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Exploring Silence in Psychoanalytic Theory and Clinical Work

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Submitted in partial requirement for the Doctorate in Psychotherapy (Child and Adolescent)

DECLARATION

I declare that the material submitted for examination is my own work. The ideas and findings of others have been referenced in accordance with the guidelines provided and any work by others has been acknowledged.

I understand that anti-plagiarism software may be used to check for appropriate use of referencing.

Candidate Number: BNZH3

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Signature:

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Impact Statement

Theoretical impact

Through reviewing the literature on silence in psychoanalytic psychotherapy this proposes that the various hypotheses articulated in psychoanalytic theory regarding the functions of silence could be seen to fall in three categories. It is noted in the review that the way silence has been written about in the theoretical literature has changed in line with developments in psychoanalytic theory and technique, which has included a broadening in the type of patient thought suitable for psychoanalytic work. While the multi-determined and dynamic nature of silence is accepted in contemporary theory, this thesis highlights the lack of explicit debate within the theoretical literature on the function of silence in psychoanalytic therapy across patients with different diagnosis. This thesis also identifies important differences in how silence appears in adolescent psychoanalytic psychotherapy compared to therapy with adults.

Research impact

This thesis adds to an existing body of work using the Pausing Inventory Categorisation System (PICS) for the first time to code silence in psychoanalytic psychotherapy with adolescents with depression. The findings from the research show that silence appears differently in this group, with more silence overall and a higher proportion of obstructive silences recorded. Adaptations of the PICS are suggested to make this tool more useful in both adolescent and psychoanalytic therapies.

Clinical impact

By reviewing the theoretical literature on silence in psychoanalytic psychotherapy, this thesis provides a framework for how silence can appear in therapy and explores the implications for clinical practice of different ways of conceptualizing silence. The research findings of this thesis highlight important difference in how silence appears in psychoanalytic therapy with adolescents (more silence overall and a greater proportion of obstructive silences), and adolescents negative views on silence in their therapy. This difference indicates a need for adaption of technique when working with this phenomenon, and that long silence may not be useful in adolescent therapy in the way they are considered to be in adult therapy.

Through tracking the authors journey in completing a clinical doctorate alongside a therapeutic training, the reflective commentary provides a case-study of how this experience can be enriching to both research and clinical skills and allows for qualified therapists joining the workforce who feel able to participate in the world of psychotherapy research.

Part 1: Literature Review

Title: Exploring Silence in Psychoanalytic Theory and Implications for Clinical Practice

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Abstract

Silence, as an element of the therapeutic encounter has been of interest in psychoanalytic theory from the early stages of its development. Theoretical views on the functions of silence have broadened considerably since the phenomenon was first examined, in line with developments of theory and technique. This literature review aims to explore silence in psychoanalytic theoretical literature and proposes three broad categories of silence in psychoanalytic psychotherapy, namely: silence as defence; silence as connection; and silence as withdrawal. From this review it appears that silences in psychoanalytic therapy may often be multidetermined in nature; it is suggested that there are limits to the extent to which these can, and possibly should, be understood. The implications of the theoretical understanding of silence for clinical practice are then explored, and the importance of each therapist finding their own way to incorporate silence into their work with each patient is acknowledged. Debate within the literature as well as research in this area are important to further understanding of this phenomenon.

Introduction

It can be said that most of those who come to psychoanalysis do so because they, or others, feel they need to talk. What is said, by both patient and analyst, is central to the psychoanalytic encounter. However, as theory and technique have developed and the range of patients seeking therapy has broadened, there has been a developing understanding and appreciation of what is happening between the words; what happens in silence.

The origins of psychoanalysis lie in Freud's work with the neurologist Charcot in the late 19th century. He demonstrated to Freud that paralysis could be neurotic, rather than organic, in origin, and could therefore be cured through hypnotic suggestion. This was Freud's first introduction to the idea that unconscious processes could have a profound effect on mental functioning. His thinking developed in collaboration with Breuer (Breuer & Freud, 1893) into the cathartic method, where they believed patients recalling the memory of when neurotic symptoms first appeared would lead to "immediate and permanent disappearance" (p.6). Hypnosis was used to aid such investigation. Psychoanalysis developed from the cathartic method in such a way that language replaced abreaction (Breuer & Freud, 1893), placing emphasis on the spoken word and repressed memories being brought to consciousness by the analyst. The technique advanced, and Freud dispensed with the abreactive function of words, favouring free association, and removing hypnosis from the method (Freud, 1914). Psychoanalysis was therefore no longer concerned with words as a method of discharge, and rested instead on free associations, the "interchange of words" (Freud, 1916, p.17).

The history of the method of psychoanalysis therefore places great emphasis on the patient's verbalisations. Silence, on the other hand, is considered something that therapists find difficult and uncomfortable, and research has indicated that they

feel unprepared by their trainings to work with it (Cook, 1964; Hill, Thompson & Ladany, 2003). The emergence of silence has therefore presented the therapist with a dilemma (Loomie, 1961). Should they respect the patient's need to be silent, or would this represent collusion? Should a therapist counter a patient's silence with their own active interpretation, or could a silence be something patient and therapist usefully experience together? Whilst some have considered the writing on the subject of silence to be limited (Sabbadini, 1992), references to it throughout theoretical and clinical work are abundant and a consideration of its functions are likely to be relevant to most therapies.

Sabbadini (1992) asserted that silence should be considered as a communication in its own right and as a "container of words" (p. 406). He proposed that different silences can have different meanings, while at the same time being "richly overdetermined" (p. 408). The extension of this idea would therefore be that none of the theoretical literature on silence can be seen to express ideas one can consider in isolation, and so different theoretical approaches to silence are not necessarily mutually exclusive. When considering silence in therapy, clinicians must be prepared to keep multiple possibilities in mind regarding understanding and technique and allow space for these to be revised as a therapy progresses.

This review explores theoretical and clinical understanding of silence in therapy. Literature for this review was compiled primarily through advanced database searches on 'PEP-web' and 'PsycINFO'. The keywords 'silent' and 'silence' were used to search journal article titles, and papers that were not psychoanalytic were excluded. Reviewing this literature led to the author exploring theoretical literature on development which considers the role of silence in mother infant interactions. This review does not aim to be exhaustive but includes key papers in this area.

This review will begin by considering therapeutic situations in which silence represents the patient's inability to speak, i.e. where there is unconscious resistance

to the observation of the fundamental rule of free association, and therefore silence functions as a defence. Next, silence as a useful medium through which to connect and communicate with the analyst and with the self will be discussed. The following section will examine literature about silences that occur when the patient has withdrawn from the therapy. The possible meanings of these silences will be explored in relation to history of early and severe emotional deprivation. The final section will consider the implications of the theoretical literature for clinical practice. The review will conclude by considering the multidetermined nature of silence and reflect on the challenge to the analyst in identifying the predominant mechanism underlying each silence, while also allowing for this understanding to evolve over time.

Silence as a Defence

When silence first arose in psychoanalysis it was considered to be a problem and a manifestation of a defence. Although thinking in this area has now diversified, contemporary psychoanalytic literature has shown it is still considered the most common reason for silence within an analytic session (Gale & Sanchez, 2005). Anna O described psychoanalysis as “the talking cure” (Freud & Breuer 1893, p.30) and it was considered that, when silent, the patient disobeyed the analytic rule to speak freely, because what was in their mind was something they were unable to say. In 1912, Freud first wrote about silences within the therapeutic encounter as related to the transference. He proposed that silence reflects a failure of free association and thought that “the stoppage can invariably be removed by an assurance” (p. 101). Freud hypothesised, (a hypothesis also supported by Ferenczi, 1911), that a patient stopped themselves from speaking so as not to divulge the sexual wishes towards their analyst that had emerged in the transference relationship. In terms of theory development, Freud had at the time articulated the topographical model of the mind. In this model, he suggested that there exist three distinct internal systems: conscious thought, as ideas we currently have in our mind; the preconscious, which was ideas that can be retrieved from memory with relatively little effort; and the unconscious, where primitive impulses and desires are kept at bay through repression, mediated by the preconscious. Resistance, such as silence, to analytic work was seen to be a function of the conscious and preconscious, and it was seen as a purposeful act. It was therefore considered that the patient could readily be made to understand that they were resisting the work of analysis and thus resume speech.

This view later changed when Freud developed the structural model of the mind (1923), and the transformative idea that a portion of the ego, in which resistance was located, could be unconscious. This called for a more dynamic view of resistance and opened up the question of silences in therapy to be conceptualised

in an entirely different way. Working with a silence no longer meant trying to undo resistances to drive activity, but rather to explore the necessity of the resistance. Silences could now be a source of insight into the patient's internal world (Arlow, 1961), and were therefore of great interest to the analyst and a fertile subject for psychoanalytic study. This view of silence in therapy as unconscious resistance to the work of analysis was accepted and developed by many in the psychoanalytic community.

Fliess (1949) further developed Freud's ideas and proposed that the function of silence was to maintain the repression of pre-gential impulses. He put forward the hypothesis that bodily erogeneity was displaced onto verbalisation, and so failures and lapses in speech during an analytic session could be themselves analysed. He suggested that how silences began, the interference they cause, the behaviours that accompanied them, and their termination must all be observed by the analyst in order for the silence to be understood. Within this framework three types of silence were defined: urethral-erotic; anal-erotic; and oral-erotic. In these categories, the type of silence is thought to emulate closure of the related orifice.

Urethral-erotic silences are described by Fliess (1949) as the more 'normal' kind and can be conceptualised as a kind of 'forgetting' of the analytic rule to speak. There is no visible conflict, and the patient can readily resume verbalisations although, when this occurs, there is often a notable change of subject. Such silences may represent resistance to certain material, but not in a way that links to the transference relationship. These silences were seen as the displacement of the prevention of urethral-erotic instinctual discharge, where stopping words being spoken imitates the closure of this sphincter.

Anal-erotic silences were thought to appear more inhibited with the patient may appearing tense or in distress. Fliess (1949) described this as a more regressed form of silence than urethral and suggested that the displacement of the excretory

process upon speech meant a word is treated like a solid and that through silence the patient resists emitting his conflictual feelings. Ferenczi (1916) had earlier written about silence related to his work with stutterers, and likened silence to anal retention. He agreed with Fliess (1949) in so far as viewing such silence as retentive but suggested that this may be favoured by a patient wishing to control the analyst or the analysis, and therefore be pleasurable. Silence considered within this framework was thought to be linked to power, and words again treated like solids and precious possessions. Fenichel (1928) agreed with this view and likened the ambivalence in the patient who comes to analysis to talk but remains silent to the retention of faeces, which can be both a defence against loss and pleasurable autoerotic activity. Reik (1924) thought that silence in anally fixated patients might be motivated by the unconscious fear of losing something, and that words once spoken could be viewed as lost to the patient and as possessions of the analyst. When reviewing the role of the id in silence, Levy (1958) proposed it emerges in “anal obstinacy” (p.51) as in the infantile transference, or as an aggressive act, again related to infantile struggles. Although there are slight differences in these conceptualisations, there seems to be broad agreement that anal silences denote words being imbued with power and the patient may therefore both fear their loss and enjoy holding on to them.

Oral-erotic silences are distinct in that the silence is not an interruption of speech but rather its temporary replacement. The patient is mute with no signs of conflict, and the termination appears spontaneously. Fliess (1949) suggested that such a silence is even more regressive, and that the patient has become an infant only capable of using its oral apparatus to suck and ingest. The patient can then experience their wish for merger or fusion with the analyst in the transference and therefore find this kind of silent state gratifying. Others (Fenichel, 1928; Reich, 1928) saw such silences as defending against oral wishes and so proposed that they be countered by the analyst’s own silence, a view which provoked much debate within

psychoanalytic circles. Abraham (1925) also linked speech to oral eroticism and, in a similar vein to others who wrote about anally fixated patients, stated that in this regressed state the patient views talking as giving to the analyst and so their silence is withholding and defensive. Silences related to oral conflicts have therefore been seen both as defences against oral wishes, and, quite contrarily, as highly regressed states in which connection may be possible.

Following from the work of Fliess (1949), Sabbadini (1992) suggested the existence of a phallic silence. He suggested that in this case the patient experiences words as physical extensions of the self and to speak is experienced as penetrating the analyst with words. This leads to castration anxiety, and the patient may become silent, and in a sense phalically impotent, in order to protect themselves and the analyst from their dangerous sexual impulses.

In all the formulations described above, silence is considered within the classical view where conflict exists between libidinal aspects of the psyche. Silence and accompanying behaviours are then viewed as markers of defence or resistance. Kohut (1957) recognised the secondary gains for the patient in resisting treatment, where expressions of both the positive and negative transference are fought off by the ego, and there exists a compulsion to repeat (Freud, 1914). The superego represents the ethical component of an individual's personality and may be more, or less, useful depending on the value system it has internalised. It may block verbalisations in a psychotherapy if to speak would be to violate its moral code. It may also be the case that defences, deployed by the ego that may lead to silence, can be further maintained by the action of the superego (Coltart, 1991). This action could take the form of the re-cathection of a parental prohibition to speak (Levy, 1958), an angry silence due to identification with the aggressor (Kurtz, 1984), or silence due to shame at the gap between ego ideal and reality (Coltart, 1991; Loomie, 1961). Glover (1927) suggested that such resistance to speech would likely

arise in the early stages of an analysis, when the ego may feel highly accountable to the superego and in such a way do its bidding.

The idea in early psychoanalytic theory, as outlined by Arlow (1961) was that silence represented repression of cathexis that needed to be discharged through verbalisation. Clinical observation and theoretical developments advanced these ideas and it was later understood that resistance could still be present when the patient was talking, and that most resistance was unconscious. It was further discovered that resistance could serve to satisfy id impulses and so silence was no longer viewed as synonymous with defence. Sabbadini (1992) notes that while there is broad agreement in psychoanalysis that some silences function as defence or resistance, there is disagreement as to what other functions they may serve. It was only later in the history of psychoanalytic ideas that silence in the patient was instead associated with connection, which can take several forms: connection with the analyst, connection with the self, or connection with a particular emotion or experience. These ideas are explored in the next section of the review.

Silence as Connection

Conceptualising silence within psychoanalysis as something other than resistance was first explored by Reik (1924) who criticised the classical view that silence on the part of the patient was a defence against an impulse and that the analyst must fight against this. He later wrote that he felt it was wrong to “attribute the effect of analysis entirely to the word” (Reik, 1968, p.173), and instead claimed that “psychoanalysis shows the power of the word, and the power of silence” (Reik, 1968, p.173). In his classic paper on silence Reik (1968) explored the technical use of the analyst's silence in allowing the transference to develop and suggested that while this was first be felt as benign and thoughtful, the patient would be driven to frustration, thus eliciting a negative transference and driving the patient to “a deeper realm than he had originally intended” (Reik, 1968, p.177). Glover (1927) was also critical of the concept of silence merely representing resistance and suggested alternative ways analysts could respond to a patient's silence other than by opposing it. He proposed that the analyst's understanding of the feelings the patient's silence aroused in them (countertransference) were of prime importance. Furthermore, both Glover and Reik touched on how silences can be experienced as moments of connection in the therapy, as they spoke of it being a response to an interpretation that has been felt by the patient to be correct. Neither explored these thoughts further in their writings, but silence as a way to connect with the analyst or with the patient’s own self has continued to be elaborated on in psychoanalytic literature.

Silence has been repeatedly linked to a wish in the patient for a state of fusion with the therapist, both in a recreation of a preverbal mother-infant state and as an invitation to share in an earlier experience. Fliess (1949) suggested that oral silences are regressed states in which the patient is unable to speak and is seeking merger with the analyst through the transference relationship, akin to the early mother-infant relationship. Blos (1972) also described work with a patient in which

silence represented a recreation of a longed-for union with mother, and therefore an emotional ‘refueling’. Words, in this case, would represent separateness from the analyst, as they had previously represented separateness from the mother, and could be experienced as intrusive. However, there have been proposed ways of working with silence that allow for such separation to slowly take place. Stern (1985) wrote about ‘emerging moments’ in therapy, which represented experiences of being with another that gradually become internalised. Similarly, Ferber (2004) proposed that during silent, mutually understood moments in therapy, a similar process can take place. This suggests that if in silence the patient and analyst can exist in a state of mutual understanding, then internalisation can take place allowing for the patient to emerge from silence having profited.

As we are all born without language, consideration of theories of language development can enrich psychoanalytic understanding of what a patient may then be wishing to connect to or recreate in a silent moment. Loewald (1970) considered language acquisition as a form of sensory experience; an integrative process arising out of the mother-infant relationship that binds feelings, sensation, aspects of the self, and aspects of the other as a seamless unit. He suggested that silence was a form of language that most often developed secondary to verbal language, and that it could be used in a search of the original ‘primordial unity’ that exists between a mother and infant. For him silence could therefore be an attempt to connect to the earliest phase of the mother-infant relationship, and therefore represent a temporary regression. Serani (2000) agreed with this view and considered how silence may be used by patients as a way of recreating the safe quietness of this early relationship.

Another view, expressed by Mahler, Pine, & Bergman (1975) described language development as an achievement and as part of the process of separation from the mother. They called this the reapprochement phase and saw the toddler as gradually able to separate from mother depending on her continued availability. A

toddler who has had a ‘good enough’ early experience of mothering will be gradually able to spend periods of time away from her, if she is available for reunification. This allows the toddler to gradually internalise the supportive ego functions of the mother and create a ‘mother symbol’ that can be referred to at these moments. As the toddler gradually separates, language develops in the ‘transitional space’ between mother and infant (Winnicott,1958), and this developmental phase marks the advent of symbolisation, with language representing the lost mother. However, silences related to difficulty in the separation process could both symbolise the toddler’s struggle and be the place in which the mourning of the lost object is worked through (Arlow, 1961; Blos, 1972; Fliess, 1949; Sabbadini, 1992; Segal, 1957; Winnicott, 1958; Zeligs, 1960).

Silences can often be moments where the transference and countertransference are experienced most powerfully. Arlow (1961) suggested silences should be viewed as the patient’s attempt to connect and communicate with the analyst, rather than as purely defensive. He proposed that their power lies in their ambiguity, and that in some silent periods the patient may be inviting the analyst to share in their ‘fantasy-emotions’ and stimulate their countertransference. The analyst may be being invited by the patient, through the transference relationship, to share in a recollection, which Greenacre (1956) suggested may never have been verbalised, as the patient as a child may have been silent throughout the original experience. Through this mechanism, the patient may be using a silent state to both connect and communicate in a way that may not be possible through other means and induce an almost magical state of meeting between them and their analyst. Coltart (1991) described transference and countertransference as ‘the instruments par excellence’ (p.446) in work with silent patients, and that in the silent patient we can encounter transference in its purest form. This view of silence as something existing within the analytic encounter, links to Slochower’s (1999) thoughts on ‘being’ in analysis, and

opposed to ‘doing’ in analysis, where ‘being’ refers to what is happening within the patient and within the patient-analyst dyad. Silence in this framework could be thought of as a state that allows space for such interiorly derived phenomena as the transference/countertransference to flourish and be understood within the analysis.

While silence may allow the patient and the analyst to connect through the transference/countertransference relationship, it may also be the case that silence can allow the patient a sense of connection with themselves. Reis (2012) discussed quieting as an active verb and distinguishes between a patient being “calmed to quietness” (p. 25) (as one would an infant) as opposed to being silenced, which is considered undesirable. While verbal dialogue in analysis is at times necessary, the analyst supporting, and crucially allowing, the patient to find quietness is thought to be an intervention that allows them to find an internal place of rest and discovery. He suggested that silence in psychoanalysis refers to an aspect of technique, whereas quietness can be thought of as a more expansive term, associated with the dynamic and live relationship between the analyst and patient. Such terminology is also used in clinical papers on psychotherapeutic work with children to describe long periods of silence when the child may engage in play (Lanyado, 2008; Katz, 2000). Lanyado explained her decision to use the word ‘quietness’ being due to the perceived harshness of the word silence and its associations to defence, whereas the literal silence she experienced with her patient felt more healing and connected (personal communication, June, 21, 2017). While an analyst may choose not to respond verbally to, for example, a painful disclosure, an empathetic silence may communicate more than words ever could (Lief, 1962). Slochower (1999) suggested that in such moments, where the analyst can allow a silence or quietness to occur, the patient is allowed their own ‘interior experience’ rather than having shape given to it by the analyst’s verbalisations. This idea is similar in nature to Winnicott’s (1958) paper ‘The Capacity to be Alone’ where he outlined his thoughts on children

developing the capacity to be alone in the presence of another as an important aspect of normal development. He wrote about silence on the part of the patient as an achievement and conceptualised this capacity as emerging out of the early mother child, two-person, relationship, where the infant can experience being alone in the presence of a reliable other. This ‘good object’ is then internalised, and the individual feels it to be reliably available, allowing them to experience states of ‘aloneness’ in which they can feel contented. Winnicott referred to the situation he describes between mother and child as a state of ‘ego-relatedness’, where both may be ‘alone’ but the presence of the other remains important. He suggested that it is in this position that the infant is able to discover themselves, develop their capacity for spontaneity, and have so-called ‘real’ experiences deriving from id impulses, and not built around external stimuli.

In allowing space for silence in analysis as an active form of communication, some analysts have also considered that silence on the part of patients may at times convey a legitimate wish not to communicate. Winnicott (1963a) in his paper ‘Communicating and Not Communicating leading to a Study of Certain Opposites’ made a case for the importance for some patients not to communicate. He explored this idea from the view of early development, where an infant develops a split, one part of it communicating with objectively perceived objects and the other part with subjective objects. The part that communicates with objective objects is associated with the ‘false self’ and so verbal communication in the analytic situation can become linked with false or compliant object relating. Silent communication with subjective objects must therefore be allowed to periodically take over and restore balance. In this paradigm, non-communication is associated with feeling real and indicates that the patient is in touch with their core ‘true’ self. These communications are viewed as coming from the unconscious and are part of a so-called ‘private self’. This is proposed to be a permanently non-communicating, isolated core that exists in health,

and is felt to be an entirely ‘real’ part of the patient. Trauma can lead to defences being built around this core self and psychoanalysis can therefore be experienced as a threat to its survival. Winnicott advises against the analyst trying to influence this process, and states that the core self should never be communicated with or influenced by external reality. The analyst should instead wait and allow the patient to discover their internal self. This links to Brazelton’s work (Brazelton & Cramer, 1990) with mothers and infants, which suggests that when the infant turns away from the mother he does so to learn about himself. Silence on the part of the analyst lets the patient feel they have the ‘right’ to silence and internal experience and allows for them to choose when to speak again.

Silence in the analytic setting can therefore be thought about in relation to a recreation of early mother-infant relations; as a medium by which to induce and experience the transference/countertransference; and as a state in which the patient can connect with themselves. Silence in these situations can be viewed as powerful means of communication, and also a potentially fruitful experience in its own right. Defensive silences (as discussed in the previous section), can also be useful when they can be understood by the analyst and responded to appropriately. However, the following section of this review will examine a form of silence, namely withdrawal, that is not seen as communicative (other than in the most basic form) or beneficial for the analytic encounter.

Silence as Withdrawal

While silences that represent defence have been discussed above, silences emanating from the defence of withdrawal have been considered sufficiently distinct to be explored separately. This kind of silence is considered a primitive form of defence that does not arise from conflict. Unlike the silences explored in the previous section, it does not function to allow the patient to connect with either their analyst or themselves and is essentially a psychic removal from the situation of the therapy. Such silences are more likely to occur in patients who have suffered severe emotional neglect and trauma in their early development.

Winnicott wrote extensively on regression, dissociation, and withdrawal within psychoanalysis (1949a, 1949b, 1954a, 1954b), likening them to a psychotic state. He believed that such positions had their genesis in the early mother infant relationship (1945a), and that psychosis was a disease caused by an environmental deficiency during this early period (1945b). Winnicott wrote about infants as being born in an unintegrated state, this being distinct from later disintegration and not associated with distress. He posited that the infant is wholly dependent on the environment (in most cases the mother) for survival, and it is through the holding that the environment provides that integration is gradually achieved. The mother can facilitate this process by actively adapting to her infant's needs, but as time progresses, there can be graduated failures in this care, which the infant is able to bear through its own mental activity, e.g. through hallucinating the wished-for breast until it is actually offered. A lack of this environmental holding, or 'good enough' mothering is experienced by the infant as an impingement and, if repeated, integration may fail to occur. Defences, such as false self, will be employed by the ego and some patients may manage to be psychotic in a highly organised manner.

Winnicott (unlike, he suggests, Freud) worked with patients whom he knew had not been adequately cared for in infancy and so had not achieved integration as

he thought of it. They suffered as adults with psychotic illnesses which he viewed not in terms of a breakdown but rather as the ego's attempt at a defensive organisation against the 'primitive agonies' suffered as infants (1974). In therapy, these patients could present as silent when dissociated, withdrawn, or regressed. Dissociation within an analytic encounter represents a disconnection and in a patient without primary integration would act as a defence (1949a). Withdrawal is instead a detachment from the patient's connection to external reality and is described by Winnicott (1954a) as "like a brief sleep" (p. 255). He felt these states were not of benefit to the work of analysis and that the patient emerged unchanged. He observed how in one case the patient, when withdrawn, appeared to be in a state of 'holding' themselves, and felt that if the analyst is able to make a timely interpretation, the withdrawal may become a more useful regression. Regression, Winnicott believed, was necessary in those patients with deficits in early emotional relationships, where integration had not been achieved (1954b). He likened aspects of the analytic situation to the care provided by the ordinary, 'good enough' mother (1954b), and felt that this allowed sufficient 'holding' for the patient to regress to an unintegrated state, allowing for the maturational process of integration to occur laterally. As the period in which the fault in development occurs is preverbal, we can suppose that silence may be an important feature of this regressed state, although Winnicott does not state this. While the dissociated silences may be considered defensive and the regressive silences communicative, it is the withdrawn silences that require special attention. Described by Winnicott as a detachment from reality, they are considered to be of no profit (1954b). These states represent the failure of psychotic defence mechanisms and could be considered purely somatic moments in which no self and no other is felt to exist.

Bowlby's work on attachment (1969; 1973; 1980; 1988) was important in demonstrating that good mental health is intimately linked to consistent and reliable

attachment relationships in childhood (Kahr, 2012). While a complete review of the contribution of attachment theory to understanding of the patient therapist relationship and interactions is beyond the scope of this paper, what is important to identify is Bowlby's assertion that environmental failure can lead to the development of disorganised or avoidant attachment patterns. In his theory of 'segregated systems' (1980, 1988) he suggested that unresolved traumatic material can be blocked from conscious awareness through the strongest form of repression as a way for an individual to achieve some degree of integration. Within this framework, integration is seen to exist on a spectrum (Reisz, Duschinsky, & Siegel, 2018), with 'disorganising' material blocked from consciousness to preserve psychic homeostasis. 'Segregated processes' create barriers to communication, and although Bowlby did not discuss how such things might manifest in therapy, there are links to Greenacre's (1956) idea of silence accompanying traumatic recollections where the child has been forced to be silent, and so this being the only way initially that the experience can be conveyed (Greenson, 1961). A patient with such mental representational structures may in the therapy respond to them being brought to conscious awareness by withdrawing and becoming silent as a means of protecting themselves, and, as is suggested by Howell (2014), may be in identification with a silencing aggressor. Indeed, in the 'Adult Attachment Projective Picture System' (a free response task used in research to identify adult attachment classification), the indications of a segregated system being present are dissociation or total shut down (George & West, 2012). Brown (2017) emphasises the importance of helping such patients to achieve security through a therapeutic relationship and construct a narrative of their experiences. However, as discussed by Frank (1995) such patients are often the most difficult to listen to due to the mixed and confusing way they communicate, including silent periods.

Withdrawal is therefore considered like a psychic removal from the analytic situation and is observed in patients who have suffered severe emotional deprivation in early childhood. This type of silence may be observable in the most disturbed of our patients, as well as those with unresolved traumatic loss. While the previous three sections have considered the predominant mechanism that may exist within a silence, they have examined silence from the view of it stemming from the patient and then being received by the analyst. The next section will examine how silence in the patient is experienced by the analyst, how they may be driven to or choose to respond to it, and how it can therefore be viewed from a more interactional perspective.

Implications for Clinical Practice

While silence in the analytic encounter can be considered to emanate from the patient, and its communicative function understood, it can also be considered from a more interactional point of view with the analyst as an active participant in its creation, continuation, and termination. Freud's (1923) introduction of the structural model of the mind, along with appreciation for transference/countertransference phenomena, allowed for silence to be thought about as a more dynamic aspect of the therapeutic relationship. This shift in thinking allowed space for silence to become an aspect of the 'practice' of psychoanalysis rather than as a technical parameter (Reis, 2012), and this distinction has important implications for how the analyst positions themselves in relation to it. This section explores the emergence of silence between patient and analyst and the role of the analyst in silence. It will also include some thoughts on non-verbal, sensory, and bodily communications in the analytic setting, and how adaptation in modes of communication may be a particularly important with some patients.

In their countertransference, therapists have reported experiencing strong negative feelings towards silent patients, and this can lead to feelings of confusion, shame and ineptitude in how to work with this dimension of a patient's presentation (Hill, Thompson, & Ladany, 2003). The literature has described the therapist's experience of silence as feeling unwelcome (Coltart, 1991), controlling and provocative (Lief, 1962), as a refusal or rejection (Winnicott, 1963b), provoking hurt and anger (Katz, 2000) and as anxiety provoking and incapacitating (Vaccaro, 2008). These difficult feelings can lead to the analyst 'acting out', i.e. being driven unconsciously to behave in a manner that is in opposition to the patient's needs. This can involve making premature, rushed interpretations (Kahn, 1974; Katz, 2000; Sabbadini, 1992), opposing the patient's silence with their own retaliatory silence (Lief, 1962), or silence being used by the therapist as a way to gain control of the

analysis or the patient (Katz, 2000). The therapist can also be led to ‘act in’ and collude with the silent patient and join in silence when in fact activity may be more helpful (Lief, 1962), or begin verbalising the patient’s projections and talking for them in a way that may offer the analyst temporary relief but be of little help to the patient (Arlow, 1961). It therefore follows that therapists will differ in their capacity to allow for silence in their work with patients, and that the countertransference elicited may make this additionally challenging. However, the ability of a patient and analyst to allow for silence to be worked with in analysis may be a capacity that develops over time, and so missteps in the analyst’s response can be repaired. Coltart (1991) stressed that the analyst must adopt a benevolent and patient attitude in silence, and that difficult feelings in the countertransference must be withstood in the knowledge that they are temporary and can be survived creatively, yielding useful information.

As stated above, most explorations of silence in therapy warn against rushed or persecutory interpretations in the belief they lead to the strengthening of defences and therefore more silence (Arlow, 1961; Katz, 2000; Lief, 1962). There is however a place for interpretation in response to silence, and Coltart (1991) has extolled the virtues of the silent patient allowing the analyst the rare opportunity to formulate interpretations that are carefully thought through, economic in use of words, and cautiously timed. If the analyst can take advantage of this situation to its fullest extent they can give each word they speak the best chance of being effective in helping the patient to continue to communicate. Another perspective on interpretation is that it can be the occasion to cause a patient who is talking to become silent. As is explored in an earlier section, silences can be experienced by patients as moments of connection between the patient and analyst, and Reik (1968) and Glover (1927) both defined silence as the most convincing response to a correct interpretation. Arlow (1961) described how the analyst bringing to their patient’s attention their use of defence mechanisms such as denial, projection etc. will often be responded to by

silence. This can be seen as progress in the analysis if it represents an unconscious defence has been transformed into a conscious reluctance to talk.

Rather than using the patient's silence as an opportunity to carefully formulate interpretations, an analyst may choose to respond to a patient's silence with their own silence. While the analyst is in a state of silent listening as a patient is talking, their silence only becomes an 'intervention' once it is experienced by the patient as a stimulus (Lief, 1962). While the therapist may remain silent when they are in conflict about how best to respond to their patient and want to avoid getting something wrong, a silence is deliberate when the analyst chooses to be in silence to help the patient communicate through their own silence. However, Lief (1962) suggested that whether silence on the part of the analyst is deliberate or not, it is usually experienced by the patient as such. The therapist's silence will likely serve to stimulate the development of the transference relationship and the way this dimension of the therapy is interpreted or understood by the patient is crucial to the understanding of therapeutic communication (Knutson & Kristiansen, 2015). It may be that silence in the therapist is experienced by the patient as encouraging, and it helps them resume free associations (Lief, 1962), or it could be felt be persecutory, and induce feelings of guilt (Coltart, 1991). Despite the potential for the analyst's silence to be consciously chosen as the best means to help the patient communicate (Arlow, 1961), this may not be understood by the patient, and uncertainties arising from this can be thought about in the course of the therapy.

Periods of silence in therapy may also allow for the patient to experience a state of ego-relatedness to the analyst that allows for growth and development. Lanyado (2008) described in clinical work with a child patient how through attentive and highly attuned relation to the patient she went some way to recreate a mother in a state of 'primary maternal preoccupation' (Winnicott, 1956), creating, in silence, the illusion that reality corresponds to the patient's/infant's wish (Winnicott, 1971). The

therapy can then move to allow for the creation of ‘transitional phenomena’, which allow the patient to enter in to the ‘transitional space’ of the therapy room and begin to play. She later described being able to sit quietly while the patient plays, which she understood in terms of Winnicott’s (1958) paper ‘The Capacity to be Alone’ and described feeling able to be very present for her patient. Silence between the patient and therapist was then able to encompass the work of mourning, and Lanyado described existing in a meditative state for the patient, connected to the moment and experiencing the emotions communicated in ‘real’ way. Katz (2000) discussed in her work with a child patient and how she would talk silently to him. Although he could not hear what she was ‘saying’, she felt he could discern from her expression that she cared for him, and so helped develop trust in the therapeutic relationship. It would feel accurate in both these cases to consider these silences as live states, where communication occurs in the absence of words. This thinking is in line with Ogden’s (1996) statement that to privilege one form of communication over another is ‘unanalytic’, and that silence is a form of communication that our technique must allow space for (Winnicott, 1963a).

There are categories of patient described in the literature for whom verbal language is found to be an ineffective means, at least initially, by which to communicate in the analytic setting. Such patients may often have diagnose such as schizophrenia, and there is an argument to suggest that the analyst begin by establishing reliable nonverbal communication before attempting verbal communication (Blumenson, 1993). This is due in part to such patients often having trouble saying what they mean, and privileging communication through unconventional means such as body language. Schizophrenic patients are thought to be in an ‘embryonic psychic state’, and the analyst must attune to their rhythms, as a mother would her infant, to allow them to resume the process of growth (Vaccaro, 2008). Spotnitz (2004) advocated for the analyst’s bodily mirroring of such patients to

create a ‘twin image’ that can allow the patient to gradually trust the analyst and feel that they will not be injured by what the analyst communicates. Vaccaro (2008) explored the idea of thinking about the bodies of such patients as representing a leaking out of unconscious communications. The analyst’s mirroring of body movements functions to counter the patient’s expectation that they will act against them and ultimately gives the message that the therapist is in alliance with them. The patient’s return mirroring of the analyst can be seen to indicate that they are beginning to trust the analyst and allowing themselves to take something in. Vaccaro described a case where attention to the rhythms of the patient’s body resulted in a fuller expression of the patient’s internal state and allowed the therapist to become part of her experience.

The lack of dogma around how silence can be understood in the analytic situation links to Sabbadini’s (1992) assertion that silence exists as a ‘container of words’ (p. 406), and so understanding of it can be as varied and nuanced as verbal communications. Contemporary theory (Coltart, 1991; Knutson & Kristiansen, 2015; Sabbadini, 1992) has encouraged the use of the transference/countertransference relationship, while also acknowledging that silence may evoke difficult feelings for the therapist. This makes it hard to draw any conclusions on silence as a phenomenon in psychoanalysis and may have led to it being neglected as a subject in research and teaching. However, Coltart (1991) has suggested that analysts may grow in confidence in their work with silence over time, and the fact that the analyst may have to experience their countertransference so acutely in order to understand and help their patient may link to why she describes work with silent patients as some of the most rewarding she has engaged in.

It may be that each analyst develops over the course of their career a way to work with, allow, and incorporate silence in to their ‘practice’ (Reis, 2012) that is reflective of aspects of their individuality and analytic ‘style’. Silence in the analytic

encounter can be understood as reflective of both what the patient and analyst bring and expanding our view of silence to allow for it to be co-created allows for a more dynamic and interpersonal view of this phenomenon. It links with Sabbadini's (1992) assertion that silences in analysis are 'richly overdetermined' (p. 408), and Winnicott's (1963a) theory that we must also allow space in our technique for the patient to choose at times to not communicate. When faced with silence the analyst may therefore need to accept that they are asked to work hard, experiencing and processing difficult feelings in their countertransference, only ever understanding some of what is being communicated, and possibly needing to accept the patient's need to not communicate. This represents a challenge to an analyst's sense of omnipotence but may also allow for a significant degree of introspection and creativity in technique, allowing for the patient and analyst to find their own unique way of 'being' together (Slochower, 1999).

Conclusion

This review provides three broad categories in which silence in therapy has been conceptualised within psychoanalytic theory: silence as defence; silence as connection; and silence as withdrawal. This is followed by a section exploring the implications of the theory for clinical practice. While use of the categorisations described above in clinical work may be helpful for understanding the presence of silence in sessions and how it evolves over time, it may be at the same time simplistic to ever consider a silence as falling into only one of these groupings. Perhaps when we accept silences as 'overdetermined' (Sabbadini, 1992, p.408) it may be more useful to instead label the predominant mechanism in a given silence, thus allowing for other elements to exist within it. This approach would hope to allow for greater reflection on silence as a 'container of words' (Sabbadini, 1992, p.406), and an intrinsic part of the 'practice' of psychoanalysis rather than a technical problem (Reis, 2012).

While the literature on silence conceptualises it in different ways, it is evident that understanding of this aspect of the therapeutic situation has expanded and developed over time, alongside major theoretical developments in psychoanalytic thinking. Additionally, the 'type' of patient seen in psychoanalysis has widened from the purely neurotic to those who have experienced severe emotional neglect and trauma. This has influenced theoretical understanding and technique, as the way silence manifests is likely to also have changed. This broadening across different dimensions may go some way to account for the fact that, although there are many ways to understand silence in psychoanalytic work, there is a lack of explicit debate within psychoanalytic theory as to how to understand and work with it. While there are indications in the theoretical literature that certain 'types' of silence may be more likely to appear at certain stages of therapy, or with patients with particular difficulties, there is an absence of any attempt to overtly state these differences. Given that

understanding of the prominent mechanism underlying the use of silence in therapy has implications for clinical practice, as discussed in the fourth section of this review, this absence is significant.

Understanding of silence in psychoanalysis is undoubtedly limited by the lack of research in this area and has led to this review including primarily theoretical literature. The lack of opportunity to draw on different forms of material in understanding this phenomenon reflects the situation therapists find themselves in when faced with silence in their patients and highlights a collective ‘silence’ in the profession on how to further understand this form of communication. While clinical papers are of use in elucidating how silence manifests, is understood and responded to, and then may change and evolve over time (Ferber, 2004; Lanyado, 2008; Katz, 2000), by representing single case studies they offer little in terms of generalisability. Research that examines the manifestation and evolution of silence in psychoanalytic psychotherapy is needed alongside clarification of theory in order to progress understanding of this phenomenon.

References

Abraham, K. (1925). The Influence of Oral Erotism on Character-Formation. *International Journal of Psycho-Analysis*, *6*, 247–258.

Arlow, J. A. (1961). Silence and the theory of technique. *Journal of the American Psychoanalytic Association*, *9*(1), 44–55.

Blos, P. (1972). Silence: A clinical exploration. *Psychoanalytic Quarterly*, *41*(3), 348–363.

Blumenson, S. R. (1993). The mirror of silence: a method of treating a pre- verbal schizophrenic patient. *Modern Psychoanalysis*. *18*(2)*,* 179-189.

Bowlby, J. (1969). *Attachment and loss. Vol. I: Attachment*. London: Penguin Books.

Bowlby, J. (1973). *Attachment and loss. Vol. II. Separation: anxiety and anger.* London: Penguin Books.

Bowlby J. (1980). *Loss*. London: Routledge Press.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. London: Routledge.

Brazelton, T. B. & Cramer, B. G. (1990). *The earliest Relationship.* New York: Addison-Wesley.

Breuer, J., & Freud, S. (1895/1995), Studies on Hysteria. In. Strachey (Ed.) *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (pp. 1–335). London: Hogarth Press.

Brown, K. (2017). Psychosis from an Attachment Perspective. *British Journal of Psychotherapy*, *33*(3), 365–387.

Coltart, N. (1991). The Silent Patient. *PsychoanalyticDialogs*, *1*, 439-453.

Cook, J. J. (1964). Silence in psychotherapy. *Journal of Counseling Psychology*, *11*(1), 42–46.

Elson, M. (2001). Silence, its use and abuse: a view from self psychology. *Clinical Social Work Journal*. *29*(4), 351-360.

Fenichel, O. (1928). *On Isolation. Collected Papers I*. London: Routledge.

Ferber, S. G. (2004). Some developmental facets of silence: A case study of a struggle to have a proximity figure. *British Journal of Psychotherapy*. *20*(3), 315-332.

Ferenczi, S. (1911). On Obscene Words. In: Jones E. (Ed.), *First Contributions to Psychoanalysis* (pp. 132-153). New York: Brunner/Mazel.

Ferenczi, S. (1916). Silence is Golden. InJ. Rickman (Ed.), *Further Contributions to the Theory and Technique of Psycho-Analysis* (pp. 250-251). London: Karnac.

Fliess, R. (1949). Silence and Verbalization: A Supplement to the Theory of the Analytic Rule. *International Journal of Psycho-Analysis*, *30*, 21–30.

Frank, A. W. (1995). *The Wounded Storyteller. Body, Illness, and Ethics.* Chicago: University of Chicago Press.

Freud, S. (1912). The Dynamics of Transference. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XII (1911-1913): The Case of Schreber, Papers on Technique and Other Works* (pp. 97-108). London: The Hogarth Press and The Institute of Psycho-analysis.

Freud, S. (1914). Remembering, Repeating and Working-Through (Further Recommendations on the Technique of Psycho-Analysis II). In J. Strachey (Ed.),*The Standard Edition of the Complete Psychological Works of Sigmund*

Freud, Volume XII (1911-1913): The Case of Schreber, Papers on Technique and Other Works (pp. 145-156). London: The Hogarth Press and The Institute of Psycho-analysis.

Freud, S. (1916). Introductory Lectures on Psycho-Analysis, Part 1, Parapraxes, Lecture 1, Introduction. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XV (1915-1916): Introductory Lectures on PsychoAnalysis (Parts I and II)* (pp.15-24). London: The Hogarth Press and The Institute of Psycho-analysis.

Freud, S. (1923). The Ego and the Id. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIX (1923-1925): The Ego and the Id and Other Works* (pp. 19-27). London: The Hogarth Press and The Institute of Psycho-analysis.

Gale, J., & Sanchez, B. (2005). The meaning and function of silence in psychotherapy with particular reference to a therapeutic community treatment programme. *Psychoanalytic Psychotherapy*, *19*(3), 205–220.

George, C., & West, M. L. (2012). *The Adult Attachment Projective Picture System, Attachment Theory and Assessment in Adults*. London: The Guildford Press.

Glover, E. (1927). Lecture on Technique in Psycho-Analysis. *International Journal of Psycho-Analysis*, *8*, 486- 520.

Greenacre, P. (1956). Re-Evaluation of the Process of Working Through. *International Journal of Psycho-Analysis*, *37*, 439–444.

Greenson, R. R. (1961). On the silence and sounds of the analytic hour. *Journal of the American Psychoanalytic Association*, *9*(1), 79–84.

Hill, C. E., Thompson, B. J., &Ladany, N. (2003). Therapist use of silence in therapy: A survey. *Journal of Clinical Psychology*, *59*(4), 513–524.

Howell, E. F. (2014). Ferenczi's concept of identification with the aggressor. *American Journal of Psychoanalysis*, *74*(1), 48–59.

Khan, M. (1974). *Silence as Communication: The Privacy of the Self*. New York: International Universities Press.

Kahr, B. (2012). The infanticidal origins of psychosis. *Attachment New Directions in Psychotherapy and relational Psychoanalysis. 1*(2), 117-32.

Katz, L. (2000). Countertransference to Silence in the Treatment of a Child. *Journal of Infant, Child, and Adolescent Psychotherapy, 1(4)*, 99-122.

Knutson, H.V. & Kristiansen, A. (2015). Varieties of Silence: Understanding Different Forms and Functions of Silence in a Psychotherapeutic Setting. *Contemporary Psychoanalysis, 51*(1), 1-30.

Kohut, H. (1957). Clinical and Theoretical Aspects of Resistance. *Journal of the American Psychoanalytic Association, 5*, 548-555.

Kurtz, S. (1984). On silence. *Psychoanalytic Review*, *71*(2), 227-245.

Lanyado, M. (2008). Dwelling in the Present Moment: An Exploration of the Resonances Between Transitional Experiences and Meditative States, *Psychoanalytic Perspectives. 5*(2), 69–85.

Levy, K. (1958). Silence in the Analytic Session. *The International Journal of Psycho-Analysis*, *39*(1), 50–8.

Lief, H. I. (1962). Silence as Intervention in Psychotherapy. *American Journal of Psychoanalysis, 22*(1),80-83.

Loomie, L. S. (1961). Some Ego Considerations in the Silent Patient. *Journal of the American Psychoanalytic Association.*, *9*, 56–78.

Loewald, H. W. (1970). Psychoanalytic theory and the psychoanalytic process. *The Psychoanalytic Study of the Child, 25,* 45-68.

Mahler, M., Pine, F., Bergman, A. (1975). *The Psychological Birth of the Human Infant*. New York: Basic Books.

Ogden, T. H. (1996). Reconsidering Three Aspects of Psychoanalytic Technique. *International Journal of Psychoanalysis, 77*(5), 883-899.

Reich, W. (1928). A criticism of Recent Theories of the Problem of Neurosis. *International Journal of Psychoanalysis*, *9*, 227-240.

Reik, T. (1924). Some remarks on the study of resistance. *International Journal of Psychoanalysis*, *5*, 141-154.

Reik, T. (1968). The Psychological Meaning of Silence. *The Psychoanalytic Review*, *55*(2), 172-186.

Reis, B. (2012). Silence and Quiet: A Phenomenology of Wordlessness. *DIVISION/Rewiew, 6*, 24-26.

Reisz, S., Duschinsky, R., & Siegel, D. J. (2018). Disorganized attachment and defense: exploring John Bowlby's unpublished reflections. *Attachment & Human Development*, *20*(2), 107–134.

Sabbadini, A. (1992). Listening to Silence. *The Scandinavian Psychoanalytic Review*, *15*(1), 27–36.

Segal, H. (1957). Notes on Symbol Formation. *International Journal of Psycho-Analysis*, *38*, 391-397.

Serani, D. (2000). Silence in the analytic space, resistance or reverie? *Contemporary Psychoanalysis*, *36*(3), 505-519.

Slochower, J. (1999). Interior experience in analytic process. *Psychoanalytic Dialogues*, *9*(6), 789-809.

Spotnitz, H. (2004). *Modern Psychoanalysis of the Schizophrenic Patient*. New York: YBK Publishers.

Stern, D. (1985). *The Interpersonal World of the Infant.* New York: Basic Books.

Vaccaro, A. (2008). Working through Silence with a Schizophrenic Woman. *Modern Psychoanalysis*, *33a*(1), 142–156.

Winnicott, D. W. (1945a). Primitive Emotional Development. In: D. W. Winnicott, (Ed.), *Through Paediatrics to Psychoanalysis* (pp. 145-156). London: Karnac.

Winnicott, D. W. (1945b). Mind and its Relation to the Psyche-Soma. In: D. W. Winnicott, (Ed.), *Through Paediatrics to Psychoanalysis* (pp. 243-254). London: Karnac.

Winnicott, D. W. (1954a). Withdrawal and Regression. In: D. W. Winnicott, (Ed.), *Through Paediatrics to Psychoanalysis* (pp. 255-261). London: Karnac.

Winnicott, D. W. (1954b). Metapsychological and Clinical Aspects of Regression within the Psycho-analytical Set-Up. In: D. W. Winnicott, (Ed.), *Through Paediatrics to Psychoanalysis* (pp. 278-294). London: Karnac.

Winnicott, D.W. (1956). On Transference. *International Journal of Psycho-Analysis*, *37*, 386-388.

Winnicott, D. W. (1958). The Capacity to be Alone. *International Journal of Psycho-Analysis*, *39*, 416-420.

Winnicott, D. W. (1963a). Communicating and Not Communicating leading to a Study of Certain Opposites. In D. W. Winnicott, (Ed.) *The Maturational Processes and the Facilitating Environment*. 179-192. New York: International Universities Press.

Winnicott, D. W. (1963b). Dependence in Infant care, in Child Care, and in the Psychoanalytic Setting. *International Journal of Psycho-Analysis*, *44*, 339-344.

Winnicott, D.W. (1971). Transitional Objects and Transitional Phenomena. In D. W. Winnicott, (Ed.) *Playing and Reality*, 1-25. London: Tavistock Publications.

Winnicott, D. W. (1974). Fear of Breakdown. *International Review of Psycho-Analysis*, *1*, 103-107.

Zeligs, M. A. (1960). The Role of Silence in Transference, Countertransference, and the Psycho-Analytic Process. *The International Journal of Psycho-Analysis*, *41*, 407-412.

Part 2: Empirical Research Project

Title: Exploring Silence in Short Term Psychoanalytic Psychotherapy with Adolescents with Depression

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Abstract

Psychotherapy process research is important in developing technique and enhancing clinical skills. Silence, as an aspect of child and adolescent psychoanalytic psychotherapy, has been a neglected area of research, despite it being acknowledged as an often challenging yet therapeutically useful aspect of the work. This study aims to explore silence in adolescent psychoanalytic psychotherapy, by studying the emergence of silence in therapy sessions and the adolescents' views. Three Short Term Psychoanalytic Psychotherapies of adolescents with depression were sampled, and silences occurring in six sessions of each therapy were coded using the Pausing Inventory Categorization System (PICS). The study identified that in the three therapies sampled, on average almost one-third of session time was spent in silence, and that most of this silence was coded as 'obstructive'. The study also found that the change in silence amount through each stage of therapy was different in each patient-therapist dyad. Follow-up interviews conducted with the adolescents were analysed using thematic analysis and found that the adolescents expressed negative feelings about silence in their therapy. Findings from the follow-up interviews were related to silence and outcome data to suggest processes that may have been taking place in each of the therapies. A key hypothesis was that the majority of the silence in the therapies sampled appeared to relate to conflict, which could be viewed as both an aspect of the developmental stage of adolescence, and a symptom of depression. Clinical implications of the findings indicated that long silence do not appear to be useful in adolescent therapy in the way they are considered to be in adult therapy, and so adaptation of therapeutic technique is required.

Introduction

Silence during therapy can be thought of as co-created by therapist and patient, as both, in that moment, in some way choose not to verbally communicate. As in life, silences in therapy can vary enormously in quality and duration; there are for example brief, tense silences or long and comfortable silences, among many others. Levitt (2001) regarded silence in therapy as the language of emotional experience, suggesting that what is conveyed in silent moments may in fact speak louder than words. If we take this to be the case, silent moments would be of interest to the therapist wishing to understand their patient's emotional experience; as such silence itself can be the topic of research on therapy process.

Initially, approaches to silence in therapy from a psychoanalytic perspective are reviewed. Research on silence in psychotherapy is then examined, and the absence of research addressing silence in adolescent therapy acknowledged. Given this gap in the research, this study proposes three research questions in relation to exploring silence in Short Term Psychoanalytic Psychotherapy (STPP) for adolescents with depression. Following explanation of the methodology, the results of the research are presented, and these are then discussed in the context of existing research. Implications and limitations of this study are then explored.

Since Freud (1912) asserted that silence in therapy is a marker of intrapsychic conflict, silence has been considered a meaningful phenomenon in the psychoanalytic literature. More recently, there have been efforts to build on this existing understanding with empirical research. Whilst those practising so-called 'talking therapies' have often sought to understand the process of therapy through examining language, i.e. what is present, there has also been a developing interest in what happens between words. While early psychoanalytic theorists tended to see silence during therapy primarily as a sign of resistance (e.g. Ferenczi, 1911; Freud, 1912), later theorists (Arlow, 1961; Blos, 1972; Sabbadini, 1992) considered the

phenomenon of silence as having a communicative function, and highlighted how the way a therapist managed silence to be important in how it appears and changes through a therapy (Zeligs, 1960). .

When silence in psychoanalytic psychotherapy was first considered, it was regarded as reflecting a defence on the part of the patient. Freud (1912) originally linked silence to the transference and considered it a failure in free association that could be removed by reassurance. With the development of the structural model of the mind (Freud, 1923) silence was conceptualised as resistance and, as such, analysing silence could provide insight into the patient's internal world (Arlow, 1961). Therefore, silence came to be of great interest to analysts and was considered a fertile subject for psychoanalytic study. Several perspectives have been articulated on the defensive function of silence. Silence has been described as the result of conflict between impulses emerging from the id and the ego, and if such a conflict cannot be verbalised then silence may act as an external marker (Fenichel, 1928; Ferenczi,1916; Fliess, 1949; Levy, 1958; Reik,1924). The action of the superego can also lead to a silence, when it is in opposition to an otherwise cooperative ego (Coltart, 1991; Kurtz, 1984; Levy, 1958; Loomie, 1961).

While these initial formulations approached silence as defence, silence in therapy has subsequently been considered to be associated with processes that continue the work of therapy rather than defend against it. Again, several different hypotheses have been put forth concerning the function of silence, including viewing silence: as a way to connect to the therapist (Arlow, 1961; Lane, Koetting, & Bishop, 2002); as a wish for merger (Blos, 1972; Fleiss, 1949); as associated with the work of mourning (Arlow, 1961; Blos, 1972; Fliess, 1949; Sabbadini, 1992; Segal, 1957; Winnicott, 1958; Zeligs, 1960) or as a way to communicate preverbal experiences (Greenacre, 1956). For example, Winnicott (1958), in his seminal paper, 'The Capacity to be Alone', wrote about how, in some cases, silence on the part of the

patient can be viewed as an achievement rather than resistance. This type of silence may be particularly important for patients who have suffered deprivation in early life. For such patients there is the potential, in silent moments, to feel a continued connection to their therapist that could then be internalised and be felt to continue outside of sessions. Despite these different formulations, the patient's need to defend themselves is still considered the most common reason for silence within analytic sessions (Gale & Sanchez, 2005; Greenson, 1961).

Theoretical explanations of silence in therapy have remained limited in that they often seek to understand an aspect of silence arising in specific clinical situations under discussion. For example, Winnicott (1945a, 1945b, 1954a, 1954b, 1958, 1963, 1974) discusses differing types of silence across several papers, but with no attempt to bring these ideas together in a unifying model. Although the multifaceted nature of silence is often acknowledged in the relevant clinical and theoretical literature, attempts to offer a framework to bring these ideas together are outdated (Blos, 1972; Levy, 1958; Zeligs, 1960) or insufficient (Sabbadini, 1992).

Theoretical literature on silence in psychoanalytic psychotherapy has focussed on its existence in adult therapy. Several single case studies exist exploring silence in adolescent therapy (Anagnostaki, 2013; Bakalar, 2012; De Sauma, unpublished; Lanyado, 2008; Leira, 1995), where some similar themes emerge, but there has been no attempt of which the author is aware to draw these ideas together and explore how silence in therapy with adolescents may differ from that with adults. It is considered essential that a therapist working with children and adolescents take a developmental perspective when considering formulation and technique (A. Freud, 1966; Harris, 1965), and so the absence of consideration of how therapists manage silence when working with adolescents is therefore of concern.

Empirical research on silence in psychoanalytic psychotherapy is relatively limited and primarily exploratory in nature. It has largely focused on the patient's or therapist's view on experiences of silent moments. Research has indicated a positive relationship between the emergence of silent moments in a session and client-perceived rapport (Sharpley, 1997, Sharpley, Munro, & Elly, 2005; Sharpley & Harris, 2010). Furthermore, some studies on therapist perspectives have elucidated a view that silence may allow reflection, encourage responsibility and enable expression of feelings (Hill, Thompson, & Ladany, 2003). Recent research on silence in couples' therapy using a mixed-methods approach (including psychophysiological data) has indicated that during silent moments, participants continued the therapeutic conversation through their entire body, and that in allowing a chance for individuals to react and think, silence allowed them to arrive at words for experiences that had yet to be spoken (Itavuori, Korvela, Karvonen, Penttonen, Kaartinen, Kykyri, & Seikkula, 2015). While these studies draw a number of interesting conclusions, they remain limited in either presenting one view of the process (patient or therapist) or involving research tools that are not accessible in clinical practice. The small scope of these studies also means their results have limited generalisability. Additionally, there is no research that studies the adolescent's experience of silent moments in therapy.

In acknowledging the need for the many expressions of silence to be studied systematically, Levitt and her colleagues developed the Pausing Inventory Categorization System (PICS) (Frankel, Levitt, Murray, Greenberg, & Angus, 2006; Levitt, 2001; Levitt & Frankel, 2004) to code silences that emerge within a therapy session. This coding system was developed using grounded theory research, where patients were asked to view video recordings of their therapy sessions and comment on their experience during silent moments. Now in its second edition (Levitt & Frankel, 2004), the coding system identifies nine silence types which fall into three broad categories, namely obstructive, productive and neutral silences. PICS has

subsequently been used by Levitt and her colleagues to examine how the emergence of silence in therapy can be linked to outcome, finding that higher use of productive as opposed to obstructive silence is linked to positive outcomes, and vice-versa (Frankel et al., 2006; Stringer, Levitt, Berman, & Mathews, 2010). Frankel et al.(2006) suggested that their finding of the high use of productive silence in good outcome therapies (particularly in the first half of the therapy) could be linked to a greater capacity in these patients for emotional processing, while Gindi (2002) linked the finding that overall number of silences and particularly the sub-category of reflective silence increased as therapy progressed to the therapy having increased this capacity in the patient. Associations between in-session silence, attachment category and therapeutic alliance have also been studied and found to exist in research on a single case study (Daniel, Folke, Lunn, Gondan, & Poulsen, 2016).

A need for theory and research to come together in order to understand phenomena such as silence that arise in adolescent therapy feels pertinent, given the worrying trend of increasing incidence of mental health problems in this age group, alongside stretched public services. While half of all mental health problems are thought to manifest by the age of 14, and 75% by age 24 (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005), almost one in four young people are thought to show evidence of mental ill health (Mental Health Foundation, 2016). Prevalence of mental health problems have been shown to increase with age, with 5.5% of 2-5 year olds; 9.5% of 5-10 year olds; 14.5% of 11-16 year olds; and 16.9% of 17-19 year olds having a mental health disorder (Department of Health and Social Care, 2018). Meanwhile 3 in 4 children with a diagnosable mental health condition do not have access to the support that they need (Green, Mcginnity, Meltzer, Ford & Goodman, 2005), and the average waiting time for treatment in Child and Adolescent Mental Health Services (CAMHS) is 10 months (Firth, 2016). It therefore feels important that clinicians have a fully developed understanding of the

therapeutic framework they use to treat their adolescent patients, including the use of silence. It is also important that we listen to young people's experience of depression, and the help they receive if we are to better understand their experience of suffering from this condition (Farmer, 2002; Midgley, Parkinson, Holmes, Stapley, Eatough, & Target, 2015; Midgley, Parkinson, Holmes, Stapley, Eatough, Target, 2016a) and how treatment can be effective (Midgley, Ansaldo, & Target, 2014; Midgley, Holmes, Parkinson, Stapley, Eatough, Target, 2016b). Given our understanding of the developmental tasks of adolescence, namely separation individuation, and identity formation, alongside our ever-increasing knowledge of the adolescent brain (Arain, Haque, Johal, Mathur, Nel, Rais, (…) & Sharma, 2013; Blakemore, 2018; Fuhrmann, Knoll, & Blakemore, 2015) it seems likely that the emergence of silence may differ in this group. The case studies cited above provide some evidence that silence can play an important role in therapy with adolescents, and this may bring to the fore both theoretical and technical challenges in how it is managed therapeutically.

While theory has conceptualised silence as both a way to defend against the work of therapy, and conversely to continue it, research in this field has lagged and focused mainly on client and therapist views of silence. The development of the PICS coding system has been the first attempt at studying the manifestation of silence in all its forms, but there have as yet been no attempts to use it within an adolescent population. Considering that the presence of silence in psychoanalytic psychotherapy for adolescents may differ, developing understanding of this aspect of the process of therapy would increase therapist confidence in working with silence in therapy, and so ultimately be of benefit to the young people they treat.

This study examining the emergence of silence in three adolescent Short-Term Psychoanalytic Psychotherapies (STPP) (Cregeen, Hughes, Midgley, Rhode, & Rustin, 2016) hopes to contribute to this rather neglected area of research. This study aims to address the following questions:

1. How much silence is there in adolescent STPP, and does this change as therapy progresses?
2. What is the function of silence, as coded in the PICS in adolescent STPP, and does this change as therapy progresses?
3. What do adolescents themselves say about silent moments in their therapy?
4. Are there links between what adolescents say about their experience of therapy, and the PICS and outcome data?

Method

Research material

The research material for this study, in the form of audio recordings of STPP sessions, was drawn from the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT), a multi-site randomised controlled trial examining treatment outcomes for adolescent depression (Goodyear, Tsancheva, Byford, Dubicka, Hill, Kelvin, (…) & Fonagy, 2011; Goodyear, Reynolds, Barrett, Byford, Dubicka, Hill & Fonagy, 2017). Furthermore, research material in the form of audio recordings of the 'Experience of Therapy Interview' conducted post-therapy, were drawn from IMPACT-My Experience (IMPACT-ME) (Midgley, Ansaldo, & Target, 2014), a mixed methods study 'nested' within IMPACT. For further details on these studies see relevant publications.

From the available data, three therapies were purposively selected for further study. Inclusion criteria were: that young people were aged 15 or over, as it was felt this age group would likely privilege verbal communication in therapy as opposed to communicating through play or drawings; that cases were selected from the London sample as they would then also have participated in IMPACT-ME; and that the selected cases needed to have completed therapy, including having participated in outcome monitoring. An initial pool of seven cases, based on the inclusion criteria outlined above, was created. From those, three therapies were selected for the purposes of this study. These were selected based on practical considerations, namely that they included a good spread of recordings from each stage of therapy and a level of sound quality that allowed for coding. Care was also taken to include a gender mix in both the young people and the therapists, and that each therapist was only included once.

Six sessions were selected from each therapy, and so a total of 18 sessions were coded across the three therapies. Each therapy was divided into three stages: beginning (sessions 1-9), middle (sessions 10-19), and end (sessions 20-28). Two sessions were selected from roughly the middle of each stage. Care was taken to avoid the first three sessions of therapy and the last session, as it was thought that they may not be representative of the therapy stage. Sessions were selected close to when outcome monitoring was conducted, and consecutive sessions were selected wherever possible, with an aim to provide a fuller picture of a period in therapy.

We obtained transcripts of the 'Experience of Therapy Interviews', with patients who participated in the selected therapies, and these were then analysed using thematic analysis (TA) (Braun & Clarke, 2008). The schedule for these interviews is provided in Appendix 1.

Participants

Session audio-recordings of three therapies were selected for inclusion in this study. Table 1 shows demographic information, as well as information on the therapy and outcome for each patient. As all patients showed a clinically significant reduction in the primary outcome measure used in the IMPACT study, the 'Mood and Feelings Questionnaire' (MFQ) (Anglod, Costello, Messer, Pickles, Winder, & Silver, 1995), they can all be considered 'good outcome' therapies. However, as a score of 27 or above on the MFQ indicates a diagnosis of depression, both Patients A and B would still be viewed as depressed at 36 weeks following therapy completion, and Patient B would be classified as depressed at all stages.

Measures

Pausing Inventory Categorisation System, 2nd revision (PICS). PICS (Levitt & Frankel, 2004) is a coding system developed to code in-session pauses during therapy. Pauses of three seconds or longer are coded, using verbal or visual markers before and after the silence. The coding system includes codes for three main categories of silence, namely productive, obstructive, and neutral silences.

Productive silences are defined as moments where patients connect with the emotions elicited by the therapeutic conversation which allows them to continue it. They can further be coded as high reflective ("Client is deliberating, comparing, questioning, planning or exploring about a content or process area that is central to the self or to the core therapy issues" p.10), low reflective ("Client is deliberating, comparing, questioning, planning or exploring about a content or process area that is not central to the self or to the core therapy issues" p.11), feeling ("Clients are feeling emotion, re-experiencing emotion, or in the process of moving in to an emotional state" p.6), or expressive ("Clients are having trouble finding the correct feeling word or phrase to express themselves" p.12) silences.

Obstructive silences are defined as the patients' attempts to defend against emotions elicited during their therapy and so stop further exploration. They can be coded further as disengaged ("Client is disengaged from emotion or is avoiding emotion" p.4) or interactional ("Pause due to client reaction to therapist and expected or perceived therapist reaction" p.8) silences.

Neutral silences are defined as silences that occur as part of the patient's speech that are not linked to the content of the therapeutic conversation. They can be coded further as mnemonic ("Pauses due to client requiring time for recall" p.15) or associational ("The process of sudden emergence of a new idea-a leap to a different topic that is not fluid" p.14) silences.

The manual outlines what the patient may be experiencing during the silence, and then describes therapist and patient behaviour both before and following each type of silence. Codes are given according to the immediate impact of the silence on the therapeutic conversation.

Mood and Feelings Questionnaire. The Mood and Feelings Questionnaire (MFQ) (Angold et al., 1995) is a screening tool for depression in children and young people aged 6-17 and consists of a series of descriptive phrases regarding how the subject has been feeling or acting in the past two weeks. Studies have found the MFQ to be a valid and reliable measure of depression in children (Wood, Kroll, Moore, & Harrington, 1995; Daviss, Birmaher, Melhem, Axelson, Michaels, & Brent, 2006).

The IMPACT study used the long version of the MFQ which consists of 33 items. A total between 0-66 is produced, where a higher score indicates poorer clinical symptoms. A score of 27 or above is an indication of depression in the respondent.

The MFQ was the main outcome measure used in the IMPACT study, and was administered at the beginning of therapy, during therapy (week 6 and 12), and then following therapy completion (week 36, 52, and 86).

Table 1

Information on study participants

	Patient A	**Patient B**	**Patient C**
Gender	Female	Male	Female
Age	15	15	16
Number of sessions offered	28	29	30
Number of sessions attended	26	29	25
Number of sessions recorded	21	29	23
Sessions selected for coding	4, 6, 14, 15, 23, 24	5, 6, 14, 15, 24, 25	5, 6, 13, 14, 23, 24
Therapy outcome	Good	good	good
MFQ at beginning of therapy	42	51	44
MFQ at 6 weeks	32	45	39
MFQ at 12 weeks	11	37	None recorded
MFQ at 36 weeks	28	38	23
MFQ at 52 weeks	25	49	22
MFQ at 86 weeks	24	36	15

IMPACT-ME post therapy interviews. Young people recruited to the IMPACT study (Goodyear et al., 2011; Goodyear et al., 2017), and within the London sample where then recruited to IMPACT-ME, a study 'nested' within IMPACT. IMPACT-ME uses mixed methods to understand the effectiveness of the interventions used in IMPACT, and aims to contextualise the findings (Midgley et al., 2014).

In this study, the 'Experience of Therapy Interviews', conducted following therapy completion, were thematically analysed to try to understand further the feelings of the young people in this study regarding their therapy, with particular focus on their experience of silence. Thematic Analysis is a method used to identify and analyse patterns of meaning within a data set (Braun and Clarke, 2006) and to highlight the themes that emerge as important to the phenomenon being studied (Daly, Kellehear, & Gliksman, 1997).

Extracts from the interviews that elucidated each young person's experience of therapy and the therapeutic alliance were selected, and these allowed hypotheses to emerge on what was happening within the therapy in relation to the quantitative data (i.e. PICS findings, and MFQ scores).

Procedure

Two coders, each a child and adolescent psychotherapist in training and completing doctoral-level research, self-trained in coding audio material over four days alongside their supervisor and with the help of the manual (Levitt & Frankel, 2004). Three sessions were coded in total as part of the training. Each session used for training was selected from a different therapy, and therapies selected for inclusion in the study were not used. During the process of training, sessions were coded by consensus; more specifically, each session was coded separately by each researcher and differences in coding were then discussed with their supervisor, until consensus on the most appropriate code was agreed upon. Coders were aware that the manual allowed for a degree of subjectivity, and that their therapeutic orientation and training impacted on their coding.

Following completion of training, the researchers continued to use the consensus coding approach. This decision was made given the researchers' experience of training on the coding system and their sense that silence emerged in a way unique to each patient-therapist dyad, which meant that discussion on how to use the coding system for each therapy would be helpful. As only six sessions were coded for each therapy, consensus coding was possible in terms of time demands.

As part of the process of training in using the coding system, the decision was made to include a tenth sub-category of silence under the category of obstructive silence, which was termed disengaged-interactional. While disengaged silences are

defined in the manual as “Client is disengaged from emotion or is avoiding emotion” (Levitt & Frankel, 2004, p.4) interactional silences are defined “Pause due to client reaction to therapist and expected or perceived therapist reaction” (p.8). We found when coding that there were many silences where the patient seemed to disengage from underlying emotions and that there was a sense of tension in their relation to their therapist. This fits with a psychodynamic model of working where the transference relationship is worked with. We decided that such silences should be categorised separately, and so created a tenth sub-category.

As indicated in the PICS manual, silences of three seconds or more were selected for coding. Silence type was then coded for and the length of the silence recorded. Silence length was categorised as short (10 seconds or less), medium (11 seconds to 1 minute) or long (longer than 1 minute). Having recorded many dimensions of the silences, the decision was made to report findings in terms of proportion of session time spent in silence. While reporting total incidence of silence would have allowed findings to have been more easily compared with other PICS studies, the fact that silence length varied so greatly meant this method of reporting would not accurately reflect the presence of silence in the sessions. A table showing number of short, medium, and long silences in each therapy is included in Appendix 2. Overall It was felt that reporting proportion of session time spent in silence would give the clearest sense of the presence of silence within the session.

Furthermore, the ‘Experience of Therapy Interviews’ were then coded thematically, with an aim to deepen understanding of the patient’s experience of therapy and of silent moments in therapy. The researcher used published guidance (Braun & Clarke, 2006; Harper & Thompson, 2012) as an aid, as well as supervision, when using this method. Transcripts were obtained and then read by the researcher. From this a ‘coding frame’ was developed, based on references made to silence in therapy, and the patient’s views on their therapy and therapist. This included both

inductive codes that emerged from the data, and codes that were based on the researcher's conceptualisations. The codes were then examined, and themes emerged. Coding was closely supervised to ensure that the emergent themes were grounded in the data.

In addition to coding explicit references to silence, parts of the narrative that shed light on how each adolescent experienced and made sense of their therapy and referred to the therapeutic alliance were also selected, and these allowed hypotheses to emerge on what was happening within the therapy in relation to the quantitative data (i.e. PICS findings, and MFQ scores).

Results

In this section, findings from the analysis of in-session silence of the three therapies will be initially presented. This will be followed by the thematic analysis of the three 'Experience of Therapy Interviews'. Each therapy will then be examined individually.

A total of 1248 pauses of 3 seconds or longer were coded in the 18 therapy sessions across the three therapies. When taking all three therapies together, almost one-third of total session time (32.2%) was spent in silence. The proportion of time spent in silence was found to fluctuate over the course therapy, being highest in the beginning stage of therapy (36.4% of session time), decreasing in the middle stage (29.6% of session time) and then increasing slightly in the end stage (30.4% of session time). While this finding does show a reduction in proportion of silence over time, there is a low level of variance from the mean.

When considering silence type across all three therapies, we see that 26% of total session time was spent in obstructive silence, 5.4% was spent in productive silence and 0.4% of time was spent in neutral silence. As such, obstructive silence was by far the most common type of silence in this data set, whereas neutral silences occurred very rarely. For this reason, neutral silences were not examined further.

Silence was discussed by all three patients in their 'Experience of Therapy Interviews' and it is interesting to note that in each interview the topic came up without a direct question regarding this aspect of therapy. Each patient spoke about **silence as a negative experience**, describing it as *"awkward"* or *"uncomfortable"*, with one patient saying she felt *"panicked"* when there was silence. Each patient spoke about silence in at least two ways, indicating that they felt **silence in therapy could mean more than one thing**. One patient spoke about being nervous to begin with and having to *"think twice"* for fear of being judged, but that this changed over

time as she grew to trust her therapist and was able to speak more. Later in the interview the same young person said that silences felt like she was "*wasting time*" and occurred when there was "*not much left to say*". Another patient spoke about some silences happening when he had nothing left to say while others provided thinking time: "*Sometimes…*[1]*I'm done saying something or sometimes I'm actually thinking of something.*" Two of the patients discussed with the researcher the relationship between silences in therapy and silences in the interview. One patient felt the two experiences were the same, and that silences occurred like this in other areas of his life as well ("*I mean it happens a lot just generally.*") Another patient spoke about the silences in the interview as *"not as awkward"*, and *"more thoughtful"* than those that had occurred in therapy, linking this to the question-answer style of the interview, the fact the interviewer would help end the silences and move the conversation on, and the background noise.

Important differences were observed in the incidence and types of pauses in each therapy. Each therapy will therefore be examined separately in the following sections.

Firstly, the amount of silence in each therapy and how this changed on average across each therapy will be investigated, followed by an examination of silence type and how this change across each therapy. Finally, extracts that elucidated the young person's experience of therapy were also selected, and together these allowed hypothesis to emerge on what was happening within the therapy considering the quantitative data regarding change in silence during treatment, and outcome data.

[1] Ellipses as written in transcription

Table 2

Percentage of time spent in silence for each patient

	Therapy A	**Therapy B**	**Therapy C**
Stage of therapy			
Beginning	17.7%	66.7%	24.8%
Middle	26.5%	30.8%	31.6%
End	28.7%	21.4%	41.1%
Mean	**24.3%**	**39.6%**	**32.5%**

Therapy A

As shown in Table 1, Therapy A was conducted with a 15-year-old young woman, who attended 26 of 28 sessions offered by her therapist and was considered to have completed therapy. Her MFQ scores decreased in the first 12 weeks of therapy but then increased at week 36 following therapy ending. They again show reduction at weeks 52 and 86.

With regards to the amount of time spent in silence, as shown in Table 2, of the 6 sessions coded for this therapy, 24.3% of the total session time was identified as silent. This is less than the mean proportion of time spent in silence across the three therapies (32.2%). The percentage of session time spent in silence increased from the beginning through to the end stage of therapy, from 17.7% of session time in the beginning stage, to 26.5% in the middle stage, and then 28.7% of the session time in the end stage. This runs counter to the findings when all three therapies were considered together, where silence was found to overall reduce as therapy progressed.

With regards to the type of silence, as shown in Table 3, the amount of time spent in obstructive silence increased over the course of therapy while the amount of time spent in productive silence increased in the middle section, and then reduced at the end. It is worth noting that in this therapy a sharp rise in obstructive silence

occurred in the end phase of therapy, and an increase in productive silence in the middle phase was observed.

Excerpts were then selected from the interview that expressed the patient's views on their therapy and this was related to the quantitative data to allow a hypothesis to develop around what might be happening in the therapy. As already mentioned, the total time spent in silence increased as this therapy progressed. This may be in part understood within the context of the patient's view of how to manage the therapeutic space and how to be with her therapist, which she explained as changing over time, as shown in the extract below:

> *"at the beginning I kind of... felt like I had to come up with some like kind of something really kind of interesting and I dunno and I kind of... slowly learnt that it didn't have to be that... kind of it could kind of be anything"*

The extract above suggests the patient feeling more relaxed as the therapy progressed, less like she needed to be entertaining for her therapist, and therefore able to allow more silence.

Furthermore, the patient expressed mixed feelings about her therapy ending ("*at some points I was kind of... relieved and-and sometimes I was a bit... worried about it"*), feeling both a positive sense of achievement (*"I'm quite kind of, it's quite at the moment it feels quite good because I feel like I kind of... achieved something coz it's like I... decided to something and they've got through it and it's like helped"*), and negative feelings around the loss of the therapeutic relationship (*"if I feel bad and I like oh I really wish I could (laughs) talk to them again then it would be quite I dunno it'll be a bit... I'll be sad about finishing erm... so it will be quite difficult").* These mixed feelings may go some way to explain the observation that the increase in overall silence in the end stage was due to a sharp rise in obstructive silences and a decrease in productive silence. Drawing upon the interview data, it could be

hypothesised that the patient expressed her ambivalence around the ending through silent withdrawal.

Therapy B

As shown in Table 1, Therapy B was conducted with a 15-year-old young man, who attended all of the 29 sessions offered, and was considered to have completed therapy. His MFQ scores decreased over the first 12 weeks of therapy, and then slightly increased at week 36 following therapy completion. They again showed reduction at weeks 52 and 86, but he was the only participant who according to MFQ scores would still receive a diagnosis of depression at the point of therapy completion.

With regards to overall amount of silence, Table 2 shows that of the 6 therapy sessions coded, 39.6% of session time was identified as having been silent. This is above the mean proportion of time of 32.2% when all three therapies were considered together.

As is shown in Table 2, the proportion of session time spent in silence decreased as the therapy progressed. This is a large decrease and can be partly accounted for by the fact that the amount of silence at the start of therapy was very high. While this pattern is in line with the findings concerning all three therapies together, it shows greater variance from the mean.

With regards to silence type, as shown in Table 3, the time spent in obstructive silence decreased significantly over the course of therapy, while time spent in productive silence increased between the beginning and middle phase and reduced slightly in the end phase. It is notable in Therapy B how great a proportion of the beginning phase is spent in obstructive silence, and how little time is spent in productive silence.

Excerpts were then selected from the interview that expressed the patient's views on their therapy and this was related to the quantitative data to allow hypothesis to develop around what might be happening in the therapy. The patient spoke about how his understanding of what could be spoken about in therapy changed as the therapy progressed, as shown in the extract below:

> *"I was sort of expecting it more to be like them asking me stuff… coz I like I sort worked a bit better like that coz then I could just respond…(I: uh-huh…)[2] but I-coz if there was nothing for them to say, then I wouldn't have anything to say either, I'd just sit there without… then I sort of caught on with the way it would work and that… and it went from there"*

This realisation that the patient describes about the open nature of the therapeutic space may in part explain the decrease in overall amount of silence as the therapy progressed, as they may have felt freer to bring their own thoughts and ideas to therapy, as opposed to waiting for the therapist to ask questions.

In general, the patient spoke quite negatively about his therapy

> *"I [don't][3] feel like it's helped that much to be honest, like I… coz, I don't really ever get much out of talking to people about things… it's not that I never have it's just with this it just hasn't helped… like I don't normally feel better after the sessions or worse so, nothing's happened"*

Although this patient's MFQ scores show there was a reduction in depression and that this improvement was maintained upon follow up, of the three patients examined in this study he entered therapy with highest rating of depression on the MFQ and continued to meet criteria for a diagnosis of depression during treatment and upon follow up. The dissatisfaction he expresses with his therapy may be related to this fact, and a sense that he could have benefitted from more help, and perhaps a

[2] Interviewer minimal response
[3] Word inserted for clarity of meaning

longer-term therapy. Indeed, in the interview he tentatively agreed when the interviewer suggested he may feel he didn't get enough in his therapy.

Therapy C

As shown in Table 1, Therapy C was conducted with a 16-year-old young woman, who attended 25 of 30 sessions offered by her therapist and was considered to have completed therapy. Her MFQ scores decreased between weeks 0-6 of her treatment, and although no questionnaire was given at week 12, we can see that at week 36, and following therapy completion, her score had decreased further.

As shown in Table 2, of the 6 sessions coded for this therapy, 32.5% of session time was identified as silent, which is similar to the mean of the three therapies (32.2%). The percentage of session time spent in silence increased from the beginning through to the end stage of therapy, starting at 24.8% of time in beginning stage, and rising to 31.6% in the middle stage, and then 41.1% of time in the end stage. This finding runs counter to the mean across the three therapies, where silence was found to decrease. However, this finding was skewed by the very high percentage of silence in Therapy B, and the overall increase in amount of silence in Therapy C is in keeping with Therapy A, where the same change was observed.

As is shown in Table 3, in Therapy C the amount of time spent in obstructive silence increased across the therapy. This is in line with the overall increase in silence across the therapy. The amount of time spent in productive silence remains low and relatively stable across the therapy.

Excerpts were then selected from the interview that expressed the patient's views on their therapy and this was related to the quantitative data to allow a hypothesis to develop around what might be happening in the therapy. The patient spoke in her interview about barriers to engagement in therapy, and this is interesting

considering the finding that this patient became more silent as the therapy progressed, and that it was the level of obstructive silence that increased. The patient spoke about anxious feelings at the start of therapy (*"I was nervous…coz I didn't really know what I should say"*), worry around what the therapist would think *("I think [I] was scared about her impression of me"*). By the end of therapy these issues still seemed relevant, as shown in the extract below.

> *"there was definitely still a little bit of barrier... (I: hmmm…) and I'd have to think twice before I said it but usually it was okay (…)*[4] *I'd think that she might have been judging me… (I: hmmm…) or like… she might have… told someone else"*

The patient's MFQ scores did decrease as the therapy progressed, indicating that she had been helped and she also reported positive feelings about her therapy *("I think it's been really good, it's been really great"*). Somewhat contradictorily, when asked what was most about helpful about therapy the patient said it was a place to let out feelings, as shown below

> *"probably the most helpful thing would be having a place to let out your feelings (...) yeah…like...yeah your thoughts and stuff so you're not like…they're not with you all the time"*

It may be that the patient was able to engage and be helped by her therapy to some extent, but that following this, unresolved issues around trust felt more present and work at a 'deeper level' was not possible. This could be linked to the model of STPP, and the fact the patient was aware throughout that there would be only 28 sessions and so perhaps not enough time for this kind of work. Indeed, the patient in some ways reflects on this herself in relation to the length of each session (*"I*

[4] Short amount of material omitted for clarity of meaning

probably like…probably like half an hour sessions coz...I didn't have that much to say").

Table 3

Occurrence of silence type for each patient at beginning, middle and end stage of therapy

	Therapy A				**Therapy B**				**Therapy C**			
	b (%)	m (%)	e (%)	**Mean (%)**	b (%)	m (%)	e (%)	**Mean (%)**	b (%)	m (%)	e (%)	**Mean (%)**
Obstructive Silence	**11.5**	**11.9**	**22.3**	**15.2**	**65.6**	**24.2**	**15.5**	**35.1**	**19.9**	**26**	**37.4**	**27.8**
Disengaged	5.7	3.2	11.5	**6.8**	63.7	22.5	13.1	**33.1**	8.5	17.3	13.6	**13.8**
Disengaged-Interactional	4.3	7.2	8.1	**6.5**	1.5	1.3	2.1	**1.6**	9.8	8.7	15.7	**11.4**
Interactional	0.8	1.5	2.9	**1.7**	0.4	0.8	0.3	**0.5**	1.7	1.8	8.1	**3.9**
Productive Silence	**5.9**	**14.6**	**6.5**	**9.0**	**1.0**	**6.4**	**5.3**	**4.2**	**3.0**	**3.1**	**2.8**	**2.9**
Expressive	1.9	9.3	3.0	**4.7**	0.6	0.8	0.8	**0.7**	1.3	0.3	0.5	**0.7**
Feeling	0.3	2.0	0.0	**0.7**	0.0	0.0	0.1	**0.0**	0.1	0.1	0.2	**0.2**
Reflective	4.2	3.4	3.3	**3.7**	0.4	5.6	4.8	**3.6**	2.5	2.5	2.1	**2.4**
Neutral Silence	**0.1**	**0.1**	**0.0**	**0.1**	**0.1**	**0.2**	**0.5**	**0.2**	**1.0**	**0.9**	**0.9**	**0.9**
Associational	0.1	0.1	0.0	**0.1**	0.0	0.0	0.5	**0.2**	0.5	0.9	0.9	**0.8**
Mnemonic	0.0	0.0	0.0	**0.0**	0.1	0.2	0.0	**0.1**	0.4	0.0	0.0	**0.1**

Notes. b= beginning stage of therapy, m= middle stage of therapy, e= end stage of therapy

Discussion

This was a mixed methods exploratory study, aiming to further our understanding of how silence emerges and develops in three adolescent Short Term Psychoanalytic Psychotherapies (STPP). The study also sought to link these findings to the adolescents' experience of their therapy, and their thoughts around silent moments in therapy. We hoped that this would help develop an understanding of silence as a phenomenon in adolescent psychoanalytic psychotherapy, and how it is experienced by the patient.

One clear finding from this research is that silence is a strong feature of the three adolescent psychotherapies, taking up on average almost one third of session time. While silence is examined primarily in this study by looking at proportion of time spent in silence, other studies using PICS have chosen to record number of times silences have occurred. As outlined in the methodology section, looking at only each time a silence occurred was felt to be limiting, and duration conveyed more accurately the amount of silence in each therapy. When comparing incidence of silence in our sample to these studies, it appears silence is a much more common occurrence in this sample. While the mean number of silences per session in our study was 69.3, other studies recorded means of 35 (Daniel et al., 2016) 16.7 (Frankel et al., 2006) and 7.1 (Gindi, 2002). However, all these studies were conducted with adult patients, and treatment length, diagnosis, and therapy type were variable, which would likely have impacted findings. Observed differences from our sample are striking and this may reflect some aspects of the clinical manifestations of depression as well as linking to the developmental stage of adolescence. As discussed earlier, a key theory regarding silence in therapy is that it is a marker of conflict between structural systems: the id and the ego (Fenichel, 1928; Ferenczi, 1916; Fliess, 1949; Levy, 1958; Reik, 1924) and the ego and the super ego (Coltart, 1991; Kurtz, 1984; Levy, 1958; Loomie, 1961). As adolescence is a time where young people will encounter both internal and external conflict as they undergo the developmental tasks inherent to this stage as part of normal development (Waddell, 2000), it

may be reasonable to hypothesise that with those adolescents who seek therapeutic help, such internal conflict is great, and may be partly expressed through silence.

Another important finding from this study is that obstructive silences were by far the most common, occurring in on average 29.2% of session time. While obstructive silences were 69.1% of silences coded in our sample, other studies found much lower levels, e.g. 13.9% (Gindi, 2002) and 11.2% (Frankel et al., 2006). This finding may again be linked to aspects this study having sampled adolescent patients, where high levels of obstructive silence may link to the internal conflicts that exist as part of this stage including the developmental need of these patients to separate from attachment figures and become more independent (A. Freud, 1966; Harris, 1965). Unfortunately, the lack of other studies using PICS with an adolescent sample means it is unclear how much this finding can be linked to the developmental stage of adolescence.

It is also important to acknowledge that patients' views on silence in therapy were largely negative. This corresponds to the finding that most silence was coded as 'obstructive', which is hypothesised in the introduction to relate to a defence on the part of the patient and may therefore feel uncomfortable to experience. Psychoanalytic theory (e.g. Arlow, 1961) suggests that silence in psychoanalytic psychotherapy acts as an external marker of internal experience linked to unconscious defences and wishes. While these moments may be experienced by the patient as uncomfortable, the theoretical literature suggests that they may be useful experiences in the therapeutic encounter if they can be understood by the therapist and worked through (Sabbadini, 1992). The view of silence expressed in this sample seems to indicate that participants do not connect what happens during silence in their therapy with the process of recovery, and that they felt it was not a valuable part of their therapy. This finding contrasts to research cited above (Sharpley, 1997, 2005; Sharpley & Harris, 2010) which found that adult patients rated 'rapport' between themselves and their therapists as higher during silent moments. It may be that adolescents have more of a tendency than adults to withdraw during silent moments, and for such

moments to represent ruptures in the alliance with their therapists. While research looking at the therapeutic alliance has acknowledged the significance of silence as an indication of ruptures (Eubanks, Muran & Safran, 2015), research has yet to fully explore the significance of the therapeutic relationship in how silence appears and changes. This is likely to be affected by developmental stage, and whilst working through issues around separation adolescents may struggle when a therapist does not seek to re-engage them during prolonged silences, and could experience feelings of abandonment, rather than feel able to use them more creatively. This finding, and the fact it contrasts with previous research in psychotherapy with adults, has important clinical implications for how child psychotherapists think about silent moments in therapy. Increased awareness of how adolescents experience silence in therapy and the fact silences may reflect ruptures in the therapeutic alliance could aid therapists in identifying cases who are at risk of dropping out of treatment. It may be that more explicit conversation about silences within therapy help adolescents understand, tolerate, and benefit from this aspect of psychoanalytic technique. However, these findings suggest that allowing long silences to occur in therapy with adolescents is not helpful, and that therapists should consider actively seeking to reengage their patients rather than waiting for them to speak.

The literature on silence in psychoanalytic psychotherapy conceptualises it as a ‘rich’ ‘overdetermined’ element of the interactions that take place between therapist and patient that can be viewed from multiple perspective (Blos, 1972; Levy, 1958; Sabbidini, 1992; Zeligs, 1960). When it is interpreted as a marker of unconscious processes, this fits with the finding that silence in our sample was found to not be a unitary phenomenon, and that each of the patients showed a unique pattern of silence as therapy progressed. Additionally, if silence is linked to the relational pattern between patient and therapist, the uniqueness of each therapeutic relationship means we would expect silence to appear differently in each therapy. Outcome data, as well as excerpts from the patients’ follow-up interviews were used to hypothesise on processes that may be taking place within each therapy. These

hypotheses suggested that the changing amount of silence as the therapy progressed could be viewed as a marker of aspects of the therapeutic or transference relationship between the therapist and the young person, as was expressed in the selected interview excerpts. This would indicate the importance of therapists being curious about how silence appears and changes in their work, but this finding is limited by this aspect of the research being subjective rather than descriptive.

The researchers' addition of the sub-category disengaged-interactional silence attempted to allow for silence of this type to emerge independently, and so further research into this sub-category of silence would be a fruitful avenue for future research. Additionally, as silence was such a strong feature of the therapies sampled it may be advisable for PICS to be used in future to code silences of 10 seconds or longer in adolescent psychoanalytic psychotherapy, which would allow the pauses coded to more accurately reflect those experienced by therapist and patient as silences and avoid inflating findings. The generalisability of these findings is limited by the small sample size, as only 18 sessions from three therapies were coded. Another limitation of this study was the reliance of audio material for coding, as video material was not available. While such material is not considered essential for using PICS, visual cues are included in the coding manual particularly for productive silences, and so lack of this material may have led to under-coding of this silence type. Furthermore, although silence occurs in interaction, the PICS coding system implicitly ascribes the silence to the patient, and this may be a limitation in its use in psychoanalytically informed therapies.

This research finds that silence is a strong feature of adolescent psychoanalytic psychotherapy, and that it appears to relate to the transference relationship. Silence is therefore an important feature of adolescent therapy, and theoretical and research developments are needed to further our understanding of this phenomenon.

References

Anagnostaki, L. (2013). Beyond silence: working with Phoebe, *Journal of Child Psychotherapy*, *39*(2), 156-170.

Angold, A., Costello, E. J., Messer, S. C., Pickles, A., Winder, F., & Silver, D. (1995). The development of a short questionnaire for use in epidemiological studies of depression in children and adolescents. *International Journal of Methods in Psychiatric Research*, 5, 237-249.

Arain, M., Haque, M., Johal, L., Mathur, P., Nel, W., Rais, A., Sandhu, R., & Sharma, S. (2013). Maturation of the adolescent brain. *Neuropsychiatric Disease and Treatment,9*, 449-461.

Arlow, J. A. (1961). Silence and the theory of technique. *Journal of the American Psychoanalytic Association*, *9*(1), 44–55.

Bakalar, N., (2012). Countertransference in the psychoanalysis of a silent adolescent boy In J. Magagna, (Ed.), *The silent child: Communication without words.* (pp. 221-242). London: Karnac Books.

Blakemore, S. (2018). *Inventing Ourselves: The Secret Life of the Teenage Brain.* London: Doubleday.

Blos, P. (1972). Silence: a clinical exploration. *Psychoanalytic Quarterly*, *41*(3), 348–363.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2)*,* 77-101.

Coltart, N. (1991). The Silent Patient. *Psychoanalytic Dialogs*, *1,* 439-453.

Cregeen, S., Hughes, C., Midgley, N., Rhode, M., and Rustin, M. (2016). *Short-Term Psychoanalytic Psychotherapy for Adolescents with Depression: A Treatment Manual.* London: Karnac Books.

Daly, J., Kellehear, A. & Gliksman, M. (1997). *The public health researcher: A methodological approach.* Melbourne, Australia: Oxford University Press.

Daniel, S., Folke, S., Lunn, S., Gondan, M., & Poulsen, S. (2016). Mind the gap: In-session silences are associated with client attachment insecurity, therapeutic alliance, and treatment outcome, *Psychotherapy Research*, *28*(2), 203-216.

Daviss, W., Birmaher, B., Melhem, N., Axelson, D., Michaels, S., & Brent, D. (2006). Criterion validity of the Mood and Feelings Questionnaire for depressive episodes in clinic and non-clinic subjects. *Journal of child psychology and psychiatry, and allied disciplines*. *47*(9), 927–34.

Department of Health and Social Care. NHS Digital. National Centre for Social Research. Office for National Statistics. Youthinmind (2018). *Mental Health of Children and Young People in England, 2017.* England: NHS Digital. Retrieved from https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

De Sauma, M. (2016). '"Where are you?" Reaching out to the silent adolescent.'. Unpublished paper.

Eubanks, C. & Muran, J. & Safran, J. (2015). RUPTURE RESOLUTION RATING SYSTEM (3RS): MANUAL. 10.13140/2.1.1666.8488.

Farmer, T. J. (2002). The experience of major depression: Adolescent's perspectives. *Issues in Mental Health Nursing, 23(*6,), 567-585.

Fenichel, O. (1928) *On Isolation. Collected Papers*. London: Routledge.

Ferenczi, S. (1911). On Obscene Words. In Jones E. (Ed.), *First Contributions to Psychoanalysis* (pp. 132-153). New York: Brunner/Mazel.

Ferenczi, S. (1916). Silence is Golden. In J. Rickman (Ed.), *Further Contributions to the Theory and Technique of Psycho-Analysis* (pp. 250-251). London: Karnac.

Fliess, R. (1949). Silence and Verbalization: A Supplement to the Theory of the Analytic Rule. *International Journal of Psycho-Analysis*, *30*, 21–30.

Frankel, E., Levitt, H., Murray, D., Greenberg, L., & Angus, L., (2006). Assessing silent processes in psychotherapy: an empirically derived categorization system and sampling strategy. *Psychotherapy Research*, *16*(5), 627-638.

Freud, A. (1966). *The ego and the mechanisms of defence.* London: Karnac.

Freud, S. (1912). The Dynamics of Transference. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XII (1911-1913): The Case of Schreber, Papers on Technique and Other Works* (pp. 97-108). London: The Hogarth Press and The Institute of Psycho-analysis.

Freud, S. (1923). The Ego and the Id. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIX (1923-1925): The Ego and the Id and Other Works* (pp. 19-27). London: The Hogarth Press and The Institute of Psycho-analysis.

Fuhrmann, D., Knoll, L., & Blakemore, S.(2015). Adolescence as a Sensitive Period of Brain Development. *Trends in Cognitive Science*, *19*(10), 558-566.

Firth, E. (2016). Progress and challenges in the transformation of children and young people's mental health care a report of the Education Policy Institute's Mental Health Commission. Retrieved from https://epi.org.uk/wp-content/uploads/2018/01/progress-and-challenges.pdf

Gale, J., & Sanchez, B. (2005). The meaning and function of silence in psychotherapy with particular reference to a therapeutic community treatment programme. *Psychoanalytic Psychotherapy*, *19*(3), 205–220.

Gindi, S. (2002). Patterns of Silence: A case study of a young adult with Learning disabilities. Unpublished Thesis.

Goodyear, I. M., Tsancheva, S., Byford, S., Dubicka, B., Hill J., Kelvin R., Reynolds S., Roberts, C., Senior, R., Suckling, J., Wilkinson, P., Target, M., & Fonagy, P. (2011). Improving mood with psychoanalytic and cognitive therapies (IMPACT): a pragmatic effectiveness superiority trial to investigate whether specialised psychological treatment reduces the risk for relapse in adolescents with moderate to severe unipolar depression: study protocol for a randomised controlled trial. *Trials.* 12: 175.

Goodyer, I., Reynolds, S., Barrett, B., Byford, S., Dubicka, B., Hill, J., Holland, F., Kelvin, R., Midgley, N., Roberts, C., Senior, R., Target, M., Widmer, B., Wilkinson, P., & Fonagy, P., (2017). Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT): a multicentre, pragmatic, observer-blind, randomised controlled superiority trial. *The Lancet Psychiatry*. *4*(2), 109–119.

Green, H., Mcginnity, A., Meltzer, F, T., Goodman, R. (2005). Mental Health of Children and Young People in Great Britain: Office for National Statistics. Retrieved from https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-great-britain/mental-health-of-children-and-young-people-in-great-britain-2004.

Greenacre, P. (1956). Re-Evaluation of the Process of Working Through. *International Journal of Psycho-Analysis*, *37*, 439–444.

Greenson, R. R. (1961). On the silence and sounds of the analytic hour. *Journal of the American Psychoanalytic Association*, *9*(1), 79–84.

Harper, D. & Thompson, A. R. (2012). *Qualitative Research methods in Mental Health and Psychotherapy.* Oxford: Wiley-Blackwell.

Harris, M. (1965). Depression and the depressive position in an adolescent boy, *Journal of Child Psychotherapy*, *1*(3), 33-40.

Hill, C. E., Thompson, B. J., & Ladany, N. (2003). Therapist use of silence in therapy: A survey. *Journal of Clinical Psychology*, *59*(4), 513–524.

Itävuori, S., Korvela, E., Karvonen, A., Penttonen, M., Kaartinen, J., Kykyri, VL., & Seikkula, J. (2015). The Significance of Silent Moments in Creating Words for the Not-Yet-Spoken Experiences in Threat of Divorce. *Psychology, 6*(11), 1360-1372.

Kessler, R., Berglund, P., Demler, O., Jin, R., Merikangas, K., & Walters, E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication*. Archives of General Psychiatry*, *62*(6), 593-602.

Kurtz, S. (1984). On silence. *Psychoanalytic Review*, *71*, 227-245.

Lane, R., Koetting, M., & Bishop, J. (2002). Silence as communication in psychodynamic psychotherapy. *Clinical Psychology Review, 22*(7), 1091-1104.

Lanyado, M. (2008). Dwelling in the Present Moment: An Exploration of the Resonances Between Transitional Experiences and Meditative States. *Psychoanalytic Perspectives,5*(2), 69–85.

Leira, T. (1995). Silence and communication: nonverbal dialogue and therapeutic action. *Scandinavian Psychoanalytic Review, 18*(1), 41-65.

Levitt, H. (2001). Sounds of Silence in Psychotherapy: The Categorization of Clients' Pauses. *Psychotherapy Research, 11*(3), 295-309.

Levitt, H. & Frankel, Z. (2004). *Pausing Inventory Classification System (PICS) Manual,* 2nd Revision. Unpublished manuscript, University of Memphis.

Levy, K. (1958). Silence in the Analytic Session. *The International Journal of Psycho-Analysis*, *39*(1), 50–8.

Loomie, L. S. (1961). Some Ego Considerations in the Silent Patient. *J. American Psychoanaytic. Association. 9*, 56–78.

Mental Health Foundation. (2016). Fundamental Facts About Mental Health 2016. London: Mental Health Foundation. Retrieved from https://www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2016.

Midgley N., Ansaldo F., & Target M., (2014). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression*. Psychotherapy*, *51*(1), 128-37.

Midgley, N., Parkinson, S., Holmes, J., Stapley, E., Eatough, V., & Target, M., (2015). Beyond a diagnosis: The experience of depression among clinically-referred adolescents. *Journal of Adolescence*, *44*, 269-279.

Midgley N., Parkinson S., Holmes J., Stapley E., Eatough V., Target M., (2016a). ???Did I bring it on myself???? An exploratory study of the beliefs that adolescents referred to mental health services have about the causes of their depression*. European Child and Adolescent Psychiatry*, *26*(1), 25–34.

Midgley N., Holmes J., Parkinson S., Stapley E., Eatough V., & Target M., (2016b). "Just like talking to someone about like shit in your life and stuff, and they help you": Hopes and

expectations for therapy among depressed adolescents. *Psychotherapy Research*, *26*(1), 11-21.

Reik, T. (1924). Some remarks on the study of resistance. *International Journal of Psychoanalysis*, *5*, 141-154.

Sabbadini, A. (1992). Listening to Silence. *Scand. Psychoanalytic Review*, *15*(1), 27–36.

Segal, H. (1957). Notes on Symbol Formation. *International Journal of Psycho-Analysis*, *38*, 391-397.

Sharpley, C. (1997). The influence of silence upon client-perceived rapport. *Counselling Psychology Quarterly,* 10(3), 237-246.

Sharpley, C., Munro, D., Elly, M., (2005). Silence and rapport during initial interviews. *Counselling Psychology Quarterly, 18*(2), 149-159.

Sharpley, C. & Harris, M., (2010). Antecedents, consequents, and effects of silence during cognitive-behavioural therapy interviews. *Scandinavian Journal of Behaviour Therapy, 24*(1), 3-13.

Stringer, J., Levitt, H., Berman, J., & Mathews, S. (2010). A study of silent disengagement and distressing emotion in psychotherapy, *Psychotherapy Research*, *20*(5), 495-510.

Waddell, M. (2000). Only Connect: Developmental issues from early to late life. *Psychoanalytic Psychotherapy*, *14*(3), 239 – 252.

Winnicott, D. W. (1945a). Primitive Emotional Development. In: D. W. Winnicott, (Ed.), *Through Paediatrics to Psychoanalysis* (pp. 145-156). London: Karnac.

Winnicott, D. W. (1945b). Mind and its Relation to the Psyche-Soma. In: D. W. Winnicott, (Ed.), *Through Paediatrics to Psychoanalysis* (pp. 243-254). London: Karnac.

Winnicott, D. W. (1954a). Withdrawal and Regression. In: D. W. Winnicott, (Ed.), *Through Paediatrics to Psychoanalysis* (pp. 255-261). London: Karnac.

Winnicott, D. W. (1954b). Metapsychological and Clinical Aspects of Regression within the Psycho-analytical Set-Up. In: D. W. Winnicott, (Ed.), *Through Paediatrics to Psychoanalysis* (pp. 278-294). London: Karnac.

Winnicott, D. W. (1958). The Capacity to be Alone. *International Journal of Psycho-Analysis*, *39*, 416-420.

Winnicott, D. W. (1963). Dependence in Infant care, in Child Care, and in the Psychoanalytic Setting. *International Journal of Psycho-Analysis*, *44*, 339-344.

Winnicott, D. W. (1974) Fear of Breakdown. *International Review of Psycho-Analysis*, *1*, 103-107.

Wood, A., Kroll, L., Moore, A., & Harrington, R.(1995). Properties of the mood and feelings questionnaire in adolescent psychiatric outpatients: a research note. *Journal of child psychology and psychiatry, and allied disciplines*, *36*(2), 327–34.

Zeligs, M. A. (1960). The Role of Silence in Transference, Countertransference, and the Psycho-Analytic Process. *The International Journal of Psycho-Analysis*, *41*, 407–412.

Appendix 1: Interview schedule for Experience of Therapy Interview

Overcoming depression in adolescence: the experience of young people and their families

Experience of Therapy Interview – Young Person

Confidentiality
Interviewing therapist?

1. The difficulties that have brought the young person into contact with Child and Adolescent Mental Health

- Can you tell me how you came to be referred to the CAMHS service [use name of clinic, if known]? What was going on for you at the time?

(Try to unpack what is said, e.g. 'When you say “depressed”, what do you mean by that?').

- In what way did these things affect your life *at the time*?

(concrete examples - daily life, relation to others, education, feelings)

2. The young person’s understanding of those difficulties

- How do you make sense of what was going on for you *at the time?* (Or ‘Can you tell me the story of how things came to be the way you described?’)

(Possible prompts: What do you think has made things get like they were? how did the whole thing begin? Was going on at that time? How’s that connected to how things became?)

3. Change

- Compared to about a year ago, how have you been feeling/how have you been experiencing things?

[Prompt with referral to CAMHS if they don’t understand about a year ago]

[E.g. of prompts: What has improved? What has got worse? (Concrete examples)]

- In thinking about the changes you have mentioned, what are the things that contributed to those changes (concrete examples)? What has been helpful/ unhelpful?

4. The story of Therapy

- What ideas did you have about therapy before you first met your therapist?

- What were your first impressions of your therapist?

(How did you feel about starting therapy with them? How did you feel after the first meeting?)

- Can you tell me the 'story' of your therapy as you see it?
  (What happened next?)

Possible prompts:

- How would you describe your relationship with your therapist? How did it change during the therapy?

- Can you think of a word to describe your therapist? Can you think of a particular moment when your therapist was [word]?

- Are there any specific moments or events that you remember about the therapy?

[E.g. of prompts: Things that happened that seemed important? Things that you or the therapist did or said that you particularly remember?]

- Were your parents/carers involved in the therapy? If so, how did this affected things?

- Can you tell me about the ending of the therapy?

[Prompts: How did therapy end? How do you feel about the way therapy ended?]

- What was it like for you knowing that your therapy was a time-limited intervention?

- Looking back, how did it feel to be in therapy? What has it been like for you overall?

5. Evaluating therapy

- What were the most helpful things about the therapy? (Concrete examples).

- What kinds of things about therapy were unhelpful, negative or disappointing (concrete examples)?

- Was medication ever discussed with you?

- If you were starting therapy again, what would you like to be different?

- If a friend of yours was in difficulty or feeling depressed, do you think you would recommend that they went for therapy?

[Why/why not?]

- If you were describing therapy to a friend who had never been, how would you describe it?

6. Involvement in research

- I'd like to ask you a few questions about what it has been like being involved in the research side of the IMPACT study...

- Can you tell me about your experience of being involved in the research side of things?

How did you feel about your therapy sessions being recorded?

- When you initially joined the IMPACT study, you were allocated to one of three treatments on a random basis. Looking back, how do you feel about that process? Did you have a view on which of the three you hoped to get / not get?

- Can you tell me a bit about the regular meetings with the research assistants?

(Prompts: What has it been like having those meetings? Have you met different research assistants? How did that feel like? Did you ever talk about those meetings in your therapy? What was it like to attend research meetings at different points in time while you were still receiving therapy? And how do you feel now about attending research meeting after the therapy has ended?)

- Overall, what difference do you think it has made that your therapy has been part of a research study?

- Do you have any suggestion for us regarding the research side of the study?

6. Therapist

- Check whether the young person is okay with their therapist being interviewed.

7. Pseudonym

- Would you like to choose your own pseudonym?

8. Interviewer's reflections

(For interviewer, after interview, to dictate into recorder) How did the interview feel? Was it difficult or easy to conduct? Was it difficult to hold the 'frame' of the interview?

Appendix 2: Table of Silence Length

Table 3

Occurrence of silences of short, medium or long length in each therapy

Silence Length	Therapy A	Therapy B	Therapy C	**Total**
Short	375	258	282	**915**
Medium	74	96	100	**270**
Long	6	22	12	**40**
Total	**455**	**376**	**394**	**1225**

Part 3: Reflective Commentary

Word Count: 3992

Candidate number: BNZH3

The experience of completing a clinical Doctorate while training as a Child and Adolescent Psychotherapist (CAP) has been rich, stimulating, and has shaped me as a clinician in a way that I was not expecting. Through this paper I will examine the ways I feel I have developed from being a reluctant participant to someone who can see both the value and limitations of research in my profession. I will chart chronologically my progress through my clinical training and Doctorate, reflecting at each stage on how my beliefs and preconceptions were challenged, and how the support I was given allowed me to reshape my thinking. This paper will end with some thoughts on the limitations of traditional research methodology in psychoanalytic process research, and new innovations in this field.

Before applying to train as a CAP I had gained some experience in research. I undertook research projects as part of both my undergraduate and postgraduate qualifications and worked as an honorary research assistant on projects at the Anna Freud National Centre for Children and Families (AFNCCF) and the Institute of Psychiatry (IoP). I combined this honorary work in research with clinical roles, which I found more engaging, and as my positions at the AFNCCF and IoP came to an end I replaced them with more clinical work. I think I moved on from these experiences with a sense of something not having worked out. I had applied unsuccessfully for paid research positions and had a feeling that all the unpaid work I had done had come to nothing. I struggled to hold on to the experience of being part of these projects, and as I did not have a sense of the Independent Psychoanalytic Child and Adolescent Psychotherapy Association (IPCAPA) training having much of a research focus, I was unsure if I would ever be able use the knowledge and skills I had gained again. I think this feeling of research somehow ‘not being for me’ stayed with me and framed my feelings about the Doctorate when I came to apply.

I recall being in a meeting after having been accepted on the training and asking how we were to fit in the Doctorate to the training as well as the clinical requirements. The answer given was that they wanted the Doctorate to be an integrated part of the training as opposed to an adjunct. This didn’t mean much to me at the time, and nothing about my

contact with the profession until that point had led me to believe that research could be an integrated part of clinical work. As I entered the profession as a trainee, I was looking very much for clinicians to identify with. I had yet to hear of anyone within the profession who had both active clinical and research careers, and the feeling I had picked up from CAPs on my journey to training was of research being a kind of 'necessary evil' and something 'other people' do. The idea of integration was a long way off in my mind, and the only sense I had of research being useful was for the purposes of proving something you already knew so that others will believe you. What I lacked was any sense that research could be exploratory or teach one something new, and my focus on what one want one's research to achieve was mirrored in my feeling that if I was going to do the Doctorate, then I wanted the experience to be quick and straightforward, with the focus being on finishing it.

In the first year of the Doctorate we participated in research seminars with MSc students from the AFNCCF. These included seminars on research methodology and seminars where guest lecturers spoke about research in action. Being made to think about evidence-based practice felt 'out of sync' with where I was in my clinical training and on reflection, I wonder if I felt threatened in these seminars. While I was tentatively developing my identity as a CAP, I felt these seminars neglected this way of working, and my response at the time was to feel contempt for the interventions I was hearing about, such as the Children and Young People's Improving Access to Psychological Therapies programme (CYP-IAPT), rather than to be able to be curious about what these different ways of working may offer. The absence of an evidence base for psychoanalytic psychotherapy was troubling, and I had a sense that we, as a profession, were not part of this conversation. I did, however, enjoy aspects of the research seminars in the first year. We planned and presented 'mock' research proposals in groups, and this allowed me to draw on my previous experiences and gave me space to reflect on my clinical practice. The experience of conducting an audit was also a positive one for me and allowed me to engage with the services in which I was training in a different way. While the findings from my audit in some

ways supported my previously held views of research (that you can use it to show something you already know to be true so that other people will believe you), it also challenged them by producing some findings I had not expected. I found that there was something satisfying about conducting the audit, and at times it felt like a welcome break from clinical work.

As I moved in to the second year of training I looked forward to designing my research project. On reflection this was probably the point when I first allowed myself to become interested in the research I was about to undertake. I had asked to be part of the research group involved in the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study (Goodyer et al, Goodyear, Reynolds, Barrett, Byford, Dubicka, Hill & Fonagy, 2017), a randomised controlled trial (RCT) looking at treatments for adolescent depression. This felt like a good fit considering that part of my training post was in an adolescent service, and it was an area of work in which I had a lot of clinical experience, having worked in adolescent inpatient wards prior to beginning the training. There was also a strange synchronicity to it, as I had once unsuccessfully applied for a job as a research assistant on this study. On reflection, I wonder if my interest in becoming involved in the study in a different way was helpful in re-engaging me to this way of working and began a sort of reparative process for me. I opted to focus my research on silence in adolescent psychotherapy, which would involve listening to audio recordings of the therapy given in the psychoanalytic arm of the study. I was excited at the prospect of being able to listen to other clinicians' work, as the privacy of the consulting room means it is not something child psychotherapists tend to have the opportunity to do. Additionally, I was interested to learn more about the psychoanalytic intervention used – Short Term Psychoanalytic Psychotherapy (STPP) (Cregeen, Hughes, Midgley, Rhode, & Rustin, 2016) – as I was conscious of the fact that if I wanted to continue to work in the NHS following my training I would have to develop my clinical work to include short-term treatments. While I was interested in this area clinically, I also felt the literature on silence in psychotherapy would be

more manageable. So, while I was becoming more emotionally engaged in my doctorate, my defences were still intact.

While we wrote brief proposals for our research projects that year, the focus was on writing a literature review. I approached this task with a degree of enthusiasm, feeling confident about my abilities to collate and analyse the theory and research on this topic. Having chosen the area partly because I expected the literature would be manageable, I was then confronted with what this actually looked like. It was frustrating to discover that there was very little research looking at silence in therapeutic work, and no research on silence in psychoanalytic psychotherapy. In response to this discovery and with the wish to keep my work within the field of psychoanalysis, I decided to write a theoretically based literature review. I was then to discover that nearly all the theory looked at silence in long-term adult psychotherapy and being engaged in a child training I felt strongly about the need for adaptation of technique for child and adolescent work. I continued with my plan and wrote my literature review looking at the theory of what silence can show us in psychoanalytic psychotherapy. While at times I felt very interested in my reading in this area, there was a lack of contemporary theory, and theory linking more traditional ways of thinking about silence in psychotherapy with current practice. Having already written a research proposal and decided to use the Pausing Inventory Categorisation System (PICS) (Frankel, Levitt, Murray, Greenberg, & Angus, 2006; Levitt, 2001) to code silences in STPP, I struggled to keep this in mind as I wrote the literature review, and the two felt quite separate. The PICS was developed using Grounded Theory Analysis (GTA), where patients were played video recordings of therapy sessions and asked to recall how they felt during silences. This explicit use of the patient's conscious thoughts felt quite in contrast to the psychoanalytically based theories on silence I was reading about, and I worried that the knowledge I was developing while writing the literature review would impair my ability to then go on to use the coding system.

Another reason the literature review was challenging for me was that I found it hard to find a place for my own creativity within it. The theoretical ideas I was immersing myself in were stimulating to my own clinical work and in my own personal analysis, but the lack of contemporary theory or theory related specifically to work with children made it hard for me to find room for my own experiences. One way I attempted to incorporate this was to try and include a chapter on theory-building case studies that analysed clinical papers where silence was a part of the work, to see what they added to the theoretical understanding. However, this also led me to the uncomfortable realisation that many of the clinical papers I reviewed seemed to have set out to prove the validity of well-established theory, rather than to suggest any new ways of understanding. This was a disappointing discovery, as these papers were ones I found most enjoyable and interesting. I felt I was developing a more critical lens through which to view such material, and while I could acknowledge that it did have value, I also felt more in touch with its limitations, and my own disappointment in this, and ultimately I made the decision to remove this section.

In moving between the clinical and research aspects to the training, it was a challenge for me to negotiate the different supervisory relationships I encountered. Through service-based and intensive case supervision I had experiences of being kept in mind that felt protective. While consciously I was aware that the supervision I would receive for the Doctorate would be different, I think unconsciously I approached it with the expectation that I would be ‘looked after’ in a similar way. Meetings with my Doctoral supervisor were less frequent, and I was expected from the start to act with more independence. Another difference was that, unlike the individual supervision I had become used to in my clinical posts, supervisions were shared between myself and three other trainees who were also using data from the IMPACT study. I was vocal early on about my preference to meet individually, but I was in the minority, as others felt it was of value to hear about each other’s developing projects and learn from our respective experiences. While I could acknowledge that some aspects of group supervision were objectively frustrating, I felt my personal

difficulty with it extended past this. For this, and other reasons, I decided to attend a group relations conference at the British Psychotherapy Foundation (BPF) which helped me think about my difficulty in embracing group supervision. Developing an understanding of this, alongside my attitude to research changing as I progressed through the training, allowed to me more curious about their work and feel the value in working more collaboratively.

As my training progressed, and I moved from the literature review to the empirical paper, I enjoyed feeling more ownership of my project and was excited by the possibilities of my research. While on the one hand I felt a sense of certainty about how I wanted my project to look, I was faced in supervision by the limits of my own understanding about what would constitute 'good' research, and on several occasions left feeling frustrated that I would need to think again about what I wanted to do. On reflection, I think I was overwhelmed by the task of designing my research, and my way of managing this was to prematurely grasp at ideas that I hoped would give me a feeling of security. When my ideas were challenged in supervision I struggled to know how to respond, as they did not have sufficiently strong foundations to withstand much scrutiny. This was a period of pseudo-maturity in my research journey, and it was painful to discover what I had yet to learn and to slowly allow my project to come together step by step. I was aware that some of my learning in the clinical side of the training was taking a similar trajectory and, on several occasions, I found myself feeling disarmed when my cases evolved in a way that made me question the understanding I had previously held. Time to work on the Doctorate was an issue throughout but became more problematic in my third year when the realities of data collection emerged. During this time, I was consciously aware of my attitude towards the Doctorate shifting, and I came to realise that I had been treating it as if I was doing it for someone else, and as something I had to do to satisfy them. In my analysis I reflected on how this adolescent attitude to my project was one I had adopted at earlier stages on my education where I had felt motivated to work to please my teachers or parents rather than finding a more personal engagement in what I was doing. As my research project started to come together I began to feel like I really

wanted to do the Doctorate and instead of resenting the time I spent on it, I felt more that this was time I was giving to myself, to my own development as a researcher, and to my career as a CAP. I also came to enjoy aspects of the work such as the coding and data management, and at times it felt like a welcome break from my patients.

As my research partner and I began coding the STPP sessions, I found a sense of satisfaction in 'ticking off' the tasks we set ourselves each week. It felt very helpful to be held accountable by one of my peers for our work, and we found a way of working together that played to both our strengths. We discussed a shared sense of pride in the data we produced, and it felt like another turning point in my Doctorate when my supervisor let us know that she felt the work we were doing was something that would be of interest and value to other clinicians and encouraged us to publish our work. Having only recently been able to feel more personally engaged in my work, it was a surprise to hear her thoughts that others could benefit from it. I found myself talking more to colleagues about my Doctorate and was encouraged by their interest in the subject and their requests to read it once it was complete. I began to feel that my research was no longer just about me, but that it could have a wider purpose.

The writing up of my research project found me again grasping for the wish to be efficient and finish the task before it was ready. I experienced some of the frustrations in my supervision that had existed at the planning stage, where aspects of the work that I felt were near completion needed rethinking. While I often felt like I wanted to be 'told' what to do, I came to understand that my supervisor could not tell me as she did not know herself, and that it was my job to explore different possibilities to find a way to present my research that would make sense. There was a danger that the resulting paper could end up reading as a mere description of how silence occurred in the STPP sessions, and that there would be no way to make any sense of these findings. This concern led me to introduce a qualitative element to my research and use material from IMPACT-My Experience (IMPACT ME) (Midgley, Ansaldo, & Target, 2014), a study 'nested' within IMPACT which used a mixed-

methods approach to more fully the impact of therapeutic interventions within complex clinical settings. I thematically analysed the ‘Experience of Therapy Interview’ that was conducted with the young people whose sessions we had coded upon completing their therapy. Although there was not a question in this interview that explicitly asked about silence, I remembered that a reason for silence being proposed as a phenomenon to research was that young people who had taken part in the psychoanalytic psychotherapy arm of the IMPACT study had commented on it following their therapy ending. Listening to these interviews and conducting thematic analysis upon them was an interesting experience for me as both a researcher and a clinician. The almost wholly negative views expressed about silence in therapy by these young people really helped me think more deeply about their experience of these moments, and how although I continued to feel strongly that they were of value, that they may be hard for patients to bear. The young people who were included in my research were purposively sampled as having completed therapy, and so one can surmise had managed to tolerate silence and be able to stay at least physically in the room. The findings of my research made me curious about how much silence in psychoanalytic psychotherapy could be a factor in some young people disengaging.

Finishing the write-up of my research put me back in touch with some of the limitations of research, and the ‘smallness’ of the work I had undertaken. I felt proud of what I had achieved, but somewhat chastened by writing my conclusion section and by how humble I had to be in interpreting my findings. While in the clinical side of my work I had learnt to be bolder in paying attention to unconscious material, I was aware that I needed to be careful about including these thoughts in my research despite them having been a guiding principle in my mind throughout. This made me curious about research in psychoanalysis more widely, and that while our work is based in attending to unconscious processes, it is observable phenomena that tend to be measured. My research found that, on average, more than one-third of sessions sampled were spent in silence, most of this silence was coded using PICS as ‘obstructive’, and that adolescents expressed negative

views about silent moments in their therapy. This could lead to a conclusion that silence should, where possible, be limited. I, however, felt strongly that although the silence was undoubtably uncomfortable for the young people experiencing it, that it was a phenomenon co-created by them and their therapist and that what happened in these moments was crucial to allow for the work of therapy to take place. 'What happened' was of course unknown to me as the researcher listening to recordings of these sessions, but I felt it linked to what was happening on an unconscious level for both the patient and therapist. I felt frustrated by this and wanted to be able to take my research a stage further. Perhaps I was identifying with the therapists who had seen these young people and wanted to be able to examine my countertransference and discuss these cases in supervision to understand further what was happening? While this avenue was not open to me, I was excited to read 'A Practical Psychoanalytic Guide to Reflexive Research' (Holmes, 2018) which explores how reverie can be used as a qualitative research tool and felt that if I were to continue with research following my Doctorate, then this would be an exciting direction to explore.

The process of undertaking psychoanalytically informed research was stimulating to both my clinical work, and my views on Child and Adolescent Psychotherapy as a profession. With my patients I felt more confident to allow for silence to exist in our sessions, as the process of writing the literature review had given me many angles from which to think about it. My research had offered the opportunity to listen to recordings of therapy sessions, and the seemingly unique way that each therapist approached the work with their patient allowed me to feel a little freer to develop my own way of working that incorporated my personality. It also emboldened me to take adolescents on for STPP, as I felt I had witnessed its effectiveness first hand in the therapies I had listened to. Rather than feeling I was 'short-changing' the adolescents I went on to work with in this way, I felt assured that STPP was an intervention of substance with the potential to effect real change in their lives. I am in no doubt that my confidence in this influenced how I was able to behave with these young people in the room and will have been to their benefit.

As I progressed with my Doctorate I felt a shift in my view of some of the child psychotherapists I was being taught by on the clinical side of my training. When I had felt that research in this field was merely about proving what one already knew, I had felt jealous that in their trainings and careers they had not had to be concerned with it. However, as my feelings on the value of research matured I felt both that they had missed out personally on what, for me, felt like a clinically very useful experience, and also that they had behaved with some arrogance to not feel that, as a profession, we needed to be able to communicate in this medium about the work they were undertaking. While I was now aware of Child Psychotherapists working as both clinicians and researchers, I could also see how large the task ahead was if our profession was to be able to show itself to be as valuable as other therapeutic modalities. Knowing how much work my small project had been made the task feel daunting, but I felt excited to read articles published using data from the IMPACT study (Midgley, Parkinson, Holmes, Stapley, Eatough, & Target, 2015; Midgley, Holmes, Parkinson, Stapley, Eatough, & Target, 2016; Midgley, Parkinson, Holmes, Stapley, Eatough, & Target, 2017; O'Keeffe, Martin, Goodyer, Wilkinson, & Midgley, 2018; O'Keeffe, Martin, Target, & Midgley, 2019) and read that new RCTs were in development (Edgington, Walwyn, Twiddy, Wright-Hughes, Tubeuf, Reed, (…) & Cottrell, 2018).

I approach the end of my training feeling certain that I will continue to be engaged with research throughout the rest of my career. While the frustrations and limitations of research in Child Psychotherapy cannot be ignored, our clinical work is not without difficulties of its own. I feel that it is the task of the new generation of CAPs whose training has given them this dual research and clinical literacy, to bring these two worlds more closely together so that each can enrich the other.

References

Cregeen, S., Hughes, C., Midgley, N., Rhode, M., & Rustin, M. (2016). *Short-Term Psychoanalytic Psychotherapy for Adolescents With Depression: A Treatment Manual.* London: Karnac Books.

Edginton, E., Walwyn, R., Twiddy, M., Wright-Hughes, A., Tubeuf, S., Reed, S., Smith, A., Stubbs, L., Birtwistle, J., Abraham, S., Ellis, L., Midgley, N., Hughes, T., Wallis, P., & Cottrell D. (2018). TIGA-CUB-manualised psychoanalytic child psychotherapy versus treatment as usual for children aged 5–11 with treatment-resistant conduct disorders and their primary carers: results from a randomised controlled feasibility trial, *Journal of Child & Adolescent Mental Health*, 1-16.

Frankel, E., Levitt, H., Murray, D., Greenberg, L., & Angus, L., (2006). Assessing silent processes in psychotherapy: an empirically derived categorization system and sampling strategy. *Psychotherapy Research*, *16*(5), 627-638.

Goodyer, I., Reynolds, S., Barrett, B., Byford, S., Dubicka, B., Hill, J., Holland, F., Kelvin, R., Midgley, N., Roberts, C., Senior, R., Target, M., Widmer, B., Wilkinson, P., & Fonagy, P., (2017). Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT): a multicentre, pragmatic, observer-blind, randomised controlled superiority trial. *The Lancet Psychiatry*. *4*, 109–19.

Holmes, J. (2018). *A Practical Psychoanalytic Guide to Reflexive Research*. Routledge.

Levitt, H. (2001). Sounds of Silence in Psychotherapy: The Categorization of Clients' Pauses. *Psychotherapy Research*. *11*(3), 295-309.

Midgley, N., Ansaldo, F., & Target, M. (2014). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression. *Psychotherapy*. *58*(1): 128-137.

Midgley, N., Parkinson, S., Holmes, J., Stapley, E., Eatough, V., & Target, M. (2015). Beyond a diagnosis: The experience of depression among clinically-referred adolescents. *Journal of Adolescence*. *44*: 267-279.

Midgley, N., Holmes, J., Parkinson, S., Stapley, E., Eatough, V., & Target, M. (2016). "Just like talking to someone about like shit in your life and stuff, and they help you": Hopes and expectations for therapy among depressed adolescents. *Psychotherapy Research*. *26*: 11-21.

Midgley, N., Parkinson, S., Holmes, J., Stapley, E., Eatough, V., & Target, M., (2017). "Did I bring it on myself?" An exploratory study of the beliefs that adolescents referred to mental health services have about the causes of their depression. *European Child and Adolescent Psychiatry*. *26*: 25–34

O'Keeffe, S., Martin, P., Goodyer, I., Wilkinson, P., & Midgley, N., (2018). Predicting dropout in adolescents receiving therapy for depression. *Psychotherapy Research*. *28*(5): 708-721.

O'Keeffe, S., Martin, P., Target, M., & Midgley, N., (2019). 'I just stopped going': A mixed methods investigation into types of therapy dropout in adolescents with depression. *Frontiers in Psychology*. *10*:75.