Dissertation Volume:

Silence in the Psychoanalytic Work with Adolescents: An Exploration of Therapy Process

Literature Review
Empirical Research Project
Reflective Commentary

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(Independent Psychoanalytic Child & Adolescent Psychotherapy Association and The Anna Freud National Centre for Children and Families)

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:

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Overview

This thesis explores the occurrence of silence in the psychoanalytic work with adolescents. **Literature Review:** The literature review outlines psychoanalytic approaches to in-session silences in the psychanalytic work with adolescents. Particular attention is paid to the psychoanalytic understanding of silence from a developmental perspective, and a conceptualisation of silence in adolescent psychoanalytic literature is provided. Therapists' responses to silence and therapeutic technique are also considered. **Empirical Paper:** The empirical part examines the occurrence of pauses and therapists' responses to particularly long silences in three pragmatically sampled dyads of Short-Term Psychoanalytic Psychotherapy (STPP) with adolescents sourced from the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study (Goodyear et al., 2017). Pauses were coded across eighteen therapy sessions from beginning, middle and end of treatment. Data included frequency, duration, and percentage of session time taken up by silence. Pause quality was coded with the Pausing Inventory Categorization System 2nd Revision (PICS; Levitt & Frankel, 2004). Therapists' responses to long pauses (>1min) were coded with the Helping Skills System (HSS; Hill, 2009). A particular focus is given to the occurrence of long pauses (>1min), and therapists' responses to these are considered from a psychoanalytic angle. Implications for clinical practice and further research are offered. **Reflective Commentary:** The final part of the thesis, the reflective commentary, offers a reflection on the author's journey through conducting this research, including its peaks and troughs and discusses the author's own interest in silence and the implications of the research on the author's clinical practice.

Impact Statement

Impact on Theory

Whilst silence in psychotherapy was originally predominantly viewed as a sign of resistance, a review of the literature highlights that silence in adolescent and adult psychotherapy is a multi-faceted, dynamic, heterogeneous process that can have many meanings and functions. It is emphasised that some in-session silences can be understood from a developmental perspective and that there appears to be a link between (developmental) trauma and the occurrence of silence in psychotherapy with adolescents. The potentially healing function of silence is also discussed. Although therapeutic technique aimed at resistance may be appropriate with some silent adolescents, using the original recommendations of resistance interpretation or meeting silence with silence without evaluating what this might bring up in the patient may potentially be damaging to the therapeutic relationship. However, at the same time, words may be experienced as very intrusive by silent adolescents. Therefore, it would be beneficial for child and adolescent psychotherapists to have a theoretical framework that can be used to understand the occurrence of silence in the work with adolescents and how to respond to it appropriately.

Impact on Research

The exploratory therapy process case series study in this thesis adds to the small database of empirical research studies on silence in adolescent patients. It also contributes to the growing number of Pausing Inventory Categorization System (PICS) studies. It highlights that the in-session silences of the depressed adolescents receiving Short-Term Psychoanalytic Psychotherapy (STPP) in this sample differed from those found in the work with adults. To the best of the author's knowledge, this is to date the only study that categorised in-session pauses into different duration categories and had a special focus on long silences and therapists' responses to these. The findings of this study show that in this sample, there was a

large number of pauses longer than 60 seconds. The longer a pause, the more likely it was to be "obstructive" to the therapeutic process, and the less likely it was to be broken by the YPs. Therapists used a range of interventions to respond to the silences, yet many of these were followed by further "obstructive" pauses. This highlights the need for further case-building clinical case studies and empirical research to deepen the understanding of the many facets of adolescent in-session silences and therapists' responses to these.

Impact on Clinical Practice

The topic of silence in the therapeutic work with adolescents is currently not part of the curriculum at the child psychotherapy training schools. Considering that silence may be a frequent and distinct feature in some adolescent patients' clinical presentation, it may be of benefit to incorporate this topic into the training so that this insight can be implemented at service level. Ultimately, fostering knowledge around how to manage and respond to silence in a clinical setting appropriately may not only add to the "toolkit" of clinicians but may also enable clinicians to justify offering therapy to very silent young people who may traditionally be viewed as non-engaging or not suitable for one-to-one therapy.

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Glossary

Anna Freud National Centre for Children and Families (AFNCCF)

Adolescent Identity Treatment (AIT)

Borderline Personality Disorder (BPD)

British Psychotherapy Foundation (BPF)

Borderline Personality Pathology (BPP)

Child and Adolescent Psychoanalytic Psychotherapist (CAP)

Client-Centred Psychotherapy (CCP)

Cognitive Behavioural Therapy (CBT)

Child and Adolescent Mental Health Service (CAMHS)

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)

Helping Skills System (HSS)

Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT)

Improving Mood with Psychoanalytic and Cognitive Therapies – My Experience (IMPACT-ME)

Interrater Reliability (IRR)

The Independent Psychoanalytic Child and Adolescent Psychotherapy Association (IPCAPA)

Mood and Feelings Questionnaire (MFQ)

National Health Service (NHS)

Pausing Inventory Categorization System (PICS)

Pausing Inventory Categorization System 2nd Revision (PICS-R)

Psychoanalytic Psychotherapy (PPT)

Short-Term Psychoanalytic Psychotherapy (STPP)

Society of Psychotherapy Research (SPR)

Statistical Package for the Social Sciences (SPSS)

Young Person (YP)

Young People (YPs)

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Part 1: Literature Review

Title:
Psychoanalytic Approaches to In-Session Silence in Psychotherapy with Adolescents

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Abstract

This literature review outlines psychoanalytic approaches to in-session silence in the therapeutic work with adolescents. Particular attention is paid to the psychoanalytic understanding of silence from a developmental perspective, and a conceptualisation of silence drawn from the adolescent psychoanalytic literature is provided. Therapists' responses to silence and therapeutic technique are also considered. The literature points towards a link between trauma and the occurrence of silence in the therapeutic work with adolescent patients. It is highlighted that an adaptation of technique is recommended. The literature further demonstrates that silence has the potential to create an environment that facilitates inner growth. The importance of, and indeed need for, theory-building case studies in psychotherapy is highlighted. It is argued that due to the current gap in the literature around this topic, there is a scope for further research to get a better understanding of this fascinating phenomenon.

Keywords: silence, adolescence, psychoanalytic psychotherapy

Introduction

Adolescence is a developmental stage of growth, change and major upheaval and turmoil. Winnicott (1962) referred to it as struggling through the "doldrums", and Erikson (1956) called it a "normative crisis". Wilson (1987) aptly used Caroll's (1866) story *Alice's Adventures in Wonderland* to compare the rapid changes Alice undergoes, as well as her bewilderment about who she is and what is happening to her, to the stage of confusion and rapid change in adolescence. Much has been written about the challenges in the psychoanalytic work with adolescent patients. Indeed, A. Freud (1958) warned that with adolescents difficulties can be encountered in relation to the beginning, the middle and the end of treatment.

One challenge therapists often seem to face is the difficulty of some adolescents to communicate freely and the technical difficulties associated with this (e.g. Graafsma & Anbeek, 1984; Kitchener, 2012; Rustin, 1971; Wilson, 2001). Nevertheless, very little psychoanalytic literature appears to have been published that has the silence of adolescents as the primary focus.

This paper reviews the psychoanalytic literature on the role of silence in the therapeutic work with adolescents. It aims to address the following key questions:

1) What is the conceptualisation of silence in psychoanalytic theory?
2) What are the psychoanalytic approaches to in-session silence
    a. from a developmental perspective?
    b. with adolescent patients?
3) What are the psychoanalytic approaches to silence and clinical technique?

This review commences by outlining the theoretical development of the psychoanalytic understanding of the phenomenon of in-session silence. Conceptualisations of silence originating within the adult psychoanalytic literature are used to highlight developmental aspects of silence before moving on to a review of the literature of silence with adolescent patients. Therapists' responses to silence and clinical technique are reviewed by drawing from the adolescent and adult literature.

Search Strategy

An initial search of the adolescent literature was performed by searching PEP-Web, PsycARTICLES, PsycBOOKS, PsycEXTRA, PsycINFO, and the library databases of University College London, Anna Freud National Centre for Children and Families, the British Psychotherapy Foundation and the British Library for articles and books published in English or German. Search terms included "silence" OR "silent" OR "nonverbal" AND "psychotherapy" OR "psychoanalysis" AND "adolescent" OR "adolescence" occurring in the title or abstract. Adolescents were defined as young people (YPs) aged 11 to 18 years. All papers described silences that occurred in a one-to-one psychoanalytic or psychodynamic setting. Papers that discussed the topic of selective mutism or pervasive refusal syndrome rather than silence in the consulting room were excluded. The literature search identified twelve papers matching the above criteria; nine clinical case studies, one of which was identified after a discussion in clinical supervision, one theory paper and two empirical papers[1]. A further search, this time of the adult literature, was carried out using the search terms "silence" OR "silent" OR "nonverbal" AND "psychotherapy" OR "psychoanalysis". This search identified 70 psychoanalytic or psychodynamic theory papers and clinical case studies on silence in one-to-one therapy, one book, 22 empirical papers on silence in various

[1] The young people in one of the empirical papers had not received a psychodynamic treatment, however, due to the sparsity of the literature the paper was included.

talking therapies, and eight unpublished doctoral/Master's theses. The findings of this review are drawn from the relevant adolescent literature, the key adult literature[2], psychoanalytic publications on silence in the work with children, other psychoanalytic literature and discussions in the author's own clinical and research supervision.

What is Silence?

Silence is ubiquitous. The word silence itself is defined as "a period without any sound"[3] or "complete absence of sound"[4]. However, silence in speech is part of language, not merely an interruption of dialogue (Gale & Sanchez, 2005), and silence in psychotherapy is a meaningful phenomenon with psychodynamic significance (Weisman, 1955).

Empirical research on silence in psychotherapy, which has seen a surge of interest in recent years (e.g. Aho-Mustonen et al., 2020; Cuttler et al., 2019; Daniel et al., 2016; Hill et al., 2019; Knol et al., 2020), has shown that in psychoanalysis and psychoanalytic psychotherapy with adults, fewer words are spoken than in other forms of therapy (Daniel et al., 2016; Huber, Schmuck, & Kächele, 2012). Therefore, the question arises at what point a period without utterance in a psychoanalytic session becomes a clinically significant silence. Weisman (1955, p. 258) differentiated between pause and silence in a therapeutic setting, with the former being described as "a natural rest in the melody of speech"; the latter as a clinical symptom. In empirical studies, silence is typically defined as a pause in speech of three seconds or longer (e.g. Daniel et al., 2016; Frankel et al., 2006; Levitt, 2001; Stringer et al., 2010). The silences described in psychoanalytic clinical case studies with adults range from relatively brief, repeated instances of silence, of a few minutes (e.g. Blos, 1972; Bravesmith, 2012), to silent sessions spanning over several days (e.g. Kreische, 1985),

[2] For a full list of all publications on silence found during the literature searches please see Appendix A.
[3] Cambridge Dictionary
[4] Oxford Dictionary

months (e.g. Coltart, 1991) or, with intermissions, even years (e.g. Fuller & Crowther, 1998; Goldstein-Ferber, 2004). Silence can be a feature early on in therapy (e.g. Cooper, 2012; Lombardi, 2010), appear later on in treatment (e.g. Goldstein-Ferber, 2004; Ronningstam, 2006), or can be a constant feature of the whole treatment (e.g. Martyres, 1995; Morgenstern, 1980). It can also have distinctly different qualities in different therapy stages (e.g. Elson, 2001; Hadda, 1991; Martyres, 1995).

Three main types of silence in psychotherapy are the patient's silence, the analyst's silence, and the analyst's and patient's silence (Blos, 1972). However, it should be borne in mind that neither the patient's nor the analyst's silence is genuinely a silence whilst the other is talking (Sabadini, 1991). Attention, therefore, needs to be paid to how and by whom a pause is initiated and who breaks it. Indeed, pause speaker patterns have been studied empirically (e.g. Daniel et al., 2016; Frankel et al., 2006; Levitt, 2001). However, ultimately, we can only understand silent moments by looking at the context in which they occur (Knutson & Kristiansen, 2015).

Most of the psychoanalytic literature on silence in the work with adults appears to have been written on the silence of the patient, some publications having "the silent patient" as the main focus. Coltart (1991) defined the silent adult patient as someone who talks for about 10% or less of their psychoanalysis. It appears that no other attempts have been made to define the silent patient, and to the best of the author's knowledge, no attempts have been made to define the "silent adolescent patient".

Historical Account of the Conceptualisation of Silence

The early evolution of the psychoanalytic theory of silence has been well-documented[5]. Freud (1912) first linked the occurrence of silence to the patient's concerns about the analyst's presence and his interpretations of the material the patient brought, which Freud thought led to a resistance to free-association and transference thoughts.

Early authors (Abraham, 1916; Fenichel, 1928; Ferenczi, 1916; Freud, 1925) linked silence to the psychosexual stages of development, the original erotogenic zones, and the repression of sexual thoughts and fantasies. The early recommendation was to meet silence with silence which left the patient little choice but to talk. Many analysts took up this technique, and it evolved into an implicit rule of treatment (Calogeras, 1967).

During the 1930s, silence continued to be regarded as a reflection of resistance. It was mainly linked to the structure of the ego and as a defence against bodily sensations connected to the psychosexual stages (Bergler, 1938; Fliess, 1949). The 1940s and 1950s brought with them a shift in how silence was conceptualised and addressed, and silence gradually began to be seen as a phenomenon with several underlying functions. In 1958 Winnicott published his seminal paper *The Capacity to be Alone*. He suggested that this capacity is developed in infancy through an internalisation of the mother's presence. Winnicott (1958) further emphasised that silence in the psychoanalytic setting can be a sign of the patient's capacity to be alone in the presence of another, and thus rather than indicating resistance, it can be regarded as a developmental achievement. Moreover, another paper by Winnicott (1965) entitled *Communicating and Not Communicating Leading to a Study of Certain Opposites*

[5] See for instance Calogeras (1967) for a comprehensive review of psychoanalytic thought on silence from 1912-1966.

explored ideas around the right to protect one's core self and the subsequent need to respect a patient's wish to be silent and not communicate.

Around that time, silence began to be seen more and more as a communication (Blos, 1972; Greenson, 1961; Khan, 1963; Lief, 1962; Liegner, 1974; Nacht, 1963; Weisman, 1955; Zeligs, 1960), and indeed as a normal phase in the therapeutic process (Loewenstein, 1961). The question of technique in the work with silent adults (Arlow, 1961; Cremerius, 1969; Enelow, 1960; Lief, 1962; Zeligs, 1960, 1961) and the analyst's silence (Brockbank, 1970) also received more attention.

Importantly, Khan's (1963) paper *Silence as Communication* about a silent 18-year-old young man was particularly innovative. Khan regarded silence as communication rather than resistance and adapted his technique to meet his adolescent patient's needs. The latter was important because although the psychoanalytic interest in the phase of adolescence had increased in the post-war years (Freud A., 1958; Spiegel, 1951), the idea of treating adolescents was mostly disregarded until the end of the 1950s (Perret-Catipovic & Ladame, 1998). Thereafter, the interest in the analytic work with adolescents began to increase. This change was especially influenced by the pioneering work done by analysts such as Blos (1962, 1967, 1970) and Laufer (1966, 1975; 1989).

Since then, the analytic understanding of silence has come a long way. Nowadays, silence in the consulting room is considered to be a multi-determined phenomenon with a wide range of meanings and functions. There is now also the recognition that due to their developmental needs, the psychoanalytic treatment of adolescents requires a different technique to that of adult patients.

A Developmental View on Silence

As highlighted above, silence is a phenomenon that is diverse, dynamic and not easily categorised. This section pays particular attention to the adult psychoanalytic literature that considers silence from a developmental perspective.

The intra-uterine existence gives the foetus the first experience of silence and sound, and thus of absence and loss, through the coming and going of the mother's voice which could be thought of as a *sound-object* (Maiello, 1995). The absence and presence of the voice are not always in tune with the baby's needs, and just as later on the breast, it can be experienced as comforting but also frustrating (Maiello, 1995). If the unborn baby experiences the mother's voice as worrisome, it might shiver and turn away and therefore miss out on the above-proposed experience of presence and absence (Woo, 1999). The foetus may thus perceive the intra-uterine environment as hostile and develop "a dread of otherness", leaving the baby unequipped for postnatal reality (Woo, 1999, p. 97).

Similarly, silence in psychotherapy has also been linked to the original silence, loss or absence of the mother or parents (Cooper, 2012; Hadda, 1991; Kurtz, 1984; Loomie, 1961; Weinberger, 1964; Zeligs, 1960). These silences are often described as hostile and could be understood as an enactment and identification with the aggressor. In this case, the treatment can assume a sadomasochistic dynamic which re-creates the original relationship, as the patient's silence punishes the analyst for his silence but at the same time invites punishment (Kurtz, 1984).

Silence has also been connected to the pre-verbal mother-child relationship (Arlow, 1961; Hadda, 1991; Levy, 1958; Nacht, 1963, 1964; Olinick, 1982; Serani, 2000; Shafii, 1973; van der Heide, 1961; Winnicott, 1971). These silences can be understood as a regression to the preverbal stage and a communication of the patient's longing for oneness

and wish to return to the idealised symbiotic relationship with the mother. In particular, the silence of the analyst may cause the adult patient to regress and long for oneness with the mother/therapist as mother imago (Nacht, 1963).

Further still, the link between some in-session silences and issues with the separation-individuation process and speech development has also been made. The wish of some patients to only communicate in single words rather than sentences may be an avoidance of a differentiation between "self" and "other" and be therefore connected to the stage of development when the emergence of language signifies attempts of separation-individuation from the primary caregiver (Busch, 1978).

Rather than just being an intrapsychic phenomenon, silence can thus act as a vehicle to communicate various subtle issues concerning identity formation of the earliest developmental stages (Kurtz, 1984; O'Toole, 2015). As these experiences were preverbal, a patient might struggle to find words to articulate themselves and may therefore revert to satisfying their needs in a non-verbal and regressive fashion (Olinick, 1982).

Developmental trauma, loss, and developmental arrest have also been linked to the occurrence of silence in psychotherapy with adults (Elson, 2001; Fuller & Crowther, 1998; Hadda, 1991; Kurtz, 1984; Ronningstam, 2006; Weinberger, 1964; Weisman, 1955).

Some authors made use of insights gained through attachment theory research following Bowlby (1969, 1973, 1988; 1980), Main & Weston (1982) and Main (1991) to gain a better understanding of their silent patients[6]. In the empirical attachment literature, pauses in speech

[6] According to Bowlby, if the primary caregiver is responsive and attuned to an infant's needs, and these needs are met, the attachment figure represents a *secure base* from which the infant can explore the world. This first attachment relationship with the primary caregiver creates a blueprint for the 'internal working models' of emotional development and attachment behaviour later in life. Ainsworth and colleagues discovered three main infant-parent attachment styles from their *Strange Situation Procedure*: secure, insecure-ambivalent, and insecure-avoidant (1979). An additional style, insecure-disorganised/disoriented, was later discovered by Main & Solomon (1986).

are often seen as a sign of unresolved feelings and trauma, manifesting as "prolonged silences as part of putative dissociation" (Daniel et al., 2016, p. 3 citing Hesse & van Ijzendoorn, 1999). Moreover, adult therapy process and outcome research have also demonstrated that therapists may be able to use in-session silences as a predictor of patient attachment insecurity (Daniel et al., 2016) and that patients' attachment anxiety and the type of silence that occurs can predict immediate outcome (Cuttler et al., 2019).

In the psychoanalytic literature, silences have been linked to patients' early ways of relating that had protected them from trauma and that they continue to employ to avoid re-traumatisation (Kiesky & Beebe, 1994) and regulate anxiety (O'Toole, 2015). Silence thus ultimately acts as a protective function for the integrity of the self (Fuller & Crowther, 1998). However, entering a relationship with an empathic therapist who appropriately regulates the patient's anxiety and fear in the here and now can have a healing function and restore a patient's sense of well-being (O'Toole, 2015).

Indeed, silence can become a communication of intrapsychic transformation and growth. Kurtz (1984) described that, as the therapy progresses and the patient feels more secure and trusting, they can assume a position that resembles "infantile receptivity", which then allows "for a new introjection" to take place alongside the original objects (p. 230). Knutson & Kristiansen aptly stated that some silences could act as "a gateway to healing" (p. 21) but also pointed out that patients must go "through a period of incubation before inner transformation takes place" (p. 20). Ronningstam (2006) clarifies that "silence can function as a protection of an inner space and promote an inner transformation and connection between experiences, affect and verbal language that enables changes in interpersonal relationships" (p. 1278). Hadda (1991) stressed that silence could allow patients to assert themselves and become

more autonomous. Fuller & Crowther, who in their paper described how the silences of their patients created a "deathlike suspension" (p. 523), concluded that "the destructive forces unleashed during the analyses [were] balanced by a measure of creativity and growth" (p. 539).

Silence in the Therapeutic Work with Adolescents

Having discussed the developmental view of silence in the adult literature, the focus of this section is the approach to in-session silence in the adolescent literature.

Before thinking about the silence of adolescent patients, it is pertinent to think about adolescence itself. Often referred to as the "storm and stress" period, adolescence is a time of significant change. Adolescents need to navigate their way through an age that is no longer childhood but not yet adulthood, and which involves plenty of maturational tasks. Following the first separation-individuation process in toddlerhood (Mahler, 1972), the second individuation process takes place in adolescence (Blos, 1967). The first process involves the infant's attempts of physical separation from the primary caregiver, first by crawling and later upright locomotion. It also involves the beginning of the psychic separation through the development of language and the formation of the superego. The separation from the parental figures is continued and renegotiated in the second process. It is a time of reorganisation and physical, emotional, and neurological change. The young person (YP) is likely to make attempts to separate from the significant adults in their life whilst at the same time remaining much dependent on them. Wilson (1987) aptly illustrates this process by stating, "There co-exists within the adolescent a wish to grow up and an underlying yearning to remain a child. Dependency and passivity remain powerful undercurrents, offering fantasies of comfort and protection, and yet fears of loss of self-coherence and determination" (p. 54). Previous difficulties which had not been sufficiently worked through can re-emerge in powerful ways

in adolescence. Thus, the need for therapy may often arise at this time, yet it is also the age when therapists need to work particularly hard to keep YPs engaged, as there is a strong pull away from parental figures and towards peers instead (Dowling, 2019). If therapy does successfully take place, the therapist can function as a *new developmental object*, an adult with whom the YP can experience a different type of relationship than that to their parents (Hurry, 1998).

The challenges of providing therapy for adolescent patients can be manifold, and as illustrated below, one such challenge may be associated with the clinical management of silence.

In the work with adolescents, especially those who are depressed or have severe developmental disturbances, the communication of the silence needs to be explored, and the young people need support from their therapists to put their thoughts and feelings into words (Cregeen et al., 2017; Baruch, 1997). In these cases, therapists need to take responsibility for where the sessions are going so that the young people are not left in silence. Indeed, silence may turn into a threatening void and absence of the object, particularly if this resembles the YP's early experiences (Horne, 2006).

Joining techniques such as "mirroring", "hyper valuation" (Marshall, 1972), and "behavioural communication", particularly body language (Osorio, 1977), have also been advocated as techniques. Nevertheless, at the same time, certain adolescent patients may experience words spoken by the therapist as too concretely and resort to "no-entry defences", thus refusing to take in the words and oral nourishment of the therapist (Cregeen et al., 2017).

Braski (1999) warns that particularly in the early stages of treatment, it is easy for therapists working with silent adolescent patients to behave in ways that the YPs expect: "telling, lecturing, getting in their faces" (p. 547). She advocated sitting quietly with the

patient and "shifting inwards", thus creating a space that facilitates reflection and strengthens the therapeutic alliance (Braski, p. 457). This ties in with Lanyado's (1985, 2004, 2009) writings on her work with severely traumatised children and her idea of the "quiet presence of the therapist". She described entering a state of *therapeutic reveri*e and discussed the healing process of the long silences in the treatment of two particularly traumatised child patients by making use of Winnicott's (1958) idea of *being alone in the presence of another* and Balint's (1968) concept of the *basic fault* which can heal itself if the conditions are right.

The above highlights that silence in the work with adolescent patients is a topic that is very much present in the psychoanalytic literature. Despite this, it appears that not much attention has been dedicated to the exploration of silence as the primary focus. A thorough literature search concluded that psychoanalytic publications focusing on the phenomenon of silence in the work with adolescents as a central theme are very sparse. A total of 12 adolescent papers were identified, consisting of nine psychoanalytic case studies, one theory paper and two empirical papers, one of which was not psychoanalytic. The case studies consisted of papers written about young adolescents aged 11-12 (Anagnostaki, 2013[7]; Cristy, 1993), mid-adolescents aged between 15-16 years (Bakalar, 2012; MacIntosh, 2017; Malberg, 2012; Wilson, 1997), and older adolescents aged 17-18 years (Khan, 1963; Leira, 1995; Moser, 1962). The theory paper (Gensler, 2015) outlined three case vignettes about YPs aged 13, 17, and 18 years. The presenting symptoms of the YPs varied, but all were in one-to-one psychoanalytic or psychodynamically informed treatments. The two empirical studies focused on depressed adolescents between 15-16 years who were in Short-Term Psychoanalytic Psychotherapy (STPP) (Acheson et al., 2020) and adolescents aged 13-19

[7] The YP was 10 ½ -year-old when they started therapy, however, the paper was included as the silent period only started after the patient had turned 11 years.

years who received adolescent identity treatment (AIT) (Zimmermann et al., 2020). The common themes which occurred in the identified literature are reviewed below.

Silence and Trauma

All clinical case studies were marked by at least one extended period of silence or a total absence of speech. The link between (developmental) trauma and silence in psychotherapy with adults, which was demonstrated earlier, was also present in the adolescent literature. Importantly, Cristy (1993) and Leira (1995) both described the neglect, abuse, physical violence, and traumatic losses their patients experienced in the contexts of their family lives. Khan (1963) and Moser (1962) outlined their patients' family pathologies and strained relationships with their parents. Khan referred to the cumulative trauma the patient had sustained through the disturbed relationship with his mother. MacIntosh's (2017) patient also presented as severely traumatised and suicidal and had a very strained relationship with her mother. Malberg (2012) outlined her patient's traumatic early separation from her preoccupied mother when she went back to work when the YP was six months old, having been cared for by a succession of nannies. Wilson's (1997) female patient had experienced a traumatic separation from her parents in infancy and then another separation from her primary caregivers in latency to be reunited with her birth parents. The YPs whom Anagnostaki's (2013) and Bakalar's (2012) worked with appeared not to have suffered any immediate trauma or traumatic separations but did not seem to have had the experience of being consistently kept in mind by their primary caregivers in early childhood.

Silence and Regression

One of the themes that appeared in the literature was the therapists' understanding of their patients' silences as regression to earlier stages of development. Leira (1995) argued that the "silent qualities" of the psychoanalytic setting, including the consistency of the space and time, as well as the analyst's neutrality, empathy and containment, "represent an ongoing

communication on a nonverbal level, analogous to the communication in the early mother-child relationship" (p. 41). Malberg's (2012) patient presented early, somatic forms of discharge and self-soothing, such as thumb sucking, biting and crying (p. 301). Malberg added that the YP regressed to an earlier way of functioning and that the silences could be understood "as a way of expressing [the patient's] longing and fantasy for union in the transference, where words are unnecessary" (p. 301).

Cristy (1993) linked her YP's silence to the hostile identification with her parental figures. She related her patient's rigid posture and silence to an aggressive impulse control which acted as a defence against the fear of falling apart, but highlighted that after a while, this gave way to a new phase in the therapy when the patient felt safe enough to surrender control and to regress. Khan (1963) reported that his patient was using him as his auxiliary ego, allowing the analyst to "experience and register what he had lived through passively at some stage in his development" (p. 304). He highlighted that by allowing the YP to be silent, he enabled the creation of an environment that facilitated the re-enactment of unconscious conflicts connected to the YP's childhood trauma and allowed him to work through these.

Being a man of his time, Moser (1962) argued that chronically silent patients present with a forceful *anal-retentive stance* (the withholding of words) but display at the same time (although initially more hidden) an *oral-receptive attitude*, revealing the wish to be looked after and fed by the mother and to merge into one entity. Moser elaborated on this by pointing out that towards the end of the analysis, his patient disclosed his constant fear of being reprimanded for saying something unacceptable during his sessions. The YP therefore often remained silent to create a distance between himself and the analyst, yet at the same time longed to be close to him. Moser argued that silence could simultaneously be understood as a defence, as well as an attempt to satisfy the urge to regress to a preverbal form of communication and the wish to create an environment where words are no longer needed or

necessary. The silence of the YP Bakalar (2012) worked with created "a quiet, safe space" to be in the therapist's presence "as the longed-for mother/analyst", effectively communicating what it had been like for the patient to feel forgotten and ignored as a baby (p. 235). Bakalar also outlined her patient's anger towards the therapist and argued that the silence protected the mother/analyst from the patient's rage.

The above findings tie in with the aforementioned findings from the adult literature, which highlighted a connection between (developmental) trauma and in-session silence with adult patients.

The Healing Function of Silence

Notably, a central theme of all clinical case studies seemed to be the healing and protective function of silence. Moser (1962) argued that patients could use silence as a protective cloak under which they can withdraw from their surroundings whilst undergoing a reorganisation of the ego. He aptly called this the "silence before the birth" (p. 623)[8]. Cristy used Eist's (1983) idea of silence acting as a screen behind which growth can take place, to highlight the development of her patient whose silence marked a regression to a "new preverbal dyadic relationship" (p. 192) which allowed her to work through some of her trauma and reach a more functioning level. Leira (1995) used Modell's (1990) concept of *dependent/containing transference*, which describes the recreation of the early mother-child relationship allowing a patient to work through their developmental conflicts on a symbolic level, to describe the function of silence in the therapy with her adolescent patient. Leira also referred to the Norwegian term *vake* (describing both the action of watching over someone, as one would with a young child, and the behaviour of a fish being on the feed, "leaping above and below the water surface") (p. 49) as a metaphor for her "dreamlike attentiveness"

[8] My translation.

and her state of "intense, empathic engagement" (p. 55). She suggested that this particular state was corresponding with her patient's developmental stage, as it created a quiet and containing space where they could re-enact themes from the separation-individuation stage that eventually allowed the YP to enter a more integrated state. Anagnostaki (2013) also made use of Modell's thinking, referring to his idea that during silent sessions, the patient recreates the missing elements that are needed to complete the task of individuation. She described that during the silence, her "[m]ost frequent thought was that [the therapist] was like a mother watching, observing, listening to her baby and providing her with a safe place to sleep" (pp. 162-163). She added that the YP appeared to have used the sessions as "a therapeutic shell from which she emerged once she knew she was a desirable infant" (p. 169). MacIntosh (2017, p. 448) used insights gained through neuroscience to make sense of her patient's dissociative state during sessions. She argues, "The nonverbal mode of communicating becomes more complex with traumatized patients where, in the absence of verbal communication, unsymbolised affects, self-states, and memories may be enacted by the patient and analyst" (p. 448).

Wilson (1997) used Winnicott's (1965) concept of protecting the *core self* by not communicating to argue that silence can be an attempt of traumatised adolescent patients to protect the integrity of the self. Malberg (2012) also made use of Winnicott's concepts of the mother as the *guardian of the instinct barrier* (Winnicott, 1958), which provides a *holding environment*, the optimal environment for *good enough* parenting (Winnicott, 1960). She stated that in the transference her role was often that of a mother figure who allowed the YP to safetly explore the difficult affects which were assicated with her preverbal experiences of not being held in mind (Malberg, 2012). Bakalar (2012, p. 238) also drew on Winnicottian theory by arguing that the YP she worked with needed to be in the *presence of another* (Winnicott, 1958) to mitigate the effects of their *basic fault*" (Balint, 1968).

Silence and Countertransference

It is generally acknowledged that a patient's silence can stimulate a particularly strong countertransference in the therapist. This theme also appeared in the adolescent literature. For instance, Moser (1962) warned that the silence of the patient may be experienced as a failure by the analyst and may lead to a "hostile emptiness", which could unconsciously cause the analyst to either woo the patient and make recurrent attempts to re-establish contact or to also withdraw into a hostile silence (p. 619). Importantly, Moser (1962) also emphasised that silent patients often had to endure inconsistent, hateful and shaming behaviours of one or both parents as they were growing up. He argued that because of this, it is essential for the analyst to be reliable and present. MacIntosh (2017) identified that she felt paralysed and that being with the YP was a torturous experience. She elaborates, "I fought back the darkness of the dissociation that threatened to suck me down" (p. 436-437). Cristy (1993) defines her countertransference as follows, "I was feeling frustration, impotence and anger at not being able to get [the patient] to speak […] in the same way the foster family felt when they were unable to help [her] learn and remember" (p. 182). Bakalar (2012, p. 230) remarked that during her patient's long silences, she "oscillated between feeling helpless, frustrated, anxious and angry, and feeling maternal towards [the YP]". She understood this as a reflection of her patient's experiences as an infant when he felt abandoned and not kept in mind by his mother. Wilson (1997) outlined his countertransference as finding himself "filled with a kind of diffuse anguish" (p. 18), and as the therapy progressed, he "was beginning to feel weary of being made to feel stupid and left out" (p. 18).

Malberg (2012) explains that at the beginning of the treatment, her countertransference reactions were "detachment and feelings of helplessness" (p. 300) and feeling "cruel and punishing" (p. 306). Anagnostaki (2013) described that by being "excluded from any form of communication with [the patient]", she felt "angry and wronged",

acknowledging that these feelings were likely to be a projective identification (p. 163). The latter is echoed by Khan (1963), who outlined his countertransference and spoke of the "reproachfulness" his patient's behaviour provoked in him, adding that it is crucial to be aware of this to avoid the error of making interpretations that may be experienced as critical by the patient or elicit guilt. He highlighted his conviction that the difficult feelings he experienced in the countertransference were all directly related to the YPs original traumatic relationship (Khan, 1963).

Interestingly, Leira (1995) reported a different experience of the transference relationship. Due to the patient's silence, she found herself unable to pick up a message through her countertransference but then followed her patient into his state of intense introversion. She reported that while this process was unfolding, she felt calm and content and had a sense "of being useful" (p. 51). She proposed that in the silence, "themes from phases of the early separation-individuation process were possibly re-enacted in the [transference-countertransference] relationship" (p. 56).

Adolescents' Experience of Silence

Importantly, two empirical studies looked at adolescents' experience of in-session silence as part of their research. Zimmermann et al. (2020) investigated silence during AIT of adolescents with borderline personality pathology (BPP) and measured the YPs experience of silence with the Session Evaluation Questionnaire. Results showed that the YPs perceived sessions which were more silent as "less smooth" and rated these as "more unpleasant, rough, difficult, and uncomfortable" (Zimmermann et al., 2020, p. 164). Acheson et al. (2020) explored silence in STPP with depressed adolescents. As part of the study, post-therapy interviews, which had been conducted with the YPs as part of a larger study, showed that the

adolescents experienced silent moments in their respective therapies as difficult and uncomfortable.

Silence and Clinical Technique

Having discussed the conceptualisation of silence and how it is experienced in the transference-countertransference relationship with adolescent patients, the question arises about how therapists respond to in-session silences.

Cristy (1993) described that, especially during the early sessions, her patient seemed to experience her voice as intrusive, and so she said barely anything but fell into the trap of introducing structured activities (drawing; the squiggle game). She argued that, on reflection, these activities may have been experienced as even more intrusive than words by the patient and acknowledged that she found it more challenging to "give up control" and let the silent process unfold than she had anticipated. Anagnostaki (2013) also described that her interventions were minimal during her patient's long silences. She outlined that when she shared thoughts about her countertransference with the patient, these were not only rejected but that by talking, she seemed to be "violating something very important" (p. 163) and therefore remained largely silent herself. Wilson also explained that all of his usual technical approaches did not seem to work and that the more he tried to talk, the more he seemed to "miss or intrude" (p. 17). Leira (1995) described that she had asked her patient how he experienced the silences early on. When he stated that his sessions felt very important and that a lot was happening inside him, Leira continued to sit in silence with her patient. She described that as long as a connection between her and the young man remained, she let her attention wander towards her patient and her own thoughts. Indeed, Moser (1962) stated that the patient's silence must be endured and tolerated by the analyst and stressed that, especially

at the beginning of treatment, the silent patient needs time until he feels trusting enough to establish contact.

Malberg (2012) outlined how she let herself be guided by her countertransference and, in particular, her unusual lack of empathy, to find a way to speak about the YP's emotional experience "without feeling like an impinging and persecutory object" (p. 302). Malberg further stated that she understood her role as a *new developmental object* with whom the patient "could explore different ways of interaction, and safely mourn losses and what she felt she had never had" (p. 311). Cristy (1993) explained that she had to rely on monitoring her patient's non-verbal communication, especially her body language, as well as heavily relying on the countertransference. She vividly described her patient's uncomfortable looking posture and proposed the idea that the posture and the patient's silence were a desperate attempt of the patient to exercise some control in her life and hold herself together. "It seemed to me that [the YP] felt as if she was impotent, an object acted upon and that her passivity and silence were her only ways of asserting power" (p. 181). Interestingly, Moser (1962) also referred to his patient's seemingly uncomfortable posture. Khan (1963) highlighted that whilst remaining largely silent, he made regular, albeit sparing, comments about observations of body language and feelings. He also would give a summary at the end of each session to communicate that he had paid attention, create a separateness between him and the patient, and provide "a verbal link to the next session" (p. 307). Throughout the therapy, Cristy (1993) adopted a similar approach and made observational comments on her patient's behaviour and body language, and eventually started to mirror the girl's body language "as a way of trying on her feelings" (p. 185). The author seemed to achieve remarkable results with this and described that her patient moved from what Searles (1979) called the *autistic phase* of treatment into the next stage, the *therapeutic symbiosis*, referring

to Searles' statement that the patient can only resolve a fixation in ego development if they feel "indispensable to the analyst's ego functioning" (p. 186).

Importantly, Bakalar (2012) described that after consulting with a colleague, she decided to start crocheting during the sessions, which helped her to fend off boredom and sleepiness, and to "be more peacefully present for [the YP] as we struggled together" (p.232). Bakalar also started to "think out loud" but also allowed her mind to wander, thinking both about her patient and about her own life. Finding meaning in these countertransference associations helped to understand the patient better. Wilson (1997) also described a variation of technique. He outlined that his adolescent patient started to write letters to him between sessions which he then commented on and interpreted during the following session. This development appeared to present a turning point in the therapy. MacIntosh (2017) also emphasised her adaptation of technique through shared art-making in her patient's sessions. Thus, both Wilson and MacIntosh allowed their patients to communicate without having to use (spoken) words, which is likely to have helped the YPs feel heard and understood and aided them in their recovery.

Gensler (2015) described a very different type of silence in adolescent psychotherapy in his theory paper. He referred to YPs who may want to speak in therapy and might even try but are unable to find a way to communicate. The silences that Gensler outlined seem to be less connected to trauma and more to the more ordinary adolescent struggle of relating and being in a room with an adult. He stressed the importance of showing continued curiosity and not giving up, acting transparent and trustworthy, showing a willingness to be influenced by the adolescents' interests, and reflecting on the countertransference and other feelings about the patient and expressing these.

Thus, it becomes clear that the tasks of the psychotherapist working with silent adolescent patients are manifold. On the one hand, the therapist has to bear in mind the need to help the adolescent patient find words for his emotions and facilitate insight into his preoccupations and relationships by taking on a more active role and asking questions and offering thoughts and ideas. On the other hand, the therapist needs to tolerate, survive and even embrace silent moments if and when they occur.

The findings described above appear to align with recommendations on techniques found in contemporary adult literature on silence. Coltart (1991) reminds the reader that it is vital to learn to be silent and "practice benevolent, neutral patience […]. If one is truly at home with oneself, then silence will not usually feel provocative" (p. 448). Allowing the periods of silence to unfold creates a space that fosters understanding and containment (Hadda, 1991) and acts as confirmation to the patient that their (non-verbal) communication is heard (Knutson & Kristiansen, 2015; Ronningstam, 2006). Indeed, orthodox techniques to encourage the patients to talk can "totally fail" (Fuller & Crowther, 1998, p. 527), especially the use of (premature) interpretations (Knutson & Kristiansen, 2015; Ronningstam, 2006). Some silent patients may not tolerate any verbal interventions by the therapist at all. For instance, Blumenson (1993) outlined the case of a preverbal paranoid schizophrenic woman. She drew upon Searles (1965), who recommended establishing nonverbal communication before verbal communication can take place. Blumenson also described her application of ego-modifying techniques advocated by Spotnitz (1985), who recommended mirroring and joining the non-verbal patient in their resistance until they have developed enough awareness and ego-strength to modify their behaviour.

However, there is the recognition that silence may cause a technical dilemma for many adult therapists, as breaking it may be perceived as intrusive, but allowing it to take place could potentially reinforce a patient's sense of isolation and abandonment. Elson (2001)

addresses this by stating that "[t]he therapist must be able to gauge the patient's tolerance for silence, whether it is providing an opportunity for integration and growth, or instead heralds anxiety and shame over primitive needs and wishes heretofore unexpressed" (p. 358). Martyres (1995) also stated that especially in the early stage of the therapy, it is crucial to evaluate the anxiety of the patient during each silence and to intervene as appropriate, adding that if a silence continues beyond a patient's tolerance levels, it could endanger the therapy. Coltart (1991, p. 447) thus suggests that at times it may be helpful for the therapist to ask direct questions, such as, "You seem stuck today. What are your thoughts?", "Is something particularly bothering you or holding you up?" or "Is there something difficult you want to say about me or being here?" (pp. 446-447). Martyres (1995) also emphasises using gentle questions such as, "What were you feeling just then?", "What was happening in the silence?" or process statements, such as "You are uncomfortable with the silence" (p. 122).

It thus appears that the perception of silence as a phenomenon has much evolved throughout the past century. The progression of psychoanalytic theory and technique and publications of insightful case studies have contributed to the exploration and understanding of silence and its conceptualisation as a multi-determined phenomenon that can communicate a wide range of functions and meanings.

Discussion

This literature review explores the conceptualisation of silence in psychoanalytic theory. It highlights the psychoanalytic approaches to in-session silence from a developmental perspective and presents common themes drawn from the adolescent literature. Psychoanalytic approaches to silence and clinical technique were also examined.

One of the key findings is that there appears to be a link between silence and trauma, especially when it occurs in the form of early parental absence or neglect. Indeed, the in-

depth case studies of silent adolescents shared several themes found in the adult literature. It seems as though most of the adolescents had experienced some type of trauma or separation from their maternal object early on in their development, and all had a very strained relationship with their parents. Much of the clinical material presented in these case studies was very moving and outlined the YPs' sense of isolation, desperation and need for containment. At the same time, the papers also illustrated the adolescent struggle and the YPs' attempts for individuation coupled with the communication of their unmet infantile needs.

Another key finding that the literature highlights is that silence can have a protective and healing function. Wilson's (1997) idea that the silence of traumatised YPs protects the integrity of the self by drawing on Winnicott (1965) seems particularly apt. If a space of acceptance and containment is provided, the silent patient may go through a period of silent regression, which takes the patient back to their longing for oneness with the primary caregiver. Indeed, this could be understood by using Searles' (1967) concept of the *autistic phase* of treatment, which, once it has been overcome, can lead to *therapeutic symbiosis*. This stage could also be thought of as a silent "incubation process" during which some of the infantile needs of the patient are partially met and during which the patient may silently work through their preoccupations in the presence of their therapist. Once they have worked through this stage, a silent patient may progress to a stage during which psychic growth and repair can occur. Importantly, having reviewed the few psychoanalytic case studies discussing the silence of adolescent patients, there appear to be remarkable similarities between the themes in these case studies and the "stages" identified in the literature on the work with adults. Strikingly, the themes of the different stages of silence seem to bear similarities to Balint's (1968) idea of *benign regression* and the "new beginning", which can take place through the healing of the *basic fault* and the resolution of Glasser's (1979) *core*

complex. Modell's (1990) concept of *dependent/containing transference*, as mentioned by Leira (1995) and Anagnostaki (2013), also seems particularly relevant. Ultimately, it appears that a healing process can begin to take place by means of *being alone in the presence of another* (Winnicott, 1958). Many of these ideas seem to tie in with Lanyado's (1985, 2004, 2009) concept of the *quiet presence of the therapist* (influenced by Winnicottian and Balintian thought), which enabled the traumatised children she worked with to undergo the process of healing and work through their trauma alone in the presence of a quiet and receptive therapist, who was able to contain her patients' feelings through the use of her countertransference. Especially Leira's (1995) description of her state of *vake* appears to be similar to Lanyado's (2004) idea of therapeutic reverie.

A third key finding was that although techniques aimed at resistance may be appropriate with some silences, using the original recommendations of resistance interpretation or meeting silence with silence without evaluating what this might bring up in the patient seem outdated and could potentially be damaging to the therapeutic relationship. Indeed, an adaptation of technique may often be necessary for adolescents, as highlighted for instance by Bakalar's (2012) decision to start crocheting. The literature also demonstrated that disturbing a patient's silence can potentially be experienced as very intrusive. Considering that it appears that many silent patients have suffered early trauma, it is essential to acknowledge that the findings of this review seem to be supported by research in neurobiology. It is known that developmental trauma and adverse childhood experiences often affect the *Broca's* area, the language centre of the brain, subsequently leading to difficulties in traumatised patients to verbalise and describe their distressing experiences (Rauch et al., 1996). Language, which is a function of explicit memory, "is [thus] not generally accessible to trauma survivors after a distressing event" (Korn, 2001, p. 4). Consequently, a traumatised person may just "shut down" as they re-experience emotions as physical states rather than explicit memories that

can be put into words (van der Kolk, 1996, p. 218). Furthermore, empirical research has also shown a link between developmentally adverse experiences with the primary caregiver in childhood and dissociative symptoms experienced in adulthood (Baradon, 2009; Chu et al., 1999).

Considering the above, it appears particularly important for therapists to pay close attention to YPs, pick up on any possible distress during periods of silence, and consider that silence could be a sign of dissociation. It was noticeable that this consideration was only discussed in detail in one of the nine adolescent case studies reviewed here, although it was implied in several. However, more generally, the psychoanalytic world has become more aware and appreciative of neuroscience, empirical infant research and attachment theory (e.g. Alvarez, 2012; Colloms, 2012; Hopkins & Phillips, 2009; Lanyado, 2017; Music, 2009; Sternberg, 2006). For instance, in her writings on her work with silent traumatised children, Lanyado (2004) incorporated insight gained through neurobiology and empirical infant research, most notably that of Schore (1994) and Stern (1985; 1998). Importantly, as demonstrated by both Wilson (1997) and MacIntosh (2017), silent traumatised adolescents may communicate in creative, non-verbal ways if the opportunity is provided. Whilst it is commonplace in psychoanalytic child psychotherapy to use a therapy box and toys with under-fives and latency children, this is not always done with adolescents. It may thus be of benefit for therapists who are working with YPs, especially those who have experienced trauma, to routinely provide files with stationery items and art material. Indeed, this also ties in with Dowling's (2019) recommendation to consider together with the children and YPs which creative materials they might like to have in their therapy boxes and files.

However, it has also been highlighted that the literature about silence in the therapeutic work with adolescents is very sparse, indicating that more research is needed in this area. In particular, the lack of empirical studies was very noticeable. While exploring the adolescents'

experience of in-session silence only constituted a small part of their respective studies, Acheson et al. (2020) and Zimmermann et al. (2020) nevertheless highlighted that the YPs in their samples experienced silence as negative. Further, Gensler's (2015) paper drew attention to a different type of adolescent silence from those outlined in the clinical case studies, which could be viewed as a manifestation of the adolescent's interpersonal struggle and developmental stage. The findings of this literature review, therefore not only highlight that adolescents can experience silence in different ways but also point towards a clear gap in the literature in terms of the exploration of adolescents' experience of silence in psychotherapy. It thus appears that there is the scope, and indeed need, for research in this area, both in the form of theory-building case studies and empirical work in regards to in-session silence with adolescents, to shed further light on this fascinating phenomenon.

Conclusion

In conclusion, the abovementioned factors highlight that 1) there may be a connection between the occurrence of silence and trauma in the work with silent adolescents, 2) the work with silent YPs may require an adaptation of technique, 3) rather than being a hindrance, if addressed appropriately, silence in adolescent psychotherapy may be a great catalyst for change and reparation. However, the findings also draw attention to how little is currently known about this phenomenon, especially in relation to the adolescents' experience of it.

References

Abraham, K. (1916). The first pregenital stage of the libido. In *Selected Papers on Psychoanalysis*. London: Hogarth Press 1957.

Acheson, R., Verdenhalven, N., Avdi, E., & Midgley, N. (2020). Exploring silence in short-term psychoanalytic psychotherapy with adolescents with depression. *Journal of Child Psychotherapy*, *46*(2), 224–240. https://doi.org/10.1080/0075417X.2020.1830297

Aho-Mustonen, P., Enckell, H., Seikkula, J., Tsatsishvili, V., & Kykyri, V.-L. (2020). A moment within the psychoanalytic psychotherapy of an adult female patient–The meanings of nonverbal and bodily expressions [Article]. *The Scandinavian Psychoanalytic Review*, 13–26. https://doi.org/10.1080/01062301.2020.1782704

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1979). *Patterns of Attachment*. London: Taylor & Francis Group.

Alvarez, A. (2012). Further reflections: countertransference, the paranoid and schiziod positions, and some speculations on parallels with neuroscience. In *The Thinking Heart: Three Levels of Psychoanalytic Therapy with Disturbed Children* (pp. 174–186). London and New York: Routledge. https://doi.org/10.1080/02668734.2013.836295

Anagnostaki, L. (2013). Beyond Silence: Working with Phoebe. *Journal of Child Psychotherapy*, *39*(2), 156–170. https://doi.org/10.1080/0075417X.2013.806053

Arlow, J. A. (1961). Silence and the Theory of Technique. *Journal of the American Psychoanalytic Association*, *9*(1), 44–55. https://doi.org/10.1177/000306516100900103

Bakalar, N. L. (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.

Balint, M. (1968). *The Basic Fault*. London: Tavistock.

Baradon, T. (2009). *Relational Trauma in Infancy* (T. Baradon, Ed.). London: Routledge. https://doi.org/10.4324/9780203856673

Baruch, G. (1997). The Process of Engaging Young People with Severe Developmental Disturbance in Psychoanalytic Psychotherapy: Patterns of Practice. *Bulletin of the Menninger Clinic*, *61*(3), 335–353.

Bergler, E. (1938). On the Resistance Situation: The Patient is Silent. *Psychoanalytic Review*, *25*(2), 170–186.

Blos, P. (1962). *On Adolescence: a psychoanalytic interpretation*. New York & London; Free Press; Collier Macmillan.

Blos, P. (1967). The Second Individuation Process of Adolescence. *The Psychoanalytic Study of the Child*, *22*(1), 162–186. https://doi.org/10.1080/00797308.1967.11822595

Blos, P. (1970). *The young Adolescent: clinical studies* [Book]. New York: The Free Press.

Blos, P. (1972). Silence: A Clinical Exploration. *Psychoanalytic Quarterly*, *41*, 348–363. https://doi.org/https://doi.org/10.1080/21674086.1972.11926602

Blumenson, S. R. (1993). The Mirror of Silence: A Method of Treating a Preverbal Schizophrenic Patient. *Modern Psychoanalysis*, *18*(2), 179–189.

Bowlby, J. (1969). *Attachment and loss / Vol. 1, Attachment*. London: Hogarth Press: Institute of Psycho-Analysis.

Bowlby, J. (1973). *Attachment and loss / Vol. 2, Separation: anxiety and anger*. London: Hogarth Press: Institute of Psycho-Analysis.

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

Bowlby, John. (1980). *Attachment and loss / Vol. 3, Loss: sadness and depression / John Bowlby* (Institute of Psycho-analysis (Great Britain) & British Psycho-Analytical Society, Eds.) [Book]. London: Hogarth Press: Institute of Psycho-Analysis.

Braski, K. M. (1999). Coming of Age: The Adolescent in Psychotherapy. *American Journal of Psychotherapy*, *53*(4), 544–551.

Bravesmith, A. (2012). Silence Lends Integrity to Speech: Transcending the Opposites of Speech and Silence in the Analytic Dialogue. *British Journal of Psychotherapy*, *28*(1), 21–34. https://doi.org/10.1111/j.1752-0118.2011.01263.x

Brockbank, R. (1970). On the analyst's silence in psychoanalysis: A synthesis of intrapsychic content and interpersonal manifestations. *The International Journal of Psychoanalysis*, *51*(4), 457–464.

Busch, F. (1978). The Silent Patient: Issues of Separation-Individuation and its Relationship to Speech Development. *International Review of Psycho-Analysis*, *5*, 491–499.

Calogeras, R. C. (1967). Silence as a Technical Parameter in Psycho-Analysis. *International Journal of Psycho-Analysis*, *48*, 536–558.

Carroll, L. (1866). *Alice's Adventures in Wonderland by Lewis Carroll. With Forty-Two Illustrations by John Tenniel* [Book]. London: Macmillan and Co.

Chu, J. A., Frey, L. M., Ganzel, B. L., & Matthews, J. A. (1999). Memories of Childhood Abuse: Dissociation, Amnesia, and Corroboration [Article]. *The American Journal of Psychiatry*, *156*(5), 749–755. https://doi.org/10.1176/ajp.156.5.749

Colloms, A. (2012). Reflections on mirrors. In A. Horne & M. Lanyado (Eds.), *Winnicott's Children* (pp. 60–76). London and New York: Routledge.

Coltart, N. (1991). The Silent Patient. *Psychoanalytic Dialogues*, *1*(4), 439–453. https://doi.org/10.1080/10481889109538914

Cooper, S. (2012). Exploring a patient's shift from relative silence to verbal expressiveness: Observations on an element of the analyst's participation. *International Journal of Psychoanalysis*, *93*(4), 897–916. https://doi.org/10.1111/j.1745-8315.2012.00608.x

Cregeen, S., Hughes, C., Midgley, N., Rhode, M., & Rustin, M. (2017). *Short-Term Psychoanalytic Psychotherapy for Adolescents with Depression* (J. Catty, Ed.). London: Karnac.

Cremerius, J. (1969). Schweigen als Problem der Psychoanalytischen Technik. *Jahrbuch der Psychoanalyse*, (6), 69–103.

Cristy, B. L. E. (1993). Beyond Words: The Psychodynamics of a Therapy in Silence with a Twelve-Year-Old Girl. *Clinical Social Work Journal*, *21*(2), 179–193. https://doi.org/https://doi.org/10.1007/BF00754533

Cuttler, E., Hill, C. E., King, S., & Kivlighan, D. M. (2019). Productive silence is golden: Predicting changes in client collaboration from process during silence and client attachment style in psychodynamic psychotherapy. *Psychotherapy (Chicago, Ill.)*, *56*(4), 568–576. https://doi.org/10.1037/pst0000260

Daniel, S. I., 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*, 1–14. https://doi.org/10.1080/10503307.2016.1177673

Dowling, D. (2019). *An Independent Practitioner's Introduction to Child and Adolescent Psychotherapy*. Abingdon, Oxon & New York: Routledge. https://doi.org/10.4324/9781315146812

Eist, H. I. (1983). Individual Treatment of the Borderline Patient. *Workshop Presentation at the Overholser Day Convocation*.

Elson, M. (2001). Silence, Its Use and Abuse: A View from Self Psychology. *Clinical Social Work Journal*, *29*(4), 351–360. https://doi.org/10.1023/A:1012215213461

Enelow, A. (1960). The Silent Patient. *Psychiatry*, *23*(2), 153–158.

Erikson, E. H. (1956). The Problem of Ego Identity. *Journal of the American Psychoanalytic Association*, *4*(1), 56–121. https://doi.org/10.1177/000306515600400104

Fenichel, O. (1928). On Isolation. In *The Collected Papers of Otto Fenichel*. New York: Norton, 1953.

Ferenczi, S. (1916). Schweigen ist Gold. *Internationale Zeitschrift für Psychoanalyse*, *4*(3), 155–156.

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

Frankel, Z., Levitt, H. M., Murray, D. M., Greenberg, L. S., & Angus, L. E. (2006). Assessing silent processes in psychotherapy: an empirically derived categorization system and sampling strategy. *Psychotherapy Research*, *16*(5), 627–638. https://doi.org/10.1080/10503300600591635

Freud A. (1958). Adolescence [Article]. *The Psychoanalytic Study of the Child*, *13*, 255–278. https://doi.org/10.1080/00797308.1958.11823182

Freud, S. (1912). The Dynamics of Transference. In *The Standard Edition of the Complete Works of Sigmund Freud* (Vol. 8, pp. 97–109).

Freud, S. (1925). An Autobiographical Study. In *SE*: *Vol. XX* (pp. 1–74).

Fuller, V. G., & Crowther, C. (1998). A dark talent: Silence in analysis. *Journal of Analytical Psychology*, *43*(4), 523–543. https://doi.org/10.1111/1465-5922.00051

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*, 205–220. https://doi.org/10.1080/02668730500238218

Gensler, D. (2015). Silence in Adolescent Psychotherapy. *Journal of Infant, Child & Adolescent Psychotherapy*, *14*(2), 188–195. https://doi.org/http://dx.doi.org/10.1080/15289168.2015.1032635

Glasser, M. (1979). Some aspects of the role of aggression in the perversions. In I. Rosen (Ed.), *Sexual Deviations* (2nd edition). Oxford: OUP.

Goldstein-Ferber, S. (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. https://doi.org/10.1111/j.1752-0118.2004.tb00146.x

Graafsma, T., & Anbeek, M. (1984). Resistance in Psychotherapy with Adolescents. *Journal of Adolescence*, *7*, 1–16.

Greenson, R. R. (1961). On the Silence and Sounds of the Analytic Hour. *Journal of the American Psychoanalytic Association*, *9*, 79–84. https://doi.org/10.1177/000306516100900105

Hadda, J. (1991). The Ontogeny of Silence in an Analytic Case. *The International Journal of Psycho-Analysis*, *72*, 117–130.

Hesse, E., & van Ijzendoorn, M. H. (1999). Propensities towards absorption are related to lapses in the monitoring of reasoning or discourse during the Adult Attachment Interview. *Attachment & Human Development*, *1*(1), 67–91. https://doi.org/10.1080/14616739900134031

Hill, C. E., Kline, K. v, O'Connor, S., Morales, K., Li, X., Kivlighan, D. M., & Hillman, J. (2019). Silence Is Golden: A Mixed Methods Investigation of Silence in One Case of Psychodynamic Psychotherapy [Article]. *Psychotherapy (Chicago, Ill.)*, *56*(4), 577–587. https://doi.org/10.1037/pst0000196

Hopkins, J., & Phillips, G. (2009). Some contributions of attachment theory and research. In M. Lanyado & A. Horne (Eds.), *The Handbook of Child and Adolescent Psychotherapy* (Second Edition, pp. 38–50). London and New York: Routledge.

Horne, A. (2006). Brief communications from the edge. In M. Lanyado & A. Horne (Eds.), *A Question of Technique* (pp. 149–165). London and New York: Routledge.

Huber, D., Schmuck, A., & Kächele, H. (2012). Die verbale Aktivität in therapeutischen Dialogen: Ein exemplarischer Vergleich. *Forum Der Psychoanalyse*, *28*(3), 299–309. https://doi.org/10.1007/s00451-012-0099-7

Hurry, A. (1998). Psychoanalysis and developmental therapy. In A. Hurry (ed.) *Psychoanalysis and Developmental Therapy*. London: Routledge.

Khan, M. (1963). Silence as communication. *Bulletin of the Menninger Clinic*, *27*(6), 300–313.

Kiersky, S., & Beebe, B. (1994). The Reconstruction of Early Nonverbal Relatedness in the Treatment of Difficult Patients a Special Form of Empathy. *Psychoanalytic Dialogues*, *4*(3), 389–408. https://doi.org/10.1080/10481889409539027

Kitchener, J. (2012). A joy to be hidden, a disaster not to be found. In A. Horne & M. Lanyado (Eds.), *Winnicott's Children* (pp. 41–59). London and New York: Routledge.

Knol, A. S. L., Koole, T., Desmet, M., Vanheule, S., & Huiskes, M. (2020). How Speakers Orient to the Notable Absence of Talk: A Conversation Analytic Perspective on Silence in Psychodynamic Therapy. *Frontiers in Psychology*, *11*. https://doi.org/10.3389/fpsyg.2020.584927

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. https://doi.org/10.1080/00107530.2015.954218

Kreische, R. (1985). Schweigen, um wahrgenommen zu werden: Über eine scheinbar paradoxe Bedeutung des Schweigens. *Zeitschrift für Psychosomatische Medizin Und Psychoanalyse*, *31*(2), 151–155.

Kurtz, S. A. (1984). On Silence. *Psychoanalytic Review*, *71*(2), 227–246.

Lanyado, M. (1985). Surviving Trauma - Dilemmas in the Psychotherapy of Traumatised Children. *British Journal of Psychotherapy*, *2*(1), 50–62.

Lanyado, M. (2004). *The Presence of the Therapist*. London and New York: Routledge.

Lanyado, M. (2009). Psychotherapy with severely traumatised children and adolescents. In M. Lanyado & A. Horne (Eds.), *Handbook of Child and Adolescent Psychotherapy* (pp. 300–315). London: Routledge.

Lanyado, M. (2017). Historical and social context. In *Transforming Despair to Hope* (pp. 17–32). London and New York: Routledge. https://doi.org/10.4324/9781315160269

Laufer, M. (1966). Object Loss and Mourning during Adolescence [Article]. *The Psychoanalytic Study of the Child*, *21*(1), 269–293. https://doi.org/10.1080/00797308.1966.11823261

Laufer, M. (1975). Preventive Intervention in Adolescence [Article]. *The Psychoanalytic Study of the Child*, *30*(1), 511–528. https://doi.org/10.1080/00797308.1975.11823317

Leira, T. (1995). Silence and Communication: Nonverbal Dialogue and Therapeutic Action. *Scandinavian Psychoanalytic Review*, *18*(1), 41–65. https://doi.org/10.1080/01062301.1995.10592330

Levitt, H. M. (2001). Sounds of Silence in Psychotherapy: The Categorization of Clients' Pauses. *Psychotherapy Research*, *11*(3), 295–309. https://doi.org/10.1080/713663985

Levy, K. (1958). Silence in the Analytic Session. *The International Journal of Psycho-Analysis*, *39*, 50–58.

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

Liegner, E. (1974). The Silent Patient. *Psychoanalytic Review*, *61*, 229–245. https://doi.org/10.1080/10481889109538914

Loewenstein, R. M. (1961). The Silent Patient — Introduction. *Journal of the American Psychoanalytic Association*, *9*, 2–6.

Lombardi, R. (2010). Flexibility of the psychoanalytic approach in the treatment of a suicidal patient: Stubborn silences as "playing dead." *Psychoanalytic Dialogues*, *20*(3), 269–284. https://doi.org/10.1080/10481885.2010.483955

Loomie, L. S. (1961). Some Ego Considerations in the Silent Patient. *Journal of the American Psychoanalytic Association*, *9*, 56–78. https://doi.org/10.1177/000306516100900104

MacIntosh, H. B. (2017). A Bridge Across Silent Trauma: Enactment, Art, and Emergence in the Treatment of a Traumatized Adolescence. *Psychoanalytic Dialogues*, *27*(4), 433–453. https://doi.org/10.1080/10481885.2017.1328188

Mahler, M. (1972). On the first three subphases of the separation-individuation process [Article]. *International Journal of Psychoanalysis*, *53*, 333–338.

Maiello, S. (1995). The sound-object: A hypothesis about prenatal auditory experience and memory. *Journal of Child Psychotherapy*, *21*(1), 23–41. https://doi.org/10.1080/00754179508254905

Main, M., & Solomon, J. (1986). Discovery of an insecure-disorganized/disoriented attachment pattern [Book]. In T. B. (Thomas B. (Thomas B. Brazelton & M. W. Yogman (Eds.), *Affective Development in Infancy* (pp. 95–124). Norwood, N.J.: Ablex Pub. Co.

Main, Mary. (1991). Metacognitive knowledge, metacognitive monitoring, and singular (coherent) vs. multiple (incoherent) models of attachment: findings and directions for further research. In C. Marris, P.; Stevenson-Hinde, J.; Parkes (Ed.), *Attachment Across the Life Cycle*. New York: Routledge.

Main, Mary, & Weston, D. (1982). Avoidance of the attachment figure in infancy: descriptions and interpretations. In C. M. Parkes & J. Stevenson-Hinde (Eds.), *The place of Attachment in Human Behaviour*. New York: Basic Books.

Malberg, N. T. (2012). “Speaking with silence and tears” - psychotherapy with an adolescent girl. In N. T. Malberg & J. Raphael-Leff (Eds.), *The Anna Freud Tradition: Lines of Development*

- *Evolution of Theory and Practice over Decades* (1st edition, pp. 296–311). London: Carnac. https://doi.org/https://doi.org/10.4324/9780429481086

Marshall, R. J. (1972). The Treatment of Resistances in Psychotherapy of Children and Adolescents. *Psychotherapy: Theory, Research and Practice*, *9*(2), 143–148.

Martyres, G. (1995). On silence: A language for emotional experience. *Australian and New Zealand Journal of Psychiatry*, *29*(1), 118–123. https://doi.org/10.3109/00048679509075900

Modell, A. H. (1990). *Other Times, Other Realities*. London: Harvard University Press.

Morgenstern, A. (1980). Reliving the Last Goodbye: The Psychotherapy of an Almost Silent Patient. *Psychiatry*, *43*(3), 251–258.

Moser, U. (1962). Übertragungsprobleme in der Psychoanalyse eines chronisch schweigenden Charakterneurotikers. *Psyche - Zeitschrift Für Psychoanalyse*, *15*(10), 592–624.

Moses Laufer. (1989). Why Psychoanalytic Treatment for These Adolescents? In *Developmental Breakdown and Psychoanalytic Treatment in Adolescence* (p. 16). Yale University Press.

Music, G. (2009). Neuroscience and child psychotherapy. In M. Lanyado & A. Horne (Eds.), *The Handbook of Child and Adolescent Psychotherapy* (Second Edition, pp. 51–72). London and New York: Routledge. https://doi.org/10.4324/9780203877616

Nacht, S. (1963). The Non-Verbal Relationship in Psycho-Analytic Treatment. *International Journal of Psychoanalysis*, *44*, 334–340.

Nacht, S. (1964). Silence As an Integrative Factor. *The International Journal of Psycho-Analysis*, *45*, 299–303.

Olinick, S. L. (1982). Meanings Beyond Words: Psychoanalytic Perceptions of Silence and Communication, Happiness, Sexual Love and Death. *International Review of Psycho-Analysis*, *9*, 461–472.

Osorio, L. C. (1977). The psychoanalysis of communication in adolescence. In S. C. Feinstein & P. L. Giovacchini (Eds.), *Development and Clinical Studies* (Vol. 5). New York: Jason Aronson.

O'Toole, M. A. (2015). The Phenomenon of Silence in Psychotherapy. *Attachment: New Directions in Psychotherapy and Relational Analysis*, *9*(3), 342–360.

Perret-Catipovic, M., & Ladame, F. (1998). Adolescence and psychoanalysis: the story and the history. In M. Perret-Catipovic & F. Ladame (Eds.), *Adolescence and Psychoanalysis* (pp. 1–18). London: Karnac.

Rauch, S. L., van der Kolk, B. A., Fisler, R. E., Alpert, N. M., Orr, S. P., Savage, C. R., … Pitman, R. K. (1996). A Symptom Provocation Study of Posttraumatic Stress Disorder Using Positron Emission Tomography and Script-Driven Imagery [Article]. *Archives of General Psychiatry*, *53*(5), 380–387. https://doi.org/10.1001/archpsyc.1996.01830050014003

Ronningstam, E. (2006). Silence Cultural Function and Psychological Transformation in Psychoanalysis and Psychoanalytic Psychotherapy. *The International Journal of Psychoanalysis*, 87(5), 1277–1295. https://doi.org/10.1516/D6W0-3E0N-MR79-J7JA

Rustin, M. (1971). Once-Weekly Work with A Rebellious Adolescent Girl. *Journal of Child Psychotherapy*, *3*(1), 40–48. https://doi.org/10.1080/00754179708257276

Sabbadini, A. (1991). Listening to Silence. *British Journal of Psychotherapy*, *7*, 406–415. https://doi.org/10.1111/j.1752-0118.1991.tb01145.x

Schore, A. N. (1994). *Affect regulation and the origin of the self: the neurobiology of emotional development* [Book]. Hillsdale, NJ: Lawrence Erlbaum.

Searles, H. (1965). *Collected Papers on Schizophrenia and Related Subjects*. New York: International Universities Press.

Searles, H. (1979). *Countertransference and Related Subjects*. New York: International Universities Press.

Serani, D. (2000). Silence in the Analytic Space, Resistance or Reverie? A Perspective from Loewald's Theory of Primordial Unity. *Contemporary Psychoanalysis*, *36*(3), 505–519. https://doi.org/10.1080/00107530.2000.10747059

Shafii, M. (1973). Silence in the service of ego: psychoanalytic study of meditation. *The International Journal of Psycho-Analysis*, *54*(1973), 431–443.

Spiegel, L. A. (1951). A Review of Contributions to a Psychoanalytic Theory of Adolescence [Article]. *The Psychoanalytic Study of the Child*, *6*(1), 375–393. https://doi.org/10.1080/00797308.1952.11822922

Spotnitz, H. (1985). *Modern Psychoanalysis of the Schizophrenic Patient: Theory of the Technique* (Second Edition). New York: Human Sciences Press.

Stern, D. (1985). *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology*. New York: Basic Books.

Stern, D. N., Sander, L. W., Nahum, J. P., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., … Tronick, E. Z. (1998). Non-interpretive mechanisms in psychoanalytic therapy: The "something more" than interpretation [Article]. *International Journal of Psychoanalysis*, *79*(5), 903–921.

Sternberg, J. (2006). Not simply "doing." In M. Lanyado & A. Horne (Eds.), *A Question of Technique* (pp. 34–59). London and New York: Routledge.

Stringer, J. v., Levitt, H. M., Berman, J. S., & Mathews, S. S. (2010). A study of silent disengagement and distressing emotion in psychotherapy. *Psychiatry Research*, *20*(5), 495–510. https://doi.org/10.1080/10503301003754515

van der Heide, C. (1961). Blank Silence and the Dream Screen. *Journal of the American Psychoanalytic Association*, *9*, 85–90. https://doi.org/10.1177/000306516100900106

van der Kolk, B. A. (1996). The Body Keeps the Score: Approaches to the Psychobiology of Posttraumatic Stress Disorder [Book]. In A. C. McFarlane, L. Weisæth, & B. A. van der Kolk

(Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society* (pp. 214–241). New York; London: Guilford Press.

Weinberger, J. L. (1964). A Triad of Silence: Silence, Masochism and Depression. *International Journal of Psycho-Analysis*, *45*, 304–309.

Weisman, A. (1955). Silence and Psychotherapy. *Psychiatry*, *18*(3), 241–464. https://doi.org/10.1080/00332747.1955.11023010

Wilson, P. (1987). Psychotherapy with adolescents. In J. Holmes (Ed.), *Textbook of Psychotherapy in Psychiatric Practice* (pp. 443–467).

Wilson, P. (1997). A Time to Think. In E. Smith (Ed.), *Integrity and Change: Mental Health in the Market Place* (1st edition, pp. 13–21). London: Routledge.

Wilson, P. (2001). "I don't know." *Journal of the British Association of Psychotherapists*, *39*, 166–176.

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

Winnicott, D. W. (1960). The Theory of the Parent-Infant Relationship. *International Journal of Psychoanalysis*, *41*, 585–595.

Winnicott, D. W. (1962). Struggling Through the Doldrums. *New Society*, *1*, 30

Winnicott, D. W. (1965). Communicating and Not Communicating Leading to a Study of Certain Opposites. In *The maturational processes and the facilitating environment: Studies in the theory of emotional development* (pp. 179-192). London: Hogarth.

Winnicott, D. W. (1971). *Playing and Reality*. London: Tavistock.

Woo, R. (1999). Sounds of Silence: The Need for Presence in Absence. *Journal of Child Psychotherapy*, *25*(1), 93–114. https://doi.org/10.1080/00754179908260283

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. https://doi.org/10.1177/000306516100900102

Zeligs, M. A. (1961). The Psychology of Silence. Its Role in Transference, Countertransference and the Psychoanalytic Process. *Journal of the American Psychological Association*, *9*(1), 7–43. https://doi.org/10.1177/000306516100900102

Zimmermann, R., Fürer, L., Schenk, N., Koenig, J., Roth, V., Schlüter-Müller, S., … Schmeck, K. (2020). Silence in the Psychotherapy of Adolescents with Borderline Personality Pathology. *Personality Disorders: Theory, Research, and Treatment*. https://doi.org/10.1037/per0000402

Part 2: Empirical Research Project

Title:
An Exploration of Silence in Short-Term Psychoanalytic Psychotherapy with Depressed Adolescents

Candidate Number: NSPG7

Word Count: 8,777

Personal contribution: The data from this project were drawn from a wider study, the Short-Term Psychoanalytic Psychotherapy (STPP) arm of "Improving Mood with Psychoanalytic and Cognitive Therapies" (IMPACT). The data were collected and coded together with my research partner Rachel Acheson. The data analysis and subsequent results presented here are my own work only.

Abstract

Objective: This exploratory therapy process case series study aims to examine the occurrence of in-session pauses and therapists' responses to long silences in the psychoanalytic work with depressed adolescents. **Method:** Pauses in three pragmatically sampled dyads of Short-Term Psychoanalytic Psychotherapy (STPP) were coded across 18 therapy sessions from beginning, middle and end of treatment. Data included frequency, duration, and percentage of session time taken up by silence. Pause type was coded with the Pausing Inventory Classification System (PICS; Frankel & Levitt, 2009; Levitt, 2001). Therapists' responses to long pauses (>1min) were coded with the Helping Skills System (HSS; Hill, 2009). **Results:** 1,248 silences (≥3 s) were identified. Most (69.0%) were coded as obstructive; the longer the pause, the less likely it was to be productive. Long silences (>1min) made up 3,4% of all pauses. Silence patterns across the dyads varied widely; however, across all therapies long pauses most frequently occurred in the therapy stages that had the highest percentage of in-session silence. Long pauses took up 12.4% of the overall session time. The vast majority of long pauses (85.7%) were broken by the therapists. The most frequent therapist responses to long pauses were interpretations (33.3%), reflection of feelings (16.7%) and open questions (16.7%). **Discussion:** Findings suggest that the patterns of silence are unique to each therapy. Whilst pause duration is associated with pause type, findings may also indicate that longer silences potentially serve different functions and communicate different meanings in different treatment stages. Therapists' responses are considered from a psychoanalytic angle and implications for clinical practice and further research are offered.

Keywords: Adolescent depression; process research; short-term psychoanalytic therapy; silence; STPP

Introduction

Silence appears to be a common phenomenon in psychotherapy with adolescents, which can be challenging to manage clinically. Whilst silence in psychoanalytic psychotherapy was traditionally seen as a sign of resistance; more contemporary psychoanalytic theory recognises that silence is a multi-determined phenomenon that may be a sign of different processes and communications (e.g. Goldstein-Ferber, 2004; Lane et al., 2002; Liegner, 1974; Sabbadini, 1991). Recent empirical research supports this theory (e.g. Daniel et al., 2016; Frankel et al., 2006; Hill et al., 2019; Levitt, 1998, 2001). Nevertheless, very little empirical research has been conducted with adolescent patients, even though this age group is generally known to be finding it more challenging to engage in talking therapies than adult patients.

The theoretical conceptualisation of silence in psychoanalytic theory evolved considerably over the years. Traditionally, in-session silences were regarded as counter-therapeutic and as a sign of resistance (Abraham, 1916; Fenichel, 1928; Ferenczi, 1916; Freud, 1912, 1913, 1914, 1925; Glover, 1927). With advances in theory and clinical practice, silence began more and more to be seen as a communication (Blos, 1972; Greenson, 1961; Liegner, 1974; Loomie, 1961; Nacht, 1963; Weisman, 1955). Winnicott's (1958) paper *The Capacity to be Alone* was significant at the time as he identified some patient silences to be a reflection of the person's ability to be alone in the presence of another, and therefore a sign of health.

Nowadays, silence in psychotherapy is regarded as a multi-determined phenomenon with a broad spectrum of meanings and functions. More specifically, silence can be understood as a communication of the patient's need to feel protected and contained (Fuller & Crowther, 1998; Ronningstam, 2006) and be noticed and accepted (Kreische, 1985). It can

be a communication of the patient's longing for mirroring (Hadda, 1991) or may point towards a regression to the pre-verbal stage and longing for oneness with the mother/therapist as mother imago (Arlow, 1961; Khan, 1963; Nacht, 1963, 1964; Serani, 2000; Shafii, 1973a; Winnicott, 1958).

The idea that silence in psychotherapy is a heterogeneous phenomenon has been confirmed by empirical research by Levitt (1998, 2001b, 2001a, 2002), who conducted interpersonal process recall interviews with seven patients about their experience of silent moments in their therapy sessions. A grounded theory (Glaser & Strauss, 1967) analysis was used to conduct a qualitative analysis of the data, leading to the development of the Pausing Inventory Categorization System (PICS). It entails three higher-order categories, namely "obstructive", "productive", and "neutral" pauses and several subtypes. The category "obstructive" refers to pauses that result from a patient emotionally disengaging from the therapeutic discourse. "Productive" pauses, which are seen as facilitative to the therapeutic process, occur when the patient has a deeply emotional experience and is overcome by emotion and pauses to reflect on this or tries to find words to express themselves. "Neutral" pauses indicate pauses that are part of a patient's way of speaking and are not linked to the therapeutic process.

In an extension of Levitt's work, Frankel et al. (2006) looked at the best and the poorest outcome of client-centred psychotherapy (CCP) dyads. They found that good outcome dyads exhibited more "productive" and fewer "obstructive" silences than poor outcome dyads but that poor outcome dyads had an overall higher frequency of pauses. Their study also confirmed that the PICS could be used reliably to code silent processes in psychotherapy. The PICS has been used in several studies since. Daniel et al. (2016) compared in-session silences of patients receiving psychoanalytic psychotherapy (PPT) to those receiving cognitive behavioural therapy (CBT). Their findings showed that pauses were

more frequent in PPT than in CBT. They also found that a higher frequency of pauses, especially that of "obstructive" pauses, was associated with poorer treatment alliance and insecure attachment of patients. Good outcome dyads had a higher frequency of "productive" pauses, especially in the middle stage of treatment. Poor outcome dyads had a higher frequency of "obstructive" pauses, especially in the end stage of treatment. Their study highlighted that in-session pauses might indicate patient attachment anxiety and predict treatment outcome. Cuttler et al. (2019) also looked at patients' attachment. Their findings revealed that patient attachment anxiety and the type of patient and therapist pauses could predict the immediate outcome of silence events. Stringer et al. (2010) specifically looked at "disengaged" pauses, which are a subtype of the "obstructive" category. Their findings showed that "disengagement" is associated with poorer treatment outcome.

Hill et al.'s (2019) PICS single case study of a male patient who received PPT looked at the first five and last five therapy sessions. Results showed that the sample had a high frequency of productive silences overall. Pauses were shorter in the later stages of treatment. Most pauses were initiated and broken by the patient. Gindi (2002) conducted a single case study of a young male patient with learning difficulties. The most frequent pause type coded were "neutral" pauses. This differed from the other PICS studies and may have been related to the patient's learning difficulties.

Notably, Hill et al.'s (2003, p. 513) study about therapists' use of silence as a therapeutic tool highlighted that silence is primarily used to "facilitate reflection, encourage responsibility, facilitate expression of feelings, not interrupt session flow, and convey empathy". During these moments of silence, the therapists, who offered differing psychological treatments, looked at the patients, thought about the therapeutic process, or conveyed interest in the patient. The therapists reported that most of the silences they described had been intentional and lasted less than a minute.

Silence in the Therapeutic Work with Adolescents

There is limited empirical and psychoanalytic literature on silence in the work with adolescent patients. The few psychoanalytic case studies available (Anagnostaki, 2013; Bakalar, 2012; Cristy, 1993; Khan, 1963; Leira, 1995; MacIntosh, 2017; Malberg, 2012; Moser, 1962; Wilson, 1997) seem to have several common themes, namely the connection between in-session silence and trauma, the patient's regression to an earlier stage of development, the need to offer flexibility around technique, and the potential healing function of silence. These case studies also have the young people's (YPs) prolonged periods of complete silence in common.

Gensler (2015) outlined another type of adolescent silence that is different to the prolonged periods of complete absence of speech outlined in the clinical case studies. It seems more related to the ordinary adolescent behaviour of feeling invested in the peer group rather than parental figures. Therefore, this type of silence may be specifically connected to the YPs developmental stage and the push and pull of adolescence. Gensler encouraged therapists to adopt an active stance and take an interest in the YPs, including asking questions, showing curiosity, and being transparent.

Limited empirical research on silence in the work with adolescents has been conducted. Zimmermann et al. (2020) looked at in-session silences in adolescent identity treatment (AIT) with female adolescents with borderline personality pathology (BPP). The YPs' experience of silence was measured and the study found that sessions with less silence were regarded as "better" by patients and experienced as "smoother". Sessions with more silence were rated as "more unpleasant, rough, difficult, and uncomfortable" (Zimmermann et al., 2020, p. 164). Acheson et al.'s study (2020) looked at silence in sessions with depressed adolescents. The data were drawn from the Short-Term Psychoanalytic Psychotherapy

(STPP) arm of "Improving Mood with Psychoanalytic and Cognitive Therapies" (IMPACT). A grounded theory (Glaser & Strauss, 1967) analysis of the YPs' post-treatment interviews, drawing on the IMPACT-My Experience data to investigate the YPs perception of silent moments in their therapies, was conducted. Their findings highlighted that YPs generally expressed negative views about silent moments in their sessions.

Clinical Depression in Adolescents

Adolescence is a time of physical, emotional, and neurological change. Part of the task of adolescence is to attempt to master individuation and to work through difficulties that occurred in earlier stages of development, and that may resurface in adolescence. It can often be a time of emotional turmoil and vulnerability. It is also a time of loss, such as the loss of the relative security of childhood and the prepubescent body. Some YPs can find the tasks of individuation challenging and frightening, which may leave them more vulnerable to experience states of depression (Cregeen et al., 2017). Prevalence rates of adolescents with depressive disorders have rapidly increased in the past few decades (Abela & Hankin, 2008). Around 5.6% of adolescents between 13 and 18 years meet the diagnostic criteria for clinical depression (Costello et al., 2006). Some estimates for the twelve-month prevalence for this age group are as high as 8% (Rice & Rawal, 2011). However, it is also known that the majority of cases of adolescent depression are not currently detected (Kessler et al., 2001). About 50-70% of successfully treated depressed adolescents have been found to relapse (Birmaher et al., 2000; Richmond & Rosen, 2005). Indeed, between 50% and potentially up to 84% of YPs who had depression in adolescence are likely to experience further depressive episodes in adulthood (Abela & Hankin, 2008; Kessler et al., 2001).

Speech patterns of adults with depression are less fluent and contain more silences than those of non-depressed adults (Alpert et al., 2000; Nilsonne, 1988; Vanger et al., 1992).

Moreover, certain non-verbal behaviours related to social withdrawal, including reduced speech rate and an increased frequency of silences, can predict the severity of a patient's depressive state (Fiquer et al., 2013; Segrin, 2000) and seem to decrease with clinical improvement (Greden & Carroll, 1980; Hoffmann et al., 1985). Importantly, it is also possible to detect depression in natural speech samples of adolescents (Low et al., 2011).

The above highlights that nowadays, silence is regarded to have a range of functions and meanings and is no longer exclusively viewed as a sign of resistance. This idea is supported by a growing body of empirical research on silence in psychotherapy. The availability of adolescent literature on silence is minimal, although a few common themes could be identified. Importantly, two existing empirical studies demonstrate that adolescents can experience silence in psychotherapy as negative. The potential impact of depression on speech has also been highlighted. This emphasises the need to understand silence with depressed adolescent patients better. Due to the lack of previous research in this area, the current study was designed as an exploratory in-session process research project. Thus, in line with exploratory research, the author did not make any specific hypotheses but attempted to maintain an open mind and be led by the data (Hill, 1990).

The Present Study

Anecdotal evidence suggests that silence is a common phenomenon in adolescent patients, which can be challenging to manage clinically. This idea is supported by clinical experience, clinical case reports and two existing empirical studies. The primary aim of this study is to further the knowledge about the phenomenon of silence in STPP with depressed adolescents. More specifically, to explore the length and duration of the pauses and their possible function. Further, the occurrence of particularly long pauses and how therapists respond to these will be looked at in detail.

This study attempts to investigate the following questions:

1) What is the frequency, duration, category, amount of session time, and speaker patterns of pauses in STPP with depressed adolescents, and does this change over time?
2) Considering that long pauses can pose a technical dilemma for therapists, what are the patterns of the longest pauses and how do therapists respond to these?

Developing a better understanding of the in-session silences that occur with this particular patient population can help to inform clinical practice.

Method

Description of the Data

The data were drawn from a wider study, the STPP arm of IMPACT; a multicentre, pragmatic, observer-blind randomised controlled superiority trial comparing STPP and CBT with a brief psychosocial intervention for adolescents diagnosed with moderate to severe depression (Goodyer et al., 2011, 2017). The trial was the largest of its kind in the UK and involved 465 adolescents aged 11-17 years who were randomly assigned to the three treatment arms. Treatment was delivered across fifteen National Health Service (NHS) Child and Adolescent Mental Health Service (CAMHS) clinics in three regions in England. Therapy sessions from both treatment arms of the trial were audio-recorded, and outcome measures were recorded at different time points during treatment.

Participants

Patients

Three patient-therapist dyads were selected from the STPP arm of the IMPACT study. The sample consisted of three adolescents with current DSM-5 unipolar Major Depressive Disorder (MDD) diagnoses with moderate to severe impairment. All YPs fit the case population of CAMHS clinics within the NHS. Table 1. below outlines information on each therapy and outcome.

Table 1
Patient Information

	Patient A	Patient B	Patient C
Gender	Female	Male	Female
Ethnicity	White British	White & Black Caribbean	White British
Age	15	15	16
Sessions attended	26	29	25
Sessions offered	28	29	30
Sessions coded	4, 6, 14, 15, 23, 24	5, 6, 14, 15, 24, 25	5, 6, 13, 14, 23, 24
Therapist	Male	Female	Female
MFQ[a] Wk 0	42	51	44
MFQ[a] Wk 6	31	45	39
MFQ[a] Wk 12	11	37	None recorded
MFQ[a] Wk 36	28	38	23

Notes.
[a]=Mood and Feelings Questionnaire (patient rated)

The cases were sampled for pragmatic reasons to ensure the availability of good quality recordings of beginning, middle and end sessions and measure scores, which meant that the cases were limited to YPs who had engaged well and had completed their therapies. Of the available cases, three treatments were chosen with adolescents aged between 15-16 years, as it was felt that this age group would be more likely to communicate verbally rather than through play or other activities.

The YPs' degree of depressive symptoms varied at baseline. All participants completed treatment, having attended a mean of 26.67 sessions (SD 2.08), and their outcome was deemed as "good" based on the fact that there was a clinically significant reduction in their MFQ score. It is of note that attendance rates of the sample were not representative of

the overall population of the STPP arm of the IMPACT study, as the median number of treatment sessions attended by the general population were 11 sessions over the average duration of 27.9 weeks (Goodyer et al., 2017). Less than 50% of patients attended more than half of the recommended number of STPP sessions (Goodyer et al., 2017; O'Keeffe et al., 2018).

Therapists

The three therapies were delivered by three different psychoanalytic child and adolescent psychotherapists who were either post-qualification or in the final year of their four-year postgraduate professional training. All were registered with the Association of Child Psychotherapists, UK. All therapists received STPP training and used the STPP treatment manual, which had been specifically developed for the IMPACT study (Cregeen et al., 2017). Supervision was provided as part of routine practice at the CAMHS clinics where treatment took place (Goodyer et al., 2017).

Treatment

STPP is a 28-session model consisting of once-weekly individual therapy sessions for the adolescent and up to seven separate sessions for the parents/carers with a different therapist. Sessions are approximately 50 minutes in length. STPP was designed for adolescents with a complex clinical picture and whose depression is severe (Cregeen et al., 2017).

Ethical considerations

As the data were sourced from the IMPACT study, ethical approval had been obtained as part of the larger trial and participants, and their parents had given written consent for their data to be used. All audio recordings of the sessions used in this study were stored on a secure drive. Session transcripts were anonymised and password protected. Hard copies of

transcripts were stored in a lockable cabinet. The data collection tool with the coded data did not contain any identifying information and was password protected.

Measures

Pausing Inventory Categorization System 2nd Revision (PICS)

The PICS-R (Frankel et al., 2006; Levitt & Frankel, 2004) is a revised version of the PICS developed by Levitt (1998, 2001b).[9] It is a therapy process measure with a conceptual basis in qualitative research. It was developed through a grounded theory (Glaser & Strauss, 1967) analysis of interviews with patients about their experiences of specific silent moments in their sessions.

The PICS was developed as an observer-based coding system and entails three higher-order categories: "obstructive", "productive", and "neutral" pauses. Productive pauses occur when the patient experiences profound emotions (e.g. "It's so hard to talk about this [cries, 15s pause] I feel really lost."), or expresses insight, awareness or curiosity about the self, existential themes or more shallow topics (e.g. "I wonder why we keep arguing about this?" [5s pause, sighs] or "The train got cancelled, [4s pause] I wonder what happened."). Productive pauses also occur when the patient pauses to seek the correct word (e.g. "He was never particularly, um, [3s pause] sensible.").

Obstructive pauses are composed of pauses during which a patient withdraws from an emotion or cuts off the possibility to explore something further (e.g. [cries] "It was a difficult time [9s pause, wipes tears away] but that's all in the past."), gives monosyllabic responses (e.g. [10s pause] "I don't know.") or remains completely silent. Another indicator that an obstructive pause has occurred is when the patient's focus shifts to the therapist, especially

[9] Please see Appendix B for all PICS categories and sub-types and an explanation of the original PICS and PICS-R.

when emotionally laden, "taboo" or complex topics come up or when the patient seeks clarification from the therapist (e.g. "I don't really know. [4s pause] What do you mean?").

Neutral pauses are neutral in their affect. These pauses occur when the patient tries to recall information (e.g. "It was blue, [3s pause] no turquoise." Or "Hm, [4s pause] I can't remember.") or when the patient moves on to a new topic after a pause.

For each pause coded, the dialogue before and after the pause and the context, length, and speaker patterns are considered. All PICS categories have several subtypes. These were coded, but given that the current study is exploratory, in the sense that it aims to examine the emergence of silence in psychotherapy with adolescents only the higher-order categories were analysed. This study thus focuses on different aspects of the emergence of silence, such as silence lengths (brief, medium, long), and speaker patterns, with a particular focus on long pauses and therapists' responses to these. As originally suggested by Levitt (1998), in the present study, speaker patterns for each pause were also coded. This provides information on who "initiates" and who "breaks" a pause, based on who is the last person to speak before and first to speak after a pause. The speaker patterns consist of four possible constellations: Patient-Patient (P-P), Patient-Therapist (P-T), Therapist-Patient (T-P), and Therapist-Therapist (T-T).

The PICS has been shown to have high interrater reliability (IRR) (Cohen's κ=0.82) (Levitt, 2001b). In the present study, a consensus coding approach was used rather than aiming to reach IRR. This approach was chosen to ensure high validity of the coded data (Hill et al., 2005; Stringer et al., 2010) as the former involves reaching a consensus on all ratings, whereas the latter leaves room for individual coder variability (e.g. Belur, 2021).

The two coders self-trained for approximately 17.5 hours using the PICS-R manual (Levitt & Frankel, 2004) and transcripts and audio recordings of a number of STPP sessions[10].

Once training was completed, a data collection tool was developed to capture the category, sub-type, speaker patterns, exact start and length of the pause, and stage in therapy[11]. Pauses were divided into three length categories: brief=3s.-10s., medium=11-60s., and long=>1min.

The coders consensus coded all sessions with the use of audio recordings. Sessions were coded individually and in chunks to minimise the possibility of influencing one another. The coders met at regular intervals to discuss disagreements and re-listen to all pauses they had not agreed on to reach an agreement. The total time spent on the coding, including reaching a consensus on the pauses coded differently, was approximately 35 hours[12].

Helping Skills System (HSS)[13]

The HSS (Hill, 2009) was used to look at the second aim of this study, therapists' responses to particularly long pauses. It is an adapted version of the Hill Counselor Verbal Response Category System (Hill, 1986, 1992; Hill et al., 1981). It consists of 12 nominal, mutually exclusive categories: approval, reassurance, closed questions, open questions, restatements, reflections of feelings, challenges, interpretations, self-disclosure, immediacy, information, direct guidance. When used for research, therapist verbal behaviour is

[10] The training sessions were from three different STPP treatments and had been chosen because transcriptions were available. None of these treatments were part of the current study. Please see Appendix C for full details of the coding training.
[11] Due to the lack of visual data a session was deemed to start at the first utterance and finish when the therapist indicated that it was the end of the session. Any pauses before or after were not coded. Pauses that occurred when the therapist was speaking (i.e., pausing mid-sentence to gather their thoughts) or when the patient or therapist was involved in an activity that let them momentarily fall silent (i.e., taking out a diary to discuss holiday dates) were not coded.
[12] Please see Appendix C for full details of the coding process.
[13] Please see Appendix D for a full list of Helping Skills.

categorised into meaning units (grammatical sentences), and each unit is assigned one helping skill. Therapists' statements unrelated to the therapeutic process are grouped into another category (other). The HSS has been shown to have high interrater reliability, especially for the predominant units of a therapist's speaking turn (Cohen's κ=0.98) (Goates-Jones et al., 2009). In the present study, a consensus coding approach was used.

The coders self-trained using *Helping Skills: Facilitating Exploration, Insight, and Action (Third Edition)* (Hill, 2009). The author then transcribed the dialogue before and immediately after each long pause verbatim. Therapists' responses were broken down into meaning units in line with the coding guidelines outlined by Hill (2009), adapted from Auld & White (1956). The coding system was then adapted to assign one overall HHS code per therapist response[14]. All therapist responses were consensus coded. Following this, the author discussed the coding decisions with her research supervisor. The approximate length of the HSS coding training and coding process was about 24 hours.

Mood and Feelings Questionnaire (MFQ)

The MFQ (Angold et al., 1995; E. Costello & Angold, 1988) is a screening tool to assess depression in children and adolescents aged six to 19 years. It consists of descriptive phrases about how the young person (YP) has felt or acted over the past fortnight. Scores of 27 or higher may indicate the presence of depression. Higher scores indicate increased depression. The MFQ has been shown to have reliability (Wood et al., 1995). In the IMPACT study, the MFQ was administered at baseline, during therapy (week 6 and 12) and after the completion of treatment (week 36).

[14] As some of the long pauses were broken by the patients, an additional code (code 0) was also introduced to indicate when no Helping Skill response occurred.

Procedure

Selection of Therapy Sessions

A total of 18 therapy sessions were selected. These included two sessions from the beginning, middle and end stages of each of the three treatments to capture a possible change over time[15]. The first two and the final two sessions were excluded, as these are typically different (Kuprian et al., 2017). The sessions selected were from the end of the beginning stage (e.g., sessions 4-6), the exact middle point of treatment (e.g., sessions 13-15) and the early sessions from the end-stage (e.g., sessions 23-25), depending on the availability of audio recordings. Whenever possible, these were consecutive sessions.

Coders

Two female clinical doctoral students in psychoanalytic child and adolescent psychotherapy coded the pauses, one being the author. All sessions used in this study were consensus coded by the author and her research partner.

Data Analysis

The data were analysed using Microsoft Excel (Office 16). The statistical analyses were conducted with Statistical Package for the Social Sciences 26 (SPSS 26).

Findings

A total number of 1,248 pauses of three seconds or longer were identified in the 18 therapy sessions. These were analysed to identify the frequency and duration of in-session silences, speaker patterns, and the percentage of session time taken up by silence. The results

[15] Due to the lack of the definition of clear treatment stages in the STPP manual, it was decided to define the beginning stage as sessions 1-6, the middle stage of sessions 7-22, and the end stage of sessions 23-28 (based on the assumption that treatment ended after 28 sessions). This was made with the idea that the middle stage roughly takes up 60% of the whole treatment duration, whereas the beginning and end stages take up roughly 20% each. This differed from the definition of treatment stages made by other researchers, such as Della Rosa & Midgley (2017) and Trowell et al. (2007).

from each therapy were collapsed together to produce combined findings for the beginning, middle, and end stages of treatment. All long pauses were then looked at more in-depth, and therapists' responses were analysed.

Frequency and Duration of In-Session Silences

The vast majority (69.0%, n=861) of in-session pauses were coded as obstructive, the most frequent silence category across all therapy stages and 29.2% (n=365) were productive. Most productive pauses were brief and tended to occur in the middle stage of therapy. Neutral pauses were rare and only made up 1.8% (n=22) of all pauses. Table 2 below depicts the frequency of brief (3-10s), medium (11-60s) and long pauses (>1min) across therapy stages and silence categories.

Table 2
Frequency of Brief, Medium and Long Pause Categories Across Therapy Stages

Categories and types per therapy stage	Brief[a] (N=929)		Medium[b] (N=277)		Long[c] (N=42)		Total (N=1,248)	
	n	(%)	n	(%)	n	(%)	n	(%)
Beginning	321	(34.6%)	95	(34.3%)	18	(42.9%)	434	(34.8%)
Obstructive	233	(72.6%)	82	(86.3%)	18	(100.0%)	333	(76.7%)
Productive	78	(24.3%)	10	(10.5%)	0	(0.0%)	88	(20.3%)
Neutral	10	(3.1%)	3	(3.2%)	0	(0.0%)	13	(3.0%)
Middle	304	(32.7%)	94	(33.9%)	11	(26.2%)	409	(32.8%)
Obstructive	180	(59.2%)	65	(69.1%)	9	(81.8%)	254	(62.1%)
Productive	120	(39.5%)	28	(29.8%)	2	(18.2%)	150	(36.7%)
Neutral	4	(1.3%)	1	(1.1%)	0	(0.0%)	5	(1.2%)
End	304	(32.7%)	88	(31.8%)	13	(31.0%)	405	(32.5%)
Obstructive	197	(64.8%)	64	(72.7%)	13	(100.0%)	274	(67.7%)
Productive	107	(35.2%)	20	(22.7%)	0	(0.0%)	127	(31.4%)
Neutral	0	(0.0%)	4	(4.5%)	0	(0.0%)	4	(1.0%)
Total	929	(74.4%)	277	(22.2%)	42	(3.4%)	1,248	(100.0%)

Notes.
[a]=Brief pauses (3-10 sec, M=5.19 sec, SD= 2.10 sec); [b]=Medium pauses (11-60 sec, M=20.07 sec, SD=9.86 sec); [c]=Long pauses (61 sec – 5 min 6 sec, Mdn= 139 sec, IQR= 83.25 sec)

Brief Pauses

Of the total pauses coded, 74.4% (N=929) were brief pauses, and these were evenly distributed across the treatment stages. The mean length of brief pauses was 5.19 seconds. The vast majority (65.7%, n=610) of brief pauses were obstructive. However, overall brief pauses had the highest frequency of productive pauses among the three length categories. The

therapy stage with the highest count of brief productive pauses was the middle stage making up 39.5% (n=120) of all brief pauses in this therapy stage.

Medium Length Pauses

Medium length pauses made up 22.2% (N=277) of all pauses coded. These had a mean duration of 21.0 seconds. The frequency of medium length pauses was distributed evenly across the treatment stages. Most medium pauses (76.2%, n=211) were obstructive. 20.9% (n=58) were coded as productive, with most occurring in the middle phase of treatment.

Long Pauses

Only 3.4% (N=42) of all pauses coded were long. Their duration ranged from 61s to 306s (5 min. 6 s.). Long pauses showed the most fluctuation across treatment stages. Notably, only two long pauses (4.8%) were coded as productive. These occurred in the middle stage of treatment, which was the treatment stage with the highest frequency of productive pauses across all pause lengths.

A Chi-Square Test of Independence was performed to assess the relationship between pause length (brief, medium, long) and pause category (obstructive, productive). There was a significant relationship between the two variables ($\chi^2(2,1226)=26.79, p=<.001$) and the pause length was associated with the obstructive pause category[16]. Results indicate that the longer a pause, the less likely it was to be productive[17].

Percentage of Session Time Spent in Silence

The duration of different silence lengths was calculated to determine the percentage of session time spent in silence across the different therapy stages. The percentage of session

[16] Due to the low frequency of neutral pauses these were excluded from this statistical analysis. A table which displays the frequency of obstructive and productive pauses across the different pause lengths can be found in Appendix E.

[17] A precise breakdown of the duration of short and medium silences can be found in Appendix F.

time taken up by silence was 36.5% in the beginning stage, 30.9% in the middle and 32.9% in the end stage of treatment, so approximately a third per session stage. Table 3 below offers a breakdown of the percentage of time spent in different silence lengths across the different therapy stages. The biggest duration of time was taken up by long pauses, although these also had the biggest fluctuation across the therapy stages. The middle stage had the lowest percentage of session time taken up by all three length categories.

Table 3
Duration of Session Time Spent in Brief, Medium and Long Pauses Across Therapy Stages

Categories and types per therapy stage	Beginning	Middle	End	Total
	(%)	(%)	(%)	(%)
Brief[a]	9.8%	9.6%	9.9%	9.8%
Medium[b]	12.2%	10.6%	10.8%	11.2%
Long[c]	14.6%	10.6%	12.1%	12.4%
Total	36.5%	30.9%	32.9%	33.4%

Notes.
[a]=Brief pauses (3-10 sec, M=5.19 sec, SD= 2.10 sec); [b]=Medium pauses (11-60 sec, M=20.07 sec, SD=9.86 sec); [c]=Long pauses (61 sec – 5 min 6 sec, Mdn= 139 sec, IQR= 83.25 sec)

Speaker Patterns

Table 4 below shows the frequency of the four different speaker patterns (P-P, P-T, T-P, T-T) across the different pause lengths. The majority of brief pauses (31.3%, n=291) were initiated and broken by the patients (P-P pauses), and a further 20.2% (n=188) of brief pauses were initiated by the therapists but broken by the YPs. 17.0% (n=47) of medium length silences were P-P pauses and 11.9% (n=33) T-P pauses. Medium silences were thus far less likely to be broken by the YPs. Of the 42 long pauses, only 14.2% (n=6) were broken by the YPs. However, it is of note that 40.8% (n=113) of medium and 50.0% (n=21) of long pauses were P-T pauses, the most common speaker patterns in both categories. Overall, just over 60% of all pauses were initiated by the YPs. The above suggests that pauses longer than ten seconds in this sample were more likely to be initiated by the YPs but broken by the therapists.

Table 4
Frequency of Speaker Patterns Across Brief, Medium and Long Pauses

Pause Length		P-P[a]	P-T[b]	T-P[c]	T-T[d]	Total
Brief[e]	Count	291	277	188	173	929
	Expected Count	253.8	305.9	166.7	202.5	929.0
	% within Pause Length	31.3%	29.8%	20.2%	18.6%	100.0%
Medium[f]	Count	47	113	33	84	277
	Expected Count	75.7	91.2	49.7	60.4	277.0
	% within Pause Length	17.0%	40.8%	11.9%	30.3%	100.0%
Long[g]	Count	3	21	3	15	42
	Expected Count	11.5	13.8	7.5	9.2	42.0
	% within Pause Length	7.1%	50.0%	7.1%	35.7%	100.0%
Total	Count	341	411	224	272	1248
	Expected Count	341.0	411.0	224.0	272.0	1248
	% within Pause Length	27.3%	32.9%	17.9%	21.8%	100.0%

Notes.
[a]=Patient-Patient pause; [b]=Patient-Therapist pause; [c]=Therapist-Patient pause; [d]=Therapist-Therapist pause; [e]=Brief pauses (3-10 sec, M=5.19 sec, SD= 2.10 sec); [f]= Medium pauses (11-60 sec, M=20.07 sec, SD=9.86 sec); [g]=Long pauses (61 sec – 5 min 6 sec, Mdn= 139 sec, IQR= 83.25 sec)

A Chi-Square Test of Independence showed a statistically significant relationship between pause length (brief, medium, long) and speaker pattern category (P-P, P-T, T-P, T-T) $\chi^2(6, 1248)=62.56, p=.001)$. Results confirm that the longer a pause, the more likely it was to be broken by the therapists rather than the patients.

Figure 1 below depicts the percentage of pauses broken by the therapists across the silence length categories and treatment stages. In this sample, the therapists broke most medium and long silences. Results also indicate a reduction in the number of silences broken by the therapists throughout treatment.

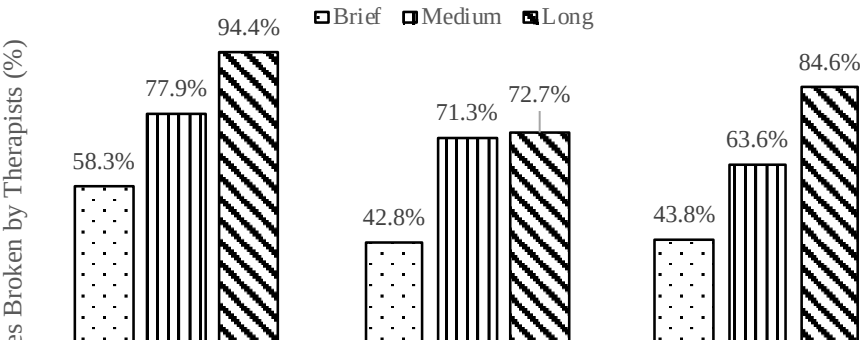

Figure 1. *Proportion (%) of pauses broken by therapists across all therapy stages*

Notes.
Brief pauses = 3-10 s, M=5.19 s, SD= 2.10 s; Medium pauses =11-60 s, M=20.07 s, SD=9.86 s; Long pauses =61 s – 5 min 6 s, Mdn= 139 s, IQR= 83.25 s

An In-Depth Look at Long Pauses

As highlighted above, long pauses that occurred were far less common than brief or medium length silences but took up most of the session time spent in silence. Long pauses in this sample were also far more likely to be broken by the therapists than the patients. Some of the long pauses that the therapists allowed to unfold went on for very long indeed, with the longest one lasting just over five minutes. Long pauses pose a particular technical dilemma for therapists. There was thus a scope to take a more in-depth look at the long pauses in each of the three therapies, as well as the therapists' responses.

Occurrence of Long Pauses in Each Therapy

Figure 2 below depicts a breakdown of the occurrence of pauses longer than 60 seconds and shows that there was much difference between the three treatments. Therapy A and C had a very low percentage of session time taken up by long pauses in the beginning stage, which rose throughout the treatment duration and peaked in the end stage. In Therapy B, the opposite trend could be observed. Most of the session time is taken up by long pauses in the beginning stage. The percentage saw a stark reduction throughout the treatment.

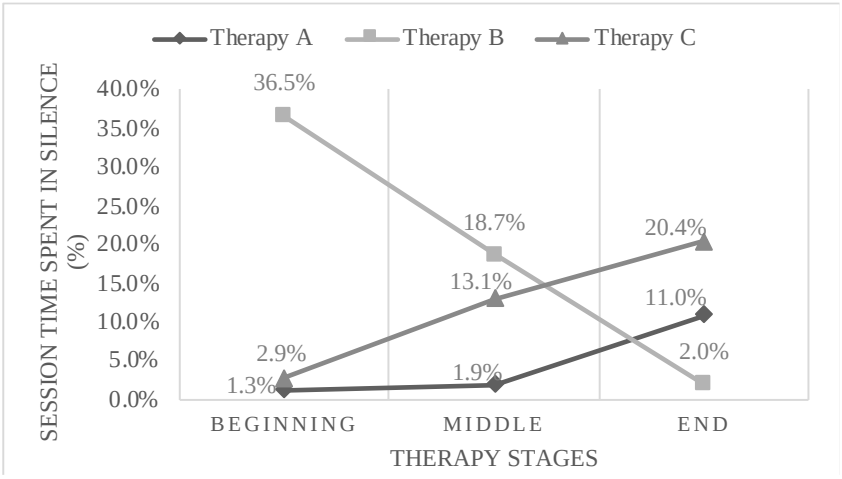

Figure 2. *Duration of session time spent in long pauses across all three therapies*

Across all therapies, long pauses most frequently occurred in the therapy stages with the highest percentage of in-session silence, which was the beginning stage for Therapy B but the final stage for Therapies A & C. Importantly, many of the long silences were followed by a cluster of silences[18].

Therapists' Responses

Frequency of Helping Skills System Interventions. Table 5 below depicts the frequency of each helping skill used by the therapists after long pauses in this sample. Results show that the most frequent helping skills coded were "interpretations", "reflections of feelings", and "open questions". A more detailed overview of the three most frequent categories is presented below.

Table 5
Frequency Therapists' Helping Skill Interventions After Long Pauses Across Therapy Stages

Helping Skill Categories	Beginning (N=18)	Middle (N=11)	End (N=13)	Total (N=42)
Challenge	0 (0.0%)	1 (9.1%)	0 (0.0%)	1 (2.4%)
Closed Question	4 (22.2%)	0 (0.0%)	0 (0.0%)	4 (9.5%)
Interpretation	4 (22.2%)	2 (18.2%)	8 (61.5%)	14 (33.3%)
Open Question	4 (22.2%)	3 (27.3%)	0 (0.0%)	7 (16.7%)
Other[a]	1 (5.6%)	1 (9.1%)	1 (7.7%)	3 (7.1%)
Reflection of Feelings	4 (22.2%)	1 (9.1%)	2 (15.4%)	7 (16.7%)
Pause Broken by Patient	1 (5.6%)	3 (27.3%)	2 (15.4%)	6 (14.3%)
Total	18 (42.9%)	11 (26.2%)	13 (31.0%)	42 (100.0%)

Notes.
[a]=Pause occurred at end of session.

Interpretations. Results show that therapists most often used interpretations as an intervention after a long pause. This category made up 33.3% (n=14) of all interventions coded. Most interpretations, 61.5% (n=8), occurred in the final stage of therapy. The majority (57.1%, n=8) of interpretations consisted of three to four meaning units, the rest (42.9%, n=6) were made up of one meaning unit. These were most often given with reflection of feelings

[18] Please see Appendix G for further information on the most silent sessions of each treatment, including the occurrence of cluster silences.

or immediacy. Interpretations were by far the "wordiest" interventions. Half of all interpretations were transference interpretations (50.0%, n=7).

Reflection of Feelings. Reflection of feelings interventions made up 16.7% (n=7) of all HS responses coded. Most were given in the beginning stage, making up 22.2% (n=4) of all interventions delivered in this stage. Of the seven reflection of feelings interventions, 57.1% (n=4) had one meaning unit. The remaining 42.9% (n=3) had two to three meaning units. These were given together with immediacy, information and restatement interventions.

Open Questions. A total of seven open questions were recorded in this sample, making up 16.7% of all interventions coded. Most took place in the beginning stage, making up 22.2% (n=4) of interventions coded in this therapy stage. None occurred in the end stage of therapy. Open questions consisted of one meaning unit only and were brief (e.g., "What are you thinking?", "I wonder what's going on?", "What do you think is going on?"). Of these, 42.9% (n=3) were about the patient's thoughts, and 57.1% (n=4) were questions to help the YP gain insight. It is of note that 85.7% (n=6) of the open questions were used as interventions in Therapy B, which was the most silent therapy of the three treatments.

Pause Clusters. Many of the long pauses either clustered together or were followed by clusters of brief or medium length pauses. Indeed, 59.5% (n=25) were either followed by an obstructive pause cluster or a further long silence within two minutes of the end of the long pause. A closer look at the three most frequent HSS responses showed that 71.4% (n=10) of interpretations were followed by an obstructive pause cluster or a further long silence. 71.4% (n=5) of open questions were also followed by obstructive pause clusters or a further long pause. An obstructive pause cluster followed 42.9% (n=3) of reflection of feeling interventions, but no further long pauses were recorded within the next two minutes.

The below interpretation, which the therapist offered after a four-minute pause, illustrates what the occurrence of further pauses can look like[19]. This sequence ends with a monosyllabic answer from the YP:

T: *"It's a bit like, this seems [to be] bringing a feeling of, feeling like people are saying you're doing the wrong thing in different places, /*

and perhaps, a worry that I might be saying something like that too, or thinking that too, /

but I wonder if it's that you feel that's what happened or if there's a part of you that sort of wants to, you know, sort of talk at school and doesn't want to really be doing the work."/

(29s)

T: *"I suppose I'm wondering if it's a bit of a protest in some ways."*

(7s)

P: *"I suppose."*

Nevertheless, it is of note that productive pause followed 7.2% (n=3) of long pauses; these occurred after an interpretation and a reflection of feelings intervention and when one of the YPs broke a pause. One of the two productive long pauses was followed by a cluster of productive pauses.

Discussion

This is a quantitative exploratory therapy process study on silence in the psychoanalytic work with depressed adolescents. The study focused on two key issues: 1) characteristics of pauses (type, frequency, duration, session time taken up by silence, speaker pattern) and their change over time, and 2) the manifestation of long pauses and the therapists' responses.

[19] Further examples for each HHS category coded can be found in Appendix H.

Frequency and Duration of In-Session Silences

In the present study, silence was a common feature in all sessions coded, of which the vast majority were coded as "obstructive". Pauses coded as "productive" were less common, and those coded as "neutral" were rare. These findings differed from previous PICS studies that showed a higher frequency of productive pauses (e.g. Daniel et al., 2016; Hill et al., 2019; Levitt, 1998) or a similar frequency of pauses coded as productive and obstructive (Cuttler et al., 2019).

The mean frequency of pauses per session in this sample was 69.3. Zimmermann et al.'s (2020) study with adolescents reported a similar average count of 70 pauses per therapy session. As reported by Acheson et al. (2020), the frequency of pauses in this current sample was much higher than in previous studies conducted with adults. In the present study, the overall frequency of pauses was spread out fairly evenly across the treatment stages. This finding differed from previous studies, such as Daniel et al.'s (2016), which showed that the beginning stage had fewer pauses than the other stages in the PPT and CBT treatment.

In the present study, the pause duration ranged from 3s to 5min 6s. Three duration categories were introduced; brief pauses, medium pauses, and long pauses. The pause duration was much longer than in previous studies. In Zimmermann et al.'s (2020) adolescent sample, pauses had a mean duration of 5 s (SD 2.7). In adult studies, the duration ranged from a mean of 6.6 s (SD 9.8) (Daniel et al., 2016) and 6.7 s (*SD* 2.39) (Hill et al., 2019) to 9.4 s (SD 4.84) (Cuttler et al., 2019). In Levitt's (1998) original study, only 0.95% of all silences were longer than 26 s.

The frequency of brief and medium-length pauses in this study remained stable across treatment stages. Long pauses, however, saw more fluctuation. An important finding was the statistically significant relationship between pause duration and pause category. The longer a

pause, the less likely it was to be productive. Along similar lines, Levitt's (1998) original study found that obstructive pauses were considerably longer than neutral or productive pauses. In Daniel et al.'s (2016) sample, the mean duration of obstructive pauses (14.8 s, SD 32.2) was more than twice as long as that of productive pauses (6.8 s, SD 7.6). This finding is important due to this sample's comparatively high frequency of obstructive pauses.

Percentage of Session Time Spent in Silence

The overall mean session time spent in silence was 33.4% per stage. In previous studies with adults, the percentage of session time taken up by silence was far less. Hill et al. (2019) reported 4.59% (*SD* 1.85, range 2%–8%). Zimmermann et al. l. (2020) reported an average of 10% per session in their study with adolescent patients.

Speaker Patterns

The speaker patterns varied in this sample across silence duration and therapy stage. The statistically significant relationship between pause length and speaker patterns was a key finding. Thus, the longer a pause, the more likely it was to be broken by the therapist in this sample. Overall, there was a reduction of silences broken by the therapists throughout treatment. Importantly, in previous adult studies, the speaker patterns differed. In some cases, therapists and patients broke the pauses about the same amount of time (52% vs. 48%). (Cuttler et al., 2019, p. 573). Hill et al.'s (2019) case study, which had a particularly high frequency of productive pauses, saw the patient breaking the pauses 69% of the time. The fact that in this sample, as treatment progressed, more silences were broken by the YPs may suggest that the therapists may have allowed more silences to unfold. It could also be a sign that the YPs became more able to work with them.

Overall, the present findings regarding pause characteristics may indicate that analytic treatments with adolescents such as STPP may leave more room for silences to unfold. This

finding is supported by previous research showing that more silences occur in psychoanalytic psychotherapy and psychoanalysis than in other forms of therapy (Daniel et al., 2016; Huber et al., 2012). Moreover, many pauses coded as "obstructive" appeared to represent the YPs' adolescent struggle. Based on the dialogue and particular "quality" of the pauses, the YPs seemed to be withdrawing and seeking contact with the therapists in equal measures. It was felt that these particular pauses were of intrapsychic nature and related to the developmental stage of adolescence and the transference relationship in the therapy. These pauses seemed more in line with the phenomenon Gensler (2015) described. It may therefore be that some obstructive silences are part of the YP's individuation process (Blos, 1967). Furthermore, it is of note that the YPs' depression in this sample seemed ever-present, especially during the long silences. Indeed, some depressed adolescents may experience profound anxiety of annihilation, such as the fear of being swallowed up by a "black hole" (Cregeen et al., 2017). Considering the known link between depression and reduced speech rate, some silences in this sample may have reflected the YPs depressive state, and indeed, a possible sign of dissociation.

An In-Depth Look at Long Pauses

In this study, only a small percentage of pauses were coded as "long"; however, these took up a considerable amount of session time. There were apparent individual differences for these in each therapy. This finding might suggest that long pauses serve different functions at different treatment stages, unique for each patient-therapist dyad. For instance, in Therapies A and C, the highest frequency of long pauses occurred in the final stage of therapy. This finding seems to be is in line with existing research, which has shown that silence frequency increased as therapy progressed (Daniel et al., 2016; Gindi, 2002). Due to the time-limited nature of STPP, the end-stage can bring to the forefront the negative transference and issues around separation and loss, which can be understood in the context of

the YPs' diagnosis of depression (Cregeen et al., 2017). The increase of long pauses in the final stage of therapy in Therapies A and C may therefore have been linked to the YPs feelings about the ending process.

The high percentage of session time taken up by long pauses in the early phase of Therapy B indicates that the occurrence of these pauses may have had a different function. As mentioned above, the YP's hopelessness and despair felt palpable during long pauses, and the YP appeared to struggle at times with "deadly" feelings. It may therefore be that the high frequency of long silences at the beginning of treatment may have been connected to the patient's depressed state. This seems to be supported by the YPs' MFQ scores, which scored 51 in week 0, which was much higher than those of the other two patients.

Whilst most long pauses were coded as "obstructive", it is of note that one of the long productive pauses was a P-P pause that was followed by three further productive pauses. This finding might indicate that there can be exceptions. This ties in with the findings of Cuttler et al. (2019), who showed that productive therapist and patient silences are linked to greater subsequent patient collaboration. Considering the "healing" aspects of silence highlighted in the adolescent literature (e.g. Cristy, 1993; Khan, 1963; MacIntosh, 2017; Malberg, 2012), it may be that long pauses can both be a sign of shutting off feelings and dissociating, as well as a process that could potentially lead to more insight if it is used to allow to be in touch with affect. This could point towards the fact that obstructive pauses may not necessarily be an indicator of the patient being in a defended state of mind but that they are not yet ready to verbalise their feelings and are working something out internally.

Therapists' Responses

In this sample, interpretations were the most frequent intervention coded. Put simply; interpretations are interventions that put into words unconscious processes that have a current

impact on patients' ways of functioning and behaviour. Working in the transference and making unconscious processes conscious are the key principles of STPP (Cregeen et al., 2017). Most interpretations were given in the end-stage, indicating that the therapists deliberately used this intervention only after enough time had passed to have formed a strong therapeutic alliance with their patients. Indeed, in the psychoanalytic adult literature on silence, some authors warn against using premature interpretations (e.g. Knutson & Kristiansen, 2015; Ronningstam, 2006). The adolescent psychoanalytic literature has also noted the difficulty of using interpretations with silent patients (Leira, 1995). It is of note that the majority of interpretations were followed by an obstructive pause cluster or a further long silence. Among other possibilities, this could be a reflection of the YPs difficulty to get meaning out of the interpretations, or it may be a potential indication that these were experienced as unhelpful or intrusive.

Reflection of feeling interventions were another common response. These were followed by fewer obstructive pause clusters than interpretations or open questions. In the HSS (Hill, 2009) reflection of feeling interventions are described as statements by therapists which explicitly describe a person's feelings. This can either be done by rephrasing or restating what a person has said or inferring feelings through body language. This seems to closely resemble the therapeutic technique referred to as "mirroring" in the STPP manual. The "mirroring" element seems important and is reminiscent of Winnicott's (1967) concept of the *mirror role of the mother*. Indeed, a number of psychoanalytic case studies highlight the mirroring of a silent patient's body language as an important technical tool in both the work with adults (e.g. Blumenson, 1993; Vaccaro, 2008) and adolescents (e.g. Cristy, 1993). Whilst the small sample size does not allow to generalise these findings; it may be that the YPs in this study experienced this type of intervention as helpful as it responded to their developmental needs. The fact that most reflection of feeling interventions were given in the

beginning stage of treatment may also have been an attempt of the therapists to build and strengthen the therapeutic alliance.

Open questions were another frequent intervention. In this sample, most open questions took place in the beginning stage of therapy. Within the HHS framework, open questions are regarded as useful for patients who find it difficult to talk (Hill, 2009). This is in line with guidelines for STPP (Cregeen et al., 2017), as although it is a non-directive, patient-led talking therapy, therapists do ask questions to encourage the YPs to facilitate a dialogue. In the work with some adolescents who present as silent in treatment, asking questions and showing curiosity can aid in helping the YP to feel safe and engaged enough to talk (Gensler, 2015). However, some psychoanalytic case studies have also shown that very withdrawn, and silent YPs may experience questions, and indeed all words, as intrusive (e.g. Anagnostaki, 2013; Bakalar, 2012; Cristy, 1993; Khan, 1963; MacIntosh, 2017; Wilson, 1997). Most open questions occurred in Therapy B, who was the most silent YPs in this sample. Considering that the YP was particularly silent in the beginning stage of therapy, taking a more concrete approach might have been the therapist's attempt to "reach" the YP and help them gain some insight into their silence.

Long periods of silence, especially those exceeding several minutes, can be technically challenging for therapists and produce powerful countertransference reactions. In a wider sense, it highlights the importance of working with the negative transference, especially in time-limited treatments such as STPP. All three therapists in this sample seemed to work hard to stay connected to the YPs. During some of their HSS interventions, the therapists displayed a rhythmic, calm, and melodic tone of voice, resembling a mother soothing her baby. Many of the interventions pointed towards the fact that the therapists held their patients in mind and continued to think about the dialogue that had taken place before

the pause, potentially allowing the YPs to have the experience of *being alone in the presence of another* (Winnicott, 1958).

Limitations of the Study

This study has a number of limitations. Importantly, the nature of the sample could be perceived as a drawback. Firstly, the small sample used in this study means that the findings are not generalisable to the psychoanalytic work with depressed adolescents. There would therefore be scope to repeat the study with a larger sample. However, it is worth noting that the findings, i.e. detailed description of the emergence and clinical management of silence in psychotherapy with adolescents, provide initial descriptions of a clinically important phenomenon. Secondly, due to the inclusion criteria regarding the availability of beginning, middle and end sessions, the sample only consisted of YPs who engaged well and had good therapy outcomes. Sampling a mix of YPs who dropped out and those who engaged well may have produced very different findings. Thirdly, there were stark differences between Therapies A & C and Therapy B in terms of the patterns of silence. The fact that the data from the three treatments were collapsed and analysed together may have led to the differences being "cancelled out". Fourth, it is known that gender differences in depression usually emerge in mid-adolescence (Gomez-Baya et al., 2017). It may therefore have been beneficial to only select patients of the same sex to increase the homogeneity of the sample.

Further, neither of the coding systems used in this study was developed for adolescent patients nor for the specific use for psychoanalytic psychotherapy sessions. Indeed, using the HSS from a psychoanalytic perspective made it difficult to code transference related responses and may have led to an overuse of the "interpretation" category. Additionally, the surprisingly high frequency of brief silences may indicate that when using PICS to code therapeutic sessions with depressed adolescents, only pauses of 10 seconds or longer should

be coded. Finally, the use of audio recordings was perceived as a major drawback. Considering the tendency of adolescents to suppress emotions, it would have been desirable to have access to video footage to observe the non-verbal communication between the therapist-patient dyads to enable a better understanding of what was happening. The lack of such information may have led to an overuse of the "obstructive" category during the PICS coding.

Conclusion and Suggestion for Further Research

This quantitative therapy process study explored the occurrence of silence and therapists' responses to long silences in STPP with depressed adolescents. The findings indicate that in this sample, in-session silences are a frequent, multi-faceted phenomenon that is individual to each therapeutic dyad. The vast majority of pauses were obstructive, and the longer the pause, the less likely it was to be productive and the more likely it was to be broken by the therapist. The overall frequency of pauses, especially obstructive pauses, was much higher than in previous PICS studies conducted with adults. Pause duration was also much longer than in previous studies conducted with adults. The particularly high frequency of obstructive pauses in this sample may be linked to 1) the type of therapy the YPs received, with both the non-directive nature of the therapy and the time-limited element likely to have had an impact; 2) the adolescents' developmental stage, and 3) the YPs' diagnosis of MDD.

Therapists' interventions to long silences mainly included interpretations, reflection of feelings and open questions. Reflection of feeling interventions were followed by fewer obstructive pause-clusters, potentially indicating these were most suited to the YPs developmental needs and presenting symptoms. The therapists' interventions in this sample emphasised that they kept their patients in mind during the most prolonged silences and continued to think about them. Nevertheless, as demonstrated by Acheson et al. (2020), the

YPs in this sample expressed negative feelings about the silent moments in their respective therapies. Whilst this is just a hypothesis, the apparent withdrawn state of the adolescents during some of the long silences may have been a sign of the YPs having entered a dissociative state. This highlights the potential need to adapt therapeutic technique and develop a therapeutic framework around long silences.

The findings also draw attention to the need for further empirical studies exploring silence in the therapeutic work with adolescents presenting with a range of diagnoses and receiving a range of psychological therapies. One suggestion would be for this research to be repeated with a larger sample and for more sessions to be coded to give a more accurate picture of the therapy process. A final suggestion would be for future studies to include a qualitative part that includes potential reflections on the occurrence of silence by the YPs and their therapists to triangulate the data in a meaningful way.

References

Abela, J. R. Z., & Hankin, B. L. (2008). Depression in Children and Adolescents: Causes, Treatment, and Prevention. In J. R. Z. Abela & B. L. Hankin (Eds.), *The Handbook of Depression in Children and Adolescents* (pp. 3–32). New York: The Guilford Press.

Abraham, K. (1916). The first pregenital stage of the libido. In *Selected Papers on Psychoanalysis*. London: Hogarth Press 1957.

Acheson, R., Verdenhalven, N., Avdi, E., & Midgley, N. (2020). Exploring silence in short-term psychoanalytic psychotherapy with adolescents with depression. *Journal of Child Psychotherapy*, *46*(2), 224–240. https://doi.org/10.1080/0075417X.2020.1830297

Alpert, M., Pouget, E. R., & Silva, R. R. (2000). Reflections of depression in acoustic measures of the patient's speech. *Journal of Affective Disorders*, *66*, 59–69. https://doi.org/http://dx.doi.org/10.1016/S0165-0327%2800%2900335-9

Anagnostaki, L. (2013). Beyond Silence: Working with Phoebe. *Journal of Child Psychotherapy*, *39*(2), 156–170. https://doi.org/10.1080/0075417X.2013.806053

Angold, A., Costello, E., Messer, S., Pickles, A., Winder, F., & Silver, D. (1995). Development of a short questionnaire for use in epidemiological studies of depression in children and adolescents. *International Journal of Methods in Psychiatric Research*, *5*(4), 237–249.

Arlow, J. A. (1961). Silence and the Theory of Technique. *Journal of the American Psychoanalytic Association*, *9*(1), 44–55. https://doi.org/10.1177/000306516100900103

Auld, F., & White, A. M. (1956). Rules for Dividing Interviews into Sentences. *The Journal of Psychology*, *42*(2), 273–281. https://doi.org/10.1080/00223980.1956.9713040

Bakalar, N. L. (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.

Belur, J., Tompson, L., Thornton, A., & Simon, M. (2021). Interrater Reliability in Systematic Review Methodology: Exploring Variation in Coder Decision-Making. *Sociological Methods & Research*, *50*(2), 837–865. https://doi.org/10.1177/0049124118799372

Birmaher, B., Brent, D. A., Kolko, D., Baugher, M., Bridge, J., Holder, D., … Ulloa, R. E. (2000). Clinical Outcome After Short-Term Psychotherapy for Adolescents with Major Depressive Disorder. *Archives of General Psychiatry*, *57*(1), 29–36.

Blos, P. (1967). The Second Individuation Process of Adolescence [Article]. *The Psychoanalytic Study of the Child*, *22*(1), 162–186. https://doi.org/10.1080/00797308.1967.11822595

Blos, P. (1972). Silence: A Clinical Exploration. *Psychoanalytic Quarterly*, *41*, 348–363. https://doi.org/https://doi.org/10.1080/21674086.1972.11926602

Blumenson, S. R. (1993). The Mirror of Silence: A Method of Treating a Preverbal Schizophrenic Patient. *Modern Psychoanalysis*, *18*(2), 179–189.

Costello, E., & Angold, A. (1988). Scales to Assess Child and Adolescent Depression: Checklists, Screens, and Nets. *Journal of the American Academy of Child and Adolescent Psychiatry*, *27*(6), 726–737. https://doi.org/10.1097/00004583-198811000-00011

Costello, J. E., Erkanli, A., & Angold, A. (2006). Is there an epidemic of child or adolescent depression? *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *47*(12), 1263–1271. https://doi.org/10.1111/j.1469-7610.2006.01682.x

Cregeen, S., Hughes, C., Midgley, N., Rhode, M., & Rustin, M. (2017). *Short-Term Psychoanalytic Psychotherapy for Adolescents with Depression* (J. Catty, Ed.). London: Karnac.

Cristy, B. L. E. (1993). Beyond Words: The Psychodynamics of a Therapy in Silence with a Twelve-Year-Old Girl. *Clinical Social Work Journal*, *21*(2), 179–193. https://doi.org/https://doi.org/10.1007/BF00754533

Cuttler, E., Hill, C. E., King, S., & Kivlighan, D. M. (2019). Productive silence is golden: Predicting changes in client collaboration from process during silence and client attachment style in psychodynamic psychotherapy. *Psychotherapy (Chicago, Ill.)*, *56*(4), 568–576. https://doi.org/10.1037/pst0000260

Daniel, S. I., 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*, 1–14. https://doi.org/10.1080/10503307.2016.1177673

Della Rosa, E., & Midgley, N. (2017). Adolescent Patients' Responses to Interpretations Focused on Endings in Short-Term Psychoanalytic Psychotherapy. *Journal of Infant, Child, and Adolescent Psychotherapy*, *16*(4), 279–290. https://doi.org/10.1080/15289168.2017.1378531

Fenichel, O. (1928). On Isolation. In *The Collected Papers of Otto Fenichel*. New York: Norton, 1953.

Ferenczi, S. (1916). Schweigen ist Gold. *Internationale Zeitschrift für Psychoanalyse*, *4*(3), 155–156.

Fiquer, J. T., Boggio, P. S., & Gorenstein, C. (2013). Talking bodies: Nonverbal behavior in the assessment of depression severity. *Journal of Affective Disorders*, *150*(3), 1114–1119. https://doi.org/10.1016/j.jad.2013.05.002

Frankel, Z., Levitt, H. M., Murray, D. M., Greenberg, L. S., & Angus, L. E. (2006). Assessing silent processes in psychotherapy: an empirically derived categorization system and sampling strategy. *Psychotherapy Research*, *16*(5), 627–638. https://doi.org/10.1080/10503300600591635

Freud, S. (1912). The Dynamics of Transference. In *The Standard Edition of the Complete Works of Sigmund Freud* (Vol. 8, pp. 97–109).

Freud, S. (1913). On beginning the treatment (Further recommendations on the technique of psycho-analysis I). In *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*. Retrieved from http://www.pep-web.org/document.php?id=SE.012.0121A

Freud, S. (1914). Remembering, Repeating and Working-Through (Further Recommendations on the Technique of Psycho-Analysis II). In *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* (Vol. 12, pp. 145–156).

Freud, S. (1925). An Autobiographical Study. In *SE*: *Vol. XX* (pp. 1–74).

Fuller, V. G., & Crowther, C. (1998). A dark talent: Silence in analysis. *Journal of Analytical Psychology*, *43*(4), 523–543. https://doi.org/10.1111/1465-5922.00051

Gensler, D. (2015). Silence in Adolescent Psychotherapy. *Journal of Infant, Child & Adolescent Psychotherapy*, *14*(2), 188–195. https://doi.org/http://dx.doi.org/10.1080/15289168.2015.1032635

Gindi, S. (2002). *Patterns of Silences: A Case Study of a Young Adult with Learning Disabilities*. [Unpublished Master's thesis]: University of Toronto. https://doi.org/10.16953/deusbed.74839

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: strategies for qualitative research* (B. G. Glaser & A. L. Strauss, Eds.). Hawthorne, N.Y: Aldine de Gruyter.

Glover, E. (1927). Lectures on Technique in Psycho-Analysis. *The International Journal of Psychoanalysis*, *8*, 486–520. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc1&NEWS=N&AN=1928-00956-001

Goates-Jones, M. K., Hill, C. E., Stahl, J. v., & Doschek, E. E. (2009). Therapist response modes in the exploration stage: Timing and effectiveness. *Counselling Psychology Quarterly*, *22*(2), 221–231. https://doi.org/10.1080/09515070903185256

Goldstein-Ferber, S. (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. https://doi.org/10.1111/j.1752-0118.2004.tb00146.x

Gomez-Baya, D., Mendoza, R., Paino, S., Sanchez, A., & Romero, N. (2017). Latent Growth Curve Analysis of Gender Differences in Response Styles and Depressive Symptoms during Mid-Adolescence [Article]. *Cognitive Therapy and Research*, *41*(2), 289–303. https://doi.org/10.1007/s10608-016-9822-9

Goodyer, I. M., Reynolds, S., Barrett, B., Byford, S., Dubicka, B., Hill, J., … Fonagy, P. (2017). Cognitive-behavioural therapy and short-term psychoanalytic psychotherapy versus brief psychosocial intervention in adolescents with unipolar major depression (IMPACT): A multicentre, pragmatic, observer-blind, randomised controlled trial. *Health Technology Assessment*, *21*(12), 1–93. https://doi.org/10.3310/hta21120

Goodyer, I. M., Tsancheva, S., Byford, S., Dubicka, B., Hill, J., Kelvin, R., … 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. *Trials*, *12*, 1–12. https://doi.org/10.1186/1745-6215-12-175

Greden, J. F., & Carroll, B. J. (1980). Decrease in speech pause times with treatment of endogenous depression. *Biological Psychiatry*, *15*(4), 575–587.

Greenson, R. R. (1961). On the Silence and Sounds of the Analytic Hour. *Journal of the American Psychoanalytic Association*, *9*, 79–84. https://doi.org/10.1177/000306516100900105

Hadda, J. (1991). The Ontogeny of Silence in an Analytic Case. *The International Journal of Psycho-Analysis*, *72*, 117–130.

Hill, C. E. (1986). An overview of the Hill Counselor and Client Verbal Response Modes Category Systems. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook*. New York: Guilford.

Hill, C. E. (1990). Exploratory in-session process research in individual psychotherapy: A review. *Journal of Consulting and Clinical Psychology*, *58*(3), 288–294. https://doi.org/10.1037/0022-006X.58.3.288

Hill, C. E. (1992). An Overview of Four Measures Developed to Test the Hill Process Model: Therapist Intentions, Therapist Response Modes, Client Reactions, and Client Behaviors [Article]. *Journal of Counseling and Development*, *70*(6), 728–739. https://doi.org/10.1002/j.1556-6676.1992.tb02156.x

Hill, C. E. (2009). *Helping Skills: Facilitating Exploration, Insight, and Action (Third Edition)*. Washington, DC: American Psychological Association.

Hill, C. E., Kline, K. v, O'Connor, S., Morales, K., Li, X., Kivlighan, D. M., & Hillman, J. (2019). Silence Is Golden: A Mixed Methods Investigation of Silence in One Case of Psychodynamic Psychotherapy. *Psychotherapy (Chicago, Ill.)*, *56*(4), 577–587. https://doi.org/10.1037/pst0000196

Hill, C. E., Siegelman, L., Gronsky, B. R., Sturniolo, F., & Fretz, B. (1981). Nonverbal communication and counseling outcome. *Journal of Counseling Psychology*, *28*(3), 203–212. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=yrovfta&NEWS=N&AN=00001192-198105000-00003.

Hill, C. E., Thompson, B. J., Hess, S. A., Knox, S., Williams, E. N., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology*, *52*(2), 196–205. https://doi.org/10.1037/0022-0167.52.2.196

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. https://doi.org/10.1002/jclp.10155

Hoffmann, G. M. A., Gonze, J. C., & Mendlewicz, J. (1985). Speech Pause Time as a Method for the Evaluation of Psychomotor Retardation in Depressive Illness. *British Journal of Psychiatry*, *146*, 535–538.

Huber, D., Schmuck, A., & Kächele, H. (2012). Die verbale Aktivität in therapeutischen Dialogen: Ein exemplarischer Vergleich. *Forum der Psychoanalyse*, *28*(3), 299–309. https://doi.org/10.1007/s00451-012-0099-7

Kessler, R. C., Avenevoli, S., & Ries Merikangas, K. (2001). Mood Disorders in Children and Adolescents: An Epidemiologic Perspective. *Biological Psychiary*, *49*(12), 1002–1014. https://doi.org/10.1007/978-1-4939-2528-5_19

Khan, M. (1963). Silence as communication. *Bulletin of the Menninger Clinic*, *27*(6), 300–313.

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. https://doi.org/10.1080/00107530.2015.954218

Kreische, R. (1985). Schweigen, um wahrgenommen zu werden: Über eine scheinbar paradoxe Bedeutung des Schweigens. *Zeitschrift für Psychosomatische Medizin Und Psychoanalyse*, *31*(2), 151–155.

Kuprian, N., Chui, H., & Barber, J. P. (2017). Effective therapists in psychodynamic therapy for depression: What interventions are used and how? In *How and why are some therapists better than others? Understanding therapist effects* (pp. 235–258). Washington: American Psychological Association. https://doi.org/10.1037/0000034-014

Lane, R. C., Koetting, M. G., & Bishop, J. (2002). Silence as Communication in Psychodynamic Psychotherapy. *Clinical Psychology Review*, *22*, 1091–1104. https://doi.org/10.1016/S0272-7358(02)00144-7

Leira, T. (1995). Silence and Communication: Nonverbal Dialogue and Therapeutic Action. *Scandinavian Psychoanalytic Review*, *18*(1), 41–65. https://doi.org/10.1080/01062301.1995.10592330

Levitt, H. M. (1998). *Silence in Psychotherapy: The Meaning and Function of Pauses*. [Unpublished doctoral thesis]: York University, Toronto, Ontario. Retrieved from https://www-proquest-com.libproxy.ucl.ac.uk/dissertations-theses/silence-psychotherapy-meaning-function-pauses/docview/304470243/se-2?accountid=14511

Levitt, H. M. (2001a). Clients' experiences of obstructive silence: Integrating conscious reports and analytic theories. *Journal of Contemporary Psychotherapy*, *31*(4), 221–244. https://doi.org/10.1023/A:1015307311143

Levitt, H. M. (2001b). Sounds of Silence in Psychotherapy: The Categorization of Clients' Pauses. *Psychotherapy Research*, *11*(3), 295–309. https://doi.org/10.1080/713663985

Levitt, H. M. (2002). The unsaid in the psychotherapy narrative: Voicing the unvoiced. *Counselling Psychology Quarterly*, *15*(4), 333–350. https://doi.org/10.1080/0951507021000029667

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

Liegner, E. (1974). The Silent Patient. *Psychoanalytic Review*, *61*, 229–245. https://doi.org/10.1080/10481889109538914

Loomie, L. S. (1961). Some Ego Considerations in the Silent Patient. *Journal of the American Psychoanalytic Association*, *9*, 56–78. https://doi.org/10.1177/000306516100900104

Low, L.-S. A., Maddage, N. C., Lech, M., Sheeber, L. B., & Allen, N. B. (2011). Detection of Clinical Depression in Adolescents' Speech During Family Interactions [Article]. *IEEE Transactions on Biomedical Engineering*, *58*(3), 574–586. https://doi.org/10.1109/TBME.2010.2091640

MacIntosh, H. B. (2017). A Bridge Across Silent Trauma: Enactment, Art, and Emergence in the Treatment of a Traumatized Adolescence [Article]. *Psychoanalytic Dialogues*, *27*(4), 433–453. https://doi.org/10.1080/10481885.2017.1328188

Malberg, N. T. (2012). "Speaking with silence and tears" - psychotherapy with an adolescent girl. In N. T. Malberg & J. Raphael-Leff (Eds.), *The Anna Freud Tradition: Lines of Development - Evolution of Theory and Practice over Decades* (1st edition, pp. 296–311). London: Carnac. https://doi.org/https://doi.org/10.4324/9780429481086

Moser, U. (1962). Übertragungsprobleme in der Psychoanalyse eines chronisch schweigenden Charakterneurotikers. *Psyche - Zeitschrift für Psychoanalyse*, *15*(10), 592–624.

Nacht, S. (1963). The Non-Verbal Relationship in Psycho-Analytic Treatment. *International Journal of Psychoanalysis*, *44*, 334–340.

Nacht, S. (1964). Silence As an Integrative Factor. *The International Journal of Psycho-Analysis*, *45*, 299–303.

Nilsonne, A. (1988). Speech characteristics as indicators of depressive illness [Article]. *Acta Psychiatrica Scandinavica*, *77*(3), 253–263. https://doi.org/10.1111/j.1600-0447.1988.tb05118.x

O'Keeffe, S., Martin, P., Goodyer, I. M., Wilkinson, P., Midgley, N., Keeffe, S. O., … Wilkinson, P. (2018). Predicting dropout in adolescents receiving therapy for depression Predicting dropout in adolescents receiving therapy for depression. *Psychotherapy Research*, *28*(5), 708–721. https://doi.org/10.1080/10503307.2017.1393576

Rice, F., & Rawal, A. (2011). Can Basic Risk Research Help in the Prevention of Childhood and Adolescent Depression? Examining a Cognitive and Emotional Regulation Approach. *Depression Research and Treatment*, *2011*(871245), 1–12. https://doi.org/10.1155/2011/871245

Richmond, T. K., & Rosen, D. S. (2005). The Treatment of Adolescent Depression in the Era of the Black Box Warning. *Current Opinion in Pediatrics*, *17*(4), 466–472. https://doi.org/10.1097/01.mop.0000166347.53102.e7

Ronningstam, E. (2006). Silence Cultural Function and Psychological Transformation in Psychoanalysis and Psychoanalytic Psychotherapy. *The International Journal of Psychoanalysis*, *87*(Pt 5), 1277–1295. https://doi.org/10.1516/D6W0-3E0N-MR79-J7JA

Sabbadini, A. (1991). Listening to Silence. *British Journal of Psychotherapy*, *7*, 406–415. https://doi.org/10.1111/j.1752-0118.1991.tb01145.x

Segrin, C. (2000). *SOCIAL SKILLS DEFICITS ASSOCIATED WITH DEPRESSION*. *20*(3), 379–403.

Serani, D. (2000). Silence in the Analytic Space, Resistance or Reverie? A Perspective from Loewald's Theory of Primordial Unity. *Contemporary Psychoanalysis*, *36*(3), 505–519. https://doi.org/10.1080/00107530.2000.10747059

Shafii, M. (1973). Silence in the service of ego: psychoanalytic study of meditation. *The International Journal of Psycho-Analysis*, *54*(1973), 431–443.

Stringer, J. v., Levitt, H. M., Berman, J. S., & Mathews, S. S. (2010). A study of silent disengagement and distressing emotion in psychotherapy. *Psychiatry Research*, *20*(5), 495–510. https://doi.org/10.1080/10503301003754515

Trowell, J., Joffe, I., Campbell, J., Clemente, C., Almqvist, F., Soininen, M., … Tsiantis, J. (2007). Childhood depression: a place for psychotherapy [Article]. *European Child & Adolescent Psychiatry*, *16*(3), 157–167. https://doi.org/10.1007/s00787-006-0584-x

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

Vanger, P., Summerfield, A. B., Rosen, B. K., & Watson, J. P. (1992). Effects of communication content on speech behavior of depressives [Article]. *Comprehensive Psychiatry*, *33*(1), 39–41. https://doi.org/10.1016/0010-440X(92)90077-4

Weisman, A. (1955). Silence and Psychotherapy. *Psychiatry*, *18*(3), 241–464. https://doi.org/10.1080/00332747.1955.11023010

Wilson, P. (1997). A Time to Think. In E. Smith (Ed.), *Integrity and Change: Mental Health in the Market Place* (1st edition, pp. 13–21). London: Routledge.

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

Winnicott, Donald W. (1967). Mirror-role of mother and family in child development. In *Playing and Reality* (pp. 111–118). London: Tavistock, 1971.

Wood, A., Kroll, L., Moore, A., & Harrington, R. (1995). Properties of the Mood and Feelings Questionnaire in Adolescent Psychiatric Outpatients: A Research Note [Article]. *Journal of Child Psychology and Psychiatry*, *36*(2), 327–334. https://doi.org/10.1111/j.1469-7610.1995.tb01828.x

Zimmermann, R., Fürer, L., Schenk, N., Koenig, J., Roth, V., Schlüter-Müller, S., … Schmeck, K. (2020). Silence in the Psychotherapy of Adolescents with Borderline Personality Pathology. *Personality Disorders: Theory, Research, and Treatment*. https://doi.org/10.1037/per0000402

Part 3: Reflective Commentary

Title: But where is the Reverie? Reflections on Conducting Research on Silence while Training as a Child and Adolescent Psychotherapist

Candidate Number: NSPG7

Word Count: 4,276

Still-born silence, thou that art
Floodgate of the deeper heart
Richard Flecknoe, Love's Kingdom

Introduction

The following is a reflection on completing a clinical doctorate while training as a Child and Adolescent Psychotherapist (CAP). The overall process of this training was rigorous, demanding, and challenging, but also incredibly enriching, enlightening, inspiring, stimulating, and indeed, life-changing. Just as the clinical part of the training, the research considerably impacted my development and identity as a CAP. Thoughts on the peaks and troughs of this journey, as well as my interest in silence and the implications of this research on my clinical practice, are offered below.

Tentative Beginnings

When I embarked on the journey of becoming a child psychotherapist, I was in only the second cohort of trainees who had been accepted onto the newly established professional doctorate in Child and Adolescent Psychoanalytic Psychotherapy which consists of the clinical training component, the NHS placement, and the integrated clinical doctorate. The weekly training day had the mornings reserved for the research component at the Anna Freud National Centre for Children and Families (AFNCCF) and the afternoons and evenings for the clinical part of the training at the British Psychotherapy Foundation (BPF). The research components in the first year of training included several elements, ranging from seminars, a journal club, a service-related project, and a critical reading exam to completing a fictitious research proposal. There were many requirements and tasks to be completed, and at the time, it felt hard to believe that it would be possible to fit in the clinical, academic and research elements on top of a long commute, my training analysis, and finding my feet in my NHS placement.

As the first term progressed, there were moments when I felt somewhat disengaged from the research aspect of the training. My clinical work with patients had started to fill my days at the clinic, and this experience and the discussion of the clinical cases in supervision and seminars made the material feel very "real". On the other hand, the research felt at the time abstract and even 'dull' in comparison. I vividly remember sitting in one of the research seminars, which took place first thing in the morning on my training day. I sat at the back of the room, clinging to my cup of coffee and trying very hard not to give in to closing my heavy eyes. Looking back now, I feel curious about my sense of disengagement, considering that I had felt so very privileged to have been accepted onto the training. On reflection, the act of splitting the training into "exciting" and "boring" (or "good" and "bad") (Klein, 1932) may have been my way of coping with my own more primitive anxieties about starting the training and may have acted as a defence to me feeling overwhelmed. Nevertheless, at the same time, it may have been a reflection of a broader sentiment within the profession and the question of where we, as CAPs, sit on the "[research] fence" (Henton & Midgley, 2012) and, at the time, my very limited understanding of this issue.

My experience began to change when I started conducting my service-related project, a clinical audit on the origin and appropriateness of referrals to the clinic where I was based. The process was much more enjoyable than I had anticipated. Not having had any previous experience with quantitative research, and having had what can only be described as an aversion to maths whilst at school, I noticed with surprise how much I enjoyed the weekly input of the data and the achievement I felt when I learnt how to create figures and charts at the click of a button. I felt that there was purpose in what I was doing. These numbers were not abstract but related to young people (YPs) and their presenting difficulties, and on a wider level, the overwhelming number of referrals my service received every week.

On reflection, there was a certain comfort that I found in the concreteness of the data when so much of the other parts of the training, and in particular, the clinical work with YPs, were much concerned with the "not knowing" (Lanyado & Horne, 2009; Wilson, 2001). It is important to state that the project turned into a much bigger piece of work than planned, which felt challenging to manage on top of the other training demands. My allowing the project grow bigger than anticipated may have been related to me turning to the data in an attempt to avoid the "not knowing" but is also likely to have been connected to my wish to be perceived as a "good, capable trainee".

After completing the audit, I presented the findings to my team at my NHS placement which felt like a rewarding conclusion to the first year of the research component. It also left me feeling hopeful and excited about starting the research in the next year of training.

Silence in a World of Noise

Before the beginning of the second year of training, we were given the choice of four broad research topics. One of these entailed researching silence in sessions with depressed adolescents using data from the "Improving Mood with Psychoanalytic and Cognitive Therapies" (IMPACT) study. I felt very drawn to the topic of silence as it seemed to have a strong resonance for me on a professional and personal level. In my clinical placement, I had, for instance, come across some YPs who found it difficult to talk. Some of these encounters had left me feeling deskilled and not knowing how to respond appropriately, but also curious about the "issue" of silence. At the same time, there had also been many silent moments in my own analysis, some of which had felt very meaningful and comforting and others rather challenging. Further, I had also come to enjoy the silent moments I had to myself while doing the training, which at times felt so very busy rushing from A to B amongst the background of the noisy public transport and my own "unquiet" mind. Finally, my interest is also likely to

have been motivated by my oftentimes quiet, sometimes silent, demeanour in seminars and my struggle to confidently find my voice as a trainee CAP.

Feeling Silently Stuck

At the beginning of the second year, the research seminars took on a different form. Our cohort was divided into two smaller groups. There was the sentiment that we were now allowed to enter the "real" world of research. While we started to familiarise ourselves with our research topics, the focus was on the literature review, which was to be handed in by the end of the year.

Being in a small supervision group felt helpful and new, as there was time to get to know each other's topics and discuss our literature searches and ideas. At the same time, there seemed to have been dynamics that were reminiscent of sibling rivalry. I found myself competing with my group members as to who would get the most attention of our supervisor/mother, and there was also curiosity about the other group of trainees and their experience with their supervisor/father. Alongside this came the realisation that the expectation was for us to be much more independent in our endeavour to complete the literature review than I had anticipated. I felt some disappointment about this and looking back; I wonder whether I wished for a supervisor/mother figure who would make decisions on my behalf rather than allow me to find my way.

Nevertheless, the more I absorbed myself in the topic, the more interesting I found it. As thoughts and ideas about the empirical project slowly started to take shape, the literature review seemed less straightforward. Sourcing and identifying the literature had seemed like an uncomplicated, albeit labour-intensive task. Considering the limited availability of adolescent literature, I decided to include the adult literature too. However, reading it all and

making sense of it felt challenging. I especially seemed to struggle with finding the right structure for the review.

We had been encouraged to keep a reflective journal to record thoughts, choices, ideas, and feeling throughout our research experience.[20] An entry in my journal from that time states: "I feel overwhelmed and downhearted by the wealth of information. Where to start? How will I be able to work my way through all of these articles? How can one use words to describe a process which takes place without words?" Much of my time was spent trying to map the types of silences described in the adult clinical case studies and theory papers onto the Pausing Inventory Categorization System Second Revision (PICS-R) (Frankel et al., 2006; Levitt & Frankel, 2004) categories. Nevertheless, as I was to discover, the various silences seemed so multi-faceted and dynamic that it made it impossible for me to disentangle them to an extent that would have allowed for them to be divided into the PICS categories and sub-types. In hindsight, it seems that the attempts to categorise and map the silences that I read about was an intellectual exercise and thus a defence mechanism to fend off anxiety about my progress.

Moreover, reading the early analytic publications on silence felt dry, and some of the ideas presented felt outdated, and may I say, harsh by today's standards. In these moments, I often felt stuck and disenchanted with psychoanalysis. During my readings, I eventually came across a comment by Bakalar (2012), who stated that much of the language of early papers on silence "gives the impression that analysts felt under attack when patients fell silent, and that they felt they had to 'confront' the resistance" (p. 222). Bakalar elaborated on this by highlighting that especially accusing a patient of having sexual or other motives and subsequently forcing them to bear "the external attack coupled with [their] own attacking

[20] See for example Ortlipp (2015) for more information on research journals.

internal object relations" historically often led to a termination of treatment (p. 222). This comment resonated with me, especially with the more adolescent part of myself that would have quite liked to "terminate" the need to write the literature review! Looking back at that period, it seems that having been a relatively junior trainee at the time who was juggling the various aspects of the training, I may have felt embittered by the "demanding" attitude of these early psychoanalysts because a part of me may have been in identification with their patients. More precisely, I may have felt that just as these early patients, I too had entered into a relationship which was unequal in the sense that there was the expectation to adhere to the fundamental rule (in my case meeting the training requirements) which felt at times very hard to do.

Nevertheless, reading other parts of the literature left me feeling inspired and motivated. I found it particularly rewarding to read the very moving adolescent case studies on silence which reminded me of the importance of the work of CAPs. Similarly, I felt very interested in the finding that silence in psychotherapy could have a healing function. It felt like a revelation that some authors had linked their state of mind during silences that occurred in their work with YPs to a state of (therapeutic) reverie (Lanyado, 2004; Leira, 1995). I felt equally curious that quiet moments in clinical work had been linked to the quietness and stillness of meditative practice (Lanyado, 2004). One paper from the adult literature, which had a particular impact on me was that of Shafii (1973), who stated the following:

> In meditation, the controlled but deep regression returns the individual to his earliest fixation points and to the re-experience of minute and silent traumas of the separation and individuation phase on a silent and non-verbal level. This revisit and re-experience frees the psychic energies which are bound and over-cathected in all of these minute, numerous silent traumas and makes it available as a form of neutralised and free

> psychic energy in the service of the ego. Thus, cumulative trauma which is experienced in silence is re-experienced and mastered again in silence (p. 442).

Through my interest in meditation, I was led on a path to read more about the link between the practice of meditation and psychotherapy. Amongst others, I came across the writings of Coltart (1987), Lanyado (2012), Molino (1999) and Pozzi Monzo (2014). I also reread Thich Nhat Nanh's book *Silence* (2015). Whilst not directly connected to my research topic, this literature caused me to think about the many aspects of silence and how meditation can enhance a therapist's ability to listen and practise empathy. In a broader sense, it had a profound impact on me and my developing identity as a CAP in training.

The above journey through the literature also helped me redefine the focus of my literature review and become interested in long silences and therapeutic technique. This, in turn, facilitated the process of deciding on the focus of the empirical study.

Listening to Silence

At the beginning of the third year of training, the empirical projects were started. With the help of my research supervisor, I was able to create a research design for my study. It was to be an explorative project with a quantitative part to look at the silences and a second part to explore therapists' responses which could either be quantitative or qualitative. My research partner and I had chosen the PICS as the coding system we wanted to use. In my supervision group, we had discussions about whether it would be beneficial to use a coding system that had been developed by using patients' conscious memories of their pauses to capture unconscious processes. There were also conversations about the inclusion criteria, data selection and the sampling strategy, which my research partner and I had to decide on together as we were to share the data. This was followed by the PICS coding training. The training sparked further conversations, this time about the adolescent process, as we felt that

some silences seemed to be a mixture of the "obstructive" PICS subtypes "disengaged" and "interactional", which ultimately led to the introduction of a new subtype[21]. Through my newly acquired "Excel expertise", I created a data collection tool that allowed us to capture all the data in one spreadsheet. During the coding training, we had come across some very long pauses, and as I was keen to explore these, I added three duration categories to capture the different pause durations that might occur.

Embarking on the empirical side of the research was rewarding in unexpected ways. Listening to audio recordings of actual STPP sessions was a real privilege. It was a very rare opportunity to not just hear an account of another clinician's work but to *listen* to their work in action. Although we only had audio recordings, which were not always the best quality, the sessions felt so alive. I felt that just through listening, I learnt a great deal about clinical approaches in STPP, which was very valuable as I was in the process of preparing my own first STPP case.

From a research perspective, listening to whole sessions and coding sessions in chronological order felt very helpful to get a better understanding of the patient-therapist dyads and the YPs' internal worlds, which helped to consider the data we collected from a psychoanalytic stance. This highlights that whilst much more labour intensive and time-consuming, the manual detection of in-session pauses can help the researcher to familiarise themselves with the data in a way which the process of using automatic silence detection software as done in some other studies on silence (Zimmermann et al., 2020) cannot.

After having undergone the thorough PICS training with my research partner, the coding of the sessions used in our respective empirical studies were done without transcripts and by listening to the audio material only. This worked well, although the poor quality of

[21] More information on the coding process and the introduction of the new subtype can be found in Appendix D.

some recordings was a major drawback. During the coding of the data, the depression of the YPs was often very tangible, despite the lack of visual material. Especially some of the surprisingly long silences felt hard to listen to. One aspect that particularly stood out for me was the level of empathy the therapists conveyed and how in tune the therapists seemed with the depressed YPs they worked with. This caused me to read more on adolescent depression, which was beneficial for my research *and* my clinical work.

Having chosen a consensus coding approach, my research partner and I had regular meetings to discuss our results and re-code pauses, which we had coded differently. Doing the data collection together felt helpful on many levels. I felt that we were complimenting each other well in terms of our strengths and weaknesses, and the process created a sense of comradery and purpose.

But where is the Reverie?

The data analysis followed the completion of the data collection period. Having enjoyed this part during the serviced-based research project, I had been looking forward to it; however, this stage of my project turned out to be much harder than anticipated.

During the data-analysis period, one aspect that stood out was my genuine surprise about the high frequency of "obstructive" silences. During the coding process, I had, of course, noticed that a large part of the pauses was coded as "obstructive", but it was only when we started analysing the data that I became aware that the majority of pauses were coded as "obstructive". Due to the small sample size, I had taken the data-led approach and had not had any specific hypotheses. Nevertheless, one could say that I had hoped to my "private self" that the data collection would capture some of the healing aspects of silence described in the adolescent case studies that I had read. By then, I had had additional clinical experiences of silence with some of my patients. My most vivid memory was that of my

under-fives intensive case, who on one occasion entered the therapy room screaming out with fury and raged for several minutes and then curled up and fell asleep. While he was sleeping, I had a powerful countertransference experience. I had associations about quiet moments in my own childhood as well as my training analysis, and it almost felt like I was watching over [the YP] whilst also being in a meditative state, something which Lanyado (2004, p. 80) referred to as an "oceanic experience". I, therefore, noticed that I experienced some disappointment about the "fantasy" I had had about my possible findings versus the reality of it. This was a critical moment of realisation for me as a "researcher in training" and highlighted the need to be led by the data and keep an open mind.

Due to the large amount of data we had collected, it soon dawned on me that these could be analysed and displayed in many different ways. What followed was a period of trial and error in finding the most effective ways to display the data (i.e., table vs figure) and making decisions about what information to include. Everything felt interesting, and I ran many a data analysis to look at the data from different angles. Therefore, I had again encountered the threat of getting lost in the wealth of information I had "accumulated", just as I had experienced during the literature review stage. Looking back, I think this is partly a reflection of the genuine passion that I had by then developed for my research topic. However, it is also likely to have been an avoidance of moving on to the write-up stage, which I knew I would find much harder.

In addition to this, I had also begun to consider the potential overlap of results of my research partner and I, which highlighted the possible need to make our projects more distinct. Conversations with my research supervisor helped me regain focus, including the decision to exclude the PICS sub-types from my analysis, to look at the various other elements that I wanted to analyse (e.g. pause duration, speaker patterns, etc.). Due to my particular interest in the long silences, I decided to focus on these for the second part of my

project and to code therapists' responses. My supervisor helped identify a suitable coding system for this task (Helping Skills System, HSS) (Hill, 2009). Undertaking this second part, including the training, data collection and subsequent analysis, felt very rewarding, and helped to allow the data from the first part of the result section to become "more alive".

During this part of my research journey, I felt very engaged in my project and quite protective of it. Nevertheless, there were also some doubts about the idea that my small-scale project could possibly contribute anything to the CAP community or, indeed, the psychotherapy evidence base. When my supervisor mentioned to my research partner and I that we might want to consider publishing our research results, it came as a surprise, but I also felt excited about this possibility. It felt important to hear that my small project could be of interest to others, and it gave me the confidence to agree wholeheartedly when my research partner suggested submitting our abstracts to apply to speak at a conference to present our findings.

Talking about Silence

After the completion of the clinical part of the training and at the beginning of the "writing up" year, myself, my research partner, and another recent IPCAPA graduate travelled to Krakow in Poland to attend the 5th annual UK and European conference for the Society of Psychotherapy Research (SPR) to present our research findings. Prior to the conference I felt very nervous. The collegiate and collaborative atmosphere at the conference helped somewhat alleviate this anxiety, but I had doubts again on the day. On my insistence, my research partner and I had agreed to start the presentation with a full minute of silence to give the audience an authentic experience of how powerful an unexpected silence can be. However, not having had any prior experience of presenting at a conference, I suddenly felt that it might be too bold a move, and my heart sank at the thought of how the audience might

react. Nevertheless, the presentation went well, and the feedback and questions from the audience were thought-provoking and helpful.

Overall, I found the conference an enriching environment to be in. What I found particularly interesting was that the conference was a place for both experienced and student researchers to present side by side. I also felt humbled and grateful that my research partner and I were awarded travel awards from the UK Chapter of SPR for our research projects, which provided financial support to attend the conference.

The process of preparing the presentation, as well as the feedback, helped me to consolidate my research findings further. It also got me thinking about the scope for clinicians who directly work with patients to engage in research and whether this might be something I would like to do in the future. The whole conference experience was thus genuinely inspiring.

Final Stages or One Step Forward, two Steps Back

Due to my life circumstances and the ongoing global Covid-19 pandemic, the write-up period of this thesis was bumpier than anticipated. After being unable to continue with the write-up for some time, it felt challenging to re-engage with the process. Nevertheless, once I had re-familiarised myself with the literature and data, I felt able to look at my project with "fresh eyes" and reignite my passion for the topic.

Reflecting on the whole process now, it feels like a gestation period full of development and growth and a lengthy, at times painful birth and maturational process. The following analogy by MacIntosh (2017, p. 451) thus much resonated with me: "Like birthing a baby, each push brings the head out a little [further] only to slide back into the birth canal at

the end of the contraction, but ultimately the baby never returns to the womb; each contraction is accompanied by a push in the direction for life".

Conclusion

There is an assumption that if psychotherapy research is conducted by those who also work as clinicians and thus bring with them their own thirst for knowledge and clinical experience, the research activity will not only have a positive impact on their clinical work but can also contribute to an increase in the understanding of psychotherapy on a broader level (Boalt Boëthius, 2010). For me, this has undoubtedly been the case. By allowing myself to get immersed in my topic of research, exploring my feelings and thoughts towards the literature, becoming stuck and unstuck, by allowing myself to feel disappointment about certain findings whilst continuing to be led by the data, I was able to engage in a research experience which felt very authentic and real. Reading the clinical case studies on silence with adolescents and listening to the session recordings made the powerful aspects of in-session silence come alive. This process highlighted the value of conducting research as part of CAP training and emphasised the importance of the learning experience element of this. This piece of research, therefore, not only had a direct impact on my theoretical thinking and clinical work but also on my identity as a CAP as a whole. The knowledge and experience I gained is something that I will be able to hold on to in the years to come. Moreover, I now feel that I firmly sit on the research side of the fence.

References

Bakalar, N. L. (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.

Boalt Boëthius, S. (2010). Integrating research in a clinical setting for child psychotherapy: A case study about facilitating and hindering factors in psychoanalytic psychotherapy. In J. Tsiantis & J. Trowell (Eds.), *Assessing Change in Psychoanalytic Psychotherapy of Children and Adolescents* (1st Edition, pp. 29–54). London: Karnac. https://doi.org/https://doi.org/10.4324/9780429472008

Coltart, N. (1987). The Practice of Buddhism and Psycho-Analysis. *The Middle Way*, *62*(2), 91–96.

Flecknoe, R. (1664). *Love's Kingdom: A Pastoral Trage-Comedy*. London: Printed by R. Wood.

Frankel, Z., Levitt, H. M., Murray, D. M., Greenberg, L. S., & Angus, L. E. (2006). Assessing silent processes in psychotherapy: an empirically derived categorization system and sampling strategy. *Psychotherapy Research*, *16*(5), 627–638. https://doi.org/10.1080/10503300600591635

Henton, I., & Midgley, N. (2012). 'A path in the woods': Child psychotherapists' participation in a large randomised controlled trial [Article]. *Counselling and Psychotherapy Research*, *12*(3), 204–213. https://doi.org/10.1080/14733145.2012.678270

Hill, C. E. (2009). *Helping Skills: Facilitating Exploration, Insight, and Action (Third Edition)*. Washington, DC: American Psychological Association.

Klein, M. (1932). *The Psycho-Analysis of Children* (A. Strachey & E. Jones, Eds.) London: Hogarth Press and the Institute of Psycho-analysis.

Lanyado, M. (2004). *The Presence of the Therapist*. London and New York: Routledge.

Lanyado, M. (2012). Transition and change: An exploration of the resonances between transitional and meditative states of mind and their roles in the meditative process. In A. Horne & M. Lanyado (Eds.), *Winnicott's Children* (pp. 123–139). Hove and New York: Routledge.

Lanyado, M., & Horne, A. (2009). The therapeutic setting and process. In M. Lanyado & A. Horne (Eds.), *The Handbook of Child and Adolescent Psychotherapy* (Second Edition, pp. 157–174). London and New York: Routledge. https://doi.org/10.4324/9780203877616

Leira, T. (1995). Silence and Communication: Nonverbal Dialogue and Therapeutic Action. *Scandinavian Psychoanalytic Review*, *18*(1), 41–65. https://doi.org/10.1080/01062301.1995.10592330

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

MacIntosh, H. B. (2017). A Bridge Across Silent Trauma: Enactment, Art, and Emergence in the Treatment of a Traumatized Adolescence. *Psychoanalytic Dialogues*, *27*(4), 433–453. https://doi.org/10.1080/10481885.2017.1328188

Molino. (1999). *The Couch and the Tree: Dialogues in Psychoanalysis and Buddhism* (A. Molino, Ed.). London: Constable.

Ortlipp, M. (2015). Keeping and Using Reflective Journals in the Qualitative Research Process [Article]. *Qualitative Report*. https://doi.org/10.46743/2160-3715/2008.1579

Pozzi Monzo, M. (2014). *The Buddha and the Baby: Psychotherapy and Meditation in Working with Children and Adults*. London: Karnac.

Shafii, M. (1973). Silence in the service of ego: psychoanalytic study of meditation. *The International Journal of Psycho-Analysis*, *54*(1973), 431–443.

Thich Nhat Hanh. (2015). *Silence: The Power of Quiet in a World Full of Noise*. London: Ebury Publishing.

Wilson, P. (2001). "I don't know." *Journal of the British Association of Psychotherapists*, *39*, 166–176.

Zimmermann, R., Fürer, L., Schenk, N., Koenig, J., Roth, V., Schlüter-Müller, S., … Schmeck, K. (2020). Silence in the Psychotherapy of Adolescents with Borderline Personality Pathology. *Personality Disorders: Theory, Research, and Treatment*. https://doi.org/10.1037/per0000402

Appendices

Appendix A: A Full List of Literature on Silence

Adolescent literature

Psychoanalytic/psychodynamic theory papers and clinical case studies

Anagnostaki, L. (2013). Beyond Silence: Working with Phoebe. *Journal of Child Psychotherapy*, *39*(2), 156–170. https://doi.org/10.1080/0075417X.2013.806053

Bakalar, N. L. (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.

Cristy, B. L. E. (1993). Beyond Words: The Psychodynamics of a Therapy in Silence with a Twelve-Year-Old Girl. *Clinical Social Work Journal*, *21*(2), 179–193. https://doi.org/https://doi.org/10.1007/BF00754533

Gensler, D. (2015). Silence in Adolescent Psychotherapy. *Journal of Infant, Child & Adolescent Psychotherapy*, *14*(2), 188–195. https://doi.org/http://dx.doi.org/10.1080/15289168.2015.1032635

Khan, M. (1963). Silence as communication. *Bulletin of the Menninger Clinic*, *27*(6), 300–313.

Leira, T. (1995). Silence and Communication: Nonverbal Dialogue and Therapeutic Action. *Scandinavian Psychoanalytic Review*, *18*(1), 41–65. https://doi.org/10.1080/01062301.1995.10592330

MacIntosh, H. B. (2017). A Bridge Across Silent Trauma: Enactment, Art, and Emergence in the Treatment of a Traumatized Adolescence [Article]. *Psychoanalytic Dialogues*, *27*(4), 433–453. https://doi.org/10.1080/10481885.2017.1328188

Malberg, N. T. (2012). "Speaking with silence and tears" - psychotherapy with an adolescent girl. In N. T. Malberg & J. Raphael-Leff (Eds.), *The Anna Freud Tradition: Lines of Development - Evolution of Theory and Practice over Decades* (1st edition, pp. 296–311). London: Carnac. https://doi.org/https://doi.org/10.4324/9780429481086

Moser, U. (1962). Übertragungsprobleme in der Psychoanalyse eines chronisch schweigenden Charakterneurotikers. *Psyche - Zeitschrift Für Psychoanalyse*, *15*(10), 592–624.

Wilson, P. (1997). A Time to Think. In E. Smith (Ed.), *Integrity and Change: Mental Health in the Market Place* (1st edition, pp. 13–21). London: Routledge.

Empirical papers

Acheson, R., Verdenhalven, N., Avdi, E., & Midgley, N. (2020). Exploring silence in short-term psychoanalytic psychotherapy with adolescents with depression. *Journal of Child Psychotherapy*, *46*(2), 224–240. https://doi.org/10.1080/0075417X.2020.1830297

Zimmermann, R., Fürer, L., Schenk, N., Koenig, J., Roth, V., Schlüter-Müller, S., … Schmeck, K. (2020). Silence in the Psychotherapy of Adolescents with Borderline Personality Pathology. *Personality Disorders: Theory, Research, and Treatment*. https://doi.org/10.1037/per0000402

Adult Literature

Psychoanalytic/psychodynamic theory papers and clinical case studies

Arlow, J. A. (1961). Silence and the Theory of Technique. *Journal of the American Psychoanalytic Association*, *9*(1), 44–55. https://doi.org/10.1177/000306516100900103

Bergler, E. (1938). On the Resistance Situation: The Patient is Silent. *Psychoanalytic Review*, *25*(2), 170–186.

Blos, P. (1972). Silence: A Clinical Exploration. *Psychoanalytic Quarterly*, *41*, 348–363. https://doi.org/https://doi.org/10.1080/21674086.1972.11926602

Blumenson, S. R. (1993). The Mirror of Silence: A Method of Treating a Preverbal Schizophrenic Patient. *Modern Psychoanalysis*, *18*(2), 179–189.

Bravesmith, A. (2012). Silence Lends Integrity to Speech: Transcending the Opposites of Speech and Silence in the Analytic Dialogue. *British Journal of Psychotherapy*, *28*(1), 21–34. https://doi.org/10.1111/j.1752-0118.2011.01263.x

Brocher, T. (1967). Über averbale Kommunikation. *Psyche - Zeitschrift Für Psychoanalyse*, *21*(9), 633–653.

Brockbank, R. (1970). On the analyst's silence in psychoanalysis: A synthesis of intrapsychic content and interpersonal manifestations. *The International Journal of Psychoanalysis*, *51*(4), 457–464.

Busch, F. (1978). The Silent Patient: Issues of Separation-Individuation and its Relationship to Speech Development. *International Review of Psycho-Analysis*, *5*, 491–499.

Calogeras, R. C. (1967). Silence as a Technical Parameter in Psycho-Analysis. *International Journal of Psycho-Analysis*, *48*, 536–558.

Coltart, N. (1991). The Silent Patient. *Psychoanalytic Dialogues*, *1*(4), 439–453. https://doi.org/10.1080/10481889109538914

Cooper, S. (2012). Exploring a patient's shift from relative silence to verbal expressiveness: Observations on an element of the analyst's participation. *International Journal of Psychoanalysis*, *93*(4), 897–916. https://doi.org/10.1111/j.1745-8315.2012.00608.x

Cremerius, J. (1969). Schweigen als Problem der Psychoanalytischen Technik. *Jahrbuch Der Psychoanalyse*, *6*, 69–103.

DelMonte, M. (1995). Silence and Emptiness in the Service of Healing: Lessons from Meditation. *British Journal of Psychotherapy*, *11*(3), 368–378. https://doi.org/10.1111/j.1752-0118.1995.tb00742.x

Elson, M. (2001). Silence, Its Use and Abuse: A View from Self Psychology. *Clinical Social Work Journal*, *29*(4), 351–360. https://doi.org/10.1023/A:1012215213461

Enelow, A. (1960). The Silent Patient. *Psychiatry*, *23*(2), 153–158.

Ferenczi, S. (1916). Schweigen ist Gold. *Internationale Zeitschrift für Psychoanalyse*, *4*(3), 155–156.

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

Fuller, V. G., & Crowther, C. (1998). A dark talent: Silence in analysis. *Journal of Analytical Psychology*, *43*(4), 523–543. https://doi.org/10.1111/1465-5922.00051

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*, 205–220. https://doi.org/10.1080/02668730500238218

Goldstein-Ferber, S. (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. https://doi.org/10.1111/j.1752-0118.2004.tb00146.x

Graf, H. (1982). Der schweigende Analytiker. *Psyche - Zeitschrift Für Psychoanalyse*, *36*(4), 289–306.

Greenson, R. R. (1961). On the Silence and Sounds of the Analytic Hour. *Journal of the American Psychoanalytic Association*, *9*, 79–84. https://doi.org/10.1177/000306516100900105

Hadda, J. (1991). The Ontogeny of Silence in an Analytic Case. *The International Journal of Psycho-Analysis*, *72*, 117–130.

Hohage, R. (1981). Analytische Aktivität und Passivität im Hinblick auf Reden und Schweigen. *Psyche - Zeitschrift Für Psychoanalyse*, *35*(9), 819–822.

Johannesen, R. L. (1974). The functions of silence: A plea for communication research. *Western Speech*, *38*(March), 25–35. https://doi.org/10.1080/10570317409373806

Kemper, W. (1948). „ Der patient schweigt“. *Psyche - Zeitschrift für Psychoanalyse*, *1*(4), 503–522.

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. https://doi.org/10.1080/00107530.2015.954218

Kreische, R. (1985). Schweigen, um wahrgenommen zu werden: Über eine scheinbar paradoxe Bedeutung des Schweigens. *Zeitschrift Für Psychosomatische Medizin Und Psychoanalyse*, *31*(2), 151–155.

Kurtz, S. A. (1984). On Silence. *Psychoanalytic Review*, *71*(2), 227–246.

Lane, R. C., Koetting, M. G., & Bishop, J. (2002). Silence as Communication in Psychodynamic Psychotherapy. *Clinical Psychology Review*, *22*, 1091–1104. https://doi.org/10.1016/S0272-7358(02)00144-7

Laux, G. (1968). Über eine Ursache chronischen (Ver-) Schweigens. *Zeitschrift für Psychosomatische Medizin Und Psychoanalyse*, *14*(4), 274–281.

Lehmann, O. v. (2014). Towards Dialogues with and Within Silence in Psychotherapy Processes: Why the Person of the Therapist and the Client Matters? *Culture & Psychology*, *20*(4), 537–546. https://doi.org/10.1177/1354067X14551298

Lemert, C. (2018). Noise and Silence in Analytic Talk. *Contemporary Psychoanalysis*, *54*(2), 351–372. https://doi.org/10.1080/00107530.2018.1458581

Levy, K. (1958). Silence in the Analytic Session. *The International Journal of Psycho-Analysis*, *39*, 50–58.

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

Liegner, E. (1974). The Silent Patient. *Psychoanalytic Review*, *61*, 229–245. https://doi.org/10.1080/10481889109538914

Little, S. (2015). Between Silence and Words: The Therapeutic Dimension of Quiet. *Contemporary Psychoanalysis*, *51*(1), 31–50. https://doi.org/10.1080/00107530.2015.968833

Loewenstein, R. M. (1961). The Silent Patient — Introduction. *Journal of the American Psychoanalytic Association*, *9*, 2–6.

Lombardi, R. (2010). Flexibility of the psychoanalytic approach in the treatment of a suicidal patient: Stubborn silences as “playing dead.” *Psychoanalytic Dialogues*, *20*(3), 269–284. https://doi.org/10.1080/10481885.2010.483955

Loomie, L. S. (1961). Some Ego Considerations in the Silent Patient. *Journal of the American Psychoanalytic Association*, *9*, 56–78. https://doi.org/10.1177/000306516100900104

Luci, M., & Kahn, M. (2021). Analytic Therapy with Refugees: Between Silence and Embodied Narratives. *Psychoanalytic Inquiry*, *41*(2). https://doi.org/10.1080/07351690.2021.1865766

MacLure, M., Holmes, R., Jones, L., & MacRae, C. (2010). Silence as Resistance to Analysis: Or, on Not Opening One's Mouth Properly. *Qualitative Inquiry*, *16*, 492–500. https://doi.org/10.1177/1077800410364349

Maiello, S. (1995). The sound-object: A hypothesis about prenatal auditory experience and memory. *Journal of Child Psychotherapy*, *21*(1), 23–41. https://doi.org/10.1080/00754179508254905

Marjasch, J. (1940). Chronische Schweiger in der Analyse. *Internationale Zeitschrift Für Psychoanalyse*, *25*(2), 111–123.

Martyres, G. (1995). On silence: A language for emotional experience. *Australian and New Zealand Journal of Psychiatry*, *29*(1), 118–123. https://doi.org/10.3109/00048679509075900

Morgenstern, A. (1980). Reliving the Last Goodbye: The Psychotherapy of an Almost Silent Patient. *Psychiatry*, *43*(3), 251–258.

Nacht, S. (1963). The Non-Verbal Relationship in Psycho-Analytic Treatment. *International Journal of Psychoanalysis*, *44*, 334–340.

Nacht, S. (1964). Silence As an Integrative Factor. *The International Journal of Psycho-Analysis*, *45*, 299–303.

Olinick, S. L. (1982). Meanings Beyond Words: Psychoanalytic Perceptions of Silence and Communication, Happiness, Sexual Love and Death. *International Review of Psycho-Analysis*, *9*, 461–472.

O'Toole, M. A. (2015). The Phenomenon of Silence in Psychotherapy. *Attachment: New Directions in Psychotherapy and Relational Analysis*, *9*(3), 342–360.

Prince, R. (1997). Is Talk Cheap or Silence Golden: The Negotiation of Activity in Psychotherapy. *Psychoanalytic Inquiry*, *17*, 549–558. https://doi.org/10.1080/07351699709534148

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

Ritter, M. (2014). Silence as the Voice of Trauma. *American Journal of Psychoanalysis*, *74*, 176–194. https://doi.org/10.1057/ajp.2014.5

Ronningstam, E. (2006). Silence Cultural Function and Psychological Transformation in Psychoanalysis and Psychoanalytic Psychotherapy. *The International Journal of Psychoanalysis*, *87*(Pt 5), 1277–1295. https://doi.org/10.1516/D6W0-3E0N-MR79-J7JA

Sabbadini, A. (1991). Listening to Silence. *British Journal of Psychotherapy*, *7*, 406–415. https://doi.org/10.1111/j.1752-0118.1991.tb01145.x

Serani, D. (2000). Silence in the Analytic Space, Resistance or Reverie? A Perspective from Loewald's Theory of Primordial Unity. *Contemporary Psychoanalysis*, *36*(3), 505–519. https://doi.org/10.1080/00107530.2000.10747059

Shafii, M. (1973). Silence in the service of ego: psychoanalytic study of meditation. *The International Journal of Psycho-Analysis*, *54*(1973), 431–443.

Strean, H. S. (1969). Non-verbal Intervention in Psychotherapy. *Psychotherapy: Theory, Research and Practice*, *6*, 235–237.

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

van Buren, J. (2000). Silences from the deep: Mapping being and nonbeing in The Piano and in a schizoid young woman. In *American Journal of Psychoanalysis*. https://doi.org/10.1023/A:1001960707705

van der Heide, C. (1961). Blank Silence and the Dream Screen. *Journal of the American Psychoanalytic Association*, *9*, 85–90. https://doi.org/10.1177/000306516100900106

Vasilyuk, F. E. (2016). Prayer, Silence, and Psychotherapy. *Russian Social Science Review*, *57*(4), 275–281. https://doi.org/10.1080/10611428.2016.1197732

Weinberger, J. L. (1964). A Triad of Silence: Silence, Masochism and Depression. *International Journal of Psycho-Analysis*, *45*, 304–309.

Weisman, A. (1955). Silence and Psychotherapy. *Psychiatry*, *18*(3), 241–464. https://doi.org/10.1080/00332747.1955.11023010

Wheeler Vega, J. A. (2013). Silence, Now. *Journal of the American Psychoanalytic Association*, *61*(6), 1211–1225. https://doi.org/10.1177/0003065113515510

Wilmer, H. A. (1995). Silence: Something We Rarely Hear, Which Does Not Exist. *Journal of American Academy of Psychoanalysis*, *23*(4), 723–730. https://doi.org/10.1521/jaap.1.1995.23.4.723

Woo, R. (1999). Sounds of Silence: The Need for Presence in Absence. *Journal of Child Psychotherapy*, *25*(1), 93–114. https://doi.org/10.1080/00754179908260283

Yousef, N. (2010). Romanticism, Psychoanalysis and the Interpretation of Silence. *European Romantic Review*, *21*(5), 653–672. https://doi.org/10.1080/10509585.2010.499031

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. https://doi.org/10.1177/000306516100900102

Zeligs, M. A. (1961). The Psychology of Silence. Its Role in Transference, Countertransference and the Psychoanalytic Process. *Journal of the American Psychological Association*, *9*(1), 7–43. https://doi.org/10.1177/000306516100900102

Books

Dimitrijević, A., & Buchholz, M. B. (Eds.). (2021). *Silence and Silencing in Psychoanalysis* (1st edition). Abingdon, Oxon; New York, NY: Routledge.

Empirical papers

Cook, J. J. (1964). Silence in Psychotherapy. *Journal of Counseling Psychology*, *11*(1), 42–46. https://doi.org/10.1037/h0049176

Cuttler, E., Hill, C. E., King, S., & Kivlighan, D. M. (2019). Productive silence is golden: Predicting changes in client collaboration from process during silence and client attachment style in psychodynamic psychotherapy. *Psychotherapy (Chicago, Ill.)*, *56*(4), 568–576. https://doi.org/10.1037/pst0000260

Daniel, S. I. F., 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*, 1–14. https://doi.org/10.1080/10503307.2016.1177673

Frankel, Ze'ev, Levitt, H. M., Murray, D. M., Greenberg, L. S., & Angus, L. E. (2006). Assessing silent processes in psychotherapy: an empirically derived categorization system and sampling strategy. *Psychotherapy Research*, *16*(5), 627–638. https://doi.org/10.1080/10503300600591635

Hill, C. E., Kline, K. v, O'Connor, S., Morales, K., Li, X., Kivlighan, D. M., & Hillman, J. (2019). Silence Is Golden: A Mixed Methods Investigation of Silence in One Case of Psychodynamic Psychotherapy [Article]. *Psychotherapy (Chicago, Ill.)*, *56*(4), 577–587. https://doi.org/10.1037/pst0000196

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. https://doi.org/10.1002/jclp.10155

Itävuori, S., Korvela, E., Karvonen, A., Penttonen, M., Kaartinen, J., Kykyri, V.-L., & 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. https://doi.org/10.4236/psych.2015.611133

Jarret, F. J. (1966). Silence in psychiatric interviews. *British Journal of Medical Psychology*, *39*(4), 357–362. https://doi.org/10.1111/j.2044-8341.1966.tb00986.x

Knol, A. S. L., Koole, T., Desmet, M., Vanheule, S., & Huiskes, M. (2020). How Speakers Orient to the Notable Absence of Talk: A Conversation Analytic Perspective on Silence in Psychodynamic Therapy. *Frontiers in Psychology*, *11*. https://doi.org/10.3389/fpsyg.2020.584927

Levitt, H. (2001a). Clients' experiences of obstructive silence: Integrating conscious reports and analytic theories. *Journal of Contemporary Psychotherapy*, *31*(4), 221–244. https://doi.org/10.1023/A:1015307311143

Levitt, H. (2001b). Sounds of Silence in Psychotherapy: The Categorization of Clients' Pauses. *Psychotherapy Research*, *11*(3), 295–309. https://doi.org/10.1080/713663985

Levitt, H. M. (2002). The unsaid in the psychotherapy narrative: Voicing the unvoiced. *Counselling Psychology Quarterly*, *15*(4), 333–350. https://doi.org/10.1080/0951507021000029667

Mahl, G. F. (1956). Disturbances and Silences in the Patient's Speech in Psychotherapy. *The Journal of Abnormal and Social Psychology*, *53*(1), 1–15. https://doi.org/10.1037/h0047552

Matarazzo, J. D., Hess, H. F., & Saslow, G. (1962). Frequency and duration characteristics of speech and silence behavior during interviews [Article]. *Journal of Clinical Psychology*, *18*(4), 416–426. https://doi.org/10.1002/1097-4679(196210)18:4<416::AID-JCLP2270180408>3.0.CO;2-9

Nagaoka, C., Kuwabara, T., Yoshikawa, S., Watabe, M., Komori, M., Oyama, Y., & Hatanaka, C. (2013). Implication of silence in a Japanese psychotherapy context: a preliminary study using quantitative analysis of silence and utterance of a therapist and a client. *Asia Pacific Journal of Counselling and Psychotherapy*, *4*(2), 147–152. https://doi.org/10.1080/21507686.2013.790831

Regev, D., Chasday, H., & Snir, S. (2016). Silence during art therapy-The client's perspective. *Arts in Psychotherapy*, *48*, 69–75. https://doi.org/10.1016/j.aip.2016.02.001

Regev, D., Kurt, H., & Snir, S. (2016). Silence during art therapy: The art therapist's perspective. *International Journal of Art Therapy: Inscape*, *21*(3). https://doi.org/10.1080/17454832.2016.1219754

Sharpley, C. F. (1997). The influence of silence upon client-perceived rapport. *Counselling Psychology Quarterly*, *10*(3), 237–246. https://doi.org/10.1080/09515079708254176

Sharpley, C. F., & Harris, M. A. (1995). Antecedents, consequents, and effects of silence during cognitive-behavioural therapy interviews. *Scandinavian Journal of Behaviour Therapy*, *24*(1), 3–13. https://doi.org/10.1080/16506079509455978

Stringer, J. v., Levitt, H. M., Berman, J. S., & Mathews, S. S. (2010). A study of silent disengagement and distressing emotion in psychotherapy. *Psychiatry Research*, *20*(5), 495–510. https://doi.org/10.1080/10503301003754515

Tomicic, A., Pérez, J. C., Martínez, C., & Rodríguez, E. (2017). Vocalization–Silence Dynamic Patterns: A system for measuring coordination in psychotherapeutic dyadic conversations [Article]. *Revista Latinoamericana de Psicología*, *49*(1), 48–60. https://doi.org/10.1016/j.rlp.2016.09.004

VanMeter, J. B., McMinn, M. R., Bissell, L. D., Kaur, M., & Pressley, J. D. (2001). Solitude, silence, and the training of psychotherapists: A preliminary study [Article]. *Journal of Psychology and Theology*, *29*(1), 22–28. https://doi.org/10.1177/009164710102900103

Unpublished dissertations

Adams, M. B. (1991). *A Hermeneutic Interpretation of Silence in Jungian-Oriented Psychotherapy*. [Unpublished doctoral thesis]: University of San Francisco. https://doi.org/10.16953/deusbed.74839

Beazley, S. (1997). *Silence in the Space Between: A Theoretical Model of Nonactivity in the Therapeutic Relationship*. [Unpublished doctoral thesis]: Pepperdine University. https://doi.org/10.16953/deusbed.74839

Davis-McEntire, S. (2005). *Silence: A Depth Psychological Exploration*. [Unpublished doctoral thesis]: Pacifica Graduate Institute. Retrieved from https://www-proquest-com.libproxy.ucl.ac.uk/docview/305392852?accountid=14511

Elkins, D. W. (2006). *A Qualitative Study of Silence as Experienced by Christian Psychotherapists*. [Unpublished doctoral thesis]: Seattle Pacific University. Retrieved from https://www-proquest-com.libproxy.ucl.ac.uk/dissertations-theses/qualitative-study-silence-as-experienced/docview/304926442/se-2?accountid=14511

Gindi, S. (2002). *Patterns of Silences: A Case Study of a Young Adult with Learning Disabilities*. [Unpublished Master's thesis]: University of Toronto. https://doi.org/10.16953/deusbed.74839

Graham, E. (2008). *Telling Silences in Analytic Sessions: Clinical Meanings of Pauses and Affective Valence in the Referral Process*. [Unpublished doctoral thesis]: Adelphi University. Retrieved from https://www-proquest-com.libproxy.ucl.ac.uk/dissertations-theses/telling-silences-analytic-sessions-clinical/docview/305121354/se-2?accountid=14511

Levitt, H. M. (1998). *Silence in Psychotherapy: The Meaning and Function of Pauses*. [Unpublished doctoral thesis]: York University, Toronto, Ontario. Retrieved from https://www-proquest-com.libproxy.ucl.ac.uk/dissertations-theses/silence-psychotherapy-meaning-function-pauses/docview/304470243/se-2?accountid=14511

Warin, T. (2007). *Silence in Psychotherapy: Therapists' Difficulties in Using Silence as a Therapeutic Technique*. [Unpublished Master's thesis]: Auckland University of Technology. https://doi.org/10.1037/h0049176

Appendix B: PICS Categories and Subtypes

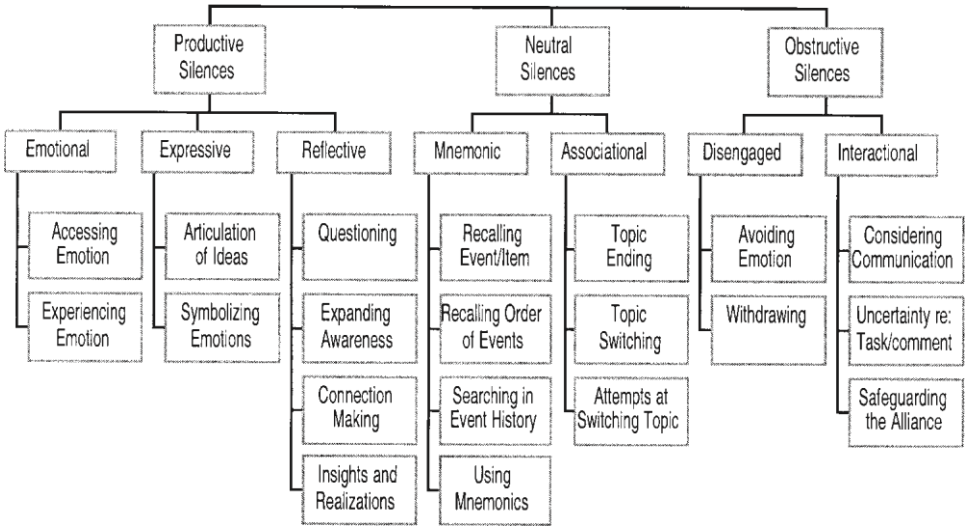

Figure B1. PICS categories and sub-types. From: "Sounds of Silence in Psychotherapy: The Categorization of Clients' Pauses", by H. M. Levitt, 2001, *Psychotherapy Research*, 11(3), p. 300 (https://doi10.1080/713663985). Copyright 2001 by the Society for Psychotherapy Research.

N.B. The coding system used in the present study was the PICS-R (Frankel et al., 2006; Levitt & Frankel, 2004) which divides the subcategory "reflective" into "high-reflective" and "low-reflective".

Appendix C: PICS Coding Information

Coding Training

During the PICS coding training the researchers felt that some silences did not fit the existing PICS-R system as they appeared to be of a particular nature that differed to the other pauses that occurred. In particular, there were a surprising number of pauses which felt distinctly different from purely obstructive and interactional pauses. Whilst listening to these pauses the researchers pictured the patients oscillating between leaning back and withdrawing, and leaning forward and wanting to be helped by the therapists in equal measures; creating a palpable tension. It was felt that these particular pauses were of intrapsychic nature, and related to the specific developmental stage of adolescence as well as the transference relationship in the therapy. It seemed to capture the push and pull between wanting to be cared for and looked after and wanting to be independent and self-sufficient. Due to this the coders decided to introduce an additional sub-type to the PICS-R which they called ‘disengaged-interactional’. Whilst the decision was made not to include an analysis of the frequency of subtypes in this paper it nevertheless felt important to mention the development of this new sub-type.

PICS Coding Process

Apart from capturing the PICS pause category, PICS sub-type, speaker patterns, exact start and length of pause, and stage in therapy, the data collection tool also captured the therapy section in which each pause occurred. Therapy sections were divided in a similar way as the therapy stages (i.e., beginning: 20%, middle: 60%, and end: 20%). However, the decision was made not to include an analysis of the session stages in this piece of research.

All pauses were coded from a psychoanalytic perspective. The coders therefore felt it was beneficial to code sessions in order of appearance to become more familiar with the dynamics of each individual patient-therapist dyad. The coders felt it was important for them to immerse themselves in the data and for the coding to reflect what they felt was happening in the room. This was at times problematic as PICS had derived from an empirical study which was based on the patients' understanding of their silences. PICS is therefore based on patients' conscious thoughts about their understanding of what was happening at the time of the silence, rather than a psychoanalytic approach and it therefore does not reflect unconscious processes or motivations which may have contributed to the pause. Consequently, the decision was made that when in doubt to code 'up' rather than 'down' and then to discuss this further at the consensus coding meetings in order to make appropriate changes together.

Appendix D: Helping Skills Categories and Subtypes

1 = approval and reassurance

2 = closed questions

3a = open questions about thoughts; **3b** = open questions about feelings; **3c** = open questions for insight; **3d** = open questions about action

4 = restatement

5 = reflection of feelings

6 = challenge

7 = interpretation

8 = self-disclosure

9 = immediacy

10a = information about the process of helping; **10b =** data, facts, or opinions; **10c =** feedback about client

11a = process advisement; **11b =** directives

12 = other

Source:

Web Form F – Using the Helping Skills System for Research
From: "Helping Skills: Facilitating Exploration, Insight, and Action", by C. E. Hill, 2009, American Psychological Association: Washington, DC. Copyright 2009 by the American Psychological Association.

Appendix E: Frequency of Pause Categories Without Neutral Pauses

Table E1

Frequency of Pause Categories[a] *across Brief, Medium and Long Pauses*

Pause Length		Ob[b]	Prod[c]	Total
Brief[d]	Count	610	305	915
	Expected Count	642.6	272.4%	915.0
	% within Pause Length	66.7%	33.3%	100.0%
	% within Pause Cat[e]	70.8%	83.6%	74.6%
Medium[f]	Count	211	58	269
	Expected Count	188.9	80.1	269.0
	% within Pause Length	78.4%	21.6%	100.0%
	% within Pause Cat[e]	24.5%	15.9%	21.9%
Long[g]	Count	40	2	42
	Expected Count	29.5	12.5	42.0
	% within Pause Length	95.2%	4.8%	100.0%
	% within Pause Cat[e]	4.6%	0.5%	3.4%
Total	Count	861	365	1226
	Expected Count	861.0	365.0	1226.0
	% within Pause Length	70.2%	29.8%	100.0%
	% within Pause Cat[e]	100.0%	100.0%	100.0%

Notes.

[a]= Due to the low frequency of neutral pauses these were excluded from this table; [b]=Obstructive pauses; [c]=Productive pauses; [d]=Brief pauses (3-10 sec, M=5.19 sec, SD= 2.10 sec); [e]=Pause category (e.g., obstructive, productive); [f]=Medium pauses (11-60 sec, M=20.07 sec, SD=9.86 sec); [g]=Long pauses (61 sec – 5 min 6 sec, Mdn= 139 sec, IQR= 83.25 sec)

Results are shown without neutral silences as due to the low frequency these were excluded from this table and the Chi-Square test analysis.

Appendix F: Duration of Brief and Medium Pauses

Table F1
Break-Down of Duration of Brief Pauses[a] for all Silence Categories

	Frequency of silences			
Duration	Obstructive (n=610)	Productive (n=305)	Neutral (n=14)	Total (n=929)
3sec	139	107	6	252
4sec	139	55	4	198
5sec	86	40	2	128
6sec	86	31	1	118
7sec	61	19	1	81
8sec	34	22		56
9sec	36	16		52
10sec	29	15		44

Notes.
[a]=Brief pauses (3-10 sec, M=5.19 sec, SD= 2.10 sec)

Table F2
Break-Down of Duration of Medium Pauses[a] for all Silence Categories

	Frequency of pauses			
Duration	Obstructive (n=211)	Productive (n=58)	Neutral (n=8)	Total (n=277)
11-20sec	129	41	6	176
21-30sec	50	11		61
31-40sec	21	5	1	27
41-50sec	10	1	1	12
51-60sec	1			1

Notes.
[a]=Medium pauses (11-60 sec, M=20.07 sec, SD=9.86 sec)

Appendix G: The Most Silent Session of Each Therapy

Figures F1-3 below offer a closer look at the timelines of the most silent session of each treatment. It is shown that long pauses often seemed to appear in clusters; either with further long pauses or brief or medium length pauses.

Therapy A

Session 23 in Therapy A was the most silent session in this therapy with a third (34.1%) of the session time being taken up by silence. Three long pauses occurred in this session. Of the three sessions coded for clusters it had the lowest percentage of session time spent in silence. This therapy was also the least silent overall. A look at the speaker patterns shows that in Session 23 of Therapy A all long pauses were broken by the therapist, but only 30.3% (n=20) of the overall pauses in that session. Importantly, out of the three sessions, this session had the highest percentage of productive pauses (25.8%, n=17). Indeed, Therapy A was also the therapy with the highest percentage of productive pauses overall (37.6%, n=172) and with the fewest number of long pauses (n=6).

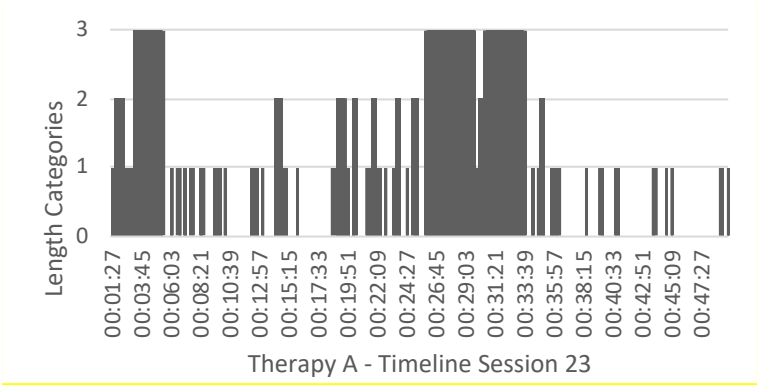

Figure G1. *Timeline of most silent session in Therapy A* (Length categories: 1= brief, 2=medium, 3=long)

Therapy B

The build-up of cluster silences was especially apparent in Therapy B; Session 6 having been the session with the highest percentage of session time taken up by silence (71.9%) out of all eighteen sessions coded across the three therapies. It also contained the

longest pause recorded across all therapies (306 s/five min and one s) and the highest frequency of long pauses recorded in one session (n=8). The speaker patterns in Therapy B's Session 6 show that all long pauses were broken by the therapist. Importantly, all pauses of all lengths which occurred in this session were coded as obstructive (n=86).

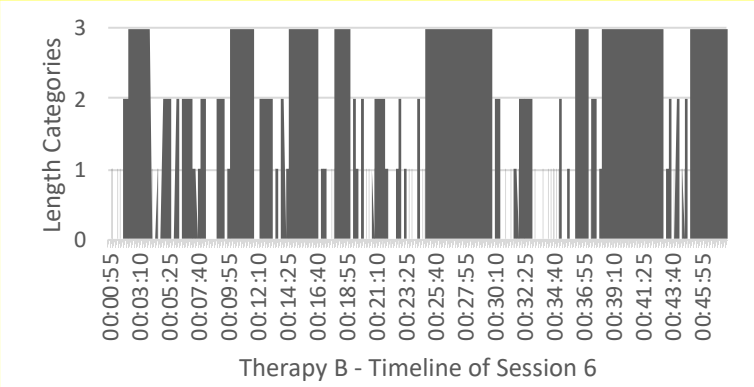

Figure G2. *Timeline of most silent session in Therapy B* (Length categories: 1= brief, 2=medium, 3=long)

Therapy C

Session 24 in Therapy C had a much lower percentage of in-session silence (43.2%), but had a cluster a three long pauses in the middle section of the session and a particularly long pause at the end (275 s). In session 24 of Therapy C, 80.0% (n=4) of the long pauses and 66.7% (n=32) of all pauses occurring in this session were broken by the therapist. In this session 81.3% (n=39) of pauses were coded as obstructive.

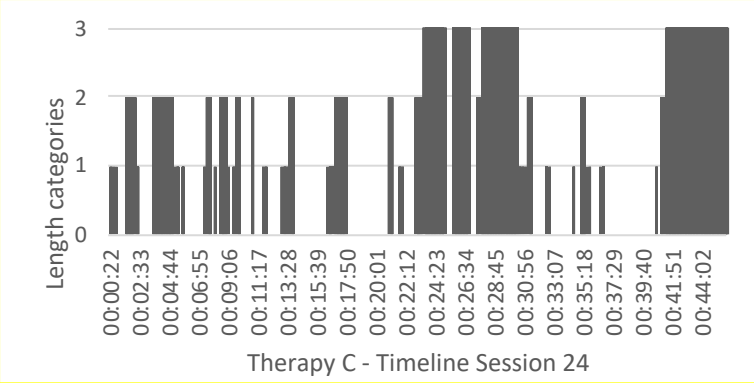

Figure G3. *Timeline of most silent session in Therapy C* (Length categories: 1=brief, 2=medium, 3=long)

Appendix H: Transcriptions of Long Pauses and Helping Skills System Coding

Below can be found a selection of therapists' responses to long pauses, including information on the dialogue before the long pause, pause length and HSS coding.

Interpretation

Therapy B, Beginning Stage, P-T pause which therapist broke after four minutes and one second:

Before pause	The therapist points out that it is interesting that when the YP is at school and is supposed to focus on their school work, they feel the need to talk and when they are at their therapy and might feel that they are supposed to say particular things they seem to keep things to themselves. The YP responds by saying 'yeah'.
Meaning Unit 1 (Interpretation)	T: 'It's a bit like, **this seems bringing a feeling of, feeling like people are saying you're doing the wrong thing in different places**, /
Meaning Unit 2 (Interpretation)	and perhaps, **a worry that I might be saying something like that too, or thinking that too**, /
Meaning Unit 3 (Challenge)	**but I wonder if it's that you feel that's what happened or if there's a part of you that sort of wants to, you know, sort of talk at school, and doesn't want to really be doing the work**.' (29 s) T: 'I suppose I'm wondering if it's a bit of a protest in some ways.' (7 s) P: 'I suppose.'

Open Question

Therapy B, Middle Stage, T-T pause which therapist broke after two minutes and thirty-seven seconds:

Before pause	The therapist addresses the YP's tendency to think of things as either being really important or not really worth it and acknowledges that the YP seems to have started to allow themselves 'to do little steps without feeling that they are worthless'.
Meaning Unit 1 (Open question for insight)	T: '**I wonder what's going on**.' P: 'Just thinking about what you said.' T: 'Uhum. (15 s) Did it sound right to you or not right..or?' P: 'A bit right?'

Reflection of Feelings

Therapy C, Middle Stage, P-T pause which therapist broke after three minutes and seventeen seconds:

Before pause	Conversation about two of the YP's friends and the fact that the YP is currently having difficulties with one of them.
Meaning Unit 1 (Immediacy)	T: '**So we've kind of stopped**, haven't we?/
Meaning Unit 2 Information (Feedback about the client)	**And you've actually been telling me quite a lot about yourself**./

Meaning Unit 3 Reflection of feelings	In a way **and that [the YP's two friends] and your friendship (inaudible) is made up of loyalty but also some dislike and discontent.**'/

Closed Question

Therapy B, Beginning Stage, T-T pause which therapist broke after one minute four seconds:

Before pause	Directly before the long pause the dialogue is about the YP getting into trouble at school for talking during lesson time.
Meaning Unit 1 (Closed question)	T: '**And when you talk to other people, is it about particular things?**' (10 s) P: 'No. I don't think so.' (20 s) T: 'But it sounds like you're saying you feel a part of you comes in and makes it very difficult for you to resist talking. (4s) I don't know if you feel you would rather not be talking and getting on with your work.' P: 'Not really, no.' T: 'No.'

Challenge

Therapy C, Beginning Stage, P-T pause which therapist broke after one minute four seconds:

Before pause	Directly before the long pause a conversation takes place about how difficult the YP finds it to show themselves and open up to people as well as their therapist and how difficult they find it to talk. The YP acknowledges that this is connected to a worry about how other people might perceive them and as a consequence often doesn't get invited to social events.
Meaning Unit 1 (Challenge)	T: '**But then I wonder if that can leave you feeling quite (..) annoyed and resentful with others for not showing interest in you and asking things?**' P: 'Um, I probably don't. (laughs) yeah. Like, I don't want to be spoken to, really, by people I don't know. But then if I like someone, I talk to them, but it's quite hard.'

Other

Therapy B, End Stage, P-T pause which therapist broke after one minute forty-nine seconds:

Before pause	Directly before the long pause the YP describes that they feel judged by others and feel that others are not able to recognise how hard they are trying and that the YP feels they are holding their feelings in rather than letting them out. Therapist explores with them whether the YP may be able to 'let them out' in the final few sessions of their therapy.
Meaning Unit 0 (Other)	T: 'Okay, it's time.' (End of session)

Silence Broken by Patient

Therapy A, Middle Stage, T-P pause which therapist broke after two minutes fifty-two seconds:

Before pause	T: 'So you may feel something like, "Where were you? Why weren't you there?"'
Meaning Unit 1 (n/a patient broke silence)	YP: 'I don't know' (YP is crying and most of it is inaudible)