discuss free association towards the end of the consultation. US.K, for one, says: 'I bring it in after I've gone through my diagnostic evaluation and once I make the recommendation for the form of treatment I've recommended. So maybe after four or five sessions.' (para 37)

UK.P presents free association on rare occasions. He says: 'I would bring it in to the preliminary consultation if there was a particular reason.' (para 11). Some

[49] UK.A (para 22), UK.B (para 28), UK.C (para 13), UK.D (para 4), UK.F (para 25), UK.H (para 9, 23), UK.I (para 10), UK.J (para 35), UK.N (para 5), UK.M (para 13), UK.P (para 37), UK.Q (para 18), UK.T (para 26), US.B (para 4, 22), US.C (para 27), US.D (para 7, 10), US.E (para 26), US.J (para 21), US.K (para 37), US.N (para 77), US.O (para 30), US.M (para 44), US.P (para 19), US.Q (para 7), US.R (para 30), US.S (para 34), US.T (para 6).

participants vary the time they present free association, for example, UK.M sometimes raises it in the first session but mostly raises it in the 'preliminary meeting' (para 13).

4.10.1.2 First or second session (7) [50]

Fewer participants introduce free association once the analysis has begun – only 18.9 percent. UK.E makes a comment at the first couch session: 'I would tend to give the instruction more when the patient is on the couch, after the assessment stage.' (para 20). US.G, if a patient is already in therapy with him, will discuss free association at the point of transition. But for new patients, his practice is to raise it 'at the beginning of that initial couch session' (para 7). UK.O only occasionally introduces it, but will do so in the 'first session' (para 32).

4.10.2 Introduction given later (3)

Three participants introduce free association at a later point. US.A will raise the idea of free association at the first sign of resistance, which is likely to occur at the beginning of treatment. He explains reasons for his timing: 'you don't give instructions at the beginning because people don't really hear them.' He waits until 'there is something that's being defended against, when it's clear that there is some kind of resistance coming up' (para 48) at which point he will introduce free association (para 48). US.H also introduces free association if the patient is resisting, and again, this is likely to occur at the beginning of analysis (para 30). UK.G might raise free association in relation to a dream, which can come up at any time: 'I find it comes very naturally for example from a dream. They dream something and you can say "what comes to mind about that?"' (para 11). However, this is not an introductory remark, but a prompt that refers to the idea of free association.

[50] UK.E (para 20), UK.L (para 25), UK.O (para 32), US.F (para 12),US.G (para 7), US.I (para 11), US.L (para 12).

4.10.3 Section summary

Nearly all the initial comments about free association occur at the beginning of treatment, the majority being offered in the consultation phase. However, as we will soon see, this is not the end of the discussion of free association; many participants will raise the idea again by repeating their statement or referring to it in other ways. Before that, we review the length, content, and tone of the initial introductions.

4.11 LENGTH OF INTRODUCTION

To assess the length of the introduction given to patients, quotes of the fundamental rule were grouped into the headings 'brief', 'mid-length', 'lengthy', and 'extensive'. Reviewing these four codes, it appeared that there was a similar word count for each, for example 'brief' quotes seemed to all be under 30 words. The number of words was in some instances difficult to attain. If a participant quoted different versions of the introduction, then an average was taken.

RESULTS (=40):

No introduction (0 words)	(3)
Brief (<30)	(10)
Mid-length (31-60)	(12)
Lengthy (61-100)	(11)
Extensive (101>)	(4)

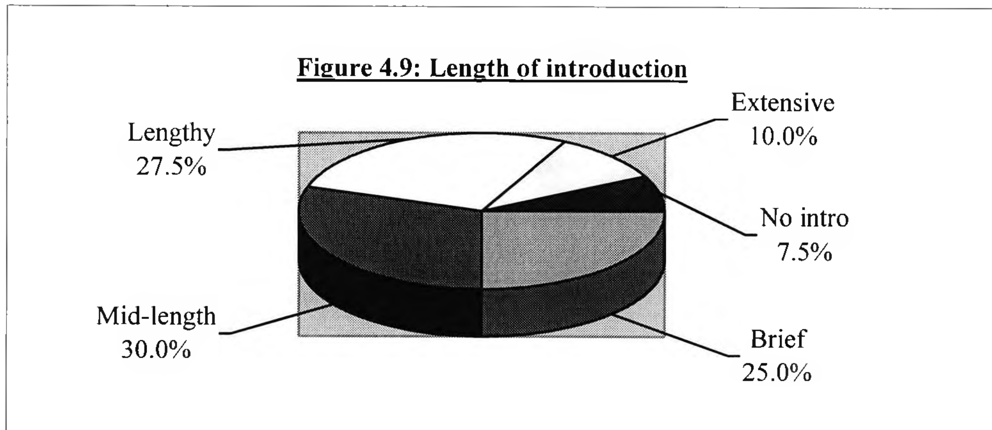


Figure 4.9: Length of introduction

Figure 4.9 shows that quotes were distributed almost evenly between brief, mid-length and lengthy.

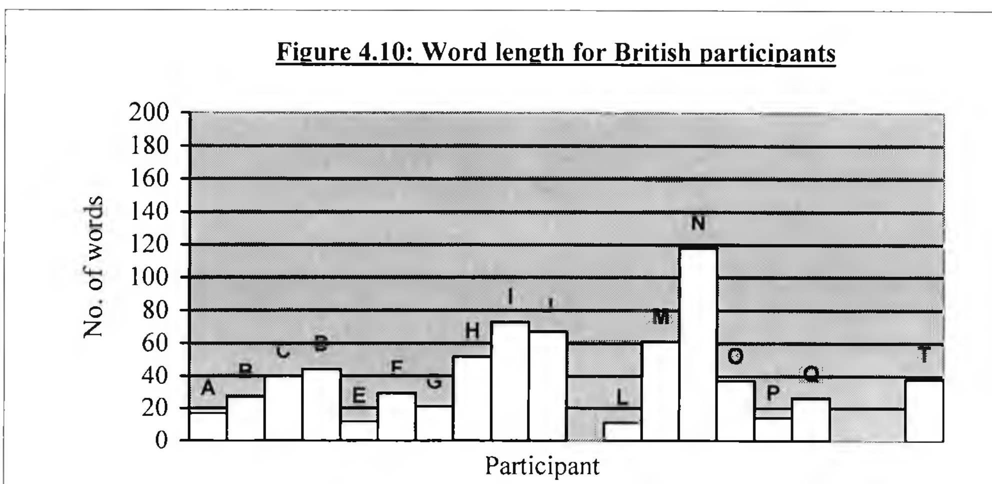


Figure 4.10: Word length for British participants

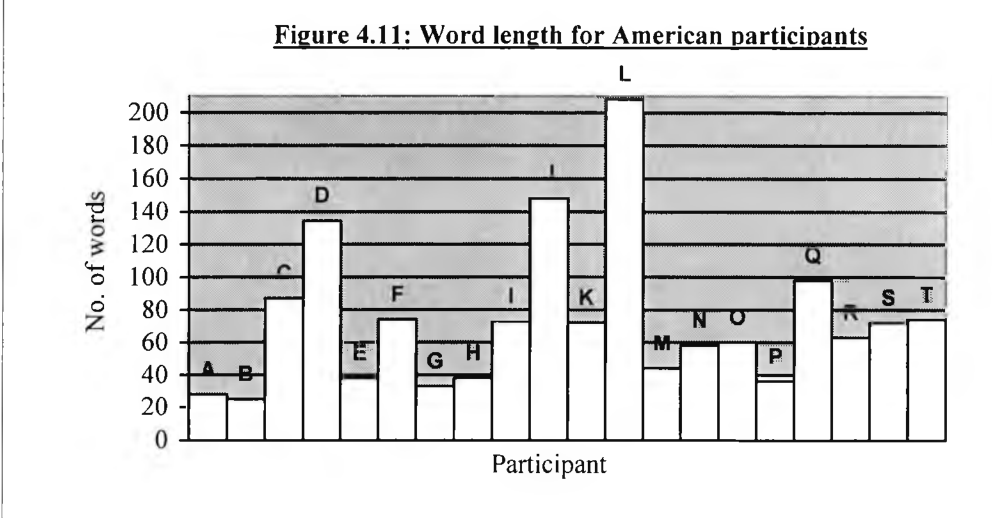


Figure 4.11: Word length for American participants

Figures 4.10 and 4.11 show that the quotes of the American participants are, on average, longer than those of the British participants.

Mean average length for all (37) participants:	(58 words)
US participants	(73 words)
UK participants	(40 words)

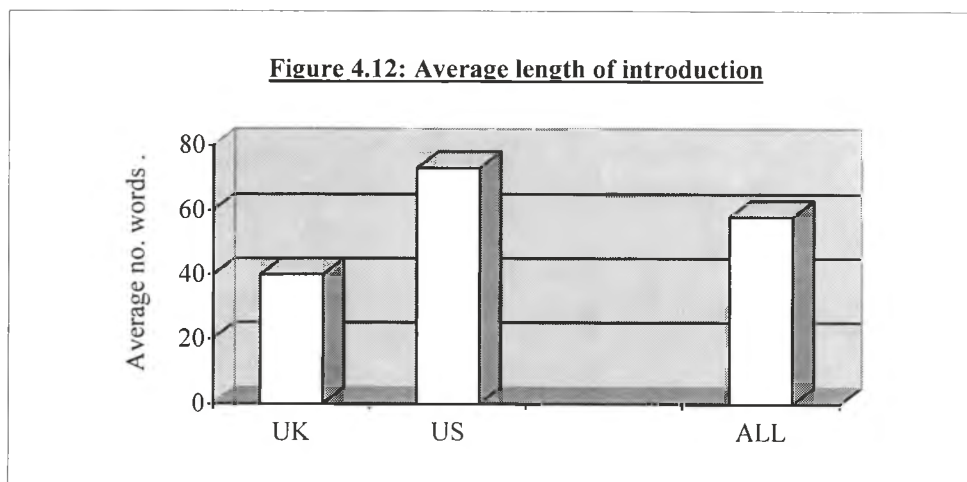


Figure 4.12: Average length of introduction

Figure 4.12 illustrates how the average number of words used by American participants is nearly twice that of British participants. A t-distribution test confirmed that the introductions of American participants are significantly longer than those of the British participants ($t=2.5834$ $df=35$, $p=0.0141$). An explanation for this significant difference can be found in the participants' rationale behind their presentation, which is discussed in the section 'considerations'. Also, the average comment of all participants is 58 words. The median (middle value when placed in order) is 44 words and the mode (most common value) is 38 words. Thus, the average length of the introductions, judged by three measurements, is 'mid-length' (between 31 and 60 words).

4.11.1 Brief introduction (10) [51]

An example of a brief introduction is made by UK.E who says to a new patient: "try to say what comes into your head, what thoughts you have" (para 14). UK.B also makes a brief comment: "the thing I ask you to do, the kind of fundamental rule, is to just say whatever comes into your mind, however apparently disconnected or silly it may sound" (para 24).

4.11.2 Mid-length introduction (12) [52]

An example of a mid-length quote is supplied by US.G who tells patients: "the way we would proceed is for you to simply to say everything that comes to your mind as openly as you can, and including whatever thoughts and feelings you have about me". (para 5).

UK.H's mid-length comment is:

one thing you should try to do is to, however difficult it might be, is to try at least to say whatever is in your mind, whatever thoughts or feelings or images you have, to try to describe them in words. (para 9).

4.11.3 Lengthy comment (11) [53]

UK.I gives a lengthy introduction to patients. She tells them:

[51] UK.A (para 6), UK.B (para 24), UK.E (para 14), UK.F (para 21), UK.G (para 19), UK.L (para 29), UK.P (7, 13, 15), UK.Q (para 14, 18), US.A (para 22), US.B (para 4).
[52] UK.C (para 11, 13), UK.D (para 4, 22), UK.H (para 9), UK.O (para 20, 30, 32), UK.T (para 30, 62), US.E (para 8), US.G (para 5), US.H (para 10, 30), US.M (para 16, 44), US.O (para), US.N (para 49), US.P (para 35).
[53] UK.I (para 22), UK.J (para 35), UK.M (para 13), US.C (para 27, 29), US.F (para 8), US.I (para 11), US.K (para 19, 35, 37), US.Q (para 7), US.R (para 24), US.S (para 22, 30), US.T (para 6, 12).

when we next meet, the only thing that I will require of you when you come to see me, for our first session and from then onwards, is that you will try to say what comes to mind, even if it's something you don't want to talk about or you feel is irrelevant or silly, and I will respond to that and take that up, but that is how the process will begin. (para 22).

US.F gives another example of a lengthy introduction:

basically the way that this works is that you tell me what comes to mind - whatever comes to mind - and that when I feel that I have a question or I have something to add to what you've said, I will intervene. But basically just say whatever comes to mind even if it sounds trivial, even if it doesn't seem to fit what you've been talking about (para 8).

4.11.4 Extensive introduction (4) [54]

US.L is one participant who gives an extensive introduction:

I'll be sitting back here listening, and the idea that you and I are working on is that there are thoughts and feelings and ideas and attitudes that you may not be aware of, and if you just say everything that comes up, I'll be able to from time to time get a picture of what's going on underneath. And if I think I see something that's useful, then I'll ask you about it, or try to point it out to you, and we'll talk about whether it's really there or not. So your job is to just do your best to tell me everything. I want to warn you ahead of time that it's going to be very difficult to do that, you're going to be able to go along for a while, but you're going to find all kinds of things interfere. And that's fine. We want to see what keeps you from saying things, and what interferes with it, as much as we want to see what the things are that are there underneath. So if you have a hard time with it, try and we'll see where we go. (para 12).

[54] UK.N (para 5, 29, 31), US.D (para 7), US.J (para 17, 21), US.L (para 12).

US.D also gives an extensive introduction:

we would like to study together the mind - the inner workings of your mind - and the best way of doing that is not by setting ourselves specific goals and topics, but just to allow the mind to wander and say whatever comes to mind regardless of how bizarre or embarrassing or ridiculous or crazy it may appear. All is important, and what is especially important is to see what the obstacles to that are, and to look at the obstacles. And then we stop from time to time and look at what has come up, and try to understand together the meaning of what has come up. (para 7).

4.11.5 Section summary

Approximately equal numbers of participants present the introduction in brief, lengthy, or mid-length formats. However, on average, the quotes are mid-length. Also, the American participants tend to give longer introductions than British participants. We now turn to the content of these initial comments.

4.12 CONTENT OF INTRODUCTION

This section outlines the content of the thirty-seven introductions. We look first at what, if anything, the analyst suggests the patient should talk about. We then look at what other details are provided, such as comments about avoiding censorship, and warnings about the difficulty of free associating.

4.12.1 Types of associations

54 percent of participants give no references at all, meaning that they do not suggest what material the patient can speak about. On the other hand, 46 percent of participants regularly list the possible types of associations that the patient can raise.

RESULTS (=37)

Types of associations not outlined	(20)
Types of associations mentioned	(17)
Thoughts	(11)
Dreams	(9)
Feelings	(7)
Fantasies	(4)
Physical sensations	(3)
Images	(3)
Memories	(1)
References to the analyst	(1)

Figure 4.13: Associations outlined or not

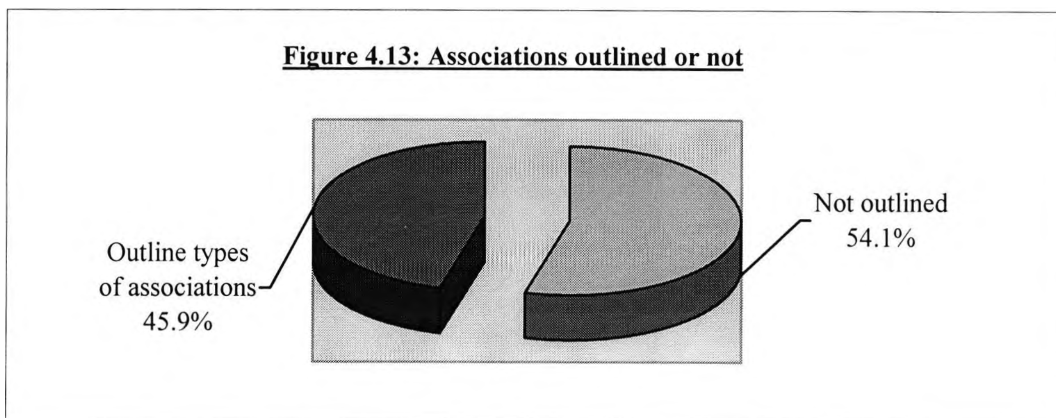


Figure 4.14: Types of associations outlined

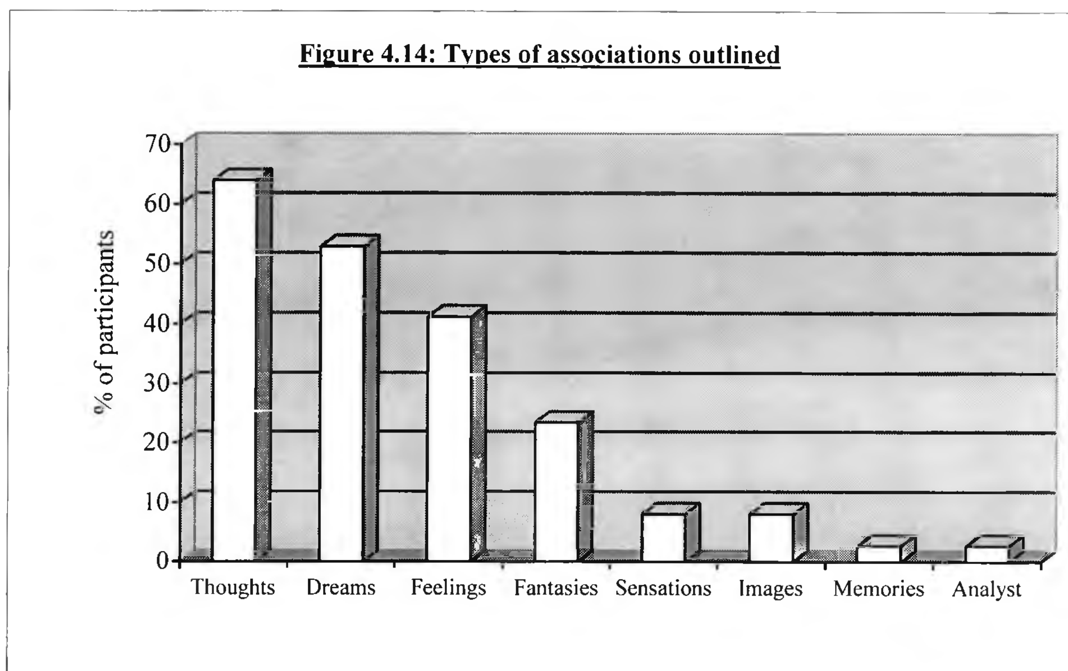


Figure 4.13 depicts that 46 percent of participants who give a guideline will outline the types of associations, though a larger number (54 percent) will not outline the possible sources of free association. A chi-squared reveals that this is not a significant difference (chi-squared=0.243, df=1, p=0.6219). Figure 4.14 shows that of the 46 percent that outline associations, the most common types are thoughts, dreams and feelings.

4.12.1.1 Types of associations not outlined (20) [55]

Over half of participants do not specify in their initial comments the type of associations that the patient can produce.

Some examples include:

- "just say whatever comes to your mind" (US.A para 22).
- "the sessions are for you to tell me what's in your mind" (UK.B para 26).
- "anything that comes to your mind is important" (UK.O para 30).
- "talk about anything that comes to your mind" (US.L para 12).
- "tell me everything that occurs to you" (US.N para 49).
- "try and speak as freely as possible" (UK.F para 21).
- "let yourself go loose, don't try and make a sophisticated comment, just say what comes into your mind" (UK.G para 19).

[55] UK.A (para 6), UK.B (para 26), UK.D (para 4), UK.F (para 21), UK.G (para 19), UK.I (para 14), UK.J (para 35), UK.L (para 25), UK.N (para 13), UK.O (para 30), UK.Q (para 14), US.A (para 22), US.C (para 27), US.F (para 18), US.L (para 12), US.K (para 21), US.N (para 49), US.Q (para 7), US.S (para 22), US.T (para 6).

4.12.1.2 Types of associations mentioned (17) [56]

In 46 percent of cases, specific kinds of associations are referred to in the introductory statement. Thoughts, dreams, and feelings (perceptions), are referred to the most followed by physical sensations, fantasies, images and memories. Some examples follow, and the types of associations are emboldened:

- 'I do usually say "try to say what comes into your head, what **thoughts** you have".' (UK.E para 14).
- 'I usually put in [...] that **dreams** can be helpful, if they can remember them.' (UK.C para 13).
- 'The patient is instructed to begin the session with a **dream**, with a **narrative**. Or if they don't have a dream, to make up a **story** on the spot, and to then associate to it' (US.O para 30).
- "whatever **thoughts** or **feelings** or **images** you have, try to describe them in words". (UK.H para 9).
- 'everything that they had in their mind was important that I was interested in their **dreams**, their **daydreams**, their **fantasies**, whatever **thoughts** come to mind' (US.B para 4).
- "if you listen to your own **thoughts** and how they come and go, and if you watch the **pictures** that come through your mind or your **dreams**, I think you can really learn a lot". (US.P para 35).
- 'the sum total your life experiences, present and past, can be discussed - all **thoughts**, **feelings**, **fantasies**, **dreams**, **associations**, **memories** - whatever you would like to talk about.' (US.J para 17).
- US.R tells her patients that:

the preface is different from psychotherapy in the sense of anything is fair game to talk about. Anything that comes to mind which includes the same

[56] UK.C (para 13^), UK.E (para 14*), UK.H (para 9*#>), UK.M (para 5, 41), UK.P (para 41*#), UK.T (para 32, 36, 62^), US.B (para 4*^$), US.D (para 7*#$), US.E (para 8*), US.G (para 5<, 23^#<~), US.H (para 28, 30*#>~), US.I (para 11*^), US.J (para 17*^#$!), US.M (para 16*), US.O (para 30^), US.P (para 35*^>), US.R (para 24^#$~), *= thoughts (11), ^= dreams (9), #=feelings (7), $=fantasies (4), ~=physical sensations (3), >=images (3), !=memories (1), <=references to the analyst (1).

*kind of **thoughts** they might be bringing up in psychotherapy, but also **dreams, fantasies, physical sensations, ideas** that pop up where they might be surprising or not seem relevant (para 24).*

65 percent of those outlining types of associations are American. Although this not significant according to chi-squared test (chi-squared=1.471, df=1, p=0.2253), it seems that the American participants give more direction to free association than their British counterparts.

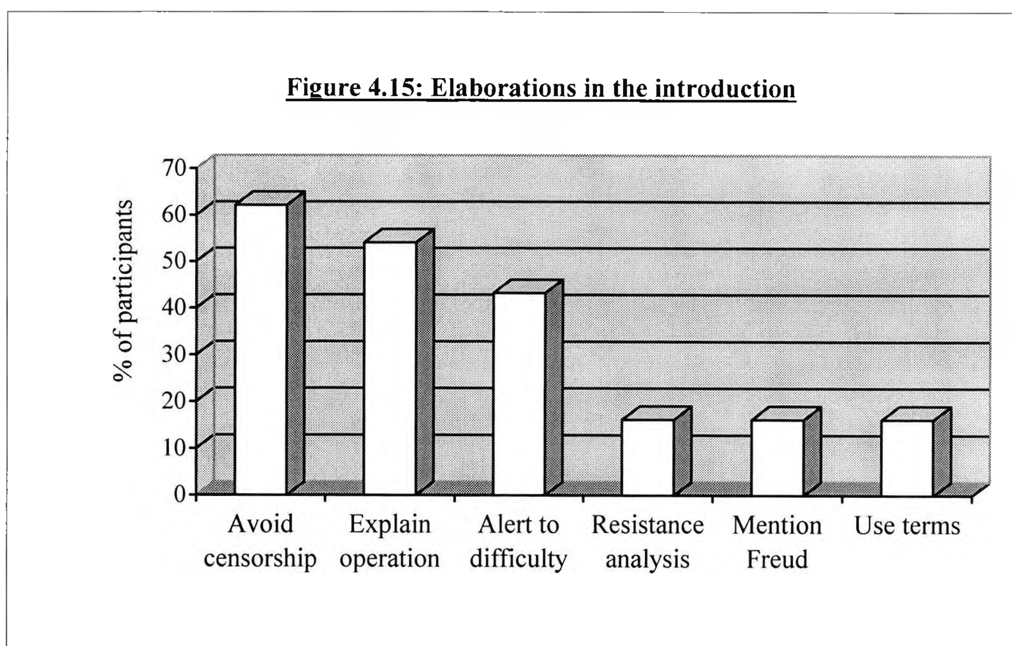
4.12.2 Other elaborations in the introduction

Participants use several elaborations in their introductory comments beyond 'say what comes to mind' and listing possible types of associations. Figure 4.15 points to the most common elaboration which is the request to avoid censorship, followed by explaining how free association operates, alerting the patient to the difficulty involved in free association, mentioning Freud or his metaphor and using psychoanalytic terminology.

In this section we do not discuss other comments such as the purpose of the couch, an explanation of psychoanalysis or why dreams can be useful. This is because they are only loosely linked with free association.

RESULTS (≠ 37)

Avoid censorship	(23)
Explain operation of free association	(20)
Not a social conversation	(3)
Free association is paradoxical	(1)
Silence is acceptable	(1)
Free association is difficult	(16)
Resistance analysis	(6)
Mention Freud or his metaphor	(6)
Use psychoanalytic terminology	(6)



4.12.2.1 Avoid censorship (23) [57]

62 percent of those who give an initial guideline will make a comment about censorship. Some ask patients to 'avoid censorship', some focus on the opportunity to be free ('as free as possible'), and some make remarks such as no matter how 'trivial', 'embarrassing', 'irrelevant', or 'unimportant'.

US.Q tells patients:

> *You should put into words whatever you find comes into your mind* ***without making*** *any* ***conscious effort to focus*** *it anywhere, and* ***without making*** *any* ***selection*** *of what to say,* ***regardless of whether it appears*** *to be* ***important*** *or* ***relevant*** *or* ***embarrassing*** *or not... (para 7).*

UK.M tells them "there is **not an agenda** in the sessions, and you are expected to say as much as you can, whatever comes into your mind, even if you find that it's

[57] UK.A (para 6), UK.B (para 22), UK.C (para 13), UK.D (para 4), UK.F (para 21), UK.G (para 19), UK.I (para 10, 22), UK.J (para 35), UK.M (para 13), UK.N (para 5), UK.O (para 20), UK.P (para 7), US.C (para 27, 29), US.D (para 7), US.F (para 8), US.G (para 5), US.K (para 21), US.M (para 16), US.N (para 49), US.Q (para 7), US.R (para 24), US.S (para 30), US.T (para 6).

silly or **embarrassing"** (para 13). US.N tells patients "let yourself, while you're here, tell me everything that occurs to you **without adding**, **without editing**, **without changing**, **without being afraid** to mention it..." (para 49). UK.F asks them '"to try and speak **as freely as possible without censorship** even if what comes to mind seems **trivial** or **embarrassing** or **irrelevant**"'. (para 21). UK.P invites the patient to 'speak their mind **without censorship**, that even if it is **difficult** and they feel **embarrassed** or **anxious** or whatever sort of reaction it is, that they are expected to be also **honest** and **truthful**.' (para 7).

4.12.2.2 Explain operation of free association (21) [58]

56.8 percent of participants explain how free association operates. Typically, this involves explaining that it provides data to understand the mind. As an example, UK.H offers an explanation to those who are uncertain about the method:

> *if they're still somewhat quizzical then I might add on that I think that after a time they will see why we recommend this method, and that they will begin to understand that it's the things that they find difficult to put into words [that] often turn out to be the clues to the things that are under the surface (para 11).*

US.S's way of explaining is to say:

> *one of the things we are trying to do is to catch a glimpse out of the corner of our eye of what might be going on in the mind, and that the best way I know how to do that is by trying to say whatever comes to mind as freely as possible (para 22).*

Some participants also explain to patients what the analyst's role will be. US.F, for example, informs patients that silence is part of her technique: 'I do let them know early on that I will be silent until I have some kind of comment to make or

[58] UK.C (para 27), UK.D (para 4, 22), UK.H (para 11), UK.I (para 22), UK.J (para 35, 41), UK.M (para 13), UK.N (para 5, 11), UK.T (para 62), US.A (para 22*), US.C (para 29^), US.D (para 7), US.E (para 8), US.F (para 8, 16, 22), US.I (para 11), US.J (para 17), US.L (para 12), US.N (para 49), US.Q (para 7), US.R (para 8*, 28~), US.S (para 22), US.T (para 12*, 14). *=unlike social conversation (3), ^=free association paradoxical (1), ~=silence acceptable (1).

question to ask.' (para 16). UK.D also explains the analyst's role: 'I make it clear that "when I have something useful to say, I will say it".' (para 4). UK.J does this too, telling patients "when I feel I've got something that may be useful to contribute, then I'll chip in." (para 35). US.T explains to patients how the method works: "it's my job to listen to what's going on between the lines and hear what the thread is and we'll think about that together" (para 14).

UK.N lets patients know that he will try to understand them: 'I say to them that my part of the job is that I'm going to be attending to the unconscious meaning of what's going on in the room, which will include the way that they feel about me' (para 5). He also takes the unique step of telling patients that he will go to supervision (para 5). He is the only participant to give patients a leaflet which,

> *summarises very simply what the process of psychoanalysis is: what their part of it is (which is the fundamental rule), and what my part is (which is not to abuse them and to try to understand the meaning of what they bring) (para 9).*

Three participants convey to patients that free association is a special kind of talking. US.A says he will 'constantly reiterate how the conversation with an analyst is not like a social conversation' (para 22). US.R also draws this distinction:

> *I do explain to patients when we first talk about analytic treatment that the format is very different from psychotherapy and that allowing one's mind to go wherever it will and to say whatever comes to mind is how we do it. (para 8).*

Only one participant, US.C, talks to patients about a paradox of free association:

sometimes not talking about the things that seem important to talk about is actually more helpful. If you talk about things that come to your mind, even though it may seem irrelevant or not serious [...] paradoxically it turns out to be the fastest way to learn about you and what's concerning you. (para 29).

US.R is the only participant to tell patients that silence is acceptable: 'even choosing not to talk is ok. I do say that sometimes.' (para 28).

US.N hints that an explanation is useful because he would like the patient to understand clearly the procedure (para 48-51). We see later that the purpose of explaining free association is linked to the desire to offer clarity.

More American participants (13) give explanations than British participants (8), but this is not statistically significant (chi-squared=1.190, df=1, p=0.2752).

4.12.2.3 Free association is difficult (16) [59]

43 percent of participants show that they warn patients of the difficulty involved in free associating. Some examples include UK.L, who would say to patients that "it's a matter of trying to simply say what's on your mind, but that **won't always be easy**". (para 33). UK.J says to patients "I recognise **how difficult** this can be, and it's something really to try for but it **won't be that easy**." (para 35). UK.J introduces them to the notion of resistance by 'letting them know that it's ok that that [the difficulty] should happen, that it's perfectly normal it should happen' (para 37).

[59] UK.C (para 13), UK.D (para 4), UK.H (para 9), UK.I (para 10), UK.J (para 35, 37), UK.L (para 33), UK.N (para 29), UK.O (para 34), UK.P (para 7), US.D (para 7), US.H (para 10, 30), US.I (para 11), US.K (para 9), US.L (para 12), US.M (para 16), US.S (para 30).

4.12.2.4 Resistance analysis (6) [60]

Six participants explicitly ask the patient to reflect on or talk about the difficulty in free associating, or to point out that together they will be exploring the resistance. This seems to go beyond warning patients about the difficulty. Some American participants call this 'defence analysis', though the more popular term is 'resistance analysis'. All six of these participants are American and they find ego psychology to be a useful set of ideas, if not their main theoretical frame. The number, however, is too small for statistical tests.

US.H asks patients to "simply report everything that comes to mind that you can, and if you're having difficulty, talk about that". (para 10). US.M, in the introduction, gets patients 'to speak their thoughts as freely as possible, and in addition I encourage them to try to notice if they don't want to say what they're thinking or if something interferes' (para 16). US.K tells patients that they will be looking at resistances together:

> *Say whatever comes to mind, as best you can. But I also recognize that at times it is difficult to do so - you may feel reluctant or embarrassed, or may think of something as trivial. And then at those moments, I'd like to try to understand with you what gets in the way of saying what comes to mind. (para 22).*

US.S relays the same message to patients telling them to "say whatever comes to mind as freely as possible, with the understanding that often won't be possible, and then we'll have to notice together what gets in the way". (para 22).

[60] US.D (para 7), US.H (para 10), US.K (para 22), US.L (para 12), US.M (para 16), US.S (para 22).

4.12.2.5 Freud and his train metaphor (6) [61]

Six participants might mention Freud or his metaphor to patients. US.F will occasionally explain what Freud's method was, and might use the expression 'basic rule':

> *"Freud said whatever comes to mind is really the best way, what we're trying to do is to see what's going on, not so much of what you're conscious of but what you're much less conscious of. And the best way would be by free associating. By just saying what comes to mind." Sometimes I might call it the "basic rule". I think it really has to do with [...] how aware the patient is of Freud and psychoanalysis (para 22).*

From time to time US.J will tell patients that free association is 'something that Freud discovered many years ago'. He says:

> *it's been rare, but sometimes I'll refer back to Freud's way of talking about riding on the train and looking out the window and how every scene changes so quickly, and just allow one's mind to do the same thing (para 21).*

Other participants raised the possibility of using Freud's train metaphor, though they all qualify that they rarely do so. For example, US.L says that: 'if it happens to be a psychoanalytic candidate, or if I happen to get into a particular kind of conversation with someone, I might use Freud's analogy of the railroad trip, but usually I don't.' (para 12). The same applies to US.C who says 'once in a great while, I use Freud's train thing. Not too often.' (para 31).

[61] US.C (para 31$), US.D (para 44$), US.F (para 22*), US.H (para 10$), US.J (para 21*), US.L (para 12$). *=mention Freud (2), $=use Freud's metaphor (4).

4.12.2.6 Use of terminology (6) [62]

Three participants use the expression 'free association'. UK.F says 'It's very rare that I don't actually introduce it, and I say "this is how I work" and I use the phrase "free association".' (para 21). UK.T also 'would probably label it as free association' (para 28). Another three participants use the term 'rule' including UK.Q, who occasionally says to patients, especially if they are likely to know about free association: "there is only one rule - that thing that is sometimes called a rule - for a patient in analysis, that is to say what comes into their minds". (para 14).

However, more participants avoid using psychoanalytic terminology than those who use it. Ten[63] participants mentioned that they do not use the terms 'free association' or 'rule' with patients. UK.B says: 'I don't think I would call it free association, unless it was a patient who used that term' (para 32). US.I says: 'of course I don't call it the fundamental rule' (para 11). US.R announces that 'typically I prefer to not use any kind of jargon when I speak with patients. So I just try to describe what I mean.' (para 8).

4.12.3 Hypothesis about content

Overall, it seems that the American participants give fuller, more explicit, more descriptive introductions compared to the British. This might explain the observation in the previous section that the average length of the Americans' introduction is more than twice that of the British. To test the hypothesis that American participants give fuller introductions, a scale was devised. Each participant was allocated one point for each aspect of the introduction discussed above.

[62] UK.F (para 21#), UK.Q (para 14^), UK.T (para 28#), US.A (para 22, 50^), US.F (para 24^), US.R (para 8#, 12). #=use expression 'free association' (3), ^= use expression 'rule' (3).
[63] UK.B (para 32), UK.H (para 30), UK.J (para 37), UK.N (para 29), UK.T (para 5), US.I (para 11), US.L (para 12), US.M (para 16), US.P (para 25), US.R (para 8).

Basic statement 'say what comes to mind' = 1 point

Mention types of associations – thoughts, feelings, memories = 1 point

Mention other types of associations – dreams, images, physical sensations = 1 point

Ask patient to avoid censorship = 1 point

Alert to the difficulty of free associating = 1 point

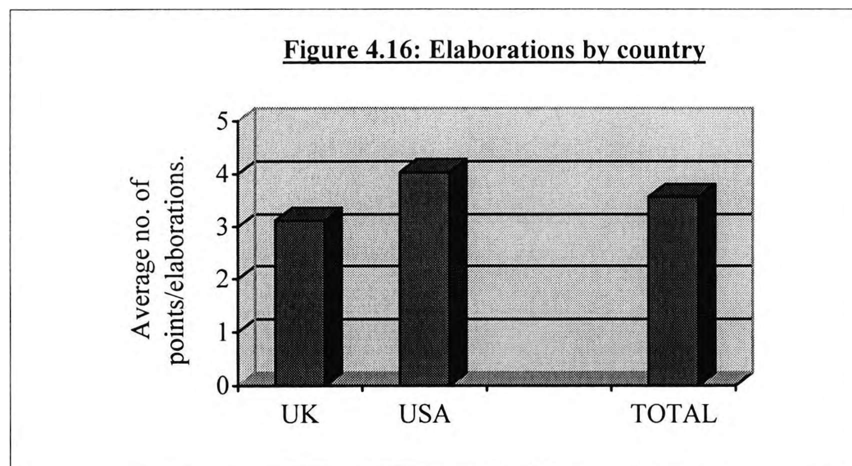
Ask patient to observe resistances = 1 point

Explain how free association works = 1 point

Mention Freud = 1 point

The results ranged from 1 point (UK.Q who gives a very basic formula 'say whatever comes to your mind') to 7 points (US.D who raised all but one aspect in his introduction). The British participants' mean average of 'points' is 3.12 and the American participants' is 4.05. This is displayed in figure 4.16. A t-test revealed that this result is statistically significant (t=2.2203, df=35, p= 0.0330).

Figure 4.16: Elaborations by country



It seems that the longer the introduction (measured by number of words), the more extensive the introduction (measured by the number of elaborations). To test whether there is a correlation, Pearson's correlation coefficient was calculated (Pearson's r= 0.578915, df=35, p=0.3246) and there proves to be positive correlation between number of elaborations and word length.

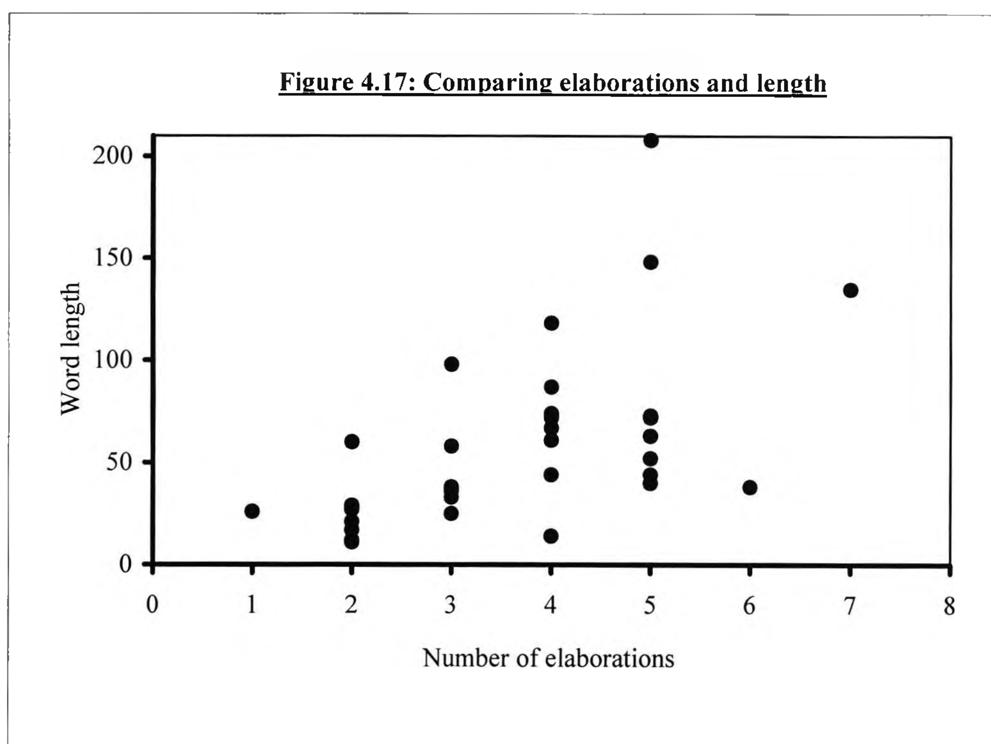


Figure 4.17 helps show the positive correlation between the number of elaborations and word length. This shows that lengthier introductions are not just expressed using more words, but do cover more points.

4.12.4 Section summary

This section has set out the content of the thirty-seven introductions. We have seen that a few more participants avoid specifying the types of associations than those who do specify them, but the difference is not statistically significant. The types of associations most mentioned are thoughts, dreams, and feelings. We have seen that the most common forms of elaboration are about avoiding censorship, explaining how free association works, and a comment that it is difficult. Other elaborations such as explaining it to be unlike a social conversation, using metaphors, or referring to Freud, are rare. We have also seen that the American participants use significantly more elaborations than the British, and that length and number of elaborations are positively correlated.

4.13 TONE OF INTRODUCTION

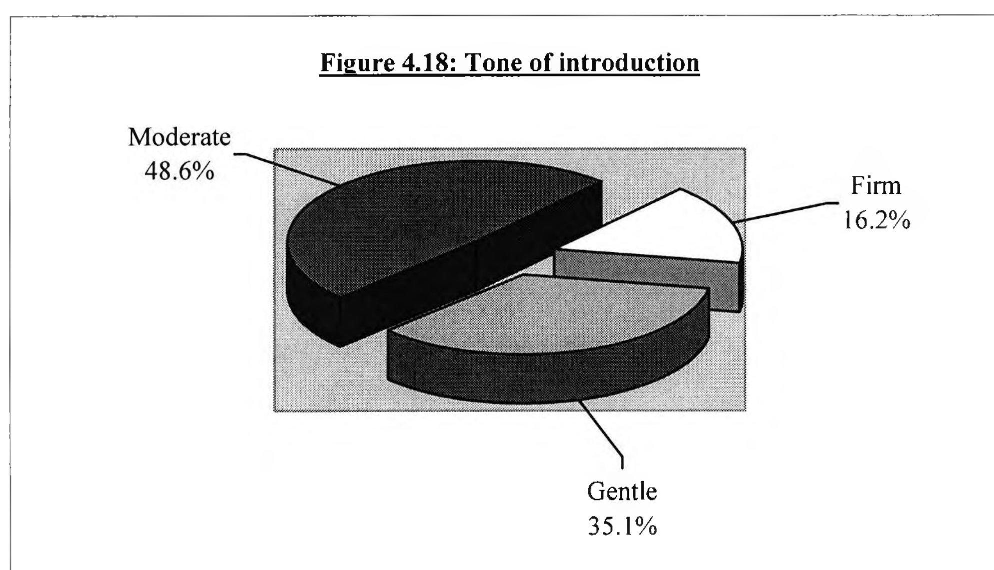
The tone of the remarks is judged by how they sound and by vocabulary used. They are placed into newly constructed categories. A 'gentle' tone entails a soft voice, and often features the word 'try'. A 'firm' tone is one that comes across as informative and serious. A 'moderate' tone lies somewhere between these two. The difference between gentle, moderate, and firm, is often slight.

Additionally, comments might be phrased in the first person singular, first person plural, or second person singular. Also, comments may be 'task-oriented' which conveys the idea of work to be done, or 'value-laden' where the importance of following the guideline is emphasised.

RESULTS (=37)

Gentle	(13)
Moderate	(18)
Firm	(6)

Figure 4.18: Tone of introduction



From figure 4.18 we see that just under half of participants who introduce free association, do so in a moderate tone. Fewer adopt a gentle tone, and fewer still use a firm tone. Although more participants use a moderate tone than gentle or firm, a chi-squared test shows that this result is 'not quite' significant (chi-squared=5.898, df=2, p=0.0524).

(RESULTS=37)

First person singular ('**I** would like you...')	(17)
First person plural ('**We** proceed by...')	(5)
Second person singular ('**You** can try...')	(15)

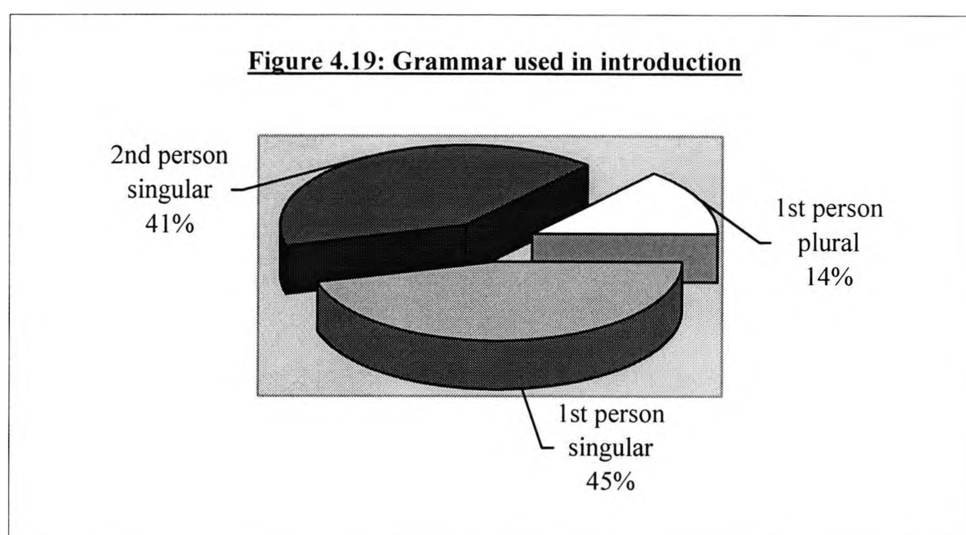


Figure 4.19: Grammar used in introduction

Figure 4.19 shows that more participants use the first-person singular than either the second-person singular, or first-person plural. A test reveals there to be a significant difference among the three grammatical configurations (chi-squared=6.709, df=2, p=0.0349). Thus, significantly more participants use the first or second person singular than they do the first person plural.

RESULTS (≠37)

Task-oriented	(26)
Value-laden	(16)

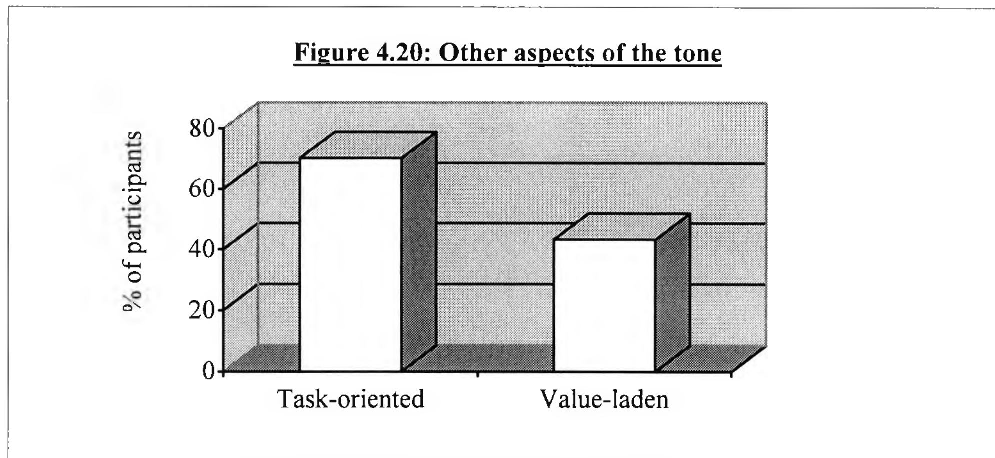


Figure 4.20 shows that 65 percent of participants giving an introduction adopt a task-oriented tone, and 43 percent have a value-laden tone.

4.13.1 Gentle tone (13)[64]

A 'gentle tone' is one that comes across as soft and encouraging, and often takes the form of a suggestion. It includes the words 'try', 'attempt', 'allow the patient', and 'you could try'. UK.E is gentle in telling the patient "**just try** to speak the thoughts that come into your mind". (para 20). Likewise, UK.A says 'I just ask the patient to **try** and tell me whatever comes into his or her mind, no matter what it is.' (para 6). UK.Q might say "well, there's one thing that **you could try** to do, and that is to say what comes into your mind".' (para 18). US.T conveys a sense of opportunity: "I **encourage** you to think of this as a place where you can speak as freely as you wish". (para 6). US.H also presents free association as an option, suggesting to patients "**one thing you could do** is just say whatever is most coming to mind at any particular moment, **as best you can** and it could be thoughts or sensations or pictures or anything". (para 30).

[64] UK.A (para 6), UK.C (para 13), UK.E (para 20), UK.G (para 19), UK.H (para 9), UK.L (para 29), UK.Q (para 18), US.H (para 30), US.I (para 11), US.M (para 16), US.P (para 35), US.S (para 22), US.T (para 30).

4.13.2 Firm tone (6)[65]

'Firm' comments sound informative and serious. Many of these comments also convey a sense of a task. For example, UK.M tells patients that "there is not an agenda in the sessions and **you are expected** to say as much as you can" (para 13). UK.N says to patients that "the only thing **you need to do** is say whatever comes into your mind" (para 31). US.O unlike other analysts, uses the word 'must': 'The patient is **instructed** to begin the session with a dream, with a narrative [...] and these associations also, they're instructed, **must** be about narrative, it **must** be about something that happened in their life...' (para 30)

As expected, the six participants who use a firm tone to present free association, also say they accept the idea of free association as a 'rule'. This number is too small to perform a chi-squared test, but it seems a plausible link.

4.13.3 Moderate tone (18)[66]

Most initial comments can be described as 'moderate' in tone, lying between gentle and firm. UK'Bs tone is classified as moderate. She tells patients that "the sessions are for you to tell me what's in your mind..." (para 26). Some of UK.I's words seem firm, while others seem gentle, so overall they are considered moderate: ''the only thing that I will **require** of you when you come to see me, for our first session and from then onwards, is that you will **try** to say what comes to mind...' (para 22).

[65] UK.M (para 13), UK.N (para 5, 29, 31), US.A (para 22, 41), US.N (para 49), US.O (para 30), US.Q (para 7).
[66] UK.B (para 24, 26), UK.D (para 4), UK.F (para 21), UK.I (para 10,22), UK.J (para 35), UK.O (para 34), UK.P (para 25), UK.T (para 30), US.B (para 4), US.C (para 24), US.D (para 7), US.E (para 8), US.F (para 8, 22), US.G (para 5), US.J (para 17), US.K (para 19), US.L (para 12), US.R (para 24).

4.13.4 First-person singular (17) [67]

Most of those introducing free association do so in the first-person singular, that is, they personalise the request. For example US.K tells patients '**I'd** like you to say whatever comes to mind….' (para 19). UK.B says to patients "the thing **I** ask you to do...' (para 24). Likewise, UK.I says, "**I** will hope that that is what you try to do" (para 22).

4.13.5 First-person plural (5) [68]

US.D is one of a handful who introduces free association using the first-person plural: "**we would like** to study together the mind - the inner workings of your mind - and the best way of doing that is not by setting **ourselves** specific goals and topics…." (para 7). US.G says "the way **we** would proceed is…" (para 5). US.M does similarly saying, 'the best guideline that **we** have is for them to say their thoughts as freely as possible.' (para 16).

All five of these participants are American, and four of the five who use the plural often spoke about mutuality as a consideration for their choice of presentation. These claims cannot be tested as the numbers are too small.

4.13.6 Second-person singular (15) [69]

UK.B phrases her introduction in the second-person singular: "**you** should feel you can say whatever comes into your mind" (para 22). US.N follows suit saying: "**let yourself**, while you're here, tell me everything that occurs to you…"

[67] UK.B (para 24), UK.C (para 13), UK.D (para 4), UK.F (para 25, 27), UK.H (para 11, 21), UK.I (para 22), UK.J (para 35), UK.T (para 23, 30), US.B (para 4), US.C (para 27), US.H (para 10, 30), US.I (para 11), US.J (para 17, 21), US.K (para 19), US.L (para 12), US.Q (para 7), US.T (para 6).
[68] US.D (para 7), US.E (para 8), US.G (para 5), US.M (para 16) US.S (para 22).
[69] UK.A (para 6), UK.E (para 14, 20), UK.G (para 19), UK.L (para 25, 33) UK.M (para 13), UK.N (para 5, 29, 31), UK.O (para 20, 30), UK.P (para 7), UK.Q (para 14, 18), US.A (para 22, 42), US.F (para 8), US.N (para 49), US.O (para 30), US.P (para 35), US.R (para 24).

4.13.7 Task-oriented (24) [70]

Many participants (65 percent) convey a sense of a task in talking about free association. UK.N says the discussion includes telling that patient what 'their part of **the job** is' (para 5) and their 'side of the **contract'** (para 29). US.E might say:

> *what I would **like to do** here, is to help you to be friends with yourself, to get to know yourself, and **the way to do that** is to say what you are thinking about. (para 8).*

US.F's comment conveys a sense of a task: "**the way that this works is** that...' (para 8), as does US.K: "as we **move forward**, here's what I'd like you **to do**" (para 37).

4.13.8 Value-laden (16) [71]

43 percent of participants impart value to their comments. For example, UK.O stresses the importance of communicating: "whatever it is, if anything comes to mind, you can say, **it's important** for us to know it". (para 20). US.Q uses value-laden words: "here's how I think it's **useful** to proceed. You **should** put into words whatever you find comes into your mind...". (para 7). US.O's comment also carries a value tone: "yes, you **should** say whatever comes to mind, because that's **necessary**" (para 30). US.H conveys a sense of excitement: "the more that you could say to me that's not selected, including where you are having difficultly, then we'll probably find it very **illuminating**." (para 30).

[70] UK.B (para 24, 26), UK.D (para 22), UK.F (para 21, 25, 27), UK.H (para 9), UK.I (para 14), UK.M (para 5), UK.N (para 5, 29, 31), UK.O (para 32), UK.Q (para 14), US.A (para 50), US.C (para 29), US.D (para 7), US.E (para 8), US.F (para 8), US.G (para 5), US.J (para 17), US.K (para 37), US.L (para 12), US.M (para 16), US.N (para 49), US.O (para 30), US.Q (para 7), US.R (para 8, 24), US.S (para 22).

[71] UK.D (para 4), UK.H (para 9), UK.J (para 35), UK.O (para 20, 30), UK.T (para 22), US.A (para 22, 42), US.B (para 4), US.D (para 7), US.E (para 8), US.G (para 13, 30), US.H (para 30), US.J (para 21), US.M (para 16), US.O (para 30), US.P (para 35), US.Q (para 7).

4.13.9 Section summary

In this section we have seen that more participants adopt a moderate tone to their introductions than a gentle tone, and even fewer use a firm tone. Almost equal numbers of participants phrase their comments in the 'first person singular' and 'second person plural', with significantly fewer using the 'first person plural'. Many use 'value-laden' phrases and many more use 'task-oriented' ones. We now see that free association continues to be referred to after this initial introduction.

4.14 FUNDAMENTAL RULE IS ONGOING

The title for this code is taken from US.P who described the fundamental rule as 'ongoing' (para 39); it is not a single instruction, but is part of the analyst's way of communicating the frame to the patient. The data confirm that the fundamental rule is not a discrete variable since all participants refer to free association directly or indirectly throughout the work, especially in the early stages. Participants show that the need to refer to free association will occur less frequently as time goes on, and as patients' skills in free associating improve. UK.P, for instance, states that the issue of free association is ongoing: 'it is something that we are always raising, all the time [...] it is not primarily a matter for a preliminary interview but a matter for every single minute of every session.' (para 17).

UK.I says that he gives an initial statement 'like a kind of thing I say' and that 'in the process, we come to a meaning of it in a very different way' (para 24). In other words, the initial introduction to free association is fleshed out as the patient tries it out in practice.

Thus, the 'fundamental rule' seems to occur in two parts – an initial statement and later references. Figure 4.21 illustrates how the topic of free association can be perceived as 'ongoing'. After the initial statement is given, around half of participants might make prompts which invoke the topic of free association. Around a third of

participants might repeat the introduction, or use guided association, and around a quarter might make reassuring remarks about free association, or dissolve resistance. All analysts work with resistance, which also alludes to the statement to varying degrees.

RESULTS (≠40):

Repeat introduction	(15)
Prompts	(18)
Prompt for thoughts, feelings. dreams etc	(16)
Prompt for specific thoughts	(4)
Guided associations	(13)
Dissolve resistance	(10)
Reassuring remarks	(11)
Resistance analysis	(40)
Drawing attention	(39)
Interpretation	(23)

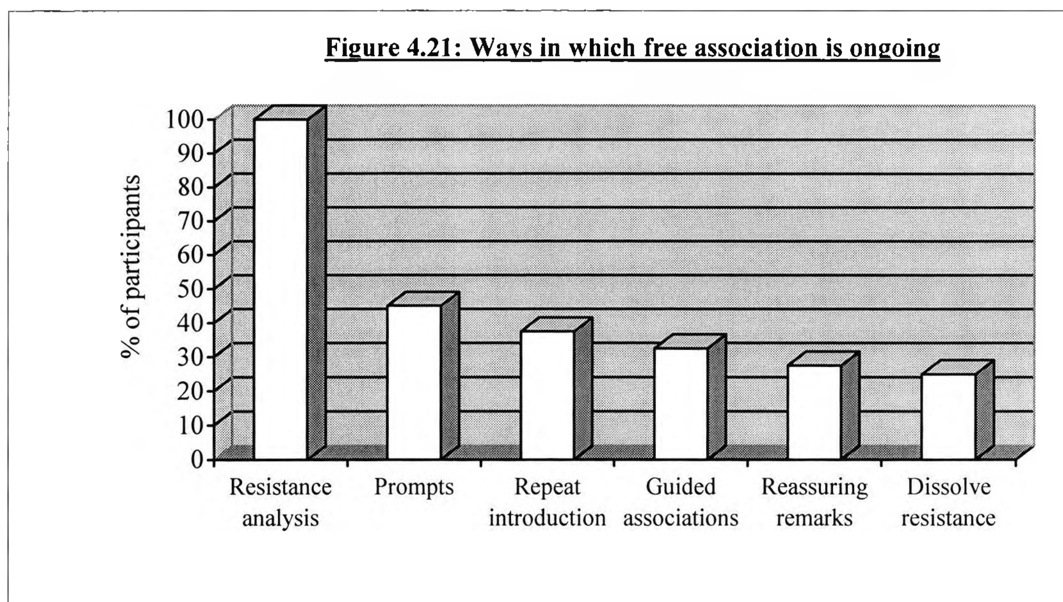


Figure 4.21: Ways in which free association is ongoing

4.14.1 Repetition (15) [72]

The fundamental rule is ongoing when the analyst repeats the initial guideline. In this study, 37.5 percent of participants show that after their introductory remark they will raise the issue of free association again, sometimes several times. For example, US.F finds that,

> *it has to be said over and over and over again. [...] So when they are on the couch it is really matter of me saying again "just say what comes to mind". And often I will say that so many times during the course of an analysis. (paras 11 & 12).*

She would also repeat the rule when the patient expresses a blank or has difficulty talking: 'it's at moments when they're trying to reach for the more rational, that I might say "what comes to mind?" (para 14). US.A introduces free association later in the treatment, but he does not stop at a single comment; he needs to make 'comments periodically' (para 22).

US.G reminds new patients about free association: 'I usually at least one more time, possibly two more times reiterate "like I'd said, it's important to say everything that comes to your mind as openly as you can".' (para 13). He will always do this if a patient hesitates, which he finds is common. If a patient asks "I don't know what to talk about, why don't you ask me a question?" his response would be in the form of repetition: "well, my basic question is 'what's on your mind?'", and "like we said I want you to say everything that's on your mind".' (para 17). UK.O says that she knows her 'little speech' 'by heart' (para 20). She says she repeats it many times because patients 'don't hear it' (para 20). US.K raises the topic of free association early on, and will 'subtly reinforce' it throughout the treatment (para 23). He gives an example of how this is done:

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[72] UK.D (para 26), UK.F (para 25, 27), UK.M (para 5, 7), UK.O (para 20, 26), UK.T (para 22), US.A (para 22), US.C (para 21), US.E (para 38), US.F (para 11, 12, 14, 56-58), US.G (para 13, 17), US.J (para 21), US.K (para 23, 37), US.Q (para 13), US.R (para 8, 20), US.T (para 6).

if someone says "well, there's something that occurred to me but right now this is more pressing", I might say "well, maybe we'll wanna talk about the more pressing thing, but also remember that other associations - other ideas - that come to mind may be important to understand as well." (para 37).

US.R reiterates the rule when patients are on the couch. If they feel they have nothing to say, rather than dissolve the resistance, she reminds them of the rule:

sometimes people will say "well nothing's on my mind today". And I'll suggest that they just let their thoughts wander and just say whatever comes up, as though we're starting from that moment. Not "well, I'm sure that you had some ideas and you've been suppressing them". But "let's just start from now and see what comes to mind". (para 20).

Other participants say they repeat the fundamental rule but not as a matter of routine. US.E, for example, repeats the rule, but only rarely. One situation that might prompt this is if the patient is 'having a lot of trouble talking, and I might say "I think it will help if you can say whatever uncomfortable thing comes to mind"' (para 38). UK.M says that free association is in the background, but can be brought into the foreground if a patient claims to be embarrassed about a subject (para 5). In these cases, he will 'remind them of the agreement or the deal about trying to say as much as possible what is in their minds, and whatever feelings are associated with it.' (para 5). He also repeats the fundamental rule if patients are anxious or uncertain of their task: 'I will remind them that they just need to talk about whatever comes into their mind, again.' (para 13). With a patient who struggled to be spontaneous, UK.T found a different way of re-communicating the idea of free association - by positive reinforcement. One of her patients, normally stilted in her speech, was talking freely, and UK.T tried to encourage her by saying: "maybe we could think about how we could usefully do a bit more of that" (para 22).

US.Q will repeat the rule when the patient is denying or withholding thoughts:

sometimes they'll say "well, yeah, but I don't think it's really relevant". And that's an occasion when I'd refer back to the initial instruction and say "the principle that we discussed at the outset is that there's no way of knowing in advance what's relevant or not. So it's useful to just say things whether they appear relevant or not" (para 13).

US.T mentions a special case that merits repetition. He finds that many patients ask if there is anything they can do to further their progress (such as reading), and he replies to them by way of a reminder:

as far as I know, there's not anything you can do to really accelerate it. There's things you can do to hinder it [...] you can lie to me [...] or you can consciously censor things [...] But I think that if you basically tell the truth about what's going on, and do say what's come to your mind, that will help the process along. (para 6).

Twice as many American participants as British referred to repeating or reminding patients about free association. This figure is not significant (chi-squared=1.667, df=1, p=0.1967) but it does hint that American participants might play a bigger part in guiding patients to free associate than the British ones.

4.14.2 Prompts (18)

Just under half of participants gave examples of how they prompt patients to free associate. A prompt relates to the current moment, as opposed to repetition which sets out a guideline for the wider duration of analysis. The most common conditions under which prompts are given are the same as for repetition: where patients show difficulty in free associating, or where they ask questions. Prompts take various forms. Guided associations and dissolving resistance are more common than prompting for thoughts, dreams, or absent material. Yet all prompts have one thing in common; they seek to gain access to content.

4.14.2.1 General prompts (16)[73]

A general prompt is a pared down version of the fundamental rule. Rather than offered as an instruction, it is phrased as a brief question. These prompts do not steer the patient's free associations in any direction and are therefore neutral requests for further material. Analysts can ask for thoughts (10), feelings (6), dreams (5) or even colour (1).

As an example, UK.G uses the prompt "I wonder what comes into your mind at that moment?" (para 23). UK.I prompts a silent patient to "try and tell me what's in your mind at this moment" (para 14). US.C will aid a patient who is 'stuck in a pause' (para 18) by asking "is something coming into your mind?" (para 12). UK.S will ask patients "I wonder what you're thinking?" in cases when he feels 'that the individual has drifted off into some rather interesting place, and you might think that it's quite useful [...] for them to speak it' (para 17). He clarifies that this is not 'a central part' of his technique (para 11). UK.Q might ask the patient "does anything come to your mind now?" or "what's going through your mind just now?" (para 10). He says he is keen to gain access to the patient's mind and by giving such a prompt he is communicating the message about free association: 'so I might, by asking a question, might be saying "well, I think it might be helpful if you tell me what goes through your mind".' (para 14).

Some participants prompt for feelings, bodily sensations or experiences, but only six participants (15 percent) do this. For example, US.S might prompt a patient, "what are you feeling now?" (para 40). US.H will prompt silent patients asking them 'do they have any picture in their mind about something?' She might also ask patients if they have 'any body sensations connected?' (para 10). When a patient is stuck, US.C is keen to 'ground them' to move free association forward. One of her

[73] UK.A (para 14), UK.B (para 16), UK.G (para 23, 25), UK.I (para 14, 16, 26), UK.Q (para 10, 14), UK.S (para 11, 17), US.B (para 10, 30, 36-40), US.C (para 10, 12, 18), US.D (para 19), US.F (para 14), US.G (para 51), US.H (para 10, 16), US.J (para 13, 17), US.L (para 22). US.O (para 30, 32), US.S (para 40).

techniques is to 'go through the door of perception' and ask "what do you notice?" or "what do you experience?" (para 31). She says:

> *sometimes I <u>really</u> have to spell it out, like "I wonder if you're notice yourself looking at anything?" or "is something catching your eye?" or "is something coming into your mind?" or "any sensations you have in your body?" (para 12).*

US.B is the only participant to ask patients if they see 'colours'. If a patient draws a blank, she'll 'go at it in an artistic way', and ask "well can you tell me do you see an image, do you have a picture in your mind, do you have a colour?" (para 10).

Five participants raise the issue of dreams in the form of a prompt. US.B believes dreams to be a part of free association and enjoys working with them. From time to time, if they 'start to feel stuck' she'll ask "have you had a dream lately?" (para 30).

<u>4.14.2.2 Directed prompts</u> (4) [74]

A directed prompt focuses the patient on an area deemed relevant. Only 10 percent of participants talked about how they might, at times, do this. These participants seem to be aware that this can alter the course of a patients' associative material. Yet, they believe that the benefits of containing the patient (US.C para 31), and of being spontaneous with the patient (US.K para 19), outweigh the downside of influencing the direction of associations.

US.K is not 'rigidly adherent' to free association. He prefers to engage in a 'more conversational' dialogue (para 19), and 'so I may at times direct the patient's associations.' (ibid). US.L prefers to understand the patient's difficulty in speaking, but will 'give them direction' in some circumstances. One instance is 'if someone is in a tremendously painful state, I'll start them off, I'll say "you were talking yesterday

[74] UK.C (para 47), US.C (para 39), US.K (para 19) US.L (para 22).

about so and so, do you think that could be on your mind?"' (para 22). If US.C believes that the patient is thinking about something, she might prompt them to talk about it. She might make 'inquiries about transference', for example, by asking them "are you thinking about me?" (para 39). She admits 'it's not entirely free in the sense that you nudge them' (para 39).

More American participants say they give prompts (general, or directed) than the British participants, but not to a significant level (chi-squared=0.889, df=1, p=0.3458).

4.14.3 Guided associations (13) [75]

Analysts will sometimes ask for associations to specific elements – patients are asked to say what comes to mind about a certain aspect of their material, often a dream. It is different to asking patients to 'elaborate' or 'clarify' their associations which participants say that they often do (such as "I'm not getting it", "can you tell me more about it?" US.E para 60). In the process of such 'guided associations', the idea of free association is intentionally, or unintentionally, alluded to. Some analysts point out that by asking for further associations they are helping the patient to free associate. The related issue of 'education' is considered in the next section. Strictly speaking, guided associations interfere with free association, because the analyst suggests the element that should be associated to, and 'freedom' is lost. However, as US.I points out, guided associations are considered to be a standard part of psychoanalytic work (para 19).

UK.G prefers not to discuss free association with patients. Yet, when a patient brings a dream he asks '"what comes to mind about that?"' (para 11). Thus, for him, this type of comment is both a guided association and an introduction to free association. UK.O also introduces free association as a guided association. In contrast to UK.G, her comment is more extensive. She asks patients:

[75] UK.G (para 11), UK.H (para 39, 41), UK.O (para 16, 20), UK.R (para 9, 15), US.B (para 30, 44), US.D (para 17), US.E (para 60), US.I (para 19), US.K (para 25, 33), US.M (para 34), US.O (para 30), US.R (para 36), US.S (para 48).

I wonder if something comes to your mind connected either to the whole dream or to some aspect and details to the dream? It may be something which seems to have nothing to do with the dream, or it may be something embarrassing or perhaps critical or whatever it is, if anything comes to mind, you can say... (para 20).

UK.R will use guided associations when his attention is struck by an element in a dream or in a conscious association in the session. For example, if he senses a 'verbal disjunction', 'odd use of language', or if the 'current isn't running smoothly' then he will intervene: 'it's moments like that that often I'll ask for more associations.' (para 15). He might ask the patient "well, does anything come to mind about that?" (para 9). Later in the interview, he gave a clinical example of how asking for more associations with one patient yielded more information, opening a new pathway of exploration (para 15).

US.B as well as prompting for feelings, images and even colour, will ask the patient to associate to specific elements: 'they'll start with the dream, and I'll let some silence go, and depending on where the patient is, I'll say well "what do you associate to that?"'(para 30). In US.O's communicative model, guided associations are central and form the basis of his second 'rule'. Patients have already been instructed to narrate a dream or to 'make up a story on the spot, and to then associate to it, what I call "guided associations"' (para 30). US.R will use guided associations, sometimes quite specifically. She'll say "you brought up this dream, what thoughts did you have, or what reactions did you have to it?" If a patient answers "well, I didn't think it meant anything", US.R will go 'step by step' through each element of the dream, such as "your office - what was the room like?" (para 36).

4.14.4 Dissolve resistance (10)[76]

An analyst dissolves resistance by asking the patient to talk about an aspect that is consciously censored. In doing so, free association is promoted without any examination of the resistances – they are simply by-passed. Of the ten participants who show that they dissolve resistance, half say that they are committed to resistance analysis, which on the surface seems contradictory. This can be explained, since in practice, participants seem to borrow from both techniques. Also, some[77] of these participants will only reserve such comments for rare instances where difficulties are encountered, and prefer to examine the resistance. Nevertheless, the comments set out here have a dual effect: they dissolve resistance, and serve as a reminder of the fundamental rule.

Six of these participants show that they dissolve resistance in a non-confrontational manner; they invite the patient to share whatever it is that they are withholding. For example, US.K says:

> *based on my knowledge of the patient I might intuitively sense that there's something missing. So I might say to the patient "in this dream, you've shared a lot of thoughts about various elements but you didn't talk about this element - that wasn't in your association". [...] I might say "is there something missing? Something maybe you didn't talk about?" (para 25).*

US.E uses humour to remove patient's censorship. She will tell her patient in a 'jokey way': "from where I'm sitting here on my pedestal, it looks like we haven't gotten to any of the bad stuff lately". (para 66). Her aim is to help the patient be 'safe' and to be able to recall 'things that are quite horrific' (para 66). US.G also appears to be asking for concealed thoughts. When his patients are silent, express a blank, or talk repetitively around a subject, he might ask "are there things that are harder to talk about?" or "is there anything you'd rather not say?" (para 13).

[76] UK.C (para 47), UK.N* (para 19, 21), UK.T* (para 42-44), US.E (para 66), US.G (para 13), US.K (para 25), US.N* (para 62-68), US.O* (para 30, 34), US.Q (para 13, 17, 34), US.T (para 27-28). *=confrontational.
[77] UK.B (para 16), UK.I (para 14), UK.Q (para 12), UK.S (para 11).

US.Q uses both resistance analysis and dissolving resistance as tools. He will dissolve resistance if he has a 'reasonable hunch that there's something they're thinking and not saying'. He will say "you look like you're thinking something" or "I have an idea that there's something you're thinking but not saying", which US.Q believes 'implicitly invites the patient to say what it is' (para 13).

Four participants are confrontational in their approach to dissolving resistances. UK.N gives a case example where he suspected a patient of keeping a thought from him. His comment to her, which he considers to be challenging, was: "look, you've just told me that you were going to go out and buy a red dress, and then there was a pause, and I think that you were having a thought that you don't want me to know about". (para 19). She replied that she was thinking about her son, and UK.N was able to show her that this had meaning (para 21). He reasons that he was working with this patient for several years, and so 'I can kind of push her to tell me the thought.' (para 21). With other patients, he says, he might not be as challenging (para 21).

UK.T is unapologetic about her occasional use of a confrontational stance. She says that 'if I think there's a real resistance, I will come in quite hard.' (para 42). Her comments might entail strong language such as "stop buggering me about", or "what's going on here? You're messing me about!" (para 44).

US.N believes that 'as you dissolve the resistance, it frees up more for free association'. His approach to dissolving the resistance is in keeping with his confrontational style. If the patient appears to be 'withholding thoughts, or has a reserved facial expression or body posture or says "to be honest with you", I say "un un - what are you concealing there?" (para 64). An example of his 'frankly confrontational' approach might be to say: '"you are lying!" Just like that!' (para 68).

US.O uses narration in the same way that other analysts use free association, but he focuses on removing resistances to it, rather than analysing why they cannot tell stories. If patients are silent, he will try to get them to speak: 'I will point out times when they violate the rule of free association.' (para 34). He admits: 'it's very direct stuff...you can call it confrontational' (para 34).

Of the ten who show that they dissolve resistance, slightly more are American (7 compared to 3 British). Although this is not statistically significant (chi-squared=1.6, df=1, p=0.2059), it does point to the possibility that, again, the American participants are more inclined to play an active role regarding the pursuit of associations.

4.14.5 Reassuring remarks (11) [78]

27.5 percent of participants show that they make reassuring comments in response to a demonstration of resistance. Such comments are containing, but at the same time they refer to the task of free association. US.C as one example, reassures her patients when they express anxiety. Patients might ask nervously "what should I do?", in which case she tries to contain them by saying "you know, it's hard, this might be a time to see what comes up, let's see where things go". (para 12). Similarly, if the patient expresses a blank such as "I don't have anything on my mind", she says 'I might then remind them, I might give them an encouragement, I might say "well I think it's good that you can't think of anything - that means that you might be ready for something new."' (para 10). If UK.O senses that patients feel very anxious, she feels it is important to acknowledge this by saying: "naturally you feel quite anxious, you don't know what's going to happen, and it is difficult to say just anything that comes to your mind". (para 32). UK.J does similarly, saying he will contain patient's worries by acknowledging how difficult and 'odd' free association can be (para 23).

[78] UK.J (para 23, 35), UK.O (para 32), UK.R (para 23), UK.S (para 21), US.C (para 10, 12), US.F (para 64), US.I (para 31), US.L (para 22), US.R (para 20-22, 32), US.S (para 40), US.T (para 8, 20).

Like other participants, he believes that containing comments reduces the patient's anxieties and helps them free associate (para 35).

US.R refers, in a containing way, to the fundamental rule. She 'reassures' a patient saying "this is a journey, it's a very long and difficult process, and it's working with someone, and all the various feelings that might come out of that, and it's hard". (para 20-22). US.T says he is aware of the 'containing function' he performs (para 20). He finds that patients frequently are often worried that they are not making sense. He replies with a reassuring remark that reminds patients of the method of free association: "that's quite your job, to be able to do that if you wish. We don't have to know in advance where you're going to go" (para 8). We have seen that UK.S does not lay out an initial guideline of free association. Rather, he tries to encourage the patient to speak through his nurturing manner. He describes the approach he takes with a patient who seems frozen:

> *one's really trying to convey something of an attitude of a mother's lap, that says 'well, come on'. So it's more coaxing in a way, an analytic version of coaxing, to try and enable someone to feel "well, it might be worthwhile saying something". (para 21).*

4.14.6 Resistance analysis

All forty participants work with resistance, and each time they do, free association is highlighted. For example, US.I (para 21) finds that 'there's a way in which I am referring back to the original instruction by referencing it'. UK.H says that when he tries to understand resistances he is effectively reminding patients of 'how best to proceed' (para 25). Participants demonstrate several approaches to analysing resistance, but are grouped using US.S's distinction between 'interpretive mode' and 'pointing out defence mode' (para 18). The second proves to be the more popular technique, and was mentioned by all but one participant.

4.14.6.1 Draw attention to resistance (39) [79]

When participants 'draw attention' to the resistance, they point out that the patient is resisting in the many ways discussed earlier. This explicitly or implicitly invites the patient to reflect on the reasons. Although the onus of reflection seems to lie with the patient, often a mutual discussion ensues (say 57.5 percent of participants). Eventually some patients learn to be self-reflective, and several participants (25 percent) say that self-reflection is a goal.

If she detects a difficulty in free association, US.P will ask the patient "What's the problem with saying whatever's coming to your mind? Is there something that's keeping you from wanting to do that?" (para 31). She finds that this refers back to the initial introduction, and leads to a discussion about the reason for such resistance, which is 'usually shame or self-criticism' (para 31). In line with her ego psychological framework she is keen to 'talk about the resistances' (para 29), and she believes that self-reflection is a 'goal' (para 35).

US.N asks the patient to think about the resistance and in so doing refers to the task of free association. He asks "what's happening now, is there a break down in your ability to free associate, and if so, what's causing it?" (para 85). UK.M also gets the patient to reflect on their difficulty by asking "what is stopping you from talking?" (para 11). He believes that commenting in this way 'can highlight that there is a resistance operating and brought into focus as something that we need to understand more' (para 7). UK.M shows that by making such remarks, the rule is alluded to: 'it's not bringing in the fundamental rule explicitly but it's somehow reminding them of it' (para 11).

[79] UK.A (para 12, 22#), UK.B (para 16, 32^), UK.C (para 31#), UK.D (para 6^, 8#), UK.E (para 18), UK.F (para 7, 13, 21, 29, 33^, 35), UK.H (para 25-27^, 43^, 45#), UK.I (para 14-18), UK.J (para 15, 17**#, 19^, 35#, 37^), UK.K (para 12** 14^), UK.L (para 15**#, 35), UK.M (para 7^, 11#), UK.N (para 23, 27), UK.O (para 22^), UK.P (para 13^, 25), UK.Q (para 40), UK.R (para 17^, 23), UK.S (para 11), UK.T (para 8^), US.A (para 36#, 40^), US.B (para 18#), US.C (para 16), US.D (para 27^#), US.E (para 46^), US.F (para 52#), US.G (para 13, 15#, 27#), US.H (para 10#, 16**#, 30), US.I (para 11^#, 25#**, 31), US.J (para 11#, 13**, 19**), US.K (para 21^, 35#), US.L (para 12^, 16^, 18#, 22), US.M (para 18**, 30#, 32#, 34^, 40), US.N (para 69^, 85#), US.O (para 30#, 34, 36), US.P (para 13, 27^, 29, 31#, 35**), US.Q (para 13, 17), US.R (para 8^, 16**, 18*#, 20), US.S (para 12, 16#, 22^, 30**, 34^), US.T (para 12^). **=self-reflection is a goal (10) ^= mutual discussion (23), #= explicitly ask patient to reflect (23).

US.M thinks that a comment on resistance 'implicitly refers to the guideline' (para 34). If a patient is struggling with speaking, he might say "it seems to be very difficult to say your thoughts today, let's see if we can understand the reasons." (para 34). If a patient changes track, he might let them 'go on for a little while', and then point out: "you paused and seemed to change the subject and go on to something else. Were you aware of that? Do you have any thoughts about it?" (para 30).

US.S announces to patients in the initial guideline that resistance analysis will be part of the session: "part of our work will be to notice what gets in the way." (para 30). During the analysis, if a patient suddenly stopped after a series of associations, she would invite them to be curious about the reasons: 'I might just say "you were moving along there, I wonder if some feeling interfered with your thought? Because you seemed to have stopped."' (para 16).

US.L, who claims to be guided by Paul Gray's defence analysis, is committed to understanding resistances. He gives a clinical example of how this leads to a discussion and promotion of free association:

> *A patient is talking about how envious she is of various people and of various women particularly. And then she mentions that she saw my previous patient come into the waiting room, and then she pauses. And I said "did you notice that you just paused there? Can you tell me what happened?" [...] And it turned out, she went on to talk about being envious of the other patient and how that's difficult to talk about (para 18).*

If US.G detects resistance in the form of repetition he will say: "I notice that we aren't talking about a lot of different things, and I wonder if you notice that too?" (para 15). He justifies such a comment saying that it gives patients a chance to 'get on board with the idea that they have been constricted', in other words to recognise that perhaps 'they're not exploring out into the things that are available to them.' (para 15). If the patient is withholding thoughts, then he might ask "what makes it so hard

to talk about it if it's so active on your mind?" (para 27). Again, we see that such a comment refers to the initial introduction to free association.

4.14.6.2 Interpret resistance (23) [80]

In offering an interpretation of the resistance, the analyst does most of the work of reflection by suggesting a meaning for it. 57.5 percent of participants claim to interpret resistances. When giving an interpretation of resistance, the analyst is also reinforcing the initial introduction.

US.S gives an example of interpreting a pause. If she can 'pinpoint' the issue, and knows the 'patient well enough', she might say:

> *"once again when you came up against your own angry feelings your mind seemed to stop or you seemed to get startled" or "jee, you were speaking really happily here, but when we got to your mother, you suddenly found yourself in that old feeling of despair, I think there's a connection" (para 16).*

US.S's comment seems to have the effect of promoting free association. Indeed this is her aim, and something she learnt in her training where one of her supervisors taught that the point of an interpretation is 'to encourage freer and freer association' (para 10).

US.T gave an interpretation to his patient which promoted free association. His patient felt that it was 'improper' for him to talk about something, and US.T interpreted from a dream: "oh, you mean you were following the correct protocol, like in your dream, just following orders [...] things that you're not supposed to talk about and think about?" (para 8). The patient agreed and took this as a cue to speak freely:

[80] UK.D (para 6), UK.E (para 18), UK.H (para 47), UK.I (para 14, 16, 28), UK.L (para 27), UK.N (para 5, 21, 23), UK.O (para 21-22), UK.P? (para 13), UK.Q (para 10, 20, 22), UK.R (para 23), UK.S (para 11), UK.T (para 8, 48), US.A (para 32), US.C (para 16), (US.D para 27/7), US.H (para 16, 20, 26), US.I (para 11, 27, 31), US.J (para 11, 13), US.L (para 22), US.N (para 69), US.O (para 30, 34), US.S (para 10, 16), US.T (para 8, 12).

"yeah, I guess so [...] but now that you're inviting me to, jee I do have some thoughts" (para 8).

UK.N handles resistance in a variety of ways, including by dissolving it. He also makes interpretations about 'the fear of the exposure' of the 'fantasy about the analyst' (para 5). He might comment to a patient that 'they feel terribly self-conscious about their thoughts [or] they're trying to please their analyst.' (para 23).

UK.Q avoids quoting the fundamental rule, preferring to invoke it via the analysis of resistance: 'I would feel more comfortable if I were able to refer to the fundamental rule without giving it as a rule. In other words, as part of an interpretation of what I think the patient is doing or what the patient's afraid of' (para 20). As an example he cites a patient who tries to take on the analyst's role by interpreting their own material. UK.Q would interpret that 'they're trying to adopt a safer position than if they were to be the patient and say what came into their mind.'

UK.I takes a different approach. Her interpretation does not centre around the patient's function but on the analyst's. She would be 'telling them what I think I'm inducing in their state of mind, which they are not able to communicate.' (para 16). UK.I says that by making an interpretation about the analyst's function, she is 'extending free association' (para 14).

4.14.7 Section summary

This section has demonstrated that the 'fundamental rule' is an ongoing matter in analysis; rather than being a single comment, it consists of an initial remark and continuous references to it thereafter. It is directly raised each time an analyst repeats the instruction. It is alluded to each time an analyst gives a prompt, uses guided association or dissolves resistance. It is alluded to each time an analyst makes a reassuring comment about the difficulty of free association, and also each time

resistances are analysed. Some of the comments in this section hinted towards an educative element to free association and this is reviewed next.

4.15 ANALYSTS' ROLES - ASSISTANCE

Participants seem to take one of four roles regarding the fundamental rule: gently helping patients to free associate (**facilitate**), playing an active part in helping patients (**teach**), occasionally offering help (**some assistance**), and allowing the patient to learn about free association independently (**no assistance**). In practice, the analyst sometimes plays a more active role, and at other times will allow the patient to take the lead, but analysts have been grouped under the role that they seem to perform most often.

RESULTS (=40):

Facilitate	(15)
Teach	(9)
Some assistance	(8)
No assistance	(8)

Figure 4.22: Analysts' role/assistance

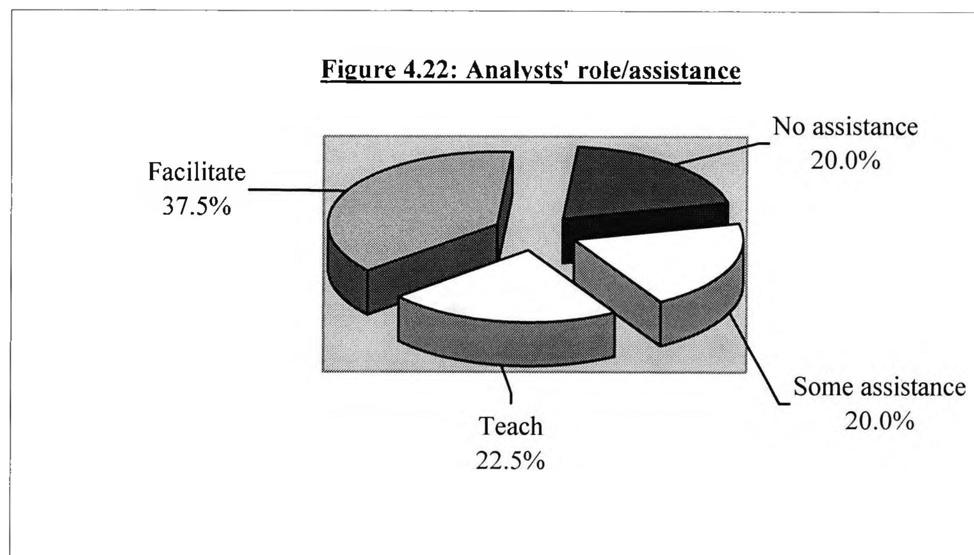


Figure 4.22 depicts how more participants viewed their role as facilitating than the other three roles. In total, 60 percent offer some assistance, and 40 percent offer little or no assistance. Although more participants give assistance than not, this is not a statistically significant result (chi-squared=1.6, df=1, p=0.2059). More American participants (17) than British (7) viewed their role as facilitator or teacher. A chi-squared test confirms that these results are statistically significant (chi-squared=4.167, df=1, p=0.042). Conversely, more British participants (13) than American (3) felt they gave some or no assistance. This is also significant (chi-squared=6.25, df=1, p=0.0124).

4.15.1 Facilitate (15)[81]

37.5 percent of participants give a gentle form of assistance, saying that they 'facilitate', 'help' or 'encourage' patients to free associate. As one example, US.M claims he facilitates it by guided association: 'I do facilitate it sometimes, that is, I might say to a patient, "I wonder what comes to mind about that?" about a particular thing that they've said. Or maybe in relation to an element of a dream or in relation to a particular spontaneous thought. So I might facilitate that way.' (para 34). UK.S, in describing her tools to help patients to free associate, uses an analogy of an artisan's workshop. She says that just as artists 'have screw-drivers and planes and things for getting out nails [...] well, every analyst has got a range of comments that just enable, just facilitate the process without them being of profound significance.' (para 17). Her tools include prompts such as "I wonder what you're thinking?" (para 17). UK.G also views himself as a 'facilitator' of free association, and thinks that it sometimes needs to be 'started by the analyst' (para 21). He finds that patients can come to free associate on their own, especially after he has repeated comments such as "what comes to mind about that?"

To a small degree, free association seems a matter of conditioning. For example, US.P, who conceives her role as 'coaching from the sidelines' (para 35),

[81] UK.C (para 27), UK.G (para 13, 21), UK.P (para 27), UK.Q (para 10), UK.S (para 17), US.A (para 22), US.B (para 6, 22), US.H (para 16, 20, 26), US.I (para 25), US.J (para 7, 13, 19), US.K (para 19, 23), US.M (para 18, 34, 40), US.P (para 13, 33, 35), US.R (para 35-36), US.S (para 34, 42).

reveals how patients might learn about analysts' preferences. In the following quote she shows how her patients may have been conditioned to bring dreams:

> *I think if patients know that their analyst is really interested in their dreams, that they dream a lot and then bring them more often. [...] I've found that people respond to the encouragement of someone saying "oh aren't dreams interesting?" which I do say. I say "aren't dreams fascinating?" I think I really encourage people by saying things like that. (para 33).*

US.H also implies that her patients are conditioned into the analytic method. If she finds that there are two thoughts that seem unconnected, she will offer the prompt "well what was the train of thought?" She says 'my patients know how to do that' (para 16), which suggests that patients can get used to such a prompt, and come to use it on their own.

Some participants place special emphasis on the patient developing a self-observing capacity. US.J is a case in point. Ideally, patients will be able to observe their resistances, but if they can't, he will assist them. He says 'earlier in therapy I have to be more interventionistic', and explains that patients need help to find their way around in this 'new territory' (para 13). By the middle phases, there needs to be less help since patients 'have come to recognize' the 'dynamic importance' of resistances (para 13). US.J finds that the need for facilitating free association will subside over the course of treatment.

4.15.2 Teach (9) [82]

Teaching is more intense than facilitating. 22.5 percent of participants are explicit about their role in teaching the patient to free associate, speaking of the need to 'train' or 'socialise' (UK.M para 15). Although participants speak of the teaching – or educative element - involved, they rarely lead patients every step of the way; often

[82] UK.M (para 15), UK.R (para 17), US.C (para 16, 21, 31, 33, 37, 41), US.F (para 58), US.G (para 13, 15, 17), US.L (para 16), US.N (para 47, 49, 57, 71), US.O (para 34), US.T (para 12, 14, 27-28).

much space is left for the patient to explore alone. Furthermore, teaching is often only resorted to with patients who are uncertain of their role.

UK.R shares his supervisor's view that 'there is an educational element to psychoanalysis, especially in the opening phases. And I still agree with that, that free association isn't something that comes easily to anybody. It's actually a capacity that you have to learn through analysis.' (para 17).

US.F regards herself as 'the guardian of the analysis' (para 58). This is something she teaches candidates too. She says of free association: 'it is up to me to keep it going, and it's up to me to pursue the unconscious material.' (para 58). Repeating the fundamental rule is one way for her to maintain her responsibility.

US.N firmly believes in the didactic nature of psychoanalysis. For him, everyone can be taught to tap into their own unconscious. His view of the analyst as teacher is evident in his language: 'I start from the assumption that I'm there to teach them a technique. I teach them to play an instrument which is their mind.' (para 49). The ability to overcome resistance 'requires additional teaching' (para 57). He compares a patient having difficulty free associating with a 'student struggling with the beginnings of mastering a technique' (para 71). He gives a clue about why analysts need to 'teach' the patient about free association - it is a method that is difficult to learn on one's own and that by implication, the process will be smoother if assistance is given (para 55).

US.T finds that if some patients are unfamiliar with free association, 'I have to teach them. Teach them that the normal rules of social discourse don't apply here' (para 12). This entails repetition and reassurance:

> *any teaching that I do, I'd rather have it be very alive and come right from something in the immediate present, or use something directly from the patient to illustrate a point, and that's best. But you can't always do what's best. So sometimes I will teach just by saying "it's ok to not make sense", and say "it's my job to listen to what's going on between the lines and hear what the thread is and we'll think about that together" (para 14).*

He also gives examples of self-disclosure and justifies that this is because he views his role as 'modelling': 'I'm setting myself up as a new object [...] that says "it's ok to say whatever is on your mind. We can think about the meaning of it".' (para 28).

US.C spells out her approach to 'teaching' the patient. She finds that some patients need little assistance, but with others she will talk them through free association, 'step by step' and 'repetitiously – a few times or many times – before they learn' (para 31). She uses the analogy of helping someone to swim: 'it's like helping someone who is skittish about water to step into water into a swimming pool step by step by step, and so they are in, and eventually they just dive in.' (para 31). They might need to be taught, she reasons, because 'not everyone is talented at knowing what's inside their mind. They don't always know "Oh I just had a thought", "That's a thought". You have to train them to do that too.' (para 31). To do this, she says she might repeat the fundamental rule: 'They may have heard it fifty times before, but I choose consciously to bring it in again.' (para 21).

Participants mention that teaching can itself be difficult. US.L recognises that explanation can only help so far, but still finds it worthwhile:

> *I've realized that you can explain forever, and that this kind of explanation of what we're doing and the 'fundamental [rule]' doesn't really make any significant change, but it's a start - it gives them a start for thinking about things. (para 16).*

US.O makes the same point, saying he 'can talk until I'm blue in the face', but resistances, often in the form of intellectualisation, will override his instructions (para 30).

We might expect that participants who see their role as facilitating or teaching would also accept the idea of a rule. Yet there is no evidence for this (chi-squared=0.444 df=1, p=0.505). On the surface these positions seem incompatible, but they might be squared if we consider that education can be gentle, supportive, and instructive.

4.15.3 Some assistance (8) [83]

20 percent of participants sometimes give assistance and sometimes leave patients to work their way through a difficulty. For example UK.B says there are 'levels' of intervention ranging from no help (she remains silent), to giving them prompts and trying 'to overcome the resistance' (para 16). As another example, UK.D prefers to let the patient discover about free association, but recognises that patients need to be encouraged sometimes, and so he will repeat the rule (para 26).

4.15.4 No assistance (8) [84]

A further 20 percent of participants spoke of how they tend not to assist the patient. All but one of these analysts will make an initial comment about free association but thereafter will not make further comments that intend to assist the patient. The underlying view is that the patient is able to learn about free association without guidance.

UK.J admits that free association is a 'difficult thing' but he tries to be patient initially, preferring that patients learn for themselves (para 23). He thinks it is possible

[83] UK.A (para 12-14), UK.B (para 16, 28), UK.D (para 26), UK.F (para 12-13, 21), UK.T (para 22), US.E (para 42), US.D (para 7), US.Q (para 13).
[84] UK.E (para 22), UK.H (para 49), UK.I (para 28), UK.J (para 23, 31), UK.K (para 8, 10), UK.L (para 27, 35), UK.N (para 13), UK.O (para 16, 20).

to 'train' patients but warns against this: 'we can all train our patients to think in a certain way, and accept certain things, but it becomes a sort of pseudo work if one's not careful.' (para 31). UK.H finds it important to allow patients to reach their own understanding, and so will foster a position where 'the patient is actually making good use of the session and finds themselves becoming aware of things through their own associations and [with that] comes a spirit of inquiry' (para 49). Thus, he finds it 'unhelpful and counterproductive to intervene' (para 49).

UK.K thinks it is pointless to teach patients about free association: 'I don't think free associating is something that you can ask people to do, because it's a question of whether somebody is able to do it, or whether the thought processes are blocked by defensive processes.' (para 8). He goes on to describe the virtues of self-discovery in infant development:

> *emotional and psychological development in the infant, for example, comes not just because the infant is taught things by the mother or by other people, [but] growth comes by the infant putting things together for itself [...] in a way that has to be free associative because it doesn't have existing structures.*

He believes the same is true for adults' psychic growth, and thus he avoids intervention wherever possible.

UK.L believes that the understanding of resistance is more important than being able to free associate well, therefore training is unnecessary:

> *free association isn't an achievement, so there isn't that much point I think trying to induct them into it [...] because if the reasons why they can't do it are unconscious and quite deep, then they're not going to be able to do it just because we keep trying to explain to them how to do it. It's really only through interpreting the unconscious content and the defences and the anxieties, that will then free them up to be able to do it. (para 27).*

Thus, her approach is to introduce free association once and then interpret the difficulty patients have: 'I think you can let them know that that's what you want them to do, but from then on I think it's about interpreting why they can't do it, and helping them with all those issues' (para 35).

UK.O will, from time to time, help patients when they get lost, by giving 'support and interaction' and 'pulling them back to the free associations' (by repeating the rule or using guided associations). Yet, generally she has a trust in the patient that they will go in that direction on their own (para 16). She thinks free association will occur regardless of whether help is offered, and that a request is often counter-productive: 'one thing is to look at some free associations as happening anyway, as I do. Another thing is to ask the patient to free associate; that is much more difficult' (para 20). She prefers to give the patient the 'responsibility and the pleasure' to free associate unassisted (para 16).

4.15.5 Section summary

For over half of participants, free association has an educative component in that the method is 'facilitated' or 'taught'. Although more participants play some part in helping the patient than those who don't, this is not a statistically significant finding. However, significantly more American participants facilitate or teach than British.

4.16 CONSIDERATIONS FOR APPROACH

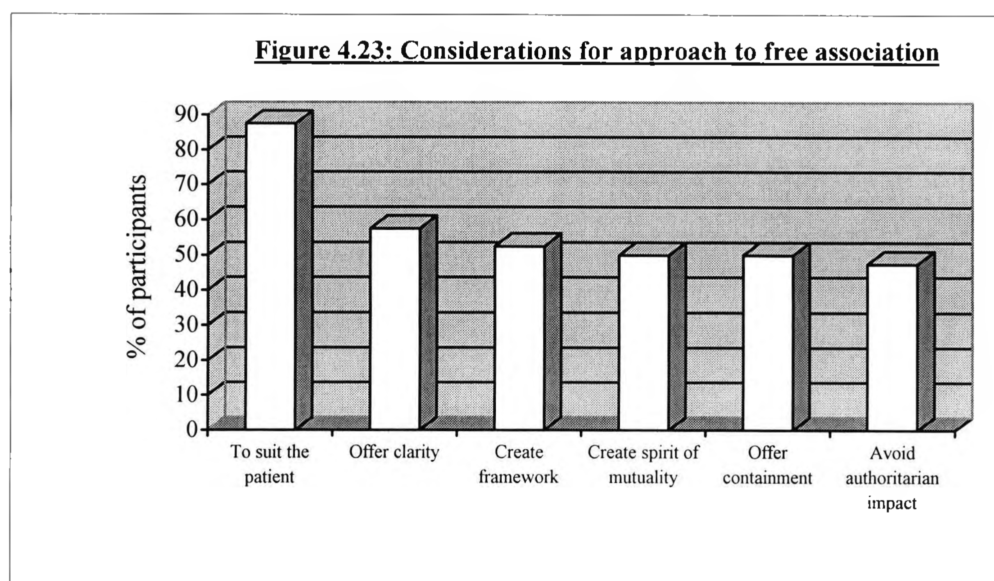
The participants were asked about their considerations for handling the fundamental rule in the chosen manner. The answer helps explain why free association is introduced at all, why it is done in a clear and extensive fashion, which elaborations they include, what tone it is delivered in, and why such an introduction is given early in the treatment.

A wide variety of explanations emerged. Nearly all participants said that how they approach the presentation of free association 'depends on the patient'. Over half of participants wish 'to demystify / offer clarity', and a similar number stressed the wish 'to create a framework', 'to provide containment', 'to create a spirit of mutuality', or 'to avoid the authoritarian impact' inherent in the rule.

There is much overlap between these considerations, for example, establishing a framework simultaneously has the effect of demystifying the method, or, in seeking to demystify the process, the analyst simultaneously offers containment. There is also a tension in some participant's motivations: on the one hand, participants want to avoid setting themselves up as an authority, but on the other, they find some direction and clarity to be helpful for the patient.

RESULTS (≠40)

To suit the patient	(35)
To avoid the authoritarian impact	(19)
To create a space to free associate	(9)
To create a spirit of mutuality	(20)
To create a framework	(21)
To set stage for resistance work	(10)
To set stage for transference work	(2)
To establish an asymmetrical relationship	(5)
To provide structure for the analyst	(3)
To offer clarity or to demystify	(23)
To provide containment	(20)



In figure 4.23 we see that 87.5 percent of participants say they will tailor their approach to suit the patient. The other considerations are given roughly equal mention.

4.16.1 To suit the patient (35) [85]

Almost all participants say that their presentation of free association is determined by who the patient is – their age, history of therapy, geographical location, and character structure – as well as the relationship between the patient and analyst.

UK.C's introduction of free association 'depends from patient to patient' (para 13), and she does not have a 'prescribed technical procedure' (para 27). US.F similarly finds that 'Everything depends on who the patient is, and what has gone on before.' (para 22). US.I agrees that 'obviously it depends on the person who is sitting in front of you' (para 11). UK.N also thinks 'you speak to what you feel the patient can understand.' (para 31). US.C's elaborations to the introduction depends on 'who

[85] UK.B (para 22, 24, 56, 62), UK.C (para 13, 21, 27), UK.E (para 20), UK.F (para 5), UK.H (para 9, 11, 15), UK.I (para 22, 24), UK.J (para 17), UK.K (para 16, 32), UK.L (para 13, 27), UK.M (para 11), UK.N (para 21), UK.O (para 34), UK.P (para 11, 13, 23), UK.Q (para 14, 18), UK.R (para 27), UK.S (para 11), UK.T (para 24), US.A (para 42), US.B (para 8, 12), US.C (para 10), US.D (para 7, 38), US.E (para 8), US.F (para 22), US.G (para 23, 29), US.H (para 30), US.I (para 11), US.K (para 31), US.L (para 12), US.M (para 32), US.N (para 73, 75), US.P (para 9, 37), US.Q (para 7), US.R (para 30), US.S (para 36), US.T (para 6).

they are, and what's going on with them, and what my conversational style with them might be.' (para 10).

US.N suggests his presentation varies according to patients' intelligence: 'It depends also on your assessment of the intellectual level of the patient that faces you.' (para 75). He might bring in humour with some patients but not with others: 'with every patient you will be different: with one patient you may joke one way, and with another not at all.' (para 73).

US.F also does not have a fixed approach. She reasons that 'I tailor-make my psychoanalyses to the patient. People talk about a cookbook or a recipe that's for everybody. I don't believe that that's so. I think you've got to communicate with whoever it is you are working with.' (para 24). As a result, she will decide how much needs to be explained, whether to use psychoanalytic jargon, and whether to mention Freud (para 22).

UK.E, along with many others, will not give an introduction to analytically informed patients: 'in that case I won't really feel the need for example to give an instruction, because the patient has already had some kind of contact of a psychoanalytic nature.' (para 20). UK.B makes the same point: 'lots of patients know that before they ever knock on my door. So [...] lots of patients in a sense you don't need to explain that to.' (para 26). UK.L would bring up the rule only if a patient was totally new to psychoanalysis:

> *I think patients are so different, they've all got such different ideas about what it is [...] I've got some analytic cases that have started out as psychotherapy cases, some of them have had analysis before. I think you just have to take it with each patient. (para 26).*

US.P shows that her tone varies according to whether the patient is new to psychoanalysis:

You have to meet the person where they are so it's certainly different for different people. One person that I work with had never been in any kind of therapy before, needed information, but the last thing he needed was to be patronised. So it's always a careful [matter], trying to get the right tone (para 37).

US.A comments that the presentation varies according to the analyst as well as the patient. He believes that you need to 'begin with where the patient is at':

It would be very hard to say that there would be something formal, a lot of the formality would tend to do with the analyst's style, and in general would be a little different. You find your way of working that is comfortable with your particular personality. (para 42).

US.S also thinks it depends on the analyst. The presentation varies 'given who the patient is and my mood at the moment [chuckles] and what I have available to me to say. And I don't have a set rule' (para 36).

<u>4.16.2 To avoid the authoritarian impact</u> (19) [86]

47.5 percent of participants have expressed reluctance to present free association in an authoritarian way. Many (13) of these participants said that they prefer the model of co-operation to that of authority, and many (8) said they wish to create a space for patients to explore the contents of their minds.

All seven British analysts who tend not to introduce free association have cited this as a consideration for their approach. For example, UK.S does not introduce free association at all, partly because he does not regard it as crucial to analysis (para 19). He objects to the idea of 'instruction', arguing that it 'undoes freedom' (para 23). He states:

[86] UK.A* (para 8, 57), UK.B (para 28), UK.C* (para 13, 15^), UK.G* (para 11, 25, 27), UK.H* (para 17), UK.K* (para 14, 16, 38^), UK.L (para 9^, 27, 37^), UK.O (para 12^, 34), UK.P* (para 11, 13, 27^), UK.Q (para 20, 26), UK.R* (para 13^, 17^, 29), UK.S* (para 19, 23), US.C* (para 29, 35), US.E* (para 48), US.K* (para 45), US.L* (para 12, 16), US.M (para 24), US.P (para 22^, 25^, 37), US.T* (para 4, 6^, 26). *=mutuality also a consideration (13), ^=wish to create a space (8).

I think I wouldn't introduce the idea at all. Most people know about the idea because all these things are in the culture these days, so it might be referred to, but I don't think I would say "now look, you're expected to say anything and everything that's in your mind as part of the treatment". (para 9).

UK.P prefers not to introduce free association because it can 'set up a notion of rules as a particular super-ego requirement' (para 11), and a 'legalistic expectation, which I think is unhelpful.' (para 13). He finds that instructions can seem 'infantilising', and that 'you would be in some way treating the patient as though they were stupid or didn't have a proper mind.' (para 13). Instead, he will work towards establishing a relationship (para 11), and a space for them to talk: 'You allow the patient to use the space of the session and the setting to communicate in an emotional way, so that you are doing anything, more or less, to facilitate that' (para 27).

UK.K objects to the asymmetry a guideline creates:

I don't like doing anything which gives an instruction to the patient about how they ought to be or what's expected of them in analysis, because implicitly it puts the analyst as the expert, the person who's in charge of what's going on (para 14).

He also fears the creation of an unhelpful transference connection:

if you tell patients something about how you want them to talk or how you want them to be, [...] you've got no idea what unconscious role you're slotting into - of an authoritarian father or a seductive mother [...]. And it seems to me that's something not to just walk straight into (para 14).

He would prefer to create a space for the patient to learn independently. He tries to set up an atmosphere conducive to free association, and convey the essence of the fundamental rule, without giving any guidance:

> *I will certainly look for some way of conveying to a person that I'm trying to offer them a space, a freedom to express anything that they might want to about anything under the sun. But I'll do that with my whole way of being, my way of listening, my way of responding (para 38).*

UK.O also prefers not to comment on free association finding it 'a complete waste of time' (para 20). She finds that it is contradictory and 'gives the wrong impression' to frame free association as a rule: 'you can't tell people "you've got to be free", it just doesn't sound right to me, it really doesn't. And also I don't want to give patients the impression that psychoanalysis is about rules.' (para 34). Rather, she believes in creating a space for patients to explore their own personality. She creates this atmosphere in other ways than via an introduction:

> *I think that really the patient guides the situation, not in the sense that I become passive, but in the sense of my job is very active in finding the space, helping to build the space for the patient to be able to go on with her work. (para 12).*

UK.Q also prefers to communicate the spirit of free association via an interpretation rather than 'giving it as a rule' (para 20). He has reservations about introducing it because he would rather not present himself as an authority:

> *there's a danger of moralism in even voicing that rule, even though it's an anti-moralistic rule. So I have a certain discomfort if I voice it in so many words [...] I would feel I'm slightly stepping outside my analytic role, that I'm not listening and interpreting [but] I'm starting to tell somebody what to do (para 20)*

He is also reluctant to discuss free association because it would be 'mean' to give patients a rule and then point out that they are resisting:

> *if you give someone the fundamental rule, and then they try to carry it out, and then one interprets in some such way [that they have used free association defensively], I think they feel tricked. I think they feel they've done what they've been told, and [...] I'm picking them up and pulling them to pieces when they're doing exactly what I asked them to do (para 26).*

UK.G contrasts Freud's 'direct and formidable' (para 25) approach to his own more relaxed approach: 'reading some of Freud, not too long ago it seemed how strong and fierce he was about this and how obligatory it was for that to happen, [...] whereas I don't do that.' (para 11). Explaining the notion of free association, he believes would be infantilising, like 'someone going to school and the headmaster says "look, now listen, one thing you not ought to do is to nick other people's sweets!"' (para 27). He comments that a formal presentation of free association does not suit his style: 'I think if it's too forceful it doesn't suit my personality anyway.' (para 27).

US.M gives a guideline, but one that is gentle. He also finds Freud's formal approach unsuitable for his work because of the effect on the superego:

> *Freud was pretty authoritarian in his style - it was part of the zeitgeist and so forth. And I think it's hard enough for people to be patients [...] they tend to project self-critical attitudes onto the analyst. So unconscious superego functioning is part of what patients suffer from, and I think giving them a rule and giving them a lecture on the application of this rule is an unnecessary stimulant to superego functioning, which I don't practice, and wouldn't teach, and would discourage practitioners from using. (para 24).*

US.E is reluctant to give firm instructions (para 8), and she sheds light on why she does not outline the difficulty of free association to patients. She believes that mutuality takes precedence over authority:

I don't think that suggesting it in advance – "this will happen" - is a good idea. One of the reasons is that I don't want to present myself as too omniscient [...] I think what's more helpful is the idea that we come across this impediment together (para 48).

Although UK.A gives an introduction to free association, it is a gentle one:

I make it a suggestion because, as I said, everything I do is voluntary. I want it to be a voluntary act by the patient, not to feel it's something that they have to do. If they have to do it, then there's going to be resentment somewhere - that you're the authority that they have to conform with or to. And that to me is not the right atmosphere for the sort of work that we do. (para 57).

He believes that it 'becomes too superegoish if you have rules.' (para 8). He also gives little assistance in free association. This means that his interventions are infrequent:

I'm not a very active interpreter. I tend to make my interventions comparatively infrequently. [...] sometimes to be active can interfere with the flow. And also in some ways, you can be imposing your own views too much upon the patient. (para 18).

US.T also finds the superego implications worrying:

to say "you must, this is a rule", my god! it's antithetical to the very nature of the whole enterprise. The enterprise is to be freeing and, most people would agree, to work with harsh superegos. Well, to say "come on in the door, here are the rules!" doesn't help the superego too much. (para 6).

He also values cooperation over authority: 'I'm not into powers, power-tripping, or authority, so I think if the process is transparent, it doesn't foster idealisation, and I think you get a better result if you get a good working alliance.' (para 26).

US.P, although she gives a guideline, tends to format it in a gentle way. She states that she is not a 'rule person': 'I think that's a personality preference, some analysts are more organised around rule and structure. [...] I don't think that's ever going to be my style, I'm just not like that.' (para 25). Her concern is to convey the idea of the rule 'which is to try to give them enough space and room to explore something without interference' (para 22). She seeks to 'get the right tone' and not appear 'patronising or lecturing' (para 37). She explains further:

> *I'm somewhat more casual about the arrangements and I might say something about wanting to give the person a chance to follow associations because they are a rich source of understanding. And it would be more that kind of explanation than "there's a fundamental rule in psychoanalysis that you have to say everything that comes to mind". That seems to me to potentially put a lot of pressure on somebody. There's enough pressure without that (para 25).*

UK.C gives a simple introduction at the beginning and avoids repeating the rule. He keeps the introduction brief, and avoids elaborations because 'an instruction of any kind probably skews something', and 'most patients try consciously or unconsciously to give you what they think that you want, and so I think that you are already sort of altering the frame.' (para 13). He comments that self-discovery is better than instruction, but in practice, some guidance is necessary:

> *ideally I shouldn't say it, because ideally it is better if people discover it by themselves. So I think that some people use a metaphor, of Freud's and so on to describe the process to somebody. I try to keep it as brief as possible, to be as uncontaminating as possible of the situation. (para 15).*

He uses a gentle tone so that patients do not feel compelled to follow the advice. For example, he tells patients:

> *dreams can be helpful, if they can remember them. I try not to put it stronger than that so that people don't feel forced to bring dreams. On the other hand, if it hadn't occurred to them, and sometimes it hasn't, then it can open the possibility of people remembering dreams. (para 13).*

His view seems to link various features together: rejecting the idea of free association as a 'rule', giving a brief introduction with few elaborations (for example, not mentioning Freud), using a gentle tone, giving little assistance to patients, and wishing to 'avoid the authoritarian tone'. In a section 'Links between findings' we see that these features do have some connection.

For the time being, we can assert the following findings about the participants who have cited 'to avoid the authoritarian impact' as a consideration:

- They are more are inclined to be against the idea of a rule than to accept it - a finding which is 'very significant' (chi-squared=6.887, df=1, p=0.0087).
- They give shorter introductions (average 42.3 words), and use fewer elaborations (average 2.89) than those who do not give this as a consideration (64.1 words and 3.81 elaborations). However these results are 'not quite' significant (t=1.6495, df=38, p=0.1073 and t=1.8876, df=38, p=0.0667).
- They use a gentle tone more than a moderate tone, and none use a firm tone, although this is 'not quite' significant (chi-squared=4.704, df=2, p=0.0952).
- More American participants cite this reason than British, but again this result is not significant (chi-squared=1.316, df=1, p=0.2513).

4.16.3 To create a spirit of mutuality (20) [87]

Half of all participants aim to create a spirit of mutuality. They talked of a 'collaborative task', 'working alliance', and 'atmosphere of cooperation'. For instance, UK.P's initial introduction is informed by the need to create a sound relationship:

> *I think what would be important is just to establish some kind of emotional rapport with the patient, so that [...] both the patient and yourself were sort of agreed that the two of you were going to want to communicate in a psychoanalytic way (para 11).*

It is important to UK.J that resistances are examined jointly and his vocabulary reflects the mutual nature of the task:

> *I feel very strongly that it's a very collaborative effort and that there has to be a therapeutic alliance between patient and analyst in which they work together on whatever it is that is difficult to bring to consciousness. (para 19).*

He tells patients that free association will be difficult because he wishes to establish a 'collaborative frame in which the two of us can think about what happens, not just the content but the form of what happens.' (para 37).

UK.A works within a model of voluntary co-operation, and thus and would never insist that the patient free associate. He explains:

> *I would rather that the patient co-operated with me, rather than laid down a rule that they must co-operate with me. I prefer to work on the basis of a voluntary association between us. In other words, it's a step towards creating a bit more equality between the patient and the analyst. (para 8).*

[87] UK.A (para 8, 24), UK.C (para 11, 27, 33), UK.G (para 15), UK.H (para 17, 25-27), UK.J (para 19), UK.K (para 18), UK.M (para 7, 27), UK.N (para 5), UK.P (para 11), UK.R (para 29), UK.S (para 13), US.C (para 37), US.D (para 44), US.E (para 46), US.I (para 11), US.K (para 33, 45), US.L (para 12, 16), US.N (para 51), US.S (para 34, 42), US.T (para 4, 6, 26).

Similarly, US.L thinks that patients may 'attempt' to free associate, but they should not be impelled to do so. For him co-operation is essential: 'I picture the two of us working together [...] So I want my patients to know what we're doing, and to have some sense of working together with me.' (para 16).

UK.M stresses the value of the 'therapeutic alliance' for his work as a whole (para 7). In this spirit, he uses his introductory remark to help establish a spirit of co-operation:

> *I don't focus on the transference relationship as the only relationship. There is also the real relationship and the therapeutic alliance. So that is from the psychoanalytic point of view how I think about it, and why I think it is worth it at the beginning to explain the rationale. (para 27).*

UK.C in his introductory comment also tries to convey a sense of working together:

> *I do add that in at the beginning: "if you bring dreams, then we'll both try to understand them". They're a provider of data, but they're also a sort of co-partner in the analysis. It's not one exactly on quite equal terms, but we're working in the same area. (para 27).*

Although there appears to be a link between the wish to create a spirit of mutuality and rejecting the idea of a 'rule', this is 'not quite significant' (chi-squared=0.3333, df=1, p=0.0679). More British participants cite this reason as a consideration than American participants, but again, not to a significant level (chi-squared=0.2, df=1, p=0.6547).

4.16.4 To create a framework (21) [88]

Over half of participants think that a guideline is helpful to structure the work. Participants spoke of wanting to create a baseline, framework, or contract. This does not mean that the patient must adhere to the contract, but the patient is expected to try his best.

US.Q outlines the main advantage of giving an explicit rule – to create a baseline against which difficulties can be compared: 'the purpose of articulating the rule is primarily to be able to refer back to the rule when it's not observed.' (para 29).

For the same reason, UK.C finds it helpful to set out some boundaries:

> *the aim is to get a process started, and also to have a baseline reference. So later on if somebody is finding it very hard or they're not telling you what they're thinking, often a patient will refer later to it and say "well I know you asked me to say everything that I was thinking but…" So there's some sort of baseline point reference for both of you. (para 17).*

UK.M talks about 'making a deal' which seems to be both laying out a contract and establishing mutuality. He introduces free association to create a framework:

> *I think it is just to be talked about at the beginning, to establish the framework and then it goes into the background if everything goes well. I don't think that it is in my mind or in the patient's mind very much that it is a rule, but I think that it helps to establish the framework. (para 35).*

[88] UK.B (para 30^), UK.C (para 17), UK.D (para 4, 25*), UK.H (para 25#), UK.I (para 5*, 10, 22), UK.J (para 19, 37#, 41^, 43), UK.M (para 7, 35), UK.N (para 5*$), UK.S^ (para 23), US.B (para 4), US.D (para 7*), US.G (para 9$, 13#), US.H (para 36#), US.I (para 11#), US.J (para 19#), US.K (para 21#, 31), US.L (para 16#), US.M (para 16#, 18), US.O* (para 30, 34), US.Q (para 29#), US.S (para 30, 34). #=set stage for resistance analysis (10 participants), *= asymmetrical setting (5), ^=structure for the analyst (3), $= set stages for transference analysis (2).

US.M says that his motive for being explicit about resistance analysis in the initial comment is to create a platform for resistance analysis: 'In that way I set the stage for attention to interferences with speaking freely - resistance, defence, internal threat. And those are the concepts that I rely on, daily in my work.' (para 16). He tries to create a framework for self-observation and reflection: 'the guideline of speaking freely forms the template for patients to become aware of how they get in their own way of speaking completely freely.' (para 18).

Similarly, UK.J's reason for letting the patient know that free association is difficult, is that it sets the stage for resistance analysis:

> *I'm introducing them to the notion of resistance, and letting them know that it's ok that that should happen, that it's perfectly normal it should happen, but it is something for us to think about. (para 37).*

He doubts that giving a rule imposes too much on the patient:

> *I don't think about this as a direction so much as establishing a framework within which we work. So I'm not directing the patient to think any particular things or to think in a particular way but really to give us the material that we need in order for us to begin to work together. (para 43).*

US.H also implies that her initial introduction is intended to set up a framework for resistance analysis. She tells patients "when you find you're having you have difficulty, let me know about that too". She justifies this: 'I actually do believe that that's where the most juice is - it's the things that you have difficulty talking about. It's not about what you can say, it's about what you <u>can't</u> say' (para 36).

Three participants mention that an introduction is useful because it provides structure for the analyst. UK.J for example, finds it helpful to delineate the terms of free association because it sets out his part of the contract and that it is 'fundamental

that the analyst has to do something in counter-point to it [the fundamental rule] within himself' (para 41). This explains why he gives a lengthy introduction, including a part about the analyst's role - that he will 'chip in from time to time' (para 41). Each time he gives the introduction, he feels that,

> *I'm saying to myself implicitly "it's your job to be laying down everything that you can pick up so that it becomes the material on the basis of which you can then begin to free associate to the patient's material within yourself." (para 41).*

Five participants wish to create a framework that establishes asymmetrical roles. UK.D for example, explains that it is necessary to give an instruction to sets out the different roles:

> *I think it also establishes the parameters of psychoanalysis, which is that analysand and analyst are in different positions, and that the responsibility to bring material is the analysand's, and I think it is important to establish that. [...] So I would try right from the beginning to set up a working pattern where it's the patient's responsibility to say what's in their mind. (para 26).*

UK.N similarly thinks that a contract gives the analyst the authority to 'behave in the very bizarre way we do' (para 5). His reason for giving an extensive introduction (including an explanation of how free association works, a comment about the difficulty and outlining the analyst's function) is to set up a contract so that UK.N may refer back to it. This he feels gives him license to act as an analyst including to make transference interpretations. For example, if a patient relates to him as a 'critical mother',

this is breaking the contract because I said that I was going to be a psychoanalyst and they're going to be a patient. So it means that it's something I can comment on the fact that the contract is being challenged. [...] the contract gives me authority because I can comment on the way that they are distorting the contract. (para 5).

All five participants who create contracts that assume asymmetry also show that they 'accept the idea of a rule'. This makes sense since both positions accept the idea and use of authority. However, the numbers are too small for statistical testing.

Also, those who give the reason 'to create a framework' are more likely to give lengthier instructions ('very significant' - t=2.9032, df=38, sed=12.379, p=0.0061), and give a higher number of elaborations ('very significant' – t=3.3179 df=38, sed= 0.459, p=0.0020) than those who do not give this as a reason.

4.16.5 To offer clarity (23) [89]

57.5 percent of participants say that they give an introduction because they wish to make the method of free association transparent, intelligible, and definitive.

UK.H likes to be 'overt' about the process to give new patients a choice of whether they wish to embark on treatment. He explains the benefit using a medical metaphor:

if you are going to see a doctor because you've got a headache, I think it would be quite appropriate that the doctor gives you some idea of the way he's going to go about sorting out the headache. [...] and also the patient needs to know there are other ways of going about things and they need to know that this is the method that you're offering for them to choose whether this is for them or not. (para 19).

[89] UK.C (para 13, 15), UK.D (para 4), UK.E (para 14), UK.H (para 17, 19), UK.I (para 22), UK.J (para 35, 37), UK.M (para 13, 15), UK.N (para 5, 7, 9, 31), UK.T (para 52), US.A (para 26, 46, 48), US.C (para 27), US.D (para 12-13), US.E (para 8, 12, 42, 52), US.F (para 18, 20), US.G (para 9, 13, 25), US.I (para 11, 23), US.J (para 17, 19), US.L (para 16), US.N (para 51), US.O (para 30), US.R (para 8, 28), US.S (para 30, 34, 42), US.T (para 6, 18).

UK.M also wishes to be fair and democratic. His belief is that patients need to 'understand the method' and it must seem logical to them (para 13). He says:

I treat them as somebody who needs to be explained about what they are getting themselves into, I just feel that it's fair. So I try to explain to them so they can make an informed decision, at that point at least, if they want to proceed with it or not. (para 15).

UK.N has strong views on the importance of patient choice, and is critical of the way some analysts proceed without giving patients the full facts:

I think that we're very bad in our profession at setting up the start of the analysis [...] we are living in an age of litigation and it seems to me that patients deserve an opportunity to make an informed choice (para 5).

He also believes that clarity will aid free association:

by making the contract explicit one enables the patient to understand, and to feel that she is really engaged in the process, in an informed way. I think that also helps the business of being able to free associate - from the point of view of the patient - because it makes sense of the business of free association. (para 7).

As part of this full disclosure, he gives prospective patients a leaflet which includes details about free association. The patient can then reflect on whether the treatment and method are suitable for them. This information is kept 'simple' and 'uncomplicated', and he says 'I don't want to make it into a seminar or something, but I do give them, I think, a pretty clear picture of what they're entering.' (para 9).

US.L also believes that the patient must have total awareness of the process:

> *the patient has got to come to understand what you're talking about, and to see the various things that you think you see [...] I therefore try to explain to them how we're working together so that they have some idea of what our mutual job and what their job is. There is a tremendous tendency, in my opinion, being in psychoanalysis it's very easy to mystify. (para 16).*

US.T demonstrates that he responds to a need for clarity: 'basically, patients start an analysis and they want to know what's expected of them.' (para 6). He also justifies why he outlines explicitly the analyst's role:

> *I am of the opinion, as many people are, that there should be no mystery surrounding how the therapeutic or analytic process works, that it should be transparent and open, that this is not Oz with somebody behind a curtain secretly pulling strings. (para 18).*

US.E is also 'very aware of the need of patients to understand what we are doing and why we are doing it.' (para 52). Her patients are mostly 'younger people who know little about psychoanalysis' and are 'frightened about what's going to happen'. Her adolescent patients might say "well, I'm going to need to know more, doctor, before I can tell you about my concerns" in which case she responds to patient's calls for clarity: 'I try to make it clear, how this works, what the purpose is, rather than simply say "you're supposed to do this"' (para 8) and 'I try to make it as simple and easy for them as possible.' (para 12).

US.S finds it useful for the patient to understand the method clearly: 'it helps to help the patient know what it is that we're tying to do.' (para 42). She remarks: 'I don't think we have to damp it all in mystery. I think analysis is hard enough without making it like some magical thing that I know something about and they don't.' (para 42).

US.N stresses the need for mutual clarity. He compares it to a game of chess, arguing that the rules must be available to both parties:

> *the analysand has to understand the technique as precisely as I do myself. We have to come to it, and meet on a common plane of understanding and doing. So there's nothing to hide, there's nothing to keep to myself as a secret. They have to know exactly what I know about how to play the game. It's like playing chess - both people have to know what moves are being made and according to what rules. (para 51).*

US.R also aims for transparency. She avoids using the term 'free association' saying that 'typically I prefer to not use any kind of jargon when I speak with patients. So I just try to describe what I mean.' (para 8). She justifies:

> *What I'm striving for is to make it as simple and transparent as possible. I want them to not think there is something mysterious about this, that it really is just as simple as it looks. I sit here, you lay on the couch, you say whatever comes to mind, and that's pretty much it, and that there's not anything particularly expected or demanded of them' (para 28).*

UK.E gives a brief introduction because his patients come from a geographical location whose population tends to be unfamiliar with analysis: 'the people who come for analysis here are what I would describe as unsophisticated in this regard. And for that reason [...] my simple instruction is "just say what comes into your head."' (para 14).

UK.C's reason for referring to dreams as a possible source of free association is to clarify the possibilities (para 13). He recognises that suggesting that 'dreams can be helpful' might affect the direction of free association, but overall, thinks that patients profit from having information. This is why he sometimes says to patients 'that there's nothing magical about dreams', though 'if they can remember them it can be helpful.' (para 17). He also alerts patients to the possible difficulty, reasoning that

his patients benefit from being informed: 'It may be partly a sort of warning and partly a reassurance' (para 15)

US.G uses an unambiguous introduction, as well as repetition, for the sake of clarity (para 13). He justifies that,

> *for some people it's the last thing they do want to talk about, or it's unnatural to them to talk about a relationship in that way, and so I want to make sure that it's clear, that it's fair game for us to talk about anything that they're thinking, including their thoughts they're having about being in the room with me. (para 9).*

Participants who cite 'to offer clarity' as a consideration will on average give longer introductions (72 words) and use more elaborations (4) than those who do not cite this reason (29 words and 2.5 elaborations). These results are 'extremely significant' (t= 3.5878, df=38, p=0.0009) and 'very significant' respectively (t=3.1642, df=38, p=0.0031). Proportionately more participants in this group accept the idea of free association as a rule and use a firmer tone, than those who do not cite this reason, although not to a significant degree (chi-squared=1.42, df=1, p=0.2334 / chi-squared=1.027, df=2, p=0.5983). Also, more of those citing 'clarity' as a consideration facilitate or teach patients than give little help. Although this result is not quite statistically significant (chi-squared=2.462 df=1, p= 0.1167), it goes some way to support the finding that helping the patient to free associate is linked to the wish to be clear.

American participants outnumber the British in giving 'clarity' as a consideration, but this difference is not significant (chi-squared=1.087, df=1, p=0.2971). Finally, fewer of these participants give prompts than we might expect (chi-squared=6.391, df=1, p=0.0115). One explanation might be that the clearer (longer and more elaborations) the introduction, the less need for prompts.

4.16.6 To offer containment (20)[90]

Half of participants say that their approach to the fundamental rule is guided by the wish to be containing to patients, for example to prevent feelings of failure or to avoid 'scaring off' patients.

UK.F's Scottish patients tend to be unfamiliar about analysis, and his consideration for offering a succinct explanation of free association is to be containing. UK.F objects to how some analysts give no explanation about free association: 'I don't know if this is apocryphal, I have heard of analysts who say absolutely nothing from the very start. And to me, that would be an incredibly frightening kind of encounter for a new patient.' (para 21). He finds such method would be undesirable: 'I think to push someone's head under water, as it were, without explanation is unlikely to be helpful in the long run.' (para 23).

US.L alerts patients to the difficulty of free association to avoid feelings of failure:

> *I tell them that they're not going to be able to free associate, because you run the danger of setting a task, of idealizing the task, and making the patient feel that if they can't free associate, which of course nobody can completely, that they've failed (para 16).*

US.J is sympathetic to the patient's task: 'It's difficult enough, and if you don't have some direction from your therapist, I think it makes it more difficult' (para 11). She justifies her lengthy and directive introduction: 'I think it has a containing function and that's one reason why I do it; because I think otherwise it's a little too open.' (para 11).

[90] UK.B (para 30, 32), UK.C (para 13, 15), UK.F (para 5, 21), UK.J (para 35), UK.K (para 16, 20?), UK.N (para 5, 29), UK.O (para 34), UK.P (para 7), UK.Q (para 14), ?UK.S (para 19), US.A (para 46), US.C (para 25, 27), US.E (para 8, 42), US.F (para 16, 18, 20), US.I (para 11, 23, 25), US.K (para 31), US.L (para 16), US.M (para 24), US.P (para 25), US.S (para 34, 42).

UK.N tries to avoid punishing the patient. For this reason, he conveys the idea that free association is 'impossible' (para 5):

> *I feel it's important at an early stage to let the patient know [...] that though I would like them to be trying to do this, I'm not expecting them to be able to do it [...] and I think one has to convey that, because otherwise it can become horribly persecuting. (para 29)*

US.A explains why he gives the introduction later. It is because remarks early on might confuse his adolescent patients or scare them away: 'that's always the danger if you make comments in the beginning, that that may be the last time you see them. I think you have to be very careful about that.' (para 46).

UK.K does not give an introduction but finds it a question of balancing a 'very difficult tightrope'. On the one hand he would like to avoid directing patients or confusing them about free association: 'to try and explain to somebody about free association is like trying to tell a blind person about colours; the person simply won't know what you're talking about.' (para 14). On the other hand he understands the need to be 'as informative as they might need you to be' (para 20). He finds that patients will need to be contained, but recommends conveying this through his state of being rather than through clear instruction:

> *it's also terribly important not to be inhuman; [...] that they're going to be in contact with someone who is a real, live human being who will have maybe an unusual way of relating - won't answer questions straightforwardly as they might expect - but somehow a person who in their own particular way is going to be available to them. It's incredibly important for that somehow to come across. (para 16).*

Comparisons were made between this consideration and the previous findings. None were significant except for a small link between providing containment and being against the idea of a rule ('not quite significant' chi-squared=3.333, df=1, p=0.0679).

4.16.7 Section summary

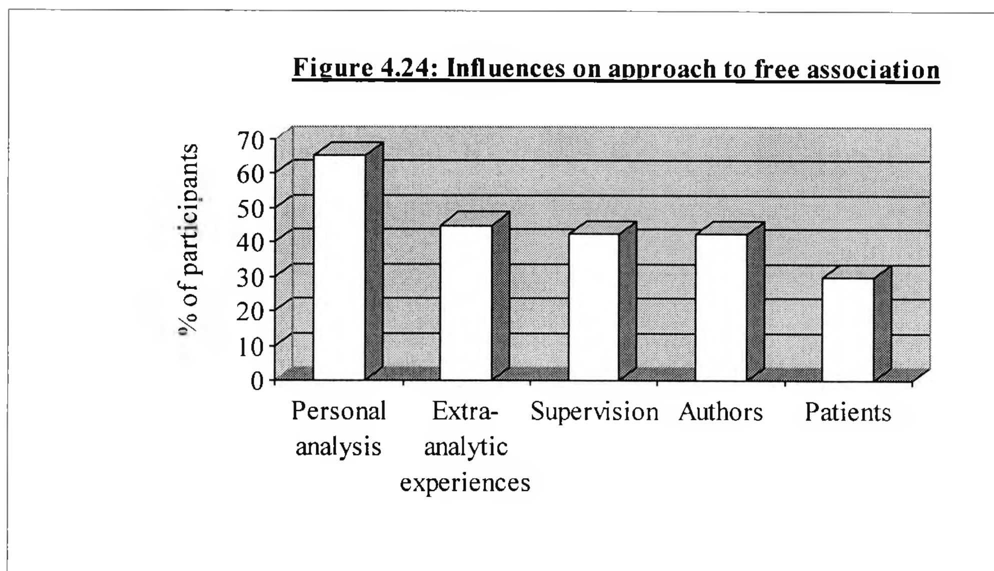
There are four main considerations for participants' approach to the fundamental rule. In order of frequency these are to offer clarity, to create a framework, to be containing, to create a spirit of mutuality and to avoid the authoritarian impact. Additionally, most participants say that how they approach the fundamental rule depends on who the patient is.

4.17 INFLUENCES ON APPROACH

Many participants volunteered information about the factors that influenced their approach to free association. The issue of influence is a troublesome one since, as some participants have pointed out, their analytic technique is formed through an indistinguishable blend of factors. Also, technique is not static, and some have explained great changes to their practice over time. Nevertheless, as figure 4.24 shows, participants referred to their own analysts as the biggest influence on their technique. Other important sources are supervisors, non-analytic experiences, authors, and patients.

RESULTS (≠40)

Influence of personal analyst/s	(26)
Influence of supervisor	(17)
Influence of extra-analytic experiences	(18)
Influence of patients	(12)
Influence of authors	(17)
Follow Freud	(10)
Challenge Freud	(7)



US.R highlights the importance of her personal analysis and how it has shaped her current work:

> *I would have to say that like just about everybody else that my own analysis gave me a model for how you do it. I happened to have an analysis before my training analysis, so I worked with two different analysts. [...] I do think back, in certain ways, to both of those experiences when I'm trying to think what to do or how to do it. (para 42).*

US.I echoes this point, and adds that her supervisor was an important guide:

> *I think it depends a lot on one's analyst [...] and that we tend to carry forth those traditions. I notice that I am more into free association now that I have an analyst who works in that way, than I was some years ago [...] And supervision is also really important. My first supervisor was very attentive to structural detail and that was very helpful. So I often think about him, especially when I am working with anxiety.' (para 15).*

US.H includes references to images in her introduction and she 'ask[s] for other kinds of information, that's not necessarily verbal.' (para 28). She attributes this to her own experience, and to her analyst: 'It's from my own experience. I think actually my old analyst did [that too]. He certainly asked me about body sensations

and I thought it was an amazing source of knowledge.' (para 28). She is also influenced by her patients, having heard some of them say, "I don't know what I thinking about it, but I'm seeing this thing", and usually what they are seeing is very useful and important.' (para 28).

UK.M mentions the influence of both his training analyst and supervisors: 'the way that I work is the way that my analyst and my supervisors work, and I think that at this stage of my career, that has still quite a strong influence.' (para 27).

US.B talks about the influence of her supervisors:

they were trained in classical analytic ego defence mechanisms style, so they supervised me that way. So yeah, it is a big part of how I organize my treatment. (para 16).

UK.F shows the potential influence of supervision. She herself is a supervisor, and she teaches candidates to use the approach that she does, which parallels Freud's:

I tell them to go to the very basic readings that they had - Freud's technique papers - and to instruct them to say to their patients "I would like you to say just what comes to mind". So I teach them what I do myself. (para 40).

UK.S admits that analytic education is crucial, but that there is room for personal growth and change in practice:

there's still a lot to be learnt from experience and teaching, and of course, one's own analysis is enormously important in this. That what you experience from your own analyst, and how far your own analyst embodies these values and understandings is terrifically important, because a training analysis is a long, extended process and it's meant to influence you and indeed it does. But after it's over, the idea is that you go through a period - a complex process - where you disidentify, you have

all sorts of reactions to this person who you've been with for years, and that you gradually work out [...] your own position. (para 23).

Many analysts talk about their 'personal style'. UK.R has found his own way to handle free association, and prefers not to introduce it in the way he has trained. He used to give an extended version of the rule, including asking the patient for thoughts, feelings and sensations. He did this on advice from his supervisor who 'believed that what was going on in their bodies was likely to be just as important as what they were thinking and what they were feeling.' (para 17). He has since discovered his own conception of 'associative freedom', and as part of this, has abandoned the rule altogether.

Some participants talk about the influence of their non-analytic experiences. In listening to the process of free association, UK.I says that her literary background helps her to listen to the manner of communications (para 14).

US.P feels similarly:

another big influence was that I was trained originally - I have a PhD in English literature - in the F.R Leavis tradition of close reading. [...] to look at every word, listen to every word in a piece of writing, and think about the relationship of the words. (para 45).

US.B's background in the visual arts has influenced the way she handles free association:

I'm very visual, so I play with images as they come up, most likely out of the unconscious either out of myself or whatever the patient is communicating to me, so I'll try to use that to keep the free association going. (para 14).

Finally, UK.P shows that it is a combination of all the above: 'it's a collective thing in the sense that one works out one's thinking in relation to colleagues and seminars and so forth' (para 37).

Throughout the interviews, participants mentioned various authors. Foremost was Freud, and 25 percent said they identified with his ideas on the fundamental rule. For example, US.N announces: 'I'm very much a follower of Freud's technique, even if I disagree with a number of his interpretations.' (para 89). However, only 7.5 percent said their presentation of free association is based on Freud's version. UK.F is one example, saying 'I then go on to elaborate a bit of what Freud said originally' (para 21) and UK.L is another: 'I think I instruct them - I think I follow pretty much from Freud "to try..."' (para 25). A further 7.5 percent say that they will on rare occasions mention Freud, or use a metaphor.

Others (17.5 percent) challenged Freud's view. For example, UK.A who does not accept the idea of a rule says of Freud: 'He of course had rules, but that was 100 years ago, which is rather different from now.' (para 10). UK.K also contrasts his own approach with Freud's: 'there are various reasons why by and large I don't use the fundamental rule in the way that Freud talked about.' (para 14).

Overall, more participants say that their approach deviates from Freud than participants who say that he has influenced their approach.

4.18 LINKS BETWEEN FINDINGS

Taking an overview of the above results, a pattern begins to emerge that connects several findings. It seems that despite the wide variety of participants' views and approaches, they are likely to fall into one of two types shown in table 4.4.

APPROACH A	APPROACH B
Accept the idea of a rule	Against the idea of a rule
Lengthy or extensive introduction	Mid-length, brief or no introduction at all.
Several elaborations (≥3)	Few elaborations (0-2)
Firm tone	Gentle tone
Facilitate or teach	Little or no assistance
Wish to create a framework	Wish to avoid authoritarian tone
Wish to offer clarity	Wish to create spirit of mutuality

Table 4.4 Features of two approaches

To test this idea, all participants were given a negative point (-1) for each of the 7 possible factors under approach A and a positive point (+1) for approach B. The scores ranged from +7 to -6, the mean average being -0.025 which shows that taken in aggregate, approach A is favoured by slightly more participants than approach B. Twenty participants adopt more elements of approach A than B, and sixteen participants adopt more features from approach B than A. Four participants score zero, which means that they borrow equal amounts from each.

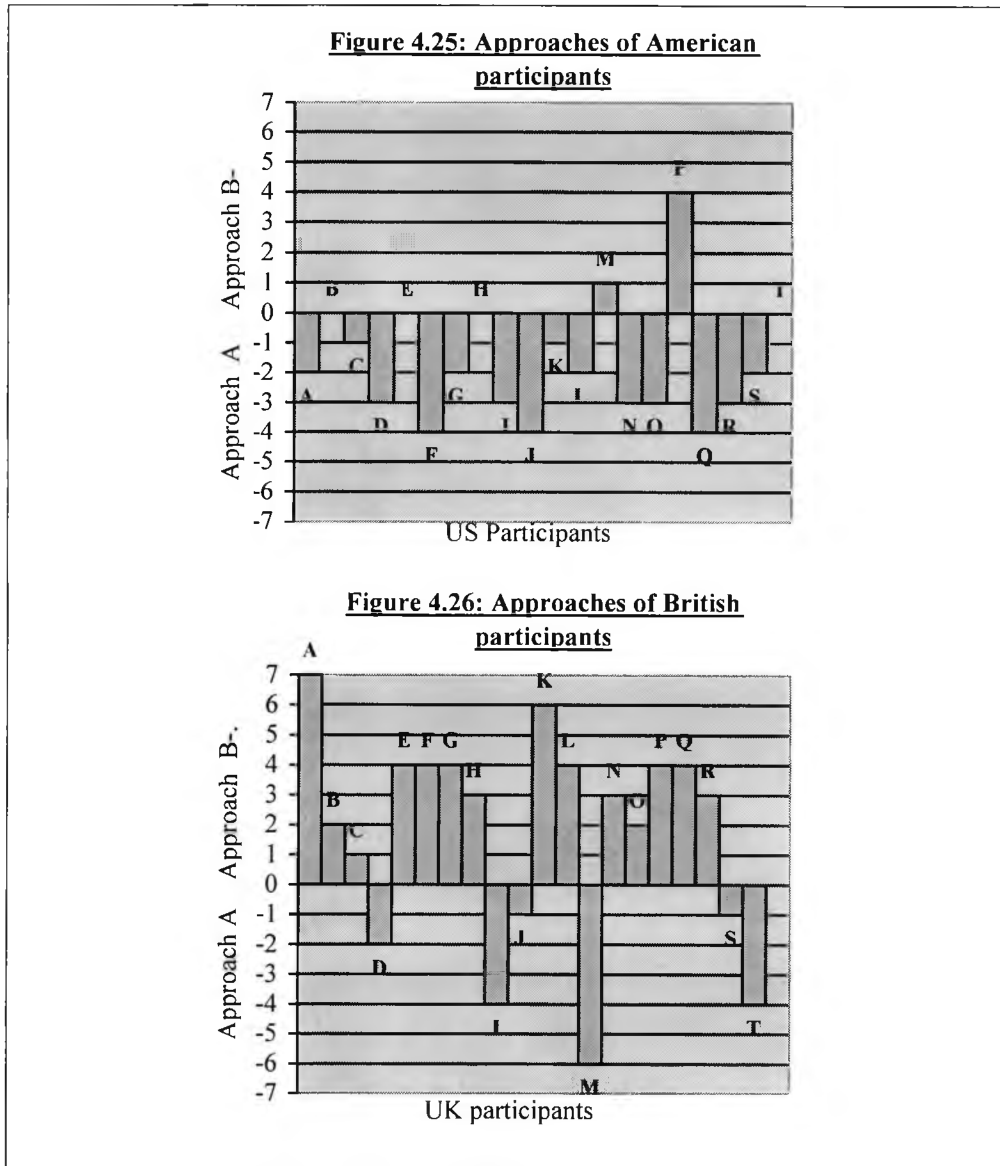


Figure 4.25: Approaches of American participants

Figure 4.26: Approaches of British participants

Figures 4.25 and 4.26 plot the number of points for each participant. They show that more American participants adopt parts of approach A and more British adopt parts of approach B. A t-test confirms this finding to be 'extremely significant' ($t=3.5790$, $df=38$, $p=0.0010$).

For example, UK.A seems a strong follower of approach B. He is against the idea of free association as a rule, gives a brief presentation of 17 words, gives few elaborations ('say what comes to mind' and a comment about avoid censorship), and presents it in a gentle tone. Also, he tends not to give assistance, and is guided by the

wish to avoid presenting himself as an authority and the wish to create a spirit of mutuality. This gives him a total score of seven plus points out of a possible seven which is displayed in figure 4.25.

US.O follows approach A to some extent. He accepts the idea of the rule, uses a firm tone in the initial introduction, believes in teaching the patient to free associate, and is motivated to offer clarity and to create a framework. This gives him five minus points but this is mitigated by his mid-length comment with few elaborations. Overall, he has three minus points, as is displayed in figure 4.24.

4.19 CHAPTER SUMMARY

The full results of the study have been presented in this chapter. We have seen that free association can be defined in various ways but some aspects were highlighted: its qualities of relaxation and freedom, the requirement of a trusting relationship and analyst's silence, that it is subject to resistances, that the ability varies, and that it improves over time. Participants on average find free association to be important, and its main benefit lies in providing access to the patients' unconscious, and in understanding resistances. We found that the most common forms of resistance are silence, shifting topic, and changes in affect. We saw that a many participants listen not only to content, but to the process of the associations including resistance and transference. Other important listening stances are free-floating attention, and paying attention to counter-transference.

We discovered that although some participants were content with the idea of free association as a 'rule', a larger number did not accept such a term, preferring to view it as a suggestion or guideline. We also saw that most participants give a clear introduction, as standard procedure, in the consultation stage. A handful of participants did not introduce free association as a matter of routine, and these were all British analysts. The average introduction is mid-length, phrased in the first

person-plural with a moderate and task-oriented tone, and will contain a comment about avoiding censorship. It may or may not include references to aspects such as thoughts, dreams or feelings, A few participants include a remark about resistance analysis in their introduction, and these were all American participants. Overall, the American participants gave longer and more detailed introductions than the British participants.

We explored how the introductory comments are referred to again either through prompts, repetition, reassurance, guided association, dissolving resistance, or most likely, through the analysis of resistance. There appears to be an 'educative' aspect to free association since several participants perceive their role as 'facilitating' or 'teaching' the patient to free associate. On the other hand, there is a small sample of participants who take the antithetical view that the patient should, and will, discover free association alone.

Nearly all participants tailor their approach to the patient, but we saw that the commonest justification for the approach is the desire to offer clarity, which might explain why most participants are explicit about free association with their patients. The way the fundamental rule is handled is also determined by the need to establish a framework, to create a spirit of co-operation, or to provide containment. Another significant reason is the wish to avoid authoritarian connotations – all the participants who rarely introduce free association cite this as a consideration.

Finally, we saw that participants referred to their own analyst as having the biggest influence on the way they handle free association. Other influences are supervisors, experience with patients, and extra-analytic personal experiences. Mostly, however, participants have been influenced by an inextricable combination of these.

Statistical tests have been used to assess the relationship between the various findings. The ones to prove significant are:

1) American participants tend to use longer introductions than the British participants.
2) American participants tend to insert more elaborations in their introductions than the British participants.
3) American participants tend to give more assistance than the British participants
4) Participants who seek 'to avoid the authoritarian tone' tend to reject the idea of free association as a 'rule'.
5) Participants who seek 'to create a framework' or 'to offer clarity' tend a) to give longer introductions; and b) to use more elaborations in their introductions.

These tests, along with others which did not quite prove to be significant, point to a new hypothesis: participants, on the whole, tend to borrow from two approaches to the fundamental rule. The first strategy, (approach A) is to accept the idea of free association as a 'rule', give a lengthy or extensive introduction with several elaboration in a moderate or firm tone, give some assistance to patients, and be guided by the considerations 'to create a framework' or 'to offer clarity'. The second strategy (approach B) is to be against the idea of free association as a 'rule', give a mid-length, brief introduction with few elaborations, in a moderate or gentle tone, or to give no introduction at all, avoid giving assistance, and be motivated 'to avoid the authoritarian tone' or 'to create a spirit of mutuality'. More American participants tend to follow approach B than British, and vice versa.

In the following chapter, these results are put into context of Freud's guidelines, the literature review and to previous studies. In the penultimate chapter, the limitations of the results are discussed along with recommendations for further research.

CHAPTER FIVE: DISCUSSION

5.1 CHAPTER OVERVIEW

In this chapter, we will see the ways in which participants' views and practices regarding free association have shifted from Freud. We will see that their views are broadly aligned with authors in the literature, and that their approaches to the fundamental rule roughly match the findings of Lichtenberg & Galler's survey. We also see which of the findings in this study serve as new hypotheses about the rule.

5.2 DEFINITIONS AND FEATURES

In their interviews, participants focused on different aspects of the **definition** of free association. Taken overall, the participant's responses seem to match the literature. For example, one recurrent observation among participants is that free association entails a state of relaxation and freedom. This chimes with the literature which defines one condition of the method as an 'altered state of consciousness' and which describes the process as a 'suspension of ego controls and superego function'. Many participants raised the fact that a trusting relationship promotes free association, a finding which parallels the views in literature (for example Ferenczi 1932 in Lichtenberg 1997, and Kernberg 1983). Participants took time to underscore the fact that free association is theoretically impossible because resistances are constantly at work. The fact that all forty participants referred to the inevitability of resistances is a significant finding, but one that was foreshadowed by Freud and other writers.

As the literature review pointed out, there are a few ways in which the fundamental rule appears to be a paradox. A quarter of participants said that it is a paradoxical because it is an order to be free or that free associations are not freely

produced but unconsciously determined. No participant raised Loewenstein's view that free association is contradictory because it is impossible to verbalise thoughts. However, many participants raised the fourth paradox, which is that it is only by the end of an analysis that patients might be able to free associate. However many participants did not see this as a paradox, but as a defining feature of a successful analysis.

The study showed that another accepted part of the definition is that free associations are reflected upon. This seems akin to views in the literature which highlight the oscillation between producing utterances and observing them with a reflective ego. Several participants believed that the ability to free associate varies, and that it often reflects underlying character structure. Opinions were mixed about whether disturbed patients can usefully use free association as a method. The literature gives the same impression; some authors make exceptions to the rule for certain patients, but others use it regardless.

Participants mentioned the **assumptions** of psychic determinism and unconscious mental activity which echoes accounts in the literature, but these have not been commented on as much as other features. Indeed, one participant even questioned whether the unconscious really exists or whether the brain produces random experiences: 'one can't be sure whether the brain does also have responses which are not anything to do with the person, but it's just like a machine doles out something' (UK.G para 11). However thirty-one participants have used the word 'unconscious', and all have indicated that they have faith in the concept. Spencer and Balter might help to explain why such comments have not appeared often, which is that most analysts take these assumptions for granted (1990: 397); participants would not need to emphasize features that are intrinsic to their work. This also applies to the assumption of intrapsychic activity which was not highlighted by a single analyst, though it is inferred in most interviews. Also, few participants spoke of standing in for the patient's superego, which was a prominent feature of early accounts in the

literature. Perhaps this reflects hesitancy about the authoritarian impact; many participants expressed weariness about the 'superego effects' of the rule.

In the literature, we saw that **conditions** for free association include confidentiality, neutrality, abstinence, silence, the couch and frequency of sessions. Some participants stressed the value of neutrality in promoting free association and the fact that it is a prerequisite for analytic work in general. However, the study revealed that a handful of participants self-disclose which is antithetical to Freud's notion of a 'blank screen'. Theoretically, the effect of self-disclosure is to interfere with the free associational process, but another effect might be to increase trust and warmth. Some participants showed that far from being predominantly silent, they often have periods of high activity. One participant (US.K para 33) goes against the precondition of silence by conducting a 'conversational' analysis at times. However, many analysts think that silence aids free association. Although participants have mentioned the pre-requisite of confidentiality (e.g. UK.P para 13), none have mentioned how it can promote free association. Perhaps this is because, again, it is an unchallenged assumption.

The literature reveals mixed views about the role of the couch. Although many contributors find the couch to aid free association, some are indifferent to its use, and a few find it unhelpful. This study echoes these findings. Two-fifths of participants commented that the couch aids free association. In total, 35 percent of participants prefer that patients use the couch, 60 percent take a flexible view and 5 percent prefer not to work using a couch. Some participants mentioned that high frequency of sessions is a condition for free association. This observation has been made in the literature review but not with much emphasis.

5.2.1 Section summary

Most of the elements raised by participants on the definition, features, assumptions and conditions of free association have their roots in Freud's ideas, and they do not differ greatly from the accounts in the literature.

5.3 IMPORTANCE OF FREE ASSOCIATION AND LISTENING STANCES

Freud viewed free association as the main psychoanalytic tool, but opinions represented in the literature are mixed – some challenge free association and others praise it. The results of the present study show that most participants find free association to be important if not fundamental. One participant finds free association to be 'very central' (US.S para 10) and is surprised that any analyst might think otherwise: 'I was actually shocked, I saw in a recent journal some question about "Is there still a place for free association in psychoanalysis?" and I just couldn't believe it! I thought are we really asking this question?' (para 18). Some participants seem to take free association as an unchallenged assumption. For example, one participant said that 'although we don't talk very much about free association, it is so much underpinning what we do' (UK.B para 44). Another participant feels similarly: 'It's quite an interesting opportunity to be asked about this, because free association, like any other analytic concept is something that I, and most people, assume they understand.' (UK.F para 51). This is a common point raised in the literature and corresponds to Ogden's remark that it is a 'static unexamined fixture' (1996: 889).

In the study, only a few participants see free association as 'not especially important'. This view has also been expressed by some in the literature such as Spence. Yet on the whole, there are not many participants in the study who raised serious objections to free association.

Participants' views about the usefulness of free association also match accounts in the literature. There is general agreement that free association is most useful because it is a tool to reach the unconscious. Some participants find that associational freedom is valuable in itself, and this corresponds to Kris' position in the literature. Another finding is that many participants talked about the absence of free association being important, and that analysis of the resistance is more important than the free associations themselves. For example, one comments: 'I don't even think of it as working with free association, it's just working with impediments and changes in the flow of what the patient has to say.' (para 18). It is unclear whether this finding represents a significant shift from Freud. Critics such as Busch and Gray believe that Freud had not sufficiently integrated resistance analysis into psychoanalytic practice. Newton & Lohser make a strong case for this in their book '*Unorthodox Freud: The View from the Couch*' where they argue that Freud did not analyze resistance, nor did he write that resistance should be analyzed:

> *he consistently wrote of resistance being uncovered (aufdecken) and overcome (überwinden), not analyzed (analysieren would have been the word, if he had wanted to say that). [...] He believed, in word and in deed, that the thing to do with resistance was to uncover it for the patient, show it to him, and then urge him, armed with this new knowledge, to resume full free association in spite of the resistance. (Newton 1998: 1003).*

If this is the case, then the results of the study represent a substantial move away from Freud's position.

Freud aside, this finding seems to chime with accounts in the literature that increasingly, resistance analysis is a priority in analysts' work. The rise of 'relational' theories noted in the literature, which place less emphasis on resistance analysis, has not been evident among participants, with only one claiming to be influenced by such theories.

The results have shed some light on the many types of resistances that analysts encounter in their practices. The findings ring true with the literature review which abounds with similar examples. Conscious censorship, or what is known in the literature as 'reluctance', is an obvious part of free association but is not quoted as often by participants as silence, change in topic and mood, and use of free association as a defence. One reason for this might be that patients are increasingly familiar with therapeutic methods; patients understand that therapy entails sharing their innermost thoughts, and any resistance is likely to be unconscious more than conscious. Acting out was not given much attention by participants. One reason might be because they view the mechanism of acting out to be outside the discussion of free association and resistance; acting out is an activity which is a <u>substitute for</u> remembering, and is not strictly speaking a <u>resistance to</u> remembering.

The listening stances that participants adopt are mostly in keeping with the literature. All participants listen to content, and although this is given little attention in the literature, it is implicitly assumed. Nearly all participants reveal that they listen out for the process, such as pattern of speaking, pauses, transference, and mood. 72.5 percent specifically look out for resistances, and this is a significant finding. Furthermore, these participants are not exclusively ego psychologists; many adhere to other theoretical frameworks. The literature matches these results as it is abundant with examples of listening for process, including transference, and resistance. Indeed, the literature review focussed on three prominent contributors - Gray, Busch and Kris - who advocate that the analyst listen to and interpret the process of free association over and above the content.

Freud's concept of 'evenly suspended attention' still applies to many participants in the study. Over half commented that they have adopted this stance at some point. In like manner to Freud, some participants defined free association as pertaining to both patient and analyst. As in the literature, it is given a variety of names, the most popular being 'free-floating attention'. Although some accounts in the literature critique free-floating attention, no participant challenged the notion.

Over half of all participants said they paid attention to their counter-transference. This is a change from Freud and one that is given much space in the literature. However, it is often treated separately from discussions of free association.

5.3.1 Section summary

Free association, to the average participant, is important, though some find it fundamental, and a few find it not especially important. On average, they do not feel as strong as Freud did about free association, but the differing views of participants on this matter echo the mixed opinions in the literature. In the study, free association is believed to be most useful because it allows access to the unconscious, and because it helps the understanding of resistances. This is in line with the literature. So too are the forms of resistances that need to be understood. Finally, the listening stances adopted by participants have also been raised in the literature to varying degrees.

5.4 VIEWS OF FREE ASSOCIATION AS A 'RULE'

The results confirmed that significantly more participants object to the idea of it as a rule than those who accept it. This represents a significant change in opinion since Freud who believed firmly in free association as a 'rule'.

This finding might reflect a wider attitude to analysis. Those who do not accept the idea of the rule seem to view other aspects of analysis in a similar way. One participant, who views free association as a suggestion, also approaches the couch with flexibility: 'I don't say "you must", I say "I normally use the couch" If a patient chooses to use the chair, they choose to use the chair.' (UK.J para 45). Another participant declares herself to be 'not a rule-person' (US.P para 23) which hints that she handles other issues in a similar way to free association.

Several authors have critiqued the rule developed by Freud because it provokes anxiety, leads to acting out (Burke in A.Freud 1949: 200), can arouse guilt (L. Spiegel 1975), and because patients have a right to withhold thoughts (Stone 1961, 1981, Blass 2003). The findings of the study reflect such concerns, since 62.5 percent of participants view free association as a suggestion or a method that patients are encouraged to follow, rather than a rule or an instruction. There are two ways to get around the problem of authority. One is to use gentle language in the introduction, and the other is to avoid giving an introduction altogether. We have seen that participants adopt both strategies. Of those participants who object to the idea of a rule, none will present the rule in a 'firm' tone – their tone is 'gentle' or 'moderate' - and 28 percent of these participants give no introduction at all. Many have given a reason for this – the dislike of the superego connotations - which is frequently spelt out in the literature.

Some participants think that Freud did not intend for free association to become a strict rule. One in particular comments: 'I don't think he envisaged what would happen to his discoveries, I don't think he would have been very happy with it becoming a "fundamental rule"!' (UK.R para 25). He believes that a more relaxed interpretation of free association is gaining favour: 'from the beginning, I thought of it as a recommendation rather than as a rule. And I think, from what people are writing at the moment, I think [it is an] increasingly widespread view from different psychoanalytic positions' (para 25). The study's overall results lend support to his view.

On the other hand, some authors have no difficulty with the authority inherent in the fundamental rule (such as E. Kris 1956, Newton 1989, L. Grossman 1996, and Kernberg 1996). This view is shared by the 37.5 percent of participants who accept the idea of free association as a 'rule' in principle even though many of them are not hard-handed in enforcing it.

5.41 Section summary

Participants are divided about whether free association is a 'rule', though the numbers are tipped slightly towards those who see it as a guideline rather than a rule. This outcome directly reflects the ongoing debate in the literature.

5.5 THE INITIAL INTRODUCTION – FORMALITY, TIMING, LENGTH, CONTENT, AND TONE

5.5.1 Formality

Freud in his recommendations to practitioners, wrote that the rule 'must be imparted' to patients (1913: 134). It seems as if many participants continue to follow Freud in this as 82.5 percent of them give a formal introduction to free association. Although many give a 'clear' introduction, they do not have a 'fixed' approach; participants often phrase the introduction differently, or give the introduction at different times, according to who the patient is. Similarly, Freud phrased his comments differently in different accounts, and we can only speculate how much his comments varied when delivering them to patients.

17.5 percent of participants tend not to introduce free association at all (10 percent of whom might give an introduction in special circumstances, 7.5 percent almost never give one). They gave a variety of reasons for this which seem interlinked – to avoid the authoritarian impact, to provide the patient with space, to create an atmosphere of co-operation, and to provide containment. However, that is not to say that they avoid discussion of free association altogether, since they might refer to it in ways that are ongoing such as through interpretation. This position is a step away from Freud, but one that the literature acknowledges has increased in recent times. We can surmise that the reason for the dislike of announcing a guideline is because of

the wish to avoid authority, and to allow patients the space to bring their own material as they choose.

Lichtenberg & Galler's survey found that only 6.1 percent of respondents tend not to give instructions, which is a much lower figure than the 17.5 percent in the present study. One reason for the difference might be the inclusion of more British participants than in Lichtenberg & Galler. Over one-third of the British participants do not give a guideline. One participant sheds some light on this, claiming that in his ten years of membership and experience as a supervisor, in his view many in the British Society would not give an introduction:

> *I would think that it is not common practice in the British Society to begin in that way. [...] We all have slightly different judgements about whether the patient needed it to be spelt out in this way and for what reasons. But I would not expect it to be felt to be universally good psychoanalytic practice to spell it out. In fact I would expect the opposite, [...] I would expect my opinion to be more mainstream, the way most of us do it. (UK.P para 15).*

He acknowledges the alternative position which is to give a guideline to offer clarity to patients 'I understand that the issue comes up, it keeps coming up in relation to modern notions of clinical governance and being clear with the patient at a cognitive level about expectations' (para 15). And yet he maintains his view that there are 'complications that arise around the fundamental rule' (para 15).

It is interesting to speculate about the effects on the patient of whether an introduction is given or not. Raising the topic does enhance transparency which is necessary for patient choice and for good practice from the angle of clinical governance. On the other hand, some participants believe that discussion is unnecessary, since patients may not hear it or understand it, and that free association will occur regardless of whether it is addressed. The study shows that overall, the first view holds sway since the majority formally present free association to patients.

5.5.2 Timing

Nearly all participants give their introduction at the beginning of treatment. This is consistent with Freud's preference and with accounts in the literature. Freud did indeed suggest that it be done 'at the very beginning' (1913: 134). He wrote that it 'is indispensable, and also advantageous, to lay down the rule in the first stages of the treatment.' (1913: 135fn). Although less than half of Lichtenberg & Galler's respondents revealed the timing of their guidelines, they found that 67 percent present them in the consultation, the remaining 33 percent presenting it just prior or during the first couch session (1987: 66). These numbers are roughly consistent with the present study, whose corresponding figures are 73 percent and 27 percent (18.9 plus 8.1 percent presenting it later on).

The question of timing does not seem to be a contentious one. Some participants explain why they introduce free association at the outset, arguing that patients have a right to know what the method entails before treatment begins. The three participants who introduce free association later on, do so because patients aren't receptive to comments at the beginning (US.A), because they prefer to wait until resistance turns up (US.H) or when a dream arises (UK.G).

We can wonder whether free association is something that needs to be consented to, or whether it is harmless to engage in without explicit discussion, or indeed whether it is advantageous to launch into the method having little understanding of it. We might also wonder whether analysts present it in the consultation because they are convinced that it is the most suitable time (since it can be tied in with other issues of the analytic frame), or whether they do this because it is accepted analytic practice and a matter of habit.

5.5.3 Length

Compared to Freud, participants' introductions have shrunk in length. In Freud's 1913 paper his comments totalled 246 words, which in this study is considered 'extensive'. Another of his comments equalled 95 words, and it is still significantly higher than the mean average of participants in this study (58 words). One explanation for participants' shorter, less detailed introduction than Freud's is that patients will have been told about it before in consultation (Sabbadini, personal communication). Also, new patients might already know about free association; this is possible given that psychoanalytic ideas are increasingly part of popular culture.

Participants' introductions vary substantially in length - from 11 words to 208 words. This parallels variations in the literature where analysts have spelt them out. This study has found that length varies according to the participants' consideration of the rule. As we have seen, the average introductions are significantly longer for participants who are guided by the need 'to offer clarity' or 'to create a framework'. Length also depends on who the patients are; if they are new to analysis or have already been assessed, the introduction is likely to be brief or omitted. It also seems to vary according to the analyst's style of communication. The length seems to be a matter of balancing two priorities - between offering full information and between taking up space or potentially confusing or crowding out the patient.

5.5.4 Content

One hypothesis of the study was that the fundamental rule has been altered from Freud's references of 'feelings, thoughts, memories' (1917: 287) to include non-verbal associations such as dreams, images, and physical sensations. Lichtenberg & Galler found that 12.2 percent of respondents 'suggest that more than thoughts belong in the analysis' (1987: 60). In this study, the equivalent figure is 30 percent (11 of 37) - nine participants include 'dreams' in their initial introduction, three refer to images or pictures.

The literature review described other types of associations such as drawing (Wimer Brakerl), noises and body movement (Scott). No participant said they outline these to the patient. Only one participant was aware of this debate in the literature; she notes Wimer Brakel's suggestion but says she does not follow it herself (UK.L para 25). Another participant was aware of the debate about reporting bodily sensations, but does not follow this track: 'they [Lichtenberg & Galler] end up talking about bodily sensations that you might want to report them, and that has never occurred to me to say and I don't say it.' (UK.C para 49). However, in some respects free association is perceived in this wider context such that anything produced by the patient (for example enactments), might be considered to be their free association. Other participants conceive of it more narrowly, separating 'pure' free association (US.C) from aspects such as 'acting out', 'resistance', or 'transference'. This seems similar to many positions expressed in the literature.

The twenty participants who do not give references have different ways of saying this, but most chose the same expression - 'say what comes to mind'. Perhaps this is because it is effective and is the best way of summing up free association. It is noteworthy that these participants outnumber those who do give references to types of associations.

We can question the effects of each strategy – outlining the types of associations and giving no references. The first strategy, while offering clarity and structure, might also place restrictions on the patient. The second strategy gives room to the patient to explore and bring to the work to the room, but can deny the patient clear direction. It also might be the case that participants use the expression most familiar to them, disseminated through supervision, seminars, personal analysis, or psychoanalytic readings.

This study has also found that of those giving an introduction, 62 percent find some way of telling patients that they should avoid censorship, and it is the most

common of elaborations. There is no comparable observation in Lichtenberg & Galler's study, and it is given little remark in the literature. It is likely that this part of the introduction is taken for granted. This tradition seems to have carried on from Freud who recommended that patients do not 'put aside' ideas that might seem 'irrelevant', 'unimportant or nonsensical' (1913: 135). Perhaps it continues to be used because it aptly describes what is required by the method of free association.

Lichtenberg & Galler's survey found that 'many' analysts alert their patients to the difficulty, but they did not specify numbers. The study here offers some answers: 43 percent of participants do so.

The literature review found conflicting views on whether analysts include a comment about resistance analysis. A hypothesis was formed that the fundamental rule has been widened to incorporate resistance analysis, and the study has given slight support to this, since 16.2 percent include such a clause. All six of these participants are American. The evidence points towards a small shift to incorporate ego psychology. This is certainly a shift from Freud who made no such remark. This figure is somewhat higher than Lichtenberg & Galler's study - 12.2 percent - but their figure seems an approximation since they say '*at least six* [my italics] of our colleagues include as a part of their guidelines suggestions to their patients to be aware of difficulties they encounter in relating their thoughts.' (1987: 61), which suggests that there may be more.

In total, 56.8 percent of participants give some explanation of how free association operates, including details such as the analyst's role. Lichtenberg & Galler found that 26.5 percent of their respondents give an explanation of free association that ties in with the purpose of psychoanalysis. However, the two figures cannot be fruitfully compared as they are measuring slightly different aspects.

Participants give other elaborations – explaining that free association is paradoxical, that is it unlike a social conversation, and that silence is acceptable.

These are much rarer in participants' introductions than in Freud and the literature. We might query why only one participant occasionally mentions the paradoxical nature of free association to the patient. Another missing elaboration is the distinction between free association and a social conversation. Freud wrote that analysts should mention that it differs 'from an ordinary conversation', but this study finds that only 7.5 percent do this. This tallies with Lichtenberg & Galler's finding of 6.1 percent. One speculation for absence of these elaborations is that it draws the patient into an intellectual understanding of free association, which analysts prefer to avoid.

Some articles on free association argue that privacy is important (Ogden 1996, Blass 2003) and that the analyst should inform the patient that silence is acceptable (Ogden 1996: 889-890). This study contradicts such views since only one participant states this, and even so, does not always remember to do it (US.R para 28). One reason for this might be because of the belief that analysis cannot proceed if the patient does not speak. Perhaps analysts accept that a certain amount of silence and private digesting will occur anyway without the analyst needing to spell this out. This applies to one participant:

> *I respect somebody who has a need to just be with their thoughts and muse and think in a private way [...] I don't have a need for all of the digestion to happen out loud [...] I think we need to respect that there are different ways that people process data, including analytic data. (US.T para 32).*

Another surprising finding is that participants rarely use metaphors in their introductions. 10 percent say that they might on occasion use Freud's metaphor of a passenger on a train. One participant used to give a metaphor of listening to an orchestra, but no longer does since he has abandoned introducing free association altogether. Lichtenberg & Galler discovered that 12.2 percent of their respondents use metaphors in their instructions, half of whom use Freud's version. Their results are similar to the present findings, and we can argue from this that the use of metaphors is

not common-place. One reason why metaphors are avoided might be because patients are aware of free association through popular culture and have an existing image of what it entails. One participant provides another insight into the reasons, which is that it is too formal and archaic (US.H para 30).

16.2 percent of participants might mention Freud to the patient, but many qualify that they do so rarely. This might be because it introduces an academic slant to the task which may not be helpful. Also, although 15 percent use the terms 'free association' or 'rule' with patients, 25 percent said that they avoid use of terminology. The reason might be linked to the fact that most of those avoiding psychoanalytic terminology object to the rule and also cited the wish to be clear to patients. Thus, jargon is avoided for the sake of clarity and simplicity.

Overall, the initial guidelines have been slimmed down since Freud. He gave more elaborations to his comments (6), compared to participants in this study (who averaged 3.2). It is difficult to assess the impact on patients of how much detail is included in the introduction. It does seem that there is a trade-off between giving detail and direction which can be helpful and between being over-guiding, protective, or confusing. Participants each find their own way of balancing these effects.

We have seen that the American participants give more elaborations and more references to types of associations, than the British. This finding might be explained in various ways. First, it might be that the American participants may be interested in clarifying the method to patients to protect themselves from a litigation stand-point. The reverse holds true for participants giving a 'simple' introduction; they are more interested in the patient discovering the nature of the method with minimal instruction and assistance. A second explanation is that analysts tend to use the introductory comment that their own analyst or supervisor used. This would be an example of technique being passed from analyst to analyst-in-training. This is backed up by the finding that 65 percent claim to have been influenced by their own analyst/s. A third, but less credible, explanation is that detail might correlate to patient sophistication so

that more explanation is given for less analytically-aware patients. This implies that the American participants have less analytically-aware patients than the British, which is difficult to verify.

5.5.5 Tone

A third hypothesis of the study was that the rule is likely to be presented as less strict than Freud's instruction (we recall his words 'must', 'injunction' etcetera). This hypothesis was fashioned out of the intense critiques in the literature about the authoritarian tone. None of the participants' comments appear as stern as Freud's written ones and most participants used a moderate or gentle tone. This finding goes some way to confirm the hypothesis.

Many of the codes for tone in this study (for example, 'gentle' and 'task-oriented') are also used by Lichtenberg & Galler. But Lichtenberg & Galler are vague on numbers; they refer to 'many' or a 'significant group' (1987: 63, 64). This makes it difficult to compare results precisely, although they loosely correspond. This study has created the additional codes 'moderate' and 'firm'. Although they are subjective concepts, they allow nuances in tone to be noted.

It is possible that the introduction (along with other aspects of the frame such as fees, holidays, and cancellations) sets the tone for treatment. The way in which it is delivered is likely to reflect the analyst's attitude towards the analysis as a whole and might well make an impression on the patient. For example, a comment expressed in the second-person singular, seems to convey the impression that it is the patient's responsibility to follow the method. On the other hand, a comment phrased in the first-personal plural is likely to convey a sense of mutuality.

5.5.6 Section summary

We have seen that the introductions typically given by participants mirror Freud's in some ways but not in others. They both give a clear introduction at the beginning of treatment, and both make a comment about avoiding censorship. Whereas Freud contrasted free association with an ordinary conversation and used his train metaphor to illustrate the concept, the participants almost never did. Freud mentioned the types of associations available, and although some participants continue to do this, a larger number do not. On the other hand, some participants expand the types of associations to include dreams, images, and physical sensations. Some participants also make an explicit reference to resistance analysis which Freud did not. Thus, there is some change in that the fundamental rule has been widened to include resistance analysis (16.2 percent do this). Compared to Freud, the initial guidelines have been reduced, and we have also seen that in some instances, no introduction is given at all. Many of the findings in the study confirm Lichtenberg & Galler's results, and additionally it has been discovered that the American participants tend to give longer and more detailed introductions than the British participants.

5.6 FUNDAMENTAL RULE IS 'ONGOING'

The study's finding that the topic of the fundamental rule is ongoing stands out from the literature. The main articles on the fundamental rule focus on the initial introduction, or lack of, and rarely pay attention to the continuing references, as implicit as they may be. We can speculate why this factor is omitted from discussion. Perhaps analysts, represented in the literature, would like to think that no further introduction is necessary. Perhaps they assume that the ideal patient will quickly get on with the task, even if resistances arise. Or perhaps analysts do not feel that their practice of repeating the rule is worthy of comment.

One survey did find that some analysts remind patients of the guideline. Lichtenberg & Galler's study found that 38 percent (8 of 21 respondents) 'present a version of instructions to patients during the consultation sessions and then expand on their guidelines when they encounter resistances during the early analytic hours.' (1987: 66). Their figure matches with the present study - 37.5 percent.

However, this study finds that besides reminders, the fundamental rule is alluded to in other ways. One type is guided associations, which is given much attention in the literature. Others, such as prompts are not discussed in the literature as part of the rule. General prompts for thoughts such as 'what comes to mind?' as we have seen, are shortened versions of the introduction, while directed prompts are targeted at a specific issue. The study has pointed to the finding that such prompts are indeed part of the rule since it is implicitly invoked[1]. Notwithstanding this finding, many participants (UK.B para 16, UK.I para 14, UK.Q para 12, UK.S para 11) say that they prefer to examine the resistance than to prompt for more associations. Thus, prompts and repetition, among other techniques, are often used sparingly, and could explain why it is not taken up in the literature.

A quarter of all participants gave clear examples where they dissolve the resistance. Although this has the effect of highlighting free association and promoting it, it means that examination of resistances (for why the patient has difficulty in speaking) is avoided. It is therefore incongruent with observations in the literature that suggest that analysts no longer focus on overcoming resistances; it harks back to the topographical model which the structural model aimed to replace. Given the surge in interest in resistance analysis, it is interesting that some participants take this route. However, it can be explained when we consider that dissolving resistances is one of many tools deployed by analysts.

[1] Fromm sheds some light on why an analyst might prompt for thoughts. He believes that it is not enough to outline the basic rule or to repeat it at the start of each session, since free association then is in danger of becoming a ritual. Rather, he thinks that free association should be 'pursued intentionally' (ibid: 4). He uses various techniques to stimulate free association including the prompt '"Tell me what is in your mind *right now*"' (1955: 3). To him, the urgency of the request encourages spontaneity.

Indeed, most participants analyse resistances. Working in such a way, the participant alludes to the fundamental rule to varying degrees. Resistance analysis comes in many guises, and analysts' styles differ. Participants either point out the resistance, or offer an interpretation. This distinction is present in the literature, and the findings here tally with many written accounts – particularly with Gray and Busch.

27.5 percent of participants said they make reassuring comments that allude to the rule in subtle ways. This seems to be an effective reminder of the need to free associate, but one that does not raise anxiety or guilt in the patient, or trigger transference reactions to the analyst. This has not been highlighted in the literature, perhaps because containment is an unexceptional feature of analysis.

Analysts seem to have a range of tools that they use in different circumstances, and each have different effects on the patient. Dissolving resistance, on the one hand, has the implication of by-passing resistance, and if it is done in a confrontational way as some participants do it, then there are effects on the patient's perception of the analyst. On the other hand, a reassuring comment or a prompt such as 'what comes to mind about that?' seems innocuous since it conveys a sympathetic attitude, and avoids directing the path of the associations. Then again, directed prompts such as 'are you thinking about me?' might force an issue on the patient and might hamper the freedom of associations. Participants seem to take these factors into account during their ongoing work with free association.

5.61 Section summary

The finding that the fundamental rule is ongoing has not had much attention in the literature. It seems an important finding because it has implications for the patient and for the analyst's role. Sometimes, by giving prompts and repetition the analyst assumes the role of teacher. This is discussed next.

5.7 ANALYTS' ROLES

The question of the analysts' role was not part of the research aim, but early on in the interviews, comments such as 'free association is taught' were frequently made. Some participants believe that teaching the patient to free associate is an inherent part of the analyst's function. However, it also emerged that some avoid teaching or facilitating altogether believing that, in the appropriate environment, patients learn for themselves.

We should not be surprised to see that analysts help patients to some degree since part of their role as analyst is to create the appropriate conditions for psychoanalytic work. What is more surprising is the extent to which the analyst takes on an educative role. At first glance, 'teaching' seems inconsistent with the psychoanalytic enterprise, though it may be benign given that the method is harmless and indeed important to the analytic process. It must be remembered that 'teaching' does not always mean that the patient is lead step by step; often much space is left for patients to explore on their own. Furthermore, teaching is often only resorted to with patients who are uncertain of their role or who ask for clarification.

Freud seems to have accepted that there is an educative element to psychoanalysis. He uses the educative model to explain his approach: 'For it is education even to induce someone who dislikes getting up early to do so all the same. Psycho-analytic treatment may in general be conceived of as such as re-education in overcoming internal resistances.' (1905: 267). In a later quote, he likens the analyst with 'some such role as that of a guide on a difficult mountain to climb.' (1940: 174). He writes that analysts, in standing in for patient's superego, have the chance to re-educate the patient, but warns against imposing their own ideals:

> *The new super-ego now has an opportunity for a sort of after-education of the neurotic; it can correct for mistakes for which his parents were responsible in educating him. But at this point a warning must be given*

against misusing this new influence. However much the analyst may be tempted to become a teacher, model and ideal for other people and to create men in his own image, he should not forget that this is not his task in the analytic relationship [...] In all his attempts at improving and educating the patient, the analyst should respect his individuality. (1940: 175).

This implies that although the analyst plays the role as educator, his approach should not be authoritarian, but impartial. Roazen shows how Freud could educate without posing as an authoritative figure: 'Freud did not lecture his patients, but his Socratic working assumption was that the patient knows everything but lacks awareness' (1974: 150). This seems to resonate with participants' views in this study; although some training is involved, it is not done with the intention of converting a patient into the analyst's model.

Although Freud writes of education in psychoanalysis, he does not write about it in context of free association. Indeed, in places, he implies that free association comes naturally and does not need to be taught (Gill 1994: 82). This is evident in Freud's comment that 'the adoption of an attitude of uncritical self-observation is by no means difficult. Most of my patients achieve it after their first instruction' (1900a: 103). In this instance, Freud has defined free association very broadly as whatever the patient says (A. Kris also takes this stance 1982). Only when free association is defined narrowly as a special type of communication does education seem to be necessary.

Only a few of the major literary contributions to free association discuss in detail the educative element or its implications (one exception is Gill 1994). Most references are passing remarks. For example in Wolberg's '*The Technique of Psychotherapy*' there is a terse comment that 'Patients must be trained to associate freely.' (1988: 668) but there is no further discussion or illustration. Pressman also comments about educating the patient to the 'cognitive rule', by which he means that patients should free associate and reflect as well: 'Therefore *the first mechanism of*

helping the patient to achieve cognition is either to state the cognitive rule or to educate the patient to the cognitive rule [author's italics] (which I believe we do, at least implicitly, during the course of every analysis, almost from the beginning).' (1969: 190).

Balint has also commented on a training element to psychoanalysis: 'From the standpoint of the analyst, all patients whether children, neurotics, psychotics, have to be educated, trained to conform to the analytic situation (appointments, free associations, interpretations, etc.)' (1942: 89). Kanzer in his thorough assessment of free association makes a brief comment that free association is not 'spontaneously acquired' but is a 'learned process' (1972: 247).

Gray, a strong proponent of ego psychology, sees an educative component to resistance analysis, which some participants in the study imply is the case - since they teach patients to observe their resistances. Gray spells this out: 'Making the patient aware of some of these internal processes at times is primarily educative, for it may never have occurred to the individual to look at such parts of himself.' (1973: 492).

The study goes beyond these brief comments, and illustrates how education to free association occurs. When referring to 'conditioning', 'facilitating' or 'teaching' we must note that the effects are often extremely subtle. However, they all have implications on the treatment. There may be consequences for the analytic dyad if the relationship is to some extent pedagogic, and if patients have to learn a technique or be socialised into a model. They might for example develop feelings of having to please the analyst by conforming and being a 'good patient'. One participant discloses that he felt pressured to adopt his supervisor's model for these reasons: 'in order to please supervisors and teachers, one had to agree more with an ego psychological approach.' (para 43). There might be a similar pressure for patients, whereby if the analyst repeatedly shows interest in say resistance analysis, then the patient will come to adopt that approach as well.

We might wonder, then, whether patients are conditioned to bring certain thoughts, or to think in a certain way. As a hypothetical example, if an analyst continually gives the prompt 'what are you feeling now?' then patients might carry on using that particular prompt. As another example, US.B's patients might be more inclined to bring dreams knowing that she finds dreams fascinating. On the other hand, teaching the 'skill' of free associating might be harmless or even useless, given some participants' belief that it cannot be taught anyway.

The consequence of education seems to depend on the format it takes. A prompt such as 'what comes to mind your mind?' is gentler than 'Ok, where's the dream?' (US.O) which is directive and likely to interrupt the flow of associations. Another possible consequence is that by teaching, the analyst rises to a position of authority. However, we have seen that it is unlikely to create an authoritarian effect since participants who facilitate or teach are weary of this.

5.71 Section summary

Since literary accounts of free association rarely discuss the educative component, this study adds a new dimension to the debate. We have seen that American participants give more direction to free association than do their British counterparts and concomitantly, are more likely to view their role as teacher or facilitator. The consequences of such a position have been considered, though they seem to be slight – most participants are weary of steering the course of free association, and certainly of moulding patients to fit their way of working.

5.8 CONSIDERATIONS AND INFLUENCES

A few participants prefaced their interviews saying much of the analytic process does not take place with full awareness. For example one said: 'all analytic technique in practice is done not very reflectively. I don't think there's time at the

time to think about it.' (UK.C para 27). Nevertheless, participants gave explanations, as best they could, for a variety of factors – whether they give an introduction, what elaborations they include, the timing and the tone of delivery. Most were guided by a combination of factors. Their considerations for the approach not only shed light on the fundamental rule but may also reflect their perspective on the psychoanalytic treatment as a whole. For example, those who stress mutuality as a consideration have also tended to use expressions such as 'therapeutic alliance' and the 'real relationship' in describing their work.

The only account in the literature that inquires into the considerations for the fundamental rule is Lichtenberg & Galler's study. They found that 28.9 percent of respondents sought to establish a 'psychoanalytic contract' from which emergence of resistances could be analysed (1987: 67). The present study found similar results; 25 percent stated this as their intention. However, a further 27.5 percent in this study wished to establish a framework for purposes other than resistance analysis. For example, a few were keen to establish a contract that set out the different roles that patient and analyst are to play, and others wanted to set the scene for transference work.

Lichtenberg & Galler also found that 21 percent of respondents wished to avoid authoritarian tendencies. The figure in the present study was double, at 47.5 percent. One reason for this discrepancy might be the relative lack of British respondents in Lichtenberg & Galler's survey (only 5.8 percent of their sample population were British, compared to 50 percent in the present study). This makes a difference because many more British participants cited 'to avoid authoritarian impact' as a consideration than American participants. If the participants who do not give a rule were detracted, all of whom were British, the finding would tally with Lichtenberg & Galler.

Lichtenberg & Galler find that only 7.9 percent of their respondents were guided by their identification with Freud. The present study arrived at a similar figure

- 7.5 percent. Further, this study revealed that 17.5 percent of participants contrasted their own style with Freud's, suggesting that they find his approach too formidable and authoritative and therefore outdated. Lichtenberg & Galler found that many analysts were torn between introducing new elements to their approach and staying faithful to psychoanalytic tradition. This study has found otherwise; no participant seemed split between the two positions.

Another consideration is to create a spirit of mutuality. Lichtenberg & Galler mention that participants try to establish an attitude of mutuality and work-sharing, but do not say how many do so, nor do they give examples. The present study has found that half of participants say their approach is determined in part by these factors.

Two further reasons which Lichtenberg & Galler have not reported are the considerations 'to offer clarity' and 'to be containing', nor have they mentioned the sources of influence. Participants in this study point to the importance of analytic training in forming their approach to the fundamental rule. Although the literature does not seem to make this link clear, it is expected that a candidate's training will shape their overall analytic attitudes and practice. Glover wrote about this link, arguing that the 'training transference' is mostly positive since candidates identify with their training analyst and carry on the taught analytic procedures. In a few cases of a negative transference, the candidate may 'ape his analyst's technique to the point of caricature or go out of his way to defend it', even at times when it is not suitable for the patient (1955: 262). Some participants in this study expressed an interest in the subject of learning from their analysts and US.I even suggested that the following questions be a topic for further study:

> *how much are people like their analysts, and if they've had more than one analysis whether they've noticed a difference in the way their analyst works, and what kind of an effect that has on their own technique around the subject? (para 50).*

The question of training influences is not pursued here as it lies outside the scope of the research. However, thorough accounts of this subject can be found in Erman's 'The Training of Psychoanalysts and the Analyst's Sense of Responsibility' (1993), a series of articles on 'Explicit and Hidden Objectives of the Process of Training Psychoanalysts' (*International Forum of Psycho-Analysis,* 1993) and Jemstedt's 'Thoughts on Tradition and Innovation in the Psychoanalytic Training System' (1995).

5.8.1 Section summary

The considerations for handling free association tally with Lichtenberg & Galler, and two further considerations have been discovered. These considerations have been linked with features of the introduction and a schema was developed, which is discussed in the next section on hypothesis testing. The finding that training analysts are the biggest impact on developing an approach to the fundamental rule is not well-documented in the literature, but neither is it unexpected.

5.9 TESTING HYPOTHESES

As well as asking the general question of 'what is the status of the fundamental rule?' the study sought to test four hypotheses of how it has changed since Freud. Here we see to what extent they have been confirmed:

1) Psychoanalysts consider free association to be 'fundamental'.
   CONFIRMED: It can be asserted with confidence participants viewed free association as 'important' or 'fundamental' more so than 'not especially important'.
2) Psychoanalysts no longer consider free association to be a 'rule'.

NOT CONFIRMED, BUT SOME SUPPORT: The study's results, though statistically not significant, give some support to the finding that more participants object to the idea of free association as a 'rule' than accept it.

3) Psychoanalysts still introduce free association to patients.

   CONFIRMED: The majority of participants gave an introduction to free association and most did this at the beginning of treatment. Only a small number of participants did not introduce it as a matter of routine. Thus, the third hypothesis is confirmed.

4) The introductions that psychoanalysts give to patients have been modified: a) to reduce the authoritarian tone, b) to include a reference to resistance analysis, c) to include associations other than 'thoughts'.

a) CONFIRMED: While Freud's presentation was 'firm', the study revealed that significantly more participants used 'moderate' or 'gentle' tones than 'firm' ones. Thus, we can confirm that the introduction voiced to patients has been adjusted to appear less authoritarian than Freud.

b) NOT CONFIRMED, BUT SOME SUPPORT: In discussing the value of free association, many participants stressed that what is important is the difficulties encountered during the attempt to free associate. A few participants make this clear to patients, so that the fundamental rule includes a remark about resistance analysis. This represents a shift from Freud's formulation, but it is not statistically relevant.

c) NOT CONFIRMED, BUT SOME SUPPORT: Another subtle shift away from Freud is the inclusion of dreams, images, and physical sensations in the initial comments, but the shift is small and not statistically relevant.

Additionally, a new hypothesis has been formed: There are two approaches to the fundamental rule from which participants draw. In a later section we see participants' responses to this. First, we summarise Freud's legacy on the fundamental rule.

5.10 ASSESSMENT OF FREUD

In many respects Freud's views and practices regarding his fundamental rule still hold sway for participants – free association is still important (indeed taken for granted), is defined in similar ways, is linked with free-floating attention, and is introduced to patients early in the treatment. If we were to place Freud along the continuum of approaches proposed in this study, we could say that he adopted most elements of approach A - he accepted the idea of the rule, gave a lengthy presentation with many elaborations, presented it with firm language and likely gave some assistance.

Where analysts have moved beyond Freud, it is often in subtle ways such as the tone, or length and types of associations contained in the introduction. Another small shift has been towards incorporating resistances in the introduction, and towards working with resistances. One big change from Freud has been a reluctance to view free association as a 'rule' and concurrently, a decrease in the authoritarian position of the analyst. The shift away from an unequal relationship seems to reflect the current concern with a more balanced rapport between analyst and patient, and a weariness of 'superego effects'. This might reflect modern society in the U.S. and U.K., which has more room for equality than it did a century ago.

We can wonder whether the finding of little variation from Freud in the importance, the formal introduction, and in timing of the rule, reflects conservatism in training institutes. Frosh has commented on the orthodox tendencies of the British Psychoanalytical Society (1997:6, 15). Kernberg says the same for the American Psychoanalytic Society:

> *Candidates as well as graduates and even faculty are prone to study and quote their teachers, often ignoring alternative psychoanalytic approaches. The disproportionate amount of time and energy given to Freud, in contrast to the brief and superficial review of other theorists, including contemporary psychoanalytic contributions [...] and the rigid*

presentation and uncritical discussion of Freud's work and theories in the light of contemporary knowledge give the educational process a sense of flatness. (1986: 799)

On the other hand, whilst some participants in this study say they follow Freud's approach, more have felt free to challenge his stance; they have revealed how their own styles differ to Freud's despite sharing his basic theoretical views of free association.

5.11 PARTICIPANT FEEDBACK

Participants were sent a two-paragraph summary of results, and a link to a website with more details on the findings (see Appendices VI and VII). Fourteen participants responded, saying whether their views and use of the fundamental rule are broadly represented.

Twelve participants indicated that the results incorporated their stance. US.L wrote that 'What you found is just about what I would have expected.' US.Q stated that 'Your conclusions represent my impressions well.' US.T said: 'I find your results to be unsurprising, but congenial to my way of practice.' UK.E wrote: 'I visited your web-site and found the results very interesting, especially the differences between the two camps. In answer to your question, yes I do think there is room in your results for my approach to free association and the fundamental rule.' UK.I wrote: 'Thank you for your synopsis which gives a picture of the commonality of approach as well as certain interesting differences, and in my view does justice to our discussion.'

Eight participants commented on the difference between the two approaches. US.J wrote: 'Very interesting findings, particularly, in respect to potential differences between two large groups of analysts.' US.K commented that 'Although I consider myself to be more in the A group, I would characterize might tone with patients as being gentle, rather than firm, when I discuss free association with them'. This

matches the studies findings, and indeed US.K was located in group A with a 'moderate' tone and rejecting the idea of free association as a rule.

US.L made a link between approaches and orientation: 'I found the last paragraph of the abstract particularly interesting. I suspect that group A would be highly correlated with those trained in ego-psychology, while group B would correspond to the relational and object relations approaches.' The study was not able to make such a distinction because it did not classify participant's orientations clearly enough. This is a limitation of the study which is discussed further in the next chapter.

Three participants critiqued the results. US.T said 'I am surprised by the finding that the Americans are more authoritarian than the Brits….I thought that the movement of egalitarianism was stronger in the U.S.' Here, US.T has assumed that approach A consists entirely of American analysts and approach B consists exclusively of British analysts. In fact, the findings were less conclusive; they revealed that more American analysts took up elements of approach A than British analysts and more British took up elements of approach B. The difference is subtle but important. Also, the study did not claim that approach A is more authoritarian and approach B more egalitarian. It is possible that the summary of results did not make these points clear enough.

US.J had doubts about the use of participant feedback: 'I appreciate that providing the opportunity for feedback enhances "validity"; however, it may further conflate the complexity and perhaps the "muddiness" of the nature of our practices and conceptualizations.' This seems to be a valid argument. As a case in point, in his feedback he aligned himself to approach B: 'In my self-reflection I would place myself in Group B as I don't give a lengthy intro nor rigidly apply it as a rule'. The study's findings agree that he does not conceive free association as a rule. However, in the interview he gave an example of an extensive introduction with many elaborations and demonstrated that he gives give assistance. Thus, the study located him in approach A, which is at odds with his feedback. This mismatch chimes with

one the study's interpretivist assumptions; there are multiple realities since meanings and behaviour are interpreted through different eyes.

UK.H questioned the division between approach A and B, believing that there is 'something in the middle – the idea in psychoanalysis of principles rather than rules.' This hints at a powerful critique against the handling of the data. This study has divided the results into 'two broad approaches' from which participants adopt more or less features. Although some might find this tidy snapshot to be useful, others will object to it since they believe that every analyst's approach to the analysis is unique and defies categorisation.

Two participants seemed to self-reflect on their position relative to the findings. For example US.S wrote:

> *I have found myself scrutinizing and re-evaluating my own views about the "fundamental rule" since we spoke, (I suppose reflecting the current zeitgeist), but I don't question the value of free association. What you have presented does "broadly ring true".*

Finally, two participants commented that the results will be of interest to others in the field. US.N commented, 'thanks for sending me the results of your research which should be of interest to psychoanalysts.' US.I asked 'Is it OK to pass the address on to others so they can see it?'

Participant feedback, although potentially adding to the complexity of the study, seems to show that the findings are broadly relevant to those who responded. The critiques are also useful because they uncover some significant limitations of the study.

5.12 CHAPTER SUMMARY

This chapter showed that participants' views and approach to free association are more akin to recent discussions in literature and to Lichtenberg & Galler's survey, than to Freud. Although Freud has a considerable legacy given that free association continues to be used and formally presented, shifts have been made in terms of length of introduction, number of elaborations, tone, and perception of free association as a 'rule' and as 'fundamental'. Participants' focus on resistance, and listening for process, also seems a shift away from Freud. Although Freud considered the role of education, and some accounts in the literature make brief comments about it, this study sheds more light on the process of educating patients to free associate.

Another finding not explicitly raised in the literature is the ways in which free association may be perceived as ongoing. We have seen that many of the considerations parallel Lichtenberg & Galler's findings and that the influences on participants' approaches do not seem out of character with the literature. We have seen that the study's hypotheses have all received some support if not outright confirmation. A new hypothesis - that there are two main approaches to the rule - has been put to participants for feedback. We have noted their broad support for the findings as well as some trenchant criticisms. The concluding chapter will look closer at some of these limitations.

CHAPTER SIX: CONCLUSION

6.1 INTRODUCTION

In this final chapter, the results of the study are summarised, the limitations discussed, some implications are outlined, recommendations are made for future areas of research and the contributions of the study are noted.

6.2 SUMMARY OF RESEARCH

The literature review showed mixed views on the status of the fundamental rule. This study was designed to address this problem of contrasting opinions: to examine views of free association among a selection of analysts and to see how they work with it. It aimed to find out how they present the fundamental rule, if at all, and the considerations for their approach. It also sought to examine four hypotheses which derived from debates in the literature and panel discussions. A sample of forty participants came forward for semi-structured telephone interviews lasting approximately forty-five minutes to one hour. The recordings were transcribed, and coded using NVivo - a Qualitative Data Analysis package. A predominantly interpretative paradigm framed the study. Results were analysed with a mix of qualitative and quantitative methods selected to best match the research questions.

Participants defined free association from many angles, but they focused on the features of relaxation, reflection, and the requirement of a trusting relationship. The definitions given are, on the whole, similar to those quoted in the literature review. Participants found free association to be useful in several ways but stressed that it is a vital route to accessing the unconscious; a finding which coincides with Freud and most other writers. Free association is also important in revealing

resistances. These come in many forms, mostly silence, changes in topic or affect, and pseudo-free associations. Participants listen out for such resistances along with content, their own counter-transference and free-floating attention. Listening for process, (especially resistance), though a post-Freudian development, is a technique increasingly evident in the literature.

The four hypotheses have been tested and given varying degrees of support: free association is still considered important if not fundamental, and is regarded as more of a guideline than a rule. It is still introduced, at the beginning of treatment, and has been modified to reduce the authoritarian tone, but only slightly modified to incorporate resistance analysis, and to include dreams, images and physical sensations.

Participants referred to their own analyst as having the biggest impact on the way they handle free association. We have surmised that the approach to the fundamental rule is transmitted from analyst to candidate and so forth, which would explain why the fundamental rule has not been dramatically altered over the years.

Two findings which have not received much attention previously are the 'ongoing' and educative aspects of free association. The fundamental rule might be considered as 'ongoing' in the respect that many participants repeat or indirectly refer to the rule through prompts, guided association, dissolving resistance, reassurance and resistance analysis. Several participants perceive their role as 'facilitating' or 'teaching' the patient to free associate. On the other hand, several participants take an opposing view that the patient should and will discover free association for himself/herself. Even in those cases, patients may be 'conditioned' into the method as they learn what the analyst's responses are. We have considered some of the implications of education, which on balance seem innocuous.

An additional finding is that despite wide differences in the presentations and considerations, participants tend adopt, to varying degrees, one of two approaches. Followers of approach A are more inclined to accept the idea of free association as a

'rule', give a lengthy or extensive introduction including several elaborations beyond 'say what comes to mind', use a firm tone, assist the patient to free associate, and be motivated to create a framework or to offer clarity. This approach is taken by significantly more American participants than British. Followers of approach B tend to be against the notion of free association as a 'rule', give a brief introduction with few elaborations (or no introduction at all), use a gentle tone, avoid helping the patient, and be motivated to avoid an authoritarian impact or to create a spirit of mutuality. Approach A has fractionally more followers than approach B.

6.3 LIMITATIONS

Various difficulties have been encountered during the study, some of which might encumber its validity. One limitation concerns the fact that participants were self-selected. Many expressed enthusiasm for the topic, and the results may have been different had participants not been interested in the subject. However, analysts cannot be forced to participate, and it is hoped that interest for the topic covered both positive and negative opinions. Indeed, participants showed varying strengths of opinion, ranging from one who was critical of free association (UK.S para 19), to one who 'loves' free association (US.H para 22). Thus, it is hoped that the study has represented a broad selection of analysts of different persuasions.

There is also a limitation about how far the results can be generalised. The results cannot be said to hold for analysts belonging to other organisations within the U.S. or the U.K., or for other organisations worldwide. The benefit though, is that a thorough analysis has been given of a specific group with limited variations in orientation and culture.

Another problem is that the distinction between American and British participants, although insightful, is on some levels too pure since it discounts overlapping influence. For example, some American participants claimed to be

influenced by British thinkers. Also, although it did not arise in the interviews, it is possible that participants underwent training in other countries.

Another possible pitfall is the relevance of orientation. Most American participants did not give enough information to permit classification into distinct theoretical groups, and many in fact thought that such division was unhelpful. This prevented thorough tests of the influence of orientation on approach.

Another limitation is that participants did not discuss some aspects of free association. An explanation for this lies in the unstructured nature of the interviews. Since participants were not offered check-lists, they were free to raise issues as they pleased. The percentages for each issue might have been higher if participants were asked a structured set of questions. In view of an interpretive perspective, the findings although low in number, often signal meaningful views. However, it is acknowledged that there might be other reasons for low responses on certain themes – such as forgetting to mention an issue, not having enough time to raise an issue, or deeming an issue too obvious to mention.

A further point is that quotes have been selected which are clearly expressed and which represent the findings, but the limitation is that many supporting viewpoints have been omitted. However, references in footnotes are presented so that the results can be credibly traced to the source. Also, quotes, where given, have taken into account the gist of the participant's viewpoint to remain in context.

Researcher bias is also a potential hindrance. Coding was carried out by extracting the intended meaning from both the content of participants' speech, and their tone, but this is subject to the researcher's biases. Also, many codes such as 'strong tone', 'gentle tone', and 'not especially important', are subjective constructions. Hopefully these biases are outweighed by the benefit of being able to manage large amounts of data. Another limitation is that contradictory view points

have often been covered up, since they have been coded under the outcome that seems most dominant or most likely. For example, one participant says he does not tell patients the basic rule, but is coded under 'gives clear introduction' since he later gave an example of something akin to an introduction (US.J para 17, 21). Although some specific details might be lost, again this contrasts with the benefit of being able to tabulate results for systematic analysis.

The study was designed to gain an accurate insight into the views and practice of analysts. Full objectivity cannot be attained, because the study relies on participants' self-constructed reports of what occurs in the analytic process. One participant implies that analysts, in their discussions with colleagues and in their written work, might represent their views and their work differently than what actually takes place. He says that there is a 'disjunction between what people write about and what they say they do compared to what they actually do do in the consulting rooms, which I think is a serious problem.' (UK.R para 9). It is possible that some participants have in the interview felt an 'unconscious pressure to agree' (UK.R para 9) with the group ideology, but it is hoped that anonymity and confidentiality will have minimised this.

In the previous section we have considered how the introduction has changed since Freud, judging by his written recommendations. This is also not without difficulties since some accounts (for example Roazen 1974) suggest he practiced differently than he claimed to, in which case we are comparing the results to a meaningless source. On the other hand, Freud's written work remains a key window to his ideas and a benchmark in the field, and is thus a suitable frame of reference.

A final point is that more men came forward to participate than women. Although not statistically relevant, it is worth noting the potential effect on the study. Gender has been correlated against the major categories in this study, and unlike the British/American distinction, has been found to be irrelevant to every finding. Thus, it is likely that the higher number of male participants has not skewed the results.

6.4 IMPLICATIONS

Most glimpses of analytic understanding contained in written accounts may present work in an admirable light and omit some details. This study, by contrast, has answered the question 'what do analysts actually do?' The answers are useful because they provide us with an insight into the work of mainstream analysts who may not have otherwise written about it.

One expected application of this research is to give analysts a clear picture of what other analysts do. Most participants in this study were curious to hear what others do. Some of them generalise about other analysts, and some are unsure of how their colleagues overseas approach this issue. The benefit of this study versus literature and panel discussions is that the results are less likely to be marred by unconscious pressures to agree.

Some of the participants who gave feedback expressed interest in difference in approach between American and British participants. This particular finding might be of interest to other non-participating analysts.

The results might also be relevant to candidates who wish to learn about strategies adopted by present-day mainstream analysts. Also, if the observation that there is a tendency to conservatism has some basis in fact, then there are implications for the way we view analytic training in general.

The results might have interest for practitioners of other therapies whose work may involve free association. They could also be useful for public information, including prospective patients wishing to inquire into analytic practice. The results therefore will illuminate aspects of practice that sometimes can be hidden from

patients. Although the topic is narrowly focused, in some ways it does open a window to the approach taken towards analysis as a whole.

Finally, the results help us to assess Freud's legacy in this one area. We have explored the changes to the fundamental rule since Freud and concluded that despite a notable shift away from an authoritarian position and the rise of resistance analysis, only small shifts have been made to the initial introduction. The participants' conception of the definition and features of free association, its importance, its uses, how it is listened to and some aspects of his initial introduction are not dissimilar to Freud's conception. This is testament to his legacy.

6.5 RECOMMENDATIONS

One limitation of the study is that the influence of orientation on the approach could not be tested. One suggestion would be to follow Hamilton's method (1996: 8-10) and ask participants to rate on a scale the authors/orientations that have influenced their technique. This innovative method would permit measurement of the influence of orientation on the outcome.

One extension of this project would be to include participants to cover other organisations, such as the International Psychoanalytic Association or other institutes such as the American Academy of Psychoanalysis or the National Association for the Advancement of Psychoanalysis. It might also be extended to other nationalities, for example from Europe or South America. This would add breadth to the findings and reflect a wider set of theoretical orientations.

Another suggestion would be to investigate further into the finding that free association entails an educative component. An interesting subject is the place of education in analysis, and how this might impact on the patient. Similarly, the effects of analytic training on an analyst's technique might be usefully investigated.

Finally, the study has examined only one part of the psychoanalytic contract – the fundamental rule – and other aspects such as the handling of the couch, and the interchange of time and money might also be a further direction for study.

6.6 SUMMARY OF STUDY'S CONTRIBUTIONS

1. An empirical assessment has been made of a topic frequently raised in the literature and in panel discussions. The findings were compared to accounts in the literature and to Freud's formulations so that a deliberation could be made on the current status and historical changes.
2. The assessment was based on recorded, semi-structured telephone interviews where previous studies have relied on written questionnaires.
3. The topic was formally approached through a combination of qualitative and quantitative methods. Coding strategies and statistical computation were used, whereas previous surveys relied on generalised statements.
4. Four hypotheses based on the literature were tested. A new hypothesis was proposed that links views towards free association as a rule, the format of the introduction, assistance given and considerations.
5. Sampling was specific and included analysts from organisations in two countries. The new hypothesis includes a finding about the significance of nationality on the views and approach taken towards the fundamental rule.

APPENDICES

Appendix I: Message posted on electronic bulletin of APsaA

From Sheri Jacobson: REQUEST FOR RESEARCH PARTICIPANTS (2004)

As part of a PhD research project I am looking to interview APsaA psychoanalysts currently working with adult patients.

RESEARCH TOPIC:
To inquire into how psychoanalysts use the fundamental rule of free association in their practice.
By making such inquiries I hope to update the findings of Lichtenberg & Galler's 1987 study on the current status of free association
Dr Lichtenberg, and the APsaA Director of Public Affairs are both aware that I am carrying out this research.
The purpose is to gain an empirical understanding of a topic that is widely discussed in the literature,
and thus to add to the body of knowledge in psychoanalytic technique.

STRUCTURE OF INTERVIEW:
By telephone, tape-recorded
Length of around thirty minutes

CONFIDENTIALITY:
I guarantee confidentiality and anonymity.

PAYMENT:
Prior to the telephone interview, I will send a cheque to the value of one hour of the analyst's time

PERSONAL DETAILS:
Sheri Jacobson
Address
Telephone
Email

* PhD student at Regent's College, London (School of Psychotherapy & Counselling)
* Full member of BACP (British Association Counselling & Psychotherapy)
* Currently working for mental health charity (MIND) in London
* MSc in Philosophy, Politics & Economics, Oxford
* MA in Social Anthropology, UCL
* Supervised by Andrea Sabbadini (British Psychoanalytical Society)

If you are able to take part, please contact me to discuss this further or to arrange a convenient time to speak.
Many thanks!

Appendix II: Letters sent to members of BPaS (British Psycho-Analytical Society)

REQUEST FOR RESEARCH PARTICIPANTS (July – Nov 2004)

Dear ,

As part of a PhD research project I am looking to speak with members of the British Psychoanalytical Society who work analytically with adult patients.

My research will look at how psychoanalysts use the fundamental rule of free association in their practice. By making such inquiries I hope to update the findings of Lichtenberg & Galler's 1987 study on the status of free association. The purpose is to gain an empirical understanding of a topic that is widely discussed in the literature, and thus to add to the body of knowledge in psychoanalytic technique.

Dr Lichtenberg, the American Psychoanalytic Association and the British Psychoanalytical Society are aware that I am carrying out this research.

The discussion would take place over the telephone for around thirty minutes, it would be tape-recorded and I would guarantee your confidentiality and anonymity. During that time I would like to explore your views on and use of the fundamental rule.

I understand that your time is valuable, and my budget allows me to pay you for your hour. If you agree to this, I can send you a cheque in advance.

We can schedule a time to speak at your convenience.

I hope very much you will be able to participate! To discuss this further or to arrange a time to speak, please contact me.

Yours sincerely,

Sheri Jacobson

- PhD student at Regent's College (School of Psychotherapy & Counselling)
- Full member of BACP (British Association Counselling & Psychotherapy)
- Currently working for mental health charity (MIND) in London
- MSc in Philosophy, Politics & Economics, Oxford
- MA in Social Anthropology, UCL

Appendix III: Example of interview reflections

Reflections on Interview (US.N) 50 minutes - 10 May 04

General impressions of the interview:
This interview got off to a strange start. He began by saying 'you are prompt!' He then began to speak of his own interest in free association, in a manner that I experienced as authoritative and defended. Throughout the interview, I felt blocked out – he spoke articulately about theory and technique, but in a manner that was vague (I found him non-responsive to questions about his technique e.g. 'can you give me examples?') and referred to other authors to back up his position. He often made long digressions and I had to try hard to steer the interview back to the questions.

Reflections on my interviewing technique & issues for further interviews:
From the start, I felt disabled as an interviewer, although I was quite active in pursuing answers which I feel he evaded. I felt as if the interview was out of my control, and I was aware of that at the time. I thought it would be best to roll with it, by picking up on some of his points made in the course of his long soliloquy, and forcing through my questions at times. I was surprised by his comment at the end that he liked the way our conversation meandered.
On transcribing the interview, I realized that I did not pick up on his comment about Freud & Jung. I could have asked about whether Jungians could be reconciled to using free association as their method.

Reflections on the analyst:
I found him energetic and confrontational. I found some of his language - 'that's bullshit' – to be very direct and at times I felt unsure how to respond. I believe that the way he is as analyst i.e. active and confrontational, is similar to the way I experienced him as co-researcher. He seemed a die-hard Freudian, and yet eschewed the basic concept of neutrality, and also faulted Freud on his view of dreams (he sees it as not merely wish fulfillment but a historical record). So, although he may ascribe to Freud's theories (and indeed knew his material very well) he seemed to me to be a firebrand who likes to stoke up confrontation. I experienced him in this way from the start.
I noticed that my tone hardened in response, and I was happy to interrupt without feeling nervous about doing so – I seemed to learn that I had to speak as confidently as he did so as not to get pushed out of the interview. He talked over me at several points e.g. [99], and I felt that I had to be kind yet forceful in returning our conversation to the research agenda.

Transference Issues:
I felt the interview started with a confrontation about me being prompt. His tone of voice suggested to me that I did something wrong, and there appeared to be a certain friction between us. I felt that he was asserting himself as the 'knowledgeable academic' – even quoting page numbers. I assumed the role of student, and at times, he checked to make sure I knew of the author etc. He didn't entirely steam-roll over me in the interview, but it came close. I didn't rate his listening skills very highly although in an odd way, I did feel that he reached out to me.

He mentioned an IPA congress on the fundamental rule, which I had attended. On the one hand, I wised to share my experiences so as to 'break the ice' with him, but I felt it would distract from the interview and thus I refrained from saying anything.

Openness about practice:
He seemed very guarded about his practice. He was speaking in very general terms, and unlike other analysts, did not volunteer a clinical example until later on (perhaps he was more relaxed by that time). I felt as if I was pushing in vain for a concrete sense of how he worked – all I was hearing for a time was abstract thinking. It took me 6 questions [til 379] to find out what kind of intervention he uses when facing resistance. He seemed to avoid the question by ignoring it, talking around the issue, invoking other authors. [this avoidance seemed to me to parallel resistance in analysis, and here I pinned him down by asking questions. Had I not asked, I think it's unlikely he would have given me an example. This was odd for me, because I hadn't interviewed somebody as evasive as US.N.] He cleared his throat immediately after he reached an apex saying 'you're lying!', and then said 'one important aspect you didn't ask me about', which immediately returned me to a lower status, and I feel he was reclaiming territory. I was eager to ask him about his reasons for confronting a client in this way, but felt that I had pushed far enough.

Note:
I began this research with the belief that analysts would not be closed about their practice or have to censor their views, since it was anonymous and confidential. I am realizing that defenses are present on both ends – they can be a bit secretive about their practices and likewise, I have been reluctant to ask certain questions for fear of coming across in a bad light. The interviews with US.N seemed particularly marked with resistance on both sides.

I am wondering about why some participants like US.N have said 'I can send you some of my work'. This might be because they feel they don't have the time or the desire to explain the relevance of it to the point we're talking about in the interview. Perhaps they are hoping to reach out to me, in some act of reciprocation or help. Or perhaps they see me as uneducated in the field, and need to brush up on the subject. Finally, could it be that they feel that they are able to express they're view better on paper than in words over the phone where they may not say it correctly e.g. are they worried about being quoted or worried about poorly expressed views being included in research.

Appendix IV: Example of interview reflections

Reflections on Interview (UK.D) 51 minutes - 30 Jul 04

General impressions of the interview:
I found this a very enjoyable interview which was packed with insights and helpful leads.

Reflections on my interviewing technique & issues for further interviews:
He spoke at length without me having to prompt him - he gave a full description of the topic, which I felt fully addressed my research questions. The drawback is that the information may have been more in-depth had I asked him questions directly.
On the other hand, by letting him speak without interruption, I think he revealed details of his practice that would not have emerged by direct questioning – for example in para 8 he shows that he gives advice to patients: 'and I'll make an interpretation, but it really is a bit of advice [speeds up speech] and I've been struggling with this.'
This shows the advantage of semi-structured questions since they hopefully encourage wide revelation of practice though there are some participants who are very withholding about their practice.

Reflections on the analyst:
He came across as highly intelligent. His points were carefully argued and he questioned many aspects of his own practice. For example, he reflected on his own inability to use the couch (para 22): 'I couldn't use the couch when I first [laughs] went to analysis, for two or three sessions I was just terrified.' He seemed to be very modest in spite of being a prominent psychoanalyst who writes articles and lectures. He offered many clinical examples, several of which were self-revealing. Perhaps this is because he was written clinical case studies in the IPJA. He also referred to other's work, but in context of how he uses it.

Transference Issues:
I felt that he was doing his best to thoroughly tackle my questions and to supply helpful information. However, I got a sense that I wasn't very present for him. He didn't ask any questions about the research or to be sent the results, which everyone has thus far. Nor did he ask about my background. I regarded him as a masterful lecturer, although a sympathetic one, who was self-disclosing and self-questioning at various stages.
I really liked him – I thought he had a soothing tone, and was warm-hearted. It even came across that he was mentoring me by giving me a 'story' about his own supervisor. He came across as very kind, even suggesting that I contact him again if I have any more questions.

Openness about practice:
He was exceptionally revealing about his practice and I thanked him for this at the end. I felt I had a very good insight into the way he worked, and even wondered how I might have been able to get others to furnish me with examples. For example, UK.B seemed very defensive about her practice in comparison.

Appendix V: Example of an interview transcript

Interview Transcript (UK.R) 18 Oct 2004

[paras 1 & 2 – personal greeting]
UK.R [para 3]: How shall we start?
SJ [para 4]: I don't have very many structured questions – I have a few things in my mind, some topics that I'd like to cover, but I thought I could start us off with a question and then maybe roam around the topic, and I'm just interested really in hearing your views on the subject and maybe to get a sense of how you work with it. So one question that I had in mind was 'what role do you think free association plays in your practice?
UK.R [para 5]: Right, well, it's um..it's fundamental, it..I work on the assumption that every analyst has to revise from time to time, review, what they believe to be the..what one writer called the 'organising principles of the work', you know the fundamental assumptions on which everything is built, as it were. And for me, that's..well I wouldn't called it free association – I'd prefer the term 'associative freedom' for the patient and for the analyst. Obviously that's derived from Freud, but to get to that position I think..I mean people vary but certainly having been educated in the British Society, to get to that position has sometimes been quite difficult because you via other routes, as it were. There's a tremendous emphasis in the British Society on interpretation of the transference and counter-transference, which of course are terribly important tools in the work. But I sometimes get the impression, certainly within the British Society – I can't speak for any others – but it's almost as if the transference and the counter-transference have almost replaced free association as the kind of fundamental organising principle, and that's something I take issue with because I think they are secondary, they're means to an end as it were. But eh, [2 sec hesitation] of course one is always looking out for..listening out for transference and counter-transference but they are essentially a means to an end, and the end, in a sense is associative freedom because..I mean I use that term because [2 sec hesitation] I prefer to think of it as a capacity for individuals whether or not they are in psychoanalysis, as being very fundamental. If you like, a sort of notion of..it maybe goes back to anci-..maybe John Stuart Mill and the liberal thinkers, the idea of you know freedom being a fundamental aspect of citizenship and I think they are not unconnected, it's not unconnected with psychoanalysis in a sense – at least the way I think of psychoanalysis. Hence 'associative freedom' because it's a connection with the outside world, in the person's everyday functioning as it were, as well as or beyond the consulting room. I mean there are other reasons for using the term as well - 'associative freedom' - but that's one reason. Um. So eh. There are other reasons more clinically based if you like, eh, that eh, it's..free association I think is in a funny sort of way, in a paradoxical way, can be restricting because it's like it can be experienced by the patient and perhaps even by the analyst as a kind of injunction 'you have to free associate' so to speak. So you've already..there's already an expectation of what to do, or how to behave or how to conduct oneself which is, if you like, already an imposition. So for me, associative freedom in a way is like..if you try to think of it is: well the patient can speak or they can not speak, they are as free not to speak as they are to speak, and that's an important part of the process. So that's the clinical reason why I prefer the term 'associative freedom' rather than a more kind of historically-rooted, and I mean clinically, as I said rather, in a paradoxical way, a rather constraining notion of what Freud called free association. But eh, that's eh..those are the sort of basic ways that I think about it. Erm. I suppose that I also said that it was something of a journey. Well, you know, it is in

a sense that it's certainly been my impression in the British Society that as I said earlier, that other people have different views and you can get kind of prevailing ideologies and educational structures, you know, which can change, as it were, over the years, and that's something that especially as psychoanalysts we have to be very careful we don't get caught up in, you know, because these things can become..once you get an ideology you get all sorts of unfortunate consequences like shibboleths which can't be questioned and then you get a secret, in my view, you get a secret idealization, sometimes it's not so secret, of certain ways of doing things and if you don't conform to that, well, if you're seen not to conform as it were, then you may be experienced as somebody who's quite difficult, kind of thing. So those are some of my thoughts [laughs] should I stop there, I've said..?

SJ [para 6]: That's great. I'd like to pick up on a few points. When you say that you like 'review' so to speak, the 'organising principles' of the way you work, have you had this view all along about the actual importance of 'associative freedom'?

UK.R [para 7]: No, no. Because of the society in which I was brought up where, as I was saying earlier, there's this emphasis on transference, um, I..although I theoret-..when I was a student and in my earlier analytic years, though I theoretically, as it were, believed in Freud's, you know the original Freudian notion of as he put it, of free association and the neutrality of the analyst, that was really more theoretical than clinical, because clinically because of the way I was taught, I was constantly..when actually working was completely pre-occupied with the transference and the counter-transference, because that's the way, as I've said earlier, that's the way so to speak I've been brought up, educated. And it wasn't until I would say..it's hard to say when but gradually over the years, I would say it's at least, I would say it's somewhere more than 10 years after I qualified, and I've been doing psychoanalysis for 10 years that you know, the way I was describing, the idea of associative freedom began to have a kind of clinical, or experiential kind of reality, and I was able to begin thinking the way that..to put a theoretical structure to it in a way that I was describing to you earlier. One of my early supervisors was somebody called Nina Coltart and in a clinical seminar when I was a student, she once said that if you want to become a psychoanalyst, first of all you qualify, but then you don't become a psychoanalyst until you've spent ten years behind the couch, and then you know, then you might become a psychoanalyst, which is still..which has certainly fitted my own experience, you know, to have the kind of..you qualify but that the internal authority to be able to think for yourself, based on your clinical experience and so on, takes a long time, maybe longer for some people than for others. But that was my experience. So, yes, calling it 'reviewing' is perhaps placing too much emphasis on it as a conscious process, that the theory, as it were, as usual comes after, lags behind, the actual clinical experience, you know, theory comes out of experience and I suppose in a similar way, when I say 'review' I would apply to that that you become aware of ideas that are around in the intellectual climate of psychoanalysis and you kind of begin to recognise here and there what you've been doing and what you feel you're clinical experience gives you a sense of conviction about, you know. So 'review' in that sense, is..part of it is unconscious I think. As to try..as you find out what works for you, as it were, whilst still..but you still have to justify that, as it were, as psychoanalysis, it isn't a case of do-as-you-please, as it were, you know, you still have to have a psychoanalytic account, as it were, of what your position is. So review in that sense I think.

SJ: Do you find it difficult to hold that position when most people are let's say put greater importance on the transference and counter-transference?

UK.R [para 9]: Well, eh. Actually, no, because partly for personal reasons because I don't mind being in a kind of a – how shall I put it? – an unpopular [laughs] minority. There's always in all of us I suppose a kind of defiant or rebellious non-conformist kind of potential, [chuckles] so it satisfies that aspect, but it also..it also gives you, I think it's also a position which gives you a kind of broader outlook you know, a willingness to or an availability to seal a point of view which is very much in the tradition of the Independent Group which is the tradition in the British Society that I belong to, it's essentially a non-..I think of it as a non-conformist tradition in the spirit of Wright Mills, not Wright Mills, the architect, oh you know, the guy who designed the Metropolitan Museum of Art in New York, what's his name? It escapes me for the moment. But he borrowed a phrase from Emerson who said that the only way to maintain your integrity is to be a non-conformist because it's the only way of staying sane. Once you start to agree with everybody around you it's a recipe for disaster. Um, so, not particularly, no, it also gives me something to think about and write about. Um, but it's..the trouble with it is, you see if you talk..I guess, if you talk to any psychoanalyst or most psychoanalysts in the British Society, they'll agree with that statement. But then, when you actually look closely at the clinical practice, eh, you know, it's something very different, it seems to me, to be going on. And it's that sort of disjunction between what people write about and what they say they do compared to what they actually do do in the consulting rooms which I think is a serious problem. You know, I'm in a seminar with other analysts from across the three groups in the British Society, they're all colleagues who I get on with. It's a group that I started because I was interested in this issue, this very issue of looking at the different approaches to the work, and so the group was kind of chosen as the people I like and get on with, because there's no point in being in a working group with people you can't…[I interrupt and block end comment]. But eh, but it's interesting that it's become very hard actually to pin down our real differences and it's a strong, I think unconscious pressure to agree. And when you say..when I emphasise this issue they all say 'well, that's what we do'. But when you listen to the clinical material, at a point where they would make a certain kind of intervention, I wouldn't. I would a kind of more focussed intervention if you like, with some structure to it, whether it's a transference interpretation or some other form of intervention. I mean, I wouldn't. I would ask the patient for, let's say I might say to the patient 'well, does anything come to mind about that?' and I'd ask for more associations, you know. So that's a problem I think, is the difference between what people actually do and what they say they do, and it's not..I mean it's not intentional, it's not conscious, you know. Obviously it's something to do with the process of self-reflection about the work, in my view influenced by the unconscious adherence to group ideologies, you know. But anyway, that's…
SJ: So would I able to ask how you might define 'associative freedom' – what would you say it meant to you?
UK.R [para 11]: Eh, it means..I think it means not having any assumptions about what a session with a patient..what might emerge [hesitates]. It's an attempt to, to get as close as one can, to Freud's original notion of – which of course he contradicted himself implicitly in – but the notion of analytic neutrality so that the analyst isn't..in a way is only responsible for one thing and that's the negotiation over the fee. Some people say you sell your time and you make available your time and your skills but I don't think you do. You don't actually make time available, I mean, you have an agreement about the length of the session but the way the patient uses the <u>time</u>, they can use in all sorts of ways, they can like not turn up, or whatever, but how they use the time is entirely a matter for understanding. Um, and the only thing I'm responsible for in a sense is that I have to, as it

were, do something about if it's not going reasonably well, is eh, is the agreement about the fee because I can't work for nothing and I can't allow patients to get into too much debt and that sort of thing. Eh, but..that's not to say that they might not get into debt sometimes, so it's..associative freedom is freedom for the analyst as much as for the patient in a sense of trying to free oneself of any kind of assumption about what might emerge in a session. Um, so although I would be, for example, listening out for issues of defence and transference and so on, and what's the underlying..listening out for what's the underlying anxiety, all those kinds of things, uh, they would be secondary to, they would be the background, as it were, to the essential position of encouraging in myself and in the patient an openness to what might emerge and it's eh, [5 sec hesitation] it's also a limit..it has it's..how shall I put it? It's an impossible position in a way because you can't have, obviously you can't have complete freedom, it's..some people would say 'well, you can't because of the ubiquity of unconscious fantasy', well I'm not sure I would agree with that particular point of view but what I do think is that there's..no matter how structured you are in your work with a patient or how, at the other end like I'm advocating, how much you encourage the opening of the associations in analyst and patient, there is still..each of those positions still implies a kind of object relationship which is best captured for me by, I mean there are a number of psychoanalytic formulations which would sort of, eh, theoretical formulations which will sort of capture that, but I mean the one which I find most useful is Michael Balint's idea of, which are you probably familiar with in his book 'The Basic Fault', eh, he talks about ocnophilia and philobatism as fundamental relations to the object. Do you know those?
SJ: No, I'm not familiar with those terms, no.
UK.R [para 13]: His emphasis in early development..in early infant development or primitive development is on..his emphasis is on omnipotence as a defence against the loss of eh, a very kind of merged relationship with the object, based on fundamental experiences in the womb, really you can take it back that far. Eh, in a sense that there's the kind of limitless expanses and there's also then the restrictions imposed upon that experience, and eh, he..his view basically is that people have different reactions to the loss of that omnipotent position. One is to cling the object, cling to the mother, which is what he calls an ocnophilic position, you know, to try and make sure the mother doesn't go away so-to-speak or whatever. And the other is to find safety actually in the space that's left by the mother and most of us are a kind of mixture of the two. And I think that sort of..they're both irrational positions of course because they're both extreme, but that sort of captures what I was trying to describe as this..there's an object relationship regardless of what you do, you can't get away from it, you know. So I tend, as it were, when I'm thinking about associative freedom I'm thinking about the analyst adopting a much more philobatic position, encouraging the experience of open spaces and exploration and so on, where there's an underlying..where there may be an underlying fear about actually approaching an object, the object might be felt to be dangerous, like the analyst in the transference. Or even vice versa – the patient is dangerous to the analyst, the analyst doesn't want to get too close to the patient because there's an unconscious fear perhaps of intimacy or sexual excitement or whatever it might be. So..and on the other hand, the analytic technique might emphasise the sort of relationship between the patient and the analyst so much, I mean as in interpreting the transference all the time, that there's no space left, and that seems to me to then indicate that the analyst is frightened of open spaces, you know, they are frightened of getting lost, so they cling to something that's highly structured and the transference is very convenient at that, if you follow me. So that's something of the…I've forgotten where we started, [laughs] what was your

question? [more laughter]. But, yeah, that's something of [hesitation] of a limitation of associative freedom – it can never be, of course, entirely free, it's always got to be limited in some way. But it's how you think about it as being limited that you have to be, I suppose, you know, you have to articulate to yourself, and that's part of that conscious reviewing of your work that I was talking about earlier, or the conscious aspect of that reviewing.

SJ: And you said that unlike some analysts perhaps you'd say things like 'does anything come to mind about that?' On what occasions might that arise?

UK.R [para 15]: Eh, most commonly in a situation, rather like interpreting dreams, what might strike my attention is an aspect in the material whether it's say an element in a dream or whether it's a conscious association in the session. It strikes me because it strikes me as being odd in some way, eh, that it's somewhere..it's like it doesn't flow freely in the patient's associations – there's anxiety around it, for example, maybe consciously..which one picks up, it may be a kind of a sense of verbal disjunction, it may be an odd use of language, it may be any number of things – but it strikes me as being kind of, what Edward Glover once called..in terms of speaking about resistance, you get a feeling that the current isn't running smoothly, that it's snagging on something, and you get that sense of a disjunction. And so, it's moments like that that often I'll ask for more associations. And it might be something in the patient's ordinary language which he or she may have talked about before on many occasions, but on this occasion for some reason it might strike me. I mean, an example that comes to mind I've used in teaching sometimes is patients who have difficulties in relationships with, <u>severe</u> difficulties in relationships with women, that's why he came to analysis because he couldn't maintain a relationship. But he turned out to be a very narcissistic, slightly perverse man. And he'd spoken about his sexual experience you know, for years on end as part of the analysis every now and again. And then one day he happened to be talking about oral sex and it suddenly occurred..he'd already mentioned before, what went on with him and his partner and for various reasons I asked him what he meant, I asked him to say more about it, and then something emerged which had been there..which I hadn't been really sufficiently aware of, which was quite conscious for him and yet he hadn't spoken about it, which was..he had a quite conscious view that that was the thing that most women want and eh that eh, if you do that, then the woman is completely under your control and this lead on to all sorts of other kind of aspects of the material. But it was just..it was just that something struck me about it during that session to ask him to say more about it. And it lead into a whole new area of his desperate need to control his objects and so on, which, and then had transferential implications, but the transference didn't emerge until..I mean the control came from not talking about certain things, yeah, namely what that meant to him. And that could then be opened out, there was a transference experience, whether it was the asking for associations which came first and led to a deepening of the transference experience. Um, but, yeah, it's essentially, um, treating the material..I think Freud actually talked about it, I can't remember if he specifically put it like this, but, you can treat any session as a dream, you know, but the patient is always engaged in compromises and..of one sort or another, and whether they are represented in the dream or whether they are represented in the behaviour, verbally or non-verbally etc in the session, in a sense is neither here nor there. And the task is to identify it. So, I think that's broadly speaking the answer to your question. Um, let me think. Uh, if the patient seems reluctant to go down a particular route when they're talking about something – if they block, you know, or change the subject – very obvious signs of resistance, that would be another occasion in which I might bring them back. Or I might interpret the resistance,

with the aim of freeing up the associations. I mean, I might do either. Uh, but I suppose the broadest statement would be any opportunity I can see to..to..for the patient and myself to think more freely, more openly about what's emerging, any opportunity like that I would try to take, to encourage that kind of atmosphere in the work. Um.

SJ: I was wondering if, at the outset of analysis, if you introduce the notion of free association to them in the form of a little statement of some sort, if you do that. And if you do or don't, I'd like to know a little bit more about why you take that position?

UK.R [para 17]: Right. I used to. Um, I was..one of my train-..one of my supervisors during training was particularly – Adam Lementani – was particularly keen on that, you know, about encouraging..he said that..he used to say that there was an educational element to psychoanalysis, especially in the early..in the opening phases. And I still agree with that, that free association isn't something that [chuckles] comes easily to anybody. It's actually a capacity that you have to learn through analysis. But, there's..certainly I used to start by saying that..something to the patient along the lines of uh..particularly in a consultation, if a patients asks, you know, what it was about, in some way, I would say something like, um, well, I would say that 'the best way you can use the time is to try speak about whatever comes..to try to say whatever you are thinking or feeling or sensing at any moment, and to try to put it into words' you know, something like that – that was the formula that Adam used – was thinking, feeling and sensing. And he used to be very keen on sensing in order to try to convey to patients that what was going on in their bodies was likely to be just as important as what they were thinking and, you know, what they were feeling. And I certainly used that formula for many years, um, and if the patient asked me what my side of it was – which didn't happen very often – but if they did, I would say something like 'well, it's my job to try to understand what you might be communicating, as it were, in between the lines' or I might use the..sometimes use the metaphor of the orchestra, that it's like being in the orchestra pit; if you are playing in the orchestra you can't hear the music in the same way that somebody outside can hear it, can hear the tune, and I'm like the person outside who can perhaps hear the tune, and you can't when you..you can't hear the whole piece when you are playing an individual instrument, as it were. I sometimes used that metaphor. Um, but, I no longer do that at the beginning of a [coughs] excuse me. I think I stopped doing that as part of this kind of moving towards the notion of associative freedom, um, because I prefer, um, the patient to bring whatever they want to bring to the analysis, their own ideas about what psychoanalysis is, and explore them as they emerge with the patient, you know, rather..because..in a way to say something about the way to use the time is itself an injunction, you know, so the same thing applies to the use of the couch, um, I mean I don't say to the patients, you know..I mean that we'll necessarily..that we'll use the couch, I mean that's another thing I used to say at the beginning, for many years 'there's a couch and there's a chair' and the patient may bring up how we're going to work and I will take that up analytically, you know, as to what the couch might mean to them. They're free to use the couch, they're free to use the chair. Um, I don't insist on the use of the couch. Really the..I don't really insist on anything other than that, I suppose that they more or less keep up to date with their payments, so that..so that financial problems don't get out of hand. Even that, you know, I don't insist on; I've had patients run up very big bills, but you know, and then they..in the end..I mean usually in a situation where you have reason to believe that they will eventually sort themselves out, other situations where I've stopped a treatment because, very rarely, because the patient was clearly getting into serious difficulties. But that only happened on one occasion in eh, twenty odd years of practice. Um, but eh, so no, I – there isn't..I no longer use a kind of introductory sort of

phrase or anything like that – I leave it absolutely open..I don't instruct the patient in any way, though, as I say, I used to for many years. [4 sec pause] uh, I think there's been a..you probably..I think there was an article in the..in JAPA, I think some time ago, some time about between 5 and 10 years ago on that issue of free association and a survey of what analysts actually said to patients. Though I can't recall what was in it other than it seemed to be a declining practice, according to the survey, I seem to remember.
SJ: And you understand why? I mean, it makes sense to you that it should be?
UK.R [para 19]: That it should be that way?
SJ: Yeah.
UK.R [para 21]: For me personally, yes. Yeah.
SJ: And for example, if a patient was struggling with what to do at the outset, how might you approach that?
UK.R [para 23]: Well, I'd eh, I'd try to, eh, detect in my sense of what was going on, what the underlying anxiety is, what defences might be in operation. The earlier..at the beginning of treatment for example, issues of shame are often very central, I mean it's implicit in Freud's original instructions, as it were, to patients to try to say whatever comes to mind, no matter how trivial or embarrassing or difficult it might be. So, it's..I might interpret that, something along the lines of 'it's obviously..it must be very difficult to talk about intimate thoughts to a complete stranger', you know, say something like that. Um, or I might pick up other anxieties like it might be an issue of conscious guilt about eh, you know, betraying parents or something or that sort, or the family. There might be issues, eh, around, eh, like I was saying earlier, about the fear of loss of control. There are all sorts of possibilities but you try to..what you would be saying to the patient would arise from what you try to understand of what the patient's anxiety and defences are..what the defences are and what they're protecting the patient against. You would speak to that, or try to speak to what you understood of that.
SJ: And, eh, I was wondering if I could ask you your views on the fundamental rule [smile in voice], I think you've talked about, you know, not wanting it to be an injunction because in some way that goes against the idea of freedom – would that apply to your views on the term 'fundamental rule'?
UK.R [para 25]: Oh yes! I think..I don't think that as a..I think I've..right from the beginning – I've never thought, even when I was, like I was saying earlier, when I was working in the way I was sort of brought up to do, um, I never thought of it as the fundamental rule, I always thought of it as a fundamental recommendation, which eh, [sounds quizzical] Freud himself actually..that was the way Freud himself worked, I think. You know, when you read about his actual..what he actually did with patients, um, rather than..it's all..rather than what's sort of been handed down over the years. It's somewhere..I think a distortion of Freud's..the spirit of Freud's writing, but also his actual clinical practice, that arose over the years in the early days of psychoanalysis, that it got called the fundamental rule, you know. Um, because even Freud himself even in the papers on technique, the title of the paper..one of the papers is 'Recommendations to Physicians' etcetera. So he used..he actually used the word 'recommendation', although he then went on in the text, as you probably know, to make it sound as if it was a rule, and it certainly got taken up that way. And I think hampered, actually, quite <u>seriously</u> the development of psychoanalysis, um, particularly in the States I think. It became a kind of ideology, in the way I was talking about earlier, you know, the sort of unconscious idealisation of a technique, which restricts development. But, yeah, from the beginning, I thought of it as a recommendation, rather than a fundamental rule, um, rather than as a rule. And I think..from what you read in..what people are writing at the moment, I think

increasingly widespread view, I suppose, from different psychoanalytic positions, um, but it always..I mean, just sort of one's own personal development, has always kind of felt to me to be, uh [hesitates] something fundamentally unanalytic about calling…about having a rule, you know [laughs]. But I could never..I mean when I was training in my early days of practice, I could never quite get my head around [laughs] why I objected to it, but I've got it more sorted out for myself now. But eh..well Freud himself wrote about this..again you probably know, in the famous letter to Ferenczi, um, where he talked about the obedient, um, you know, that the obedient will only hear it as a rule, um, and the rebellious ones will go off and do their own thing. But that his view was..what was the phrase he used, something like 'every analyst has to find a way of working which suits their own personal style', words to that effect. He..in spirit, I don't think he [hesitates] envisaged what would happen to his discoveries, I don't think eh, he would have been very happy with it becoming a 'fundamental rule' [laughs].

SJ: And so you too have found a way of handling free..eh, associative freedom to suit your personal style?

UK.R [para 27]: Well. Yes, I think I have, but..it does vary from patient to patient..because for example, patients can appear to be associating quite freely but in fact then they..you know, the way that they talk, they may be doing something else entirely, they may be using an apparent verbal freedom, or emotional, verbal and emotional freedom really in a defensive way, to avoid certain issues, I mean that's always a possibility. Um, they may be complying with what the analyst..with what they believe the analyst, you know, what the analyst's point of view is, perhaps particularly patients who are in the trans-..they may have read some of the things that you have written, you know, so they've got an idea of what you think [the analyst] is about, and so they..then they unconsciously comply, for whatever reason. So it does vary. With some patients, I may be much more <u>active</u> than with others, you know, I may be much more forceful, indeed at times, maybe even very confronting. My own analyst was very flexible in that respect, at times he could be <u>extremely</u> confronting, more so than any of my supervisors certainly when I was training. So I think it does vary, yes, as to how active or how [hesitates] I wouldn't say the opposite of active was passive, but how [hesitates] relatively inactive one is, and allowing the process to you know, with some patients you kind of just nudge things along, you know, particularly in the later stages of analysis, I mean that's something else that's different. You know, over the course of an analysis, um, the patient's use and they're capacity to associate..their develop-..I mean one of the things I think of as you know, developing in patients and how people change <u>is</u> in their capacity to be more free in their associations and so on. So that means that the analyst will, <u>I</u> will change, so I'll be kind of less active. I might draw attention to the difference between how they are now and how they used to be, you know, in terms of their capacity to be more free in that respect. So it changes over the course of an analysis, just as much as it may be different across patients.

SJ: What factors might change the patient's capacity to be free?

UK.R [para 29]: It's certainly the setting, the analytic setting, but then of course it's how the analyst and the patient together manage that setting, what they do with it. So it changes hopefully over time, as an outcome of, you know, as a collaboration between the patient and the analyst – they both play a part, but they play a different, although at a times an overlapping part in that, hopefully that change towards greater freedom, internal freedom.

SJ: And just to wrap up – I was wondering if I could ask just a couple of background questions. And I was wondering how you view analysis in terms of number of session a week?
UK.R [para 31]: Eh, that's a tricky..that's difficult question, I'm not sure I've really come to a satisfactory resolution for myself about that – it's an ongoing debate, you know, obviously within psychoanalysis but also internally, for oneself. I used to think five times a week you know, absolutely five times a week, and no compromises [laughs], but eh, if I still believe that, it's four or five times a week. A lot of my practice is now four times a week. I was warned by one of my early supervisors about the gradual erosion of psychoanalysis, he/she says once you start going down the road of four times a week, then you go down to three times a week, and before long you are not doing psychoanalysis, kind of slippery-slope argument. But I've been..probably the bulk of my practice has been four times a week for some..if you're seeing somebody once a week, you know, or twice a week. On the other hand, you can be seeing somebody five times a week and nothing's happening, you know, it isn't analysis, you're stuck in an impasse. So it's a whole tricky issue of how you're defining psychoanalysis, but I think my sense of it is, is that you should be aiming, really, to see somebody four times a week, because although an analytic process can take place at a lesser frequency, it's more likely to occur the more often you're seeing a patient, and probably the minimum is four times a week.
SJ: And sorry, that distinction was between an analytic process or a..?
UK.R [para 33]: The distinction is between an analytic process and something called psychoanalysis. You know sometimes people..there's a danger you define psychoanalysis in terms of frequency, because this is how it used to be defined in the old days. You know, it was five times a week and you would interpret the transference and the resistance, and if you do that, you're doing psychoanalysis, quote unquote, I mean that's Glover, and his famous survey in the 1930s, or was it early 40s, I can't remember when exactly. And I think that sort of is kind of is in the culture, you know, is past on from generation to generation, but I think we think about it differently now, certainly I would think about it as say the distinction between the external structure of frequency and so on, but more..I would think more of it as analytic process – is there an analytic process going on, and I mean we discuss this, obviously [chuckles] endlessly, but eh, it's something which is terribly difficult actually for many analysts, including myself, to actually articulate what you mean by an analytic process. You can see..you can hear a colleague's work and you can examine your own work and you can say sometimes it sounds like an analytic process and sometimes it doesn't, and then, you know, try to define that then becomes very difficult. But I would say, in answer to your question, you are aiming for an analytic process, whatever you mean by that, and it's more likely to occur the more frequently you see a patient, and four times a week, I think for me, works. Five times a week, yes, but it..you can [hesitates] you know, the balance tips, as it were, the centre of gravity of the work tips once you are seeing somebody four times a week. Um, three times a week, then again you may get an analytic process, but it's..there's something about the frequency of four times which seems to me to tip the balance, in terms of, it's just much more likely you'll be able to get a process going and maintain a process consistently, you know, over time.
SJ: Do you work in psychotherapy as well?
UK.R [para 35]: I used to because I worked half time in the health service and half time in private practice, but for the last eight years I've been entirely in private practice, and in that I've done very little psychotherapy, it's been mostly four times a week or five times a

week work with the occasional three times a week case, and the occasion twice a week case, but they were in the minority, as it were.
SJ: And you qualified over 20 years ago you said?
UK.R [para 37]: I qualified in 1984, so it's 20 years.
SJ: And I was wondering in terms of, briefly, influences – you've talked a bit about Freud, Balint – are there any other authors or thinkers that have particularly influenced your technique?
UK.R [para 39]: Yes, Klein, when I was starting out, particularly Klein, as well as the people I've mentioned. But latterly, all along I've been keen on Winnicott's work, but it's only in the last, I would say, five to ten years, that I think I've begun to understand what he was on about, and eh, I would say now that he's the biggest influence, influence in the sense of sort of, the ability to make theoretical sense about what I'm doing – what seems to me to be..what Freud called 'one's own personal style' I would now say that Winnicott is the biggest influence. Influence in that sense, you know, of finding that what you're doing, what you find works for you, is what he was, and what I think he was on about [laughs]. Those are the main influences I think, theoretically.
SJ: And before you did your training, what field were you in?
UK.R [para 41]: I was a clinical psychologist, [gives lengthy outline of training background and work history]. So that's the outline.
SJ: This has been so helpful, we've just covered so much territory, and I have so much to think about. [...] Thank you so much.
UK.R [para 41]: That's ok. How will I find out about the..will you let me know when something is published?
SJ: Certainly, I'll keep you informed. [..]

Appendix VI: Statistical equations used in study

1. t-test equation

$$t = \frac{M_1 - M_2}{S_{DM}}$$

$$S_{DM} = \sqrt{\left[\frac{(N_1 - 1)(s_1^2) + (N_2 - 1)(s_2^2)}{N_1 + N_2 - 2}\right]\left[\frac{1}{N_1} + \frac{1}{N_2}\right]}$$

$$s = \sqrt{\frac{\sum x^2}{N}}$$

$$df = N_1 + N_2 - 2$$

M = mean
SDM = Standard error of the difference between means
N = number of participants
s = Standard Deviation
df = degrees of freedom

2. Chi-square equation

$$\chi^2 = \sum \frac{(O-E)^2}{E}$$

O = observed outcome
E = expected outcome

3. Pearson's correlation coefficient

$$r = \frac{N\sum XY - (\sum X)(\sum Y)}{\sqrt{([N\sum X^2 - (\sum X)^2][N\sum Y^2 - (\sum Y)^2])}}$$

$$df = N - 2$$

X is the first set of data
Y is the second set of data
df = degrees of freedom
N = number of participants

(Source: Research Methods and Statistics Resources, 2004)

Appendix VII: Two paragraph summary sent to all participants

Summary - Microsoft Internet Explorer provided by BTopenworld - [Working Offline]

Address http://sherij.users.btopenworld.com/favorite1.htm

Summary

07/01/05

Home
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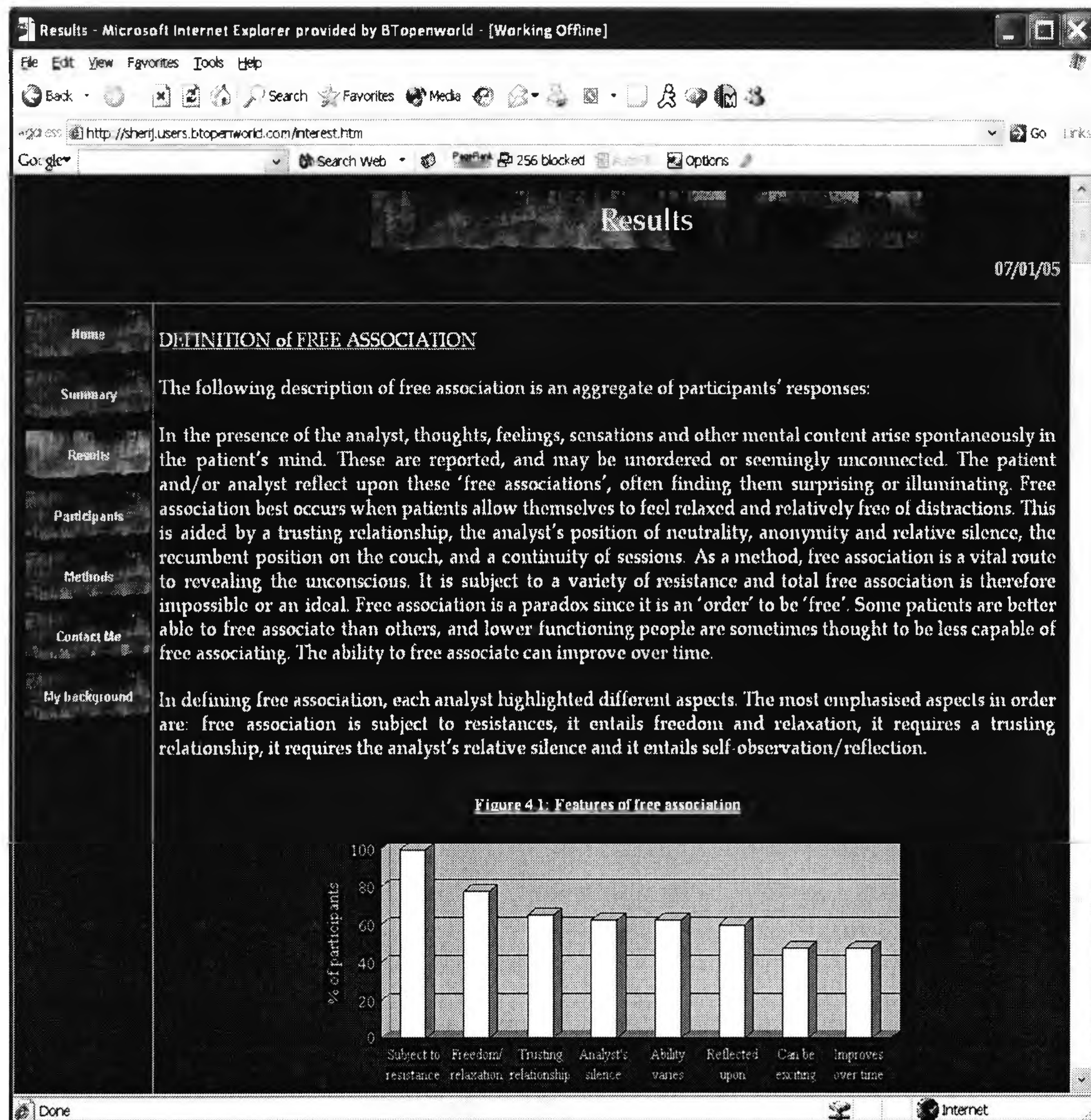
Contact Me
My background

Free association is defined from many angles but participants highlighted the fact that it entails relaxation and freedom and that it is subject to resistance. The bulk of participants feel that free association is important if not fundamental, and most think that its use lies in accessing the patient's unconscious. The most common forms of resistance mentioned by participants are silence, shifts topic and shifts in affect. A large number of participants listen not only to content, but also to the process of the associations including resistance and transference. Other important listening stances are free-floating attention and paying attention to counter-transference. A few more participants are against the idea of free association as a 'rule' than those who accept the idea; they prefer to view it as a suggestion or guideline. The majority of participants give a clear introduction in the consultation stage. The average introduction is mid-length, moderate in tone, may or may not include references to aspects such as thoughts, dreams or feelings, and will contain a comment about avoiding censorship. The fundamental rule might be considered as 'ongoing' in the respect that many participants repeat or indirectly refer to the rule through prompts, reassurance and analysis of resistance. Over half of participants facilitate or teach the patient to free associate, and the remainder give little or no assistance. Nearly all participants tailor their approach to the patient, but they are also guided by the wish to be clear, to offer a framework, to establish mutuality, to be containing and to avoid authoritarian tones. The influences on participants' approach are inter-linked and include personal analysts, supervisors, experiences with patients and extra-analytic experiences.

An additional finding is that despite many variations in presentation of free association and considerations, participants seem to adopt one of two approaches. Followers of approach A are more inclined to accept the idea of free association as a 'rule', give a lengthy or extensive introduction including several elaborations beyond 'say what comes to mind', use a firm tone, assist the patient to free associate, and are motivated to create a framework or to offer clarity. Followers of approach B tend to be against the notion of free association as a 'rule', give a brief introduction with few elaborations (or no introduction at all), use a gentle tone, avoid helping the patient, and are motivated to avoid an authoritarian impact or to create a spirit of mutuality. In total, approach A has fractionally more followers than approach B. The American participants tend to adopt more elements from approach A and the British participants tend to adopt more elements from approach B.

Appendix VIII: Website created for participants



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