

Exploring Silence in Short Term Psychoanalytic Psychotherapy with
Adolescents with Depression

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. Three Short Term Psychoanalytic Psychotherapies of adolescents with depression were used in the study and silences occurring in six sessions of each therapy were coded using the Pausing Inventory Categorization System (PICS). Findings showed that, in the three therapies sampled, almost one-third of session time was spent on average in silence, and that most of this silence was coded as 'obstructive'. Moreover, the amount of silence in 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. Analysis suggests that the majority of the silence in these therapies related to conflict, which could be viewed as both an aspect of the developmental stage of adolescence and a symptom of depression. These findings suggest that silences may not always be therapeutically productive in adolescent therapy, even if they are considered to be so in psychotherapy with adults, and so adaptation of therapeutic technique is required.

Introduction

Silence during therapy is an important clinical phenomenon. As in life, silences in therapy can vary enormously in quality and duration; there are for example brief, tense silences or long and reflective silences, among many others. Levitt (2001) regards silence in therapy as the language of emotional experience, suggesting that what is conveyed in silent moments may in fact speak louder than words. This paper focuses on silence as a clinical phenomenon in psychoanalytic psychotherapy with adolescents with an aim to explore its emergence and its possible meanings for patients.

Engaging adolescents in therapy can be challenging. It has been estimated that 45% of adolescents in therapy end treatment prematurely without the agreement of their therapist (de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013). Moreover, for adolescents who do drop out of therapy, therapist silence has been found to adversely affect the therapeutic alliance (O’Keeffe, Martin, & Midgley, 2020). Given our understanding of the developmental tasks of adolescence, namely separation, individuation, and identity formation, the meanings and functions of silence in working therapeutically with this age group need to be conceptualized from a developmental perspective. Although writing on silence in adolescent therapy is limited, several single case reports that explore silence when working with young people do exist (Anagnostaki, 2013; Bakalar, 2012; De Sauma, unpublished; Lanyado, 2008; Leira, 1995). These provide some evidence that silence can play an important role in therapy with adolescents and bring to the fore both theoretical and technical challenges in how it is managed therapeutically. However, as far as we are aware, there has been no attempt to draw these ideas together in a conceptual framework that takes a developmental perspective (A. Freud, 1966; Harris, 1965) in understanding and managing silence in adolescent therapy.

The need to better understand challenging aspects of clinical practice, such as silence, 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 the treatment they receive in order to better understand how it can be effective (Midgley, Ansaldo, & Target, 2014; Midgley et al., 2016).

Given that the literature on silence in therapy with adolescents is limited, we will begin by outlining the key elements of psychoanalytic theory regarding silence in psychotherapy with adults. Since Freud (1912) first wrote on the topic, 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. While early psychoanalytic theorists tended to conceptualize silence in therapy primarily as a sign of resistance (e.g. Ferenczi, 1911; Freud, 1912), later theorists (Arlow, 1961; Blos, 1972; Sabbadini, 1992) approached silence in terms of its communicative function and highlighted the importance that the therapists' response to the silence has for how silence develops through the course of therapy (Zeligs, 1960).

Within the psychoanalytic literature, silence was initially 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 indicated the presence of repressed material. With the development of the structural model of the mind (Freud, 1923) silence was conceptualised in terms of resistance; as such, analysing silence was seen as a way to gain insight into the patient's conflicts and internal world. Within this model, silence 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 id impulses and the ego; in cases where such conflicts cannot be verbalised, silence may emerge and so be understood as the external marker of underlying conflict (Fenichel, 1928; Ferenczi, 1916; Fliess, 1949; Levy, 1958; Reik, 1924). The action of the superego was also considered as potentially leading to silence in therapy, when this 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 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; these include viewing silence as a way to connect to the therapist (Arlow, 1961; Lane, Koetting, & Bishop, 2002); as a wish for merger (Blos, 1972; Fliess, 1949); as associated with the work of mourning (Arlow, 1961; Blos, 1972; Fliess, 1949; Sabbadini, 1992; Segal, 1957; Winnicott, 1958; Zelig, 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.

Although silence has been discussed quite extensively within the psychoanalytic literature, these theoretical hypotheses tend to focus on single aspects of silence, as

observed in specific clinical situations. Although the multifaceted nature of silence is often acknowledged in the relevant clinical and theoretical literature, attempts to develop a conceptual framework to bring these ideas together are either outdated (Blos, 1972; Levy, 1958; Zelig, 1960) or insufficient (Sabbadini, 1992).

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, in the context of adult therapy. 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, studies that examined therapists' perspectives on silence suggest that silence is conceptualized as potentially allowing reflection, encouraging responsibility and enabling the expression of feelings (Hill, Thompson, & Ladany, 2003). 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, providing an opportunity for reflection, 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.

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 experiences during silent

moments. Now in its second edition (Levitt & Frankel, 2004), the coding system identifies nine silence types that fall into three broad categories, namely 'obstructive', 'productive' and 'neutral' silences. PICS has been used to examine the association of silence in therapy with outcome, finding that higher rates of productive, as opposed to obstructive, silence are linked to positive outcomes, and vice-versa (Frankel et al., 2006; Stringer, Levitt, Berman, & Mathews, 2010). Frankel et al. (2006) suggested that the finding of increased rates of productive silences in good outcome therapies (particularly in the first half of the therapy) could be understood as resulting from a greater capacity of these patients for emotional processing. Along similar lines, Gindi (2002) found that an increase in the overall number of silences and particularly an increase in reflective silences as therapy progressed was evidence of the patients' increased capacity for emotional processing. Higher pausing frequency and frequency of obstructive pauses have been found to be associated with client insecure attachment and with poorer treatment alliance (Daniel, Folke, Lunn, Gondan, & Poulsen, 2016).

While silence has been conceptualised as both a way to defend against the work of therapy and an important component of development, 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 from that of adults, developing an understanding of this aspect of the process of therapy would hopefully increase therapist confidence in working with silence in therapy, identify when silence is therapeutically productive (and when not) and thus be of benefit to improving clinical practice.

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?

Method

Research material

The research material for this study consisted of (a) audio recordings of STPP sessions, drawn from the Improving Mood with Psychoanalytic and Cognitive Therapies study (IMPACT), (b) audio recordings of a post-therapy interview, 'Experience of Therapy Interview', drawn from the IMPACT-My Experience (IMPACT-ME) study. The IMPACT study is 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) and IMPACT-ME is a mixed methods study 'nested' within IMPACT that aimed to understand the experience of young people taking part in IMPACT and to contextualise the findings of the clinical trial (Midgley, Ansaldo, & Target, 2014).

From the available data, three therapies were purposively selected for this study. Inclusion criteria included the following: young people 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; cases that had been in the STPP arm of the study and had also participated in IMPACT-ME, so that post-therapy interviews would be available for analysis; and cases that had completed therapy and participated in outcome monitoring. Based on the inclusion criteria, an initial pool of seven cases was created. From those, three therapies were selected. 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.

Six sessions were selected for analysis 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.

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).

Participants

Session audio-recordings of three therapies were used in the 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) (Angold, 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. The coding system includes 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 in a way that allows them to continue it. Obstructive silences are defined as the patients' attempts to defend against emotions elicited during the session and so stop further exploration. Neutral silences are defined as silences that occur as part of the patient's speech that are not linked to the content or the process of the therapeutic conversation.

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; it 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 (Daviss et al., 2006; Wood, Kroll, Moore, & Harrington, 1995). The long version of the MFQ which consists of 33 items was used in the IMPACT study. A total between 0-66 is produced, with higher scores indicating increased depression and 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 attended	26	29	25
Sessions selected for coding	4, 6, 14, 15, 23, 24	5, 6, 14, 15, 24, 25	5, 6, 13, 14, 23, 24
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

IMPACT-ME post therapy interviews. The 'Experience of Therapy Interviews', conducted following therapy completion, explored the young person's experiences of depression, how they felt things had changed since they had first been referred to therapy, and how they understood those changes. The interview included an opportunity for the young person to tell 'their story' of the therapy, including any significant moments, and their views about the relationship to the therapist. Interviews 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 identified, and these allowed hypotheses to emerge on what was happening within the therapy in relation to the quantitative data.

Procedure

Two coders, both trainee child and adolescent psychotherapists conducting doctoral-level research, self-trained in coding audio material using the PICS, 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 psychoanalytic therapeutic orientation and training impacted on their coding.

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

As indicated in the PICS manual, all pauses of three seconds or more were coded for silence type. Furthermore, the duration of the silence, the stage in the session in which each pause emerged, and the speaker pattern surrounding the silence, were also recorded. In this study, findings are reported in terms of the proportion of the session time spent in silence in each case report as to make clear the impact that each type of silence has on the session, and to aid comparison of the three therapies coded.

Verbatim transcripts of the 'Experience of Therapy Interviews' for these three patients were analysed thematically, with an aim to deepen our understanding of their experiences of therapy more generally with a focus on their experience of silent moments in therapy. The first author conducted the initial thematic analysis, following published guidance (Braun & Clarke, 2006; Harper & Thompson, 2012) as an aid, as well as supervision. Following repeated readings of the interview transcripts, a 'coding frame' was developed, based on all 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 theoretical 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. These findings were used to contextualize and enrich findings from the PICS coding.

Results

In this section, findings from the analysis of in-session silence of the three therapies is presented, followed by the thematic analysis of the three 'Experience of Therapy Interviews'; excerpts from these interviews are then be presented in an attempt to make sense of the findings.

A total of 1,248 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 total 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.

Each therapy showed differences in amount of silence. As shown in Table 2, in Therapy A 24.3% of the total session time was identified as silent, while in Therapy B this was 39.6%, and in Therapy C, 32.5%. Also shown in Table 2 is that the therapies differed in how the amount of silence changed over time. While in Therapy A and C, the amount of silence increased through each stage of therapy, in Therapy B the opposite effect was seen.

When considering silence type across all three therapies, 26% of total session time was spent in silence coded as 'obstructive', 5.4% was spent in 'productive' silence and only 0.4% of time was spent in 'neutral' silence. 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.

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%

With regards to silence type, both the total contribution of obstructive and productive silences and how this developed as therapy progressed differed between therapies (Table 3). While all therapies show a change in obstructive silence that is in line with change in overall amount of silence, both Therapy A and B show a sharp increase in productive silence during the middle phase of therapy.

Table 3

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

Silence Type	Therapy A				Therapy B				Therapy C			
	b (%)	m (%)	e (%)	Mean (%)	b (%)	m (%)	e (%)	Mean (%)	b (%)	m (%)	e (%)	Mean (%)
Obstructive	11.5	11.9	22.3	15.2	65.6	24.2	15.5	35.1	19.9	26	37.4	27.8
Productive	5.9	14.6	6.5	9.0	1.0	6.4	5.3	4.2	3.0	3.1	2.8	2.9
Neutral	0.1	0.1	0.0	0.1	0.1	0.2	0.5	0.2	1.0	0.9	0.9	0.9

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

Thematic Analysis

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...¹I'm done saying something or sometimes I'm actually thinking of something.”* Two of the patients discussed with the interviewer the relationship between silences in therapy and silences in the research 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 on background noise.

Excerpts that expressed the patient's feelings about, and views on their therapy were then selected and analysed with a view to examine them in relation to the quantitative data, with the wider aim to allow a hypothesis to develop around what might be happening in the therapy.

¹ Ellipses as written in transcription to indicate a pause

Therapy A

Therapy A was conducted with a 15-year-old young woman. Her MFQ scores decreased in the first 12 weeks of therapy but then increased at week 36 following therapy ending.

The total time spent in silence increased as this therapy progressed, and 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 there was a sharp rise in obstructive silences and a decrease in productive silence in the end phase of therapy. Drawing upon the interview data, it could be hypothesised that the patient expressed her ambivalence around the ending through silent withdrawal.

Therapy B

Therapy B was conducted with a 15-year-old young man. 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.

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... 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 realization 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. The large decrease in obstructive and small increase in productive silences as the therapy progressed point to a lowering of the patient's defenses and a greater engagement with therapeutic tasks such as reflection and emotional connection.

In general, the patient spoke quite negatively about his therapy:

"I [don't] 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, 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 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

Therapy C was conducted with a 16-year-old young woman. 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 scores had decreased further.

In the interview, the patient spoke 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 (...)² I'd think that she might have been judging me... (I: hmmm...) or like... she might have... told someone else"

² Short amount of material omitted for clarity of meaning

Interestingly, this was the only therapy where level of productive silence was relatively stable, even if quite low, across all three stages. One interpretation of the patient's comments on the 'barrier' they felt could be their wanting to keep at an emotional distance from the therapist, and thus limit the moments of connection and reflection.

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"

The patient's MFQ scores did decrease as the therapy progressed and she also reported positive feelings about her therapy (*"I think it's been really good, it's been really great"*). It is worth noting that patient C had the lowest MFQ scores upon completion of therapy. It is possible that this young person became more silent as therapy progressed partly due to this improvement and a concurrent lack of need or motivation to use the sessions. Indeed, the patient in some ways reflects on this herself in relation to the length of each session (*"I probably like...probably like half an hour sessions coz...I didn't have that much to say"*).

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. Our broader aim was to develop an understanding of silence as a phenomenon in adolescent psychoanalytic psychotherapy, taking into account how this is experienced by young people themselves.

One clear finding from this study 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. When comparing incidence of silence in our sample to these studies, it again appears silence is a much more common occurrence in this sample than in previous studies of adult therapy. 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, in these studies' treatment length, diagnosis, and therapy type were all variable, which would likely have impacted findings. The prevalence of silence in this sample as compared to other studies is striking and this may reflect some aspects of the clinical manifestations of depression as well as being linked 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 the id and the ego (Fenichel, 1928; Ferenczi, 1916; Fliess, 1949; Levy, 1958; Reik, 1924) or the ego and the superego (Levy, 1958; Loomie, 1961). Adolescence is a time characterized by increased internal and external conflict, as young people undergo the developmental tasks inherent to stage 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, taking up on average 29.2% of session time. In this study, obstructive silences constituted 69.1% of total silences coded, which was a much higher percentage than that reported in other studies, e.g. 13.9% (Gindi, 2002) and 11.2% (Frankel et al., 2006). This finding may again be interpreted as related to internal conflicts that are common in adolescence, including the developmental need to separate from attachment figures and become more independent (A. Freud, 1966; Harris, 1965); or it might relate to the fact that the psychoanalytically-trained therapists in this study were more likely to allow silences, even when they were uncomfortable. Unfortunately, the lack of other studies using PICS with an adolescent sample, especially in the context of psychoanalytic therapy, means it is unclear to what stage this finding can be linked to the developmental stage of adolescence or indeed depression.

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 using the PICS as 'obstructive'. 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 largely felt that such 'obstructive' silences were 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. This is likely to be affected by developmental

stage, and whilst working through issues around separation depressed 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. Research examining the therapeutic alliance has acknowledged the significance of silence as an indication of withdrawal ruptures (Eubanks, Muran & Safran, 2015), and recent research into adolescents who drop out of therapy has suggested that therapist silence may adversely affect the therapeutic alliance (O’Keeffe et al., 2020). It may be that more explicit conversation about silences in therapy would help adolescents understand, tolerate, and benefit from this aspect of psychoanalytic technique. In the current study, it was noticeable that therapists did not speak directly with the young people about how they were experiencing the silences, or why they as therapists might sometimes allow longer silences to happen. However, these findings suggest that allowing long silences to occur in therapy with adolescents may not be helpful, and that therapists should actively explore how their adolescent patients experience periods of silence, and consider actively seeking to reengage their patients and address alliance ruptures, 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; Zelig, 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. In line with this, 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. For example, despite Therapy A and Therapy C both showing an overall increase in amount of silence as the therapy progressed, our hypotheses regarding the underlying dynamics within each therapy differed based on contextual details, which included the patient's comments on their relationship with their therapist. While these findings have a degree of subjectivity, they draw attention to the potential for changes in silence within therapy to be directly or indirectly interpreted, and that the nature of interpretation must consider the relational aspects of the therapeutic encounter.

In terms of method, the PICS was found to be a useful way of quantifying and operationalizing silence as it occurs in psychoanalytic psychotherapy with adolescents. While the research methodology used in this study does not allow us to capture the full extent of the multifaceted nature of silence, we would argue that these findings can contribute to our understanding of this important clinical phenomenon and pave the way for more research in this area. A limitation of this study was reliance on audio material for coding, as video material was not available. While video is not considered essential for using PICS, visual cues are included in the coding manual, particularly for productive silences, and so the absence of such cues may have led to under-coding of this silence type. 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. 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, particularly in psychoanalytically-informed therapies that place relational aspects centre-stage. Further research in this area is needed in order to better understand the therapist's contribution to silences in therapy, including how silences are responded to. As such, including in the analysis an account of the therapist's countertransference reactions would be a very useful addition to a research

methodology aiming to study such a complex interactional phenomenon; similarly, the therapist's responses to silence and the effects of these responses on the unfolding interaction would be an important focus of further research in this area. Finally, the generalisability of these findings is limited by the small sample size.

In sum, this study suggests that silence is a strong feature of adolescent psychoanalytic psychotherapy, and that a large proportion of those silences can be considered 'obstructive' and are seen by young people themselves as difficult and uncomfortable. Silence is therefore an important feature of adolescent therapy, but one where research findings may lead us to question some aspects of current technique. Both theoretical and research developments are needed to further our understanding of this phenomenon.

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