

Silence in Psychotherapy

Therapists' difficulties in using silence as a therapeutic technique

Tarsha Warin

A dissertation submitted to Auckland University of Technology
in partial fulfilment of the requirement
of the degree of Master of Health Science (MHSC)

November 2007

Department of Psychotherapy

TABLE OF CONTENTS

TABLE OF CONTENTS	I
LIST OF TABLES.....	III
ATTESTATION OF AUTHORSHIP.....	IV
ACKNOWLEDGEMENTS.....	V
ABSTRACT	VI
CHAPTER ONE.....	1
INTRODUCTION	1
THE MEANING OF SILENCE.....	1
CHAPTER INTRODUCTIONS	3
CHAPTER TWO	5
METHODOLOGY	5
INTRODUCTION.....	5
PSYCHOTHERAPY AND THE SOCIAL CONTEXT OF EVIDENCE-BASED PRACTICE	5
SYSTEMATIC REVIEW PROCESS	6
<i>Step One: Frame the Research Question and Choose Appropriate Methods</i>	<i>6</i>
<i>Step Two: Identify Relevant Work.....</i>	<i>7</i>
<i>Step Three: Extract Relevant Data on Outcomes and Quality.....</i>	<i>9</i>
CONCLUSION	10
CHAPTER THREE	11
THE HISTORY AND USE OF SILENCE WITHIN PSYCHOTHERAPY	11
INTRODUCTION.....	11
SILENCE AS RESISTANCE	11
SILENCE: TRANSFERENCE AND COUNTERTRANSFERENCE	12
SILENCE AS A REGRESSION.....	13
FURTHER UNDERSTANDING OF THERAPIST’S SILENCE	13
SILENCE AS COMMUNICATION.....	15
TRANSPERSONAL SILENCE	18
CONCLUSION	19
CHAPTER FOUR	20
USING SILENCE: THERAPISTS’ DIFFICULTIES	20
INTRODUCTION.....	20
THERAPIST SILENCE AND DEVELOPMENTAL THEORY	21
PROMINENT DEVELOPMENTAL THEORISTS.....	21
SILENCE AS AN EMPTY SPACE	23
SILENCE: SEPARATION AND OBJECT LOSS ANXIETY	25
CONCLUSION	30
CHAPTER FIVE	31
THERAPIST SILENCE: UNCONCIOUS PROCESSES	31
INTRODUCTION.....	31
TRANSFERENCE AND COUNTERTRANSFERENCE.....	31
THE INFLUENCE OF THE THERAPIST.....	32
THERAPISTS’ NARCISSISTIC DIFFICULTIES	34
THE INFLUENCE OF THE THERAPIST’S THEORETICAL ORIENTATION	36
THE INFLUENCE OF THE CLIENT	37
SILENCE IN THE SPACE BETWEEN.....	39
CONCLUSION	40
CHAPTER SIX.....	42

CLINICAL RELEVANCE, LIMITATIONS AND FURTHER RESEARCH	42
SILENCE AS A THERAPEUTIC TECHNIQUE	42
SILENCE: HELP OR HINDRANCE.....	43
THERAPIST SILENCE: UNCONSCIOUS PROCESSES	44
BEING AWARE OF THE THERAPIST'S NARCISSISTIC SENSITIVITIES.....	45
SILENCE AND THE UNKNOWN.....	46
INTERNAL AND EXTERNAL SILENCE.....	46
THERAPISTS DEVELOPMENT	47
RESEARCH LIMITATIONS	48
MY DEVELOPMENT THROUGH THIS STUDY	48
CONCLUSION	48
REFERENCES	50

LIST OF TABLES

TABLE 1: KEYWORD SEARCHES	7
TABLE 2: KEYWORD SEARCHES	8

ATTESTATION OF AUTHORSHIP

I hereby declare that this is my own work and that to the best of my knowledge and belief, it contains no material previously published or written by another person or material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

Signature

Tarsha Warin

ACKNOWLEDGEMENTS

This dedication begins in silence, reflection, and with heartfelt sincerity.

Words fill the silence and empty space on this page, as I realise how writing this dissertation has not only been a singular experience but a communal event. Life is filled with people who leave their footprints on your soul. It is of great honour to acknowledge these people and the 'soul therapy' that they have so graciously given through the pleasure and pain of this dissertation process.

I would like to acknowledge my clients, their dedication, courage and heart in persevering through their therapeutic journey when things have been extremely difficult. I also honour them in their growth and thank them for giving me permission to use them in the clinical work of this dissertation.

A special thank you to my supervisor, Sue Joyce, for her patience, kindness and well needed help and advice. I would like to give a big hug, to my friend Rhonda Bliss who has always given me encouragement, support (a shoulder to cry on), guidance, and her precious time. I would also like to acknowledge, Amber Davies, Jane Lowry and Natalia Solovieva for reading, reducing words and critiquing my work. Thank you to Shoba Nayar for being an amazing English scholar and a miracle worker in editing my work.

A special thank you to the following friends who dragged me away from my work and helped me maintain some sanity: Andrew Kirby and Iain Graham, Neil and Louise Pyne, Joe (Freud) and Yosiko Tregerthan, Natalia Solovieva and Mark Bond, and Celia Bell-Booth.

I acknowledge and esteem my wonderful father and mother for without them I would not be born. I love you both very much. I want to thank my dad for his understanding and love throughout such a difficult year. To my dearest and special mum, thank you for your beautiful prayers and your devoted time in being there for me always.

To my dearest sister and best friend, Charlene Warin, whose love, support and encouragement has enhanced my life and made this present work possible. Bert, thank you for your speedy typing skills and the hours you spent typing up references. Words do not seem enough when I say, thank you for being a woman whom I trust and admire, I love you.

Finally, but most importantly, I acknowledge and give honour to my heavenly Father and his faithfulness. I am in awe of his miraculous work in turning what was once, just a grain of sand inside an oyster, into some thing so beautiful, behold look at me, a pearl.

ABSTRACT

The use of silence within psychotherapy for attentive listening, observation, self exploration and creating a holding environment is well documented. Silence facilitates in creating an interpersonal space where both therapist and client can communicate. It is the gateway that leads from the conscious to unconscious; an effective vehicle for healing and change. This dissertation explores why some psychotherapists may find silence uncomfortable, causing difficulties in using silence as a therapeutic technique. Emphasis is placed on examining the therapist's developmental history and the therapist's transference and countertransference dynamics that influence the therapist's experience and use of silence. The methodology for this study is a modified systematic literature review with clinical illustrations.

Beginning with an overview of the historical development of the role and function of silence as contextualised within a classical view and moving to more relational and transpersonal approaches, silence is revealed as a multifaceted phenomenon with various contrasting meanings and attitudes. Review of the literature indicates that the therapist's preverbal developmental deficits in relation to separation and threat of, or object loss, may cause the therapist to be over-active, as words become the 'metaphoric teddy bear' used to fill the absent and empty space within the therapeutic session. Findings support the notion that the therapist's unresolved conflicts will influence and impact on the transference and countertransference dynamics, the use of silence and the therapeutic relationship. Gaining an awareness and understanding of the therapist's defences and transference and countertransference reactions can be used to indicate difficulties with silence and thus improve the quality and use of silence within the therapeutic situation. To be able to use silence effectively in the therapeutic process, findings reveal that an important step for therapists is to first learn to be alone with oneself in the silence.

Speech is silvern but silence is golden
(Sandor Ferenczi, 1916)

CHAPTER ONE

INTRODUCTION

In approaching this subject on silence, I am aware of the peculiar dilemma of having to write about something that is beyond words. On reflection, I realise how difficult the unknown and unspoken phenomena of this dissertation process has been. It has only been through the reading and writing of words, that I identified a paradox in the process of knowing and not knowing. Although words are commonly seen as the primary vehicle used to communicate within relationships, I am interested in the usefulness of silence as a communication and a therapeutic technique for the therapist with the client. Why is it that silence for some therapists can be so uncomfortable? Why do some therapists feel so 'unveiled' in stillness? These questions fuelled my fascination with silence and hence, my decision to choose silence as a research topic.

The phenomenology of silence and the use of silence in psychotherapy has been an interest of mine that has developed through my process in therapy and training as a psychotherapist. I have come to realise that both speech and silence are integral parts of psychotherapy and of life. There is, "A time to make noise and a time to be silent; a time to speak and a time to refrain from speaking" (Ballou, 1996, p. 4), a sentiment I resonate with.

As a psychotherapist, I am curious at how the use of silence may evoke a deeper level of connection with not only the conscious but unconscious processes of the client and myself. I wonder whether when I began my professional training, there was an unconscious wish or desire to find stillness or silence within me, even then. From a personal perspective my core values have always emphasised perfectionism and reliance on achievement for a sense of self worth, "Doing' is valued over 'being' or even in becoming" (Sue, Derald, Wing, & David, 1990, p. 33). Silence takes on a personal pursuit for me as my values have been challenged over the years, changing my desires from a 'doing' (external way of being) to a 'being' (internal or relational process) way of focused life. My therapeutic journey of nine years has led me to researching silence in psychotherapy; in particular, my difficulties in holding and using silence as a therapeutic technique, difficulties which I posit, are shared by many.

The Meaning of Silence

The Oxford dictionary defines silence as an, "absence of sound; abstinence from speech or noise" (Deverson, 1999, p. 498). Silence from an intersubjective perspective of psychotherapy differs as it is seen to be a part of communication taking place within a relationship and encompassing layers of thoughts and affect (Sabbadini, 1991). Silence when used in clinical practice may be understood to enable active listening, self exploration, safe communication, understanding and containment; it is the gateway that leads from the conscious into the unconscious. It is this interpsychic reflective process, which helps with the understanding and insight of both the therapist and client's process, creating a healing experience.

The silence falls. I stop inside it, sensing its depth as it arrives and leaves around me. Sensing like that is a kind of listening, but it is a listening with the body, the bodies' poise the sounding board in which the resonances of the particular qualities of a particular silence intone themselves. I notice the silence in the field is different from the silence in the therapy room. Silence then, is neither place nor absence. It is the presence of the listener in the presence of another, in the presence of the flower, the water, the bird above the valley's green. It is itself an active presence, the mantle in which our experiences come wrapped, allowing us the fullest freedom to be who and what we are, if we care to sit quietly as it arrives, ready to listen. (Author Unknown, Retrieved 20 March, 2007, from <http://www.poemsabout.com/silence>)

For the purpose of this study, silence is that which takes place within the special interpsychic and interpersonal relationship in psychotherapy. Silence is discussed as both a quality and a fundamental technique. I refer to analytic silence, analyst silence, analyst abstinence, silent, therapist silence and client silence; this is any instance of therapist or client not talking during therapy sessions.

In an initial search of the psychoanalytic literature for the topic 'silence', I discovered that client silence was the primary focus. Although the use of silence is a fundamental technique within psychoanalytic psychotherapy¹, little research investigating the therapist's relationship to silence seems to have been undertaken. The purpose of my dissertation is to investigate silence when it may be a difficult experience for the therapist. I am interested in how this relates to the therapist and how the therapist's difficulties with silence affect the client and the relationship between therapist and client.

It is important to be aware that therapists are at times in a similar psychological position to their clients, despite the difference in roles (Bacal & Thompson, 1996). That is, therapists too bring a relational history, a cumulative representation of lived experience of interaction to the therapeutic situation, remembering, "everyone is much more simply human than otherwise" (Sullivan, 1953, p. 32). It is for this reason that literature discussing clients' difficulties with silence is also used to review therapists' difficulties with silence. What is hopefully different is that therapists are more aware of their own difficulties and able to reflect on and process their experiences.

Although the therapist may also be vulnerable to similar processes as the client, it is assumed for the scope of this paper, that the therapist is at a higher level of neurotic² functioning and may be in therapy or will have had therapy. The client is also seen to be at a neurotic level and borderline and psychotic levels of functioning are excluded.

¹ Psychoanalytically orientated psychotherapy: The use of Freud's theories combined with other theories and techniques. For the purpose of this study psychoanalytic, the analytic situation and psychodynamic is used synonymously to the term psychotherapy. Psychotherapy is described as a psychological-interpersonal process intended to enhance the client's capacity to be alive as a human being (Ogden, 1996).

² A relatively mild mental disorder with predominantly stressing symptoms and without loss of insight (Colman, 2001).

Chapter Introductions

Within psychoanalytic literature, the experience and use of silence has a wealth of contrasting attitudes impacting client, therapist and the therapeutic relationship. "Silence is considered a multi-faceted psychic state serving many mental processes and systems of mind" (Calogeras, 1966, p. 541). While it is a goal for therapists to use silence competently, some therapists find holding and using silence a difficult experience. This dissertation focuses on therapists' silence as an experience that triggers emotional states of discomfort. The method used is that of a modified systematic literature review.

The next chapter discusses both the positivist, technical rational and the interpretive, post modernist and professional artistry views, in relation to evidence-based practice and practice-based evidence. I discuss the use of a modified systematic literature review as the methodological approach of choice and provide a rationale for its application to this dissertation. Furthermore, the scope and limitations of the research are outlined.

In Chapter Three, I outline the history of silence as discussed by theorists who have had significant impact in exploring the concept and in changing the understanding of silence as a phenomenon of the therapeutic relationship. I explain the role and function of silence within psychotherapy, beginning with a discussion of Freud's original hypothesis of silence as a resistance and a violation to the 'fundamental rule'.³ In addition, I address relevant theorists who discuss silence and transference and countertransference constellations, silence and regression, silence as an over-determined multi-functioning state of analytic communication and transpersonal silence.

Chapter Four aims to provide preliminary answers and links to therapists' developmental deficits and difficulties with holding and using silence. I begin with a discussion on contrasting attitudes and aspects that influence the therapist's use of silence and introduce Freud, Winnicott and Mahler and their developmental theory. Additional theorists who relate the experience of silence to being like an absence, emptiness, annihilation and/or death are considered alongside developmental theorists who specifically explore and link therapeutic silence to primary object relations, separation anxiety, and threat or object loss.

Chapter Five begins by outlining the definitions and conceptualisations of transference and countertransference. I review significant factors contributing towards understanding transference and countertransference dynamics in relation to the difficulties a therapist may encounter when experiencing silence. These factors include therapists' lack of awareness of countertransference, the influence of the therapist, therapist's narcissistic difficulties, the

³The fundamental rule: Also known as the basic rule of psychoanalysis where the client must engage wholeheartedly in telling the analyst whatever comes into their mind. This technique is known as free association (Colman, 2001).

influence of the therapist's theoretical orientation, the influence of the client and silence in the space between therapist and client.

The final chapter is a discussion and critique of conclusions drawn from Chapters Three, Four and Five. It is my hope that this research will provide deeper understanding and improve the effectiveness of both myself and other psychotherapists' capacity and ability to reflect on how to hold, allow and use silence in clinical practice.

CHAPTER TWO

METHODOLOGY

Introduction

This research topic evolved from an observation of my experience with silence within clinical practice. Through closer examination, what became evident were difficulties in allowing and using silence as a therapeutic technique. The following chapters contemplate therapist silence and question which research approach is best suited to provide the least biased answer.

In this chapter, I introduce two opposing methodological approaches situated within different social paradigms and discuss how each may be used to explore the research question. A systematic literature review is the choice of this methodological approach. I will describe the review, including a rationale for its use, and outline the scope and limitations of the research.

Psychotherapy and the Social Context of Evidence-Based Practice

Within professional practice there are two fundamental views of knowledge; these include the positivist, technical rational view, and the interpretive and post modernist, professional artistry view (Fish & Twinn, 1997). Evidence-based practice (EBP) fits within the former. The positivist paradigm in Western society focuses on science, objectivity, empirical and mechanistic reasoning and includes attributes such as, predictability and causality (Fish, 1998; Reed & Ground, 1997). Psychotherapy is situated within the interpretive paradigm, which understands the world of meaning through subjective experience, creativity and interpretation (Guba, 1990).

Our interpretations and even perceptions are conditioned by language, by culture in general, by the dominant world view of the time, by personal (including unconscious) interests, and by interests based on race, gender and social class—this recognition has led many to the conclusion that a worldview is wholly a construction, or a projection, not at all a reflection of discovery of the way things really are. (Scaeff, 1992, p. 58)

This dissertation attempts to combine the objectivity of EBP with elements of practice-based evidence (PBE), as psychotherapy is both a science and an art (Barkham & Mellor Clark, 2003; Basch, 1988; Roth, 1990). Within the scientific tradition, systematic literature reviews, "retrieve, appraise and summarise all the available evidence from scientific studies in order to provide informative, empirical answers to scientific research questions" (White & Schmidt, 2005, p. 54). Systematic literature reviews are considered the 'gold standard' for assessing the effectiveness of a treatment or intervention within the evidence-based paradigm (NHS Centre for Reviews and Dissemination cited in Hammer and Collinson, 1999). This is why I have chosen to use this research approach, as such reviews efficiently integrate existing quantitative and qualitative scientific information, enabling clinicians to make informed

decisions and define areas of future research (Mulrow & Cook 1998; Trindler & Reynolds, 2000).

EBP generally considers quantitative data from randomized controlled trials (RCT). For many psychotherapists this concept of evidence is problematic as most evidence within psychotherapy is qualitative. Qualitative research has a major influence on psychotherapy clinical practice and research (Maione & Chenail, 1999; Hinselwood, 2002). Qualitative methods allow the researcher to overcome the limitations of quantitative causal explanations and empirical generalisations applied to complex phenomena of intra and interpersonal psychotherapeutic encounters. These methods are based on investigation, observation, experience, case studies, client reports, peer discussion and professional literature (Goodheart, 2004; Starcevic, 2003).

The phenomenology of therapist silence is more of a conceptual than literal concept and for this reason makes it difficult to use standardised methodological approaches such as EBP. Therefore, although a systematic literature review framework is used for this dissertation, some modifications to the process have been required. These modifications include qualitative studies and professional literature as the key source of evidence. Further adaptations are in the use of historical case material, personal experiences, and observations in the form of clinical vignettes to illustrate and explore the clinical parameters within which this research is based.

Ethical approval for use of clinical illustrations has been authorised by the Auckland University of Technology Ethics Committee on 27th April 2004. To assure confidentiality, pseudonyms have been used in place of client names and particulars changed where appropriate. All clients whose material has been used in this dissertation provided written consent.

Systematic Review Process

This dissertation employs White and Schmidt's (2005) key components of a systematic review process. In this chapter, the first three steps are undertaken, while Chapters Three to Six summarise and interpret the evidence.

1. Frame the research question and choose appropriate methods.
2. Identify relevant work.
3. Extract relevant data on outcomes and quality.
4. Summarise the evidence.
5. Interpret the evidence.

Step One: Frame the Research Question and Choose Appropriate Methods

In keeping with the process outlined above, my work began with a clinical question: In psychotherapy, why do some therapists experience difficulties when holding and using silence as a therapeutic technique?

Step Two: Identify Relevant Work

The review was undertaken primarily at the Auckland University of Technology (AUT) library. Utilising electronic databases, dissertation abstracts with digital dissertations, books and the inter-loan services, 89 papers in total were located. The databases consisted of PsychInfo and Proquest Dissertations and Theses as they provided the most relevant literature. PsychInfo also contained the journals listed in Psychoanalytic Electronic Publishing (PEP). Table 1 provides an overview of the search process.

Table 1: Keyword Searches

Search Term	Number of Articles	Relevant Articles with Exclusion Criteria
Silence and psychotherapy	299	9
Silence in psychotherapy (Proquest dissertation and Thesis)	10	5
Silence and psychoanalytic technique	2	2
Psychotherapist silence	21	4
Therapist silence	1	1
Therapist silence and anxiety	4	2
Silence and separation	47	1
Preverbal silence	0	0
Intolerable silence	0	1
Traumatic silence	75	0
Resistance silence	135	3
Wordless and wordlessness	2	1
Non-Verbal and silence	108	5
Total	704	34

Initially I encountered difficulties in sourcing literature that discussed and investigated the use of therapist silence as opposed to client silence. In searching the databases, I used the key words listed above; however, these key words were limited as the therapist's use of silence in early psychoanalysis was traditionally termed as, analyst's rule of abstinence, verbal abstinence, analyst's neutrality or blank screening. A further search through PsychInfo using these specific terms yielded a greater number of relevant hits. As my search and reading progressed, I narrowed my focus to silence and developmental theory, and transference, countertransference and intersubjective silence. The results of further searches using new key words are provided in Table 2.

Table 2: Keyword Searches

Search Term	Number of Articles	Relevant Articles with Exclusion Criteria
Silence and transference	83	3
Silence and countertransference	70	12
Anal\$ abstin\$	108	5
Analyst abstin\$ and anxiety	40	8
Analyst abstin\$ and difficulties	18	5
Anal\$ neutral\$	125	10
Silence and intersubjectivity	5	3
Neutral\$ and intersubjectivity	19	10
Total	468	56

The literature search was not confined to databases, books and articles from AUT as the reference lists of relevant literature were fundamental in helping source other pertinent data. I searched for further data by seminal authors whom I had found useful in previous studies and referred to books and articles obtained earlier in my training as a psychotherapist, as well as literature recommended by colleagues and my supervisor.

When authors referred to primary sources, I sourced the primary literature as much as possible to minimise secondary source bias. For example, many secondary authors such as,

Weiss (1997) and Beazley (1997) summarised the works of Winnicott (1958) and Ogden (1994). In some cases, I was unable to locate primary sources due to aged publications and dates.

Step Three: Extract Relevant Data on Outcomes and Quality

The inclusion criteria captured literature related to the practice of psychoanalytic and psychodynamic perspectives. Exclusion criterion included all material not published in the English language due to my monolingual ability. This was a significant limitation as articles in German, Spanish and other European languages are excluded from the thematic analysis. I also excluded articles of child, adolescent or family psychotherapy, group psychotherapy, borderline or psychotic client groups. In addition, literature from other modalities such as, counselling, and humanistic and supportive approaches, were excluded due to the specific need to discuss the effects of silence in relation to transference and countertransference constellations.

The modified systematic literature review is limited to the theme of the therapist's relationship to silence and is comprised of literature found and selected as pertinent to the research question. Due to time and length of a dissertation, the parameters of this study have been limited to focus on silence and developmental theory and transference and countertransference constellations. Other relevant factors although significant, are not explored. These include silence and cultural and societal influences, gender related issues, health and illness, therapist's trauma and the therapist's personal and professional development.

Literature has been critiqued by the opinion of other authors, my own critique, my own and other theorists' clinical experiences, and at times my own personal experiences. As I began the search with exploration in mind and no definitive answer, this study has been discovery oriented. Themes have emerged and evolved throughout the research process as in qualitative research (Maione & Chenail, 1999).

Although this study challenges some of the positivistic ideas and methods in relation to human experiences, it is important to note how the lack of objectivity, generalisations and personal bias may influence the research outcome. According to Kant (cited in Starcevic, 2003), "the mind shapes the world that it seeks to know" (p. 279). Although rigorous data collection and analysis procedures have been maintained there may be a subjective bias, influenced by my own experiences of silence, individual therapy and supervision. Initially, I discovered a tendency to want to apply my own interpretations and theories to the work of the literature. It was my supervisor who helped me notice my own bias and defence in splitting, idealising silence and devaluing speech. Novey (1961) noted that the point of view of the

observer will inevitably influence what is observed and how it will be interpreted. Weiss (1997) was of a similar mind to Novey.

It's apparent that the greater the work under discussion, the more interpretations seem to be made about it. Any great work may very well illuminate issues in the observer that might be more central to him, than to that of the author. (Weiss, 1997, p. 60)

Other methodologies that may have been useful in attaining knowledge are interviewing and questionnaires. The focus of these interviews could be that of the therapists' difficulties with silence and the clients' responses to the therapist's use of silence. This method of research would provide relevant data in understanding intra and interpersonal dynamics of silence. This would have to be done in conjunction with systematically reviewing relevant literature, as alone this source of information would not provide sufficient data about the topic. The constraints of the AUT masters programme do not allow for such an ambitious approach and for this reason I recommend this for a doctoral thesis. Further limitations and methodological approaches are discussed in the final chapter.

Conclusion

This chapter has discussed both the positivist, technical rational and the interpretive and post modernist, professional artistry views in relation to EBP and PBE. I have discussed the use of a modified systematic literature review as the methodological approach of choice and provided a rationale for its application to this dissertation. Furthermore, the scope and limitations of the research have been outlined. The next chapter furthers the systematic review process, beginning the exploration and interpretation of the literature.

CHAPTER THREE

THE HISTORY AND USE OF SILENCE WITHIN PSYCHOTHERAPY

Introduction

The role and function of silence has been extensively explored within the development of psychoanalytic theory and technique. According to psychoanalytic literature, the history of silence began by reviewing and investigating client silence; and for this reason, it is where I begin. This chapter discusses the concept of therapist silence beginning with the classical model and progressing to relational schools of thought. In addition, the notion of psychotherapeutic silence in relation to spirituality and the transpersonal phenomenon is explored.

Silence as Resistance

Freud (1856-1939) was fundamental in the initial development and meaning of silence within classical psychoanalysis. Initially, Freud understood client silence in two ways; firstly silence as a resistance to the transference and secondly, silence as a resistance to remembering.⁴ From this understanding of silence, Freud and colleagues believed clients' verbal communication took precedence over non-verbal communication (Abraham, 1919; Breuer & Freud, 1955; Calogeras, 1966; Ferenczi, 1916; Fleiss, 1949; Freud, 1912; Levy, 1958; Meerloo, 1952).⁵ Thus, the more the client verbally communicated the more successful the therapeutic endeavour (Breuer & Freud, 1895, 1955).

Freud's early writings revealed that he was not silent; he hypnotised, questioned and instructed his clients. However, a fundamental change in Freud's work occurred when he linked the concept of analyst silence to furthering clients' free associations in the case of Frau Emmy Von N (Breuer & Freud, 1895, 1955). Freud shifted his view from silence being solely about clients' resistance to that of the importance of the analyst using silence as a technique. Although Freud did not directly discuss analyst silence, he did introduce two primary concepts in relation to psychoanalytic technique used by the analyst. These concepts included the analyst as the 'mirror' and the rule of 'analyst's abstinence'.⁶ Both concepts were subsumed into the term 'blank screen' where the client used the therapist as a projection screen for unconscious fantasies and conflicts (Fenichel, 1939; Freud, 1912; Gill, 1954; Greenacre,

⁴ The classical psychoanalytic understanding of the meaning and function of silence tended to be limited as it interpreted client silence as being a symptom. This symptom was analysed as a defence or as an opposition, resulting from restrictions on the drive of the id, a threat to the defences of the ego or an invasion of the demands of the superego that interrupts or stops the therapeutic process. The theory also considers client silence to be underlying aggression, anxiety and transference reactions and difficulties.

⁵ During treatment Bertha Pappenheim, (pseudonym, Anna O) referred to psychoanalysis as the 'talking cure' (Breuer & Freud, 1955).

⁶ The mirror refers to the idea that the therapist must be non-intrusive, not imposing values nor interfering with the client's use of the therapist as a projection screen for unconscious conflicts (Freud, 1912/1953, 1915/1953, 1919/1953). The 'rule of abstinence' refers directly to a psychoanalytic technique where the therapist denies any form of reaction to the client, who is craving for love and satisfaction that they need or demand (Rycroft, 1995). This is also referred to as verbal abstinence.

1954). Greenacre (1954) cautioned that Freud did not mean for an analyst to be cold and unresponsive but rather non-intrusive.

From 1914 to 1955 psychoanalytic literature aligned with Freud's initial theories interpreting silence as a resistance. Although the literature paid more attention to the client's use of silence as a resistance, the interpretation also included the therapist's silence. Ferenczi (1916, 1950) wrote the first paper specifically directed to the problem of silence. He believed that when a client was silent, thus violating the fundamental rule, the therapist must respond with silence, a technique known as 'the absent analyst.' Bergler (1938) also viewed client silence as resistance that once established could be technically dealt with by the therapist's silence. Glover (1928) called this, 'the pugilistic encounter,' in that the therapist meets the client's silence with silence in an attempt to force the client to speak. Glover (1955) later changed his perspective realising that to meet silence with silence, is to engage in silent combat, an interpsychic battle, therapist against client and client against therapist, negatively impacting treatment and the therapeutic process. He also referred to analyst's resistant silence as a 'relentless deprivation'.

The focus of the psychoanalytic literature thus far predominantly emphasised client silence as a resistance. Early theories do not give corresponding consideration to the meaning of the therapist's rule of abstinence, mirroring and, the blank screen, all of which rely upon therapists' silence.

Silence: Transference and Countertransference

From 1940 onwards, silence was perceived as not only a resistance but also a more complicated phenomenon. Publications on the evolving theory on therapist silence facilitating client transference began appearing. It is important to point out that up until 1951, the transference and countertransference constellations were predominantly seen as forms of resistance and obstacles that needed to be overcome.

Classical analysts heeded Freud's cautions against 'premature interruptions' and extended the idea until 'analyst abstinence' began to dominate in the session. This is interesting, as I wonder in the analyst not dominating the session by being silent; perhaps the silence itself dominated the session. The analyst's use of silence was seen as a specific, essential and irreplaceable method of treatment for overcoming client resistances, making the unconscious conscious and uncovering instinctual wishes. Over time, therapist's silence became a valued intervention and aided in generating a 'pure transference'. Ferenczi and Rank (1923, 1956) emphasised the final phase of Freud's evolution of psychoanalytic technique as they recognised the fundamental importance of the transference. Analysts after Freud came to rely more and more on waiting in silence for the transference to mature (Arlow, 1961; Fenichel, 1939; Maloney, 1947; Reik, 1926). Arlow, (1961) stated, "Silence in treatment is different to any other kinds of silences, in silence, there lies psychic riches" (p. 505).

By the 1950s, analytic thinking toward a process and technique of therapist silence was solidified with a belief that it fostered exploration and the emergence of sexual and aggressive drive conflicts (Eissler, 1953; Freud, 1954; Greenacre, 1954; Kris, 1956; Menninger, 1958). Silence became the de facto identifying characteristic of classical psychoanalysis and of the analyst as anonymous and non-intrusive (Fenichel, 1941; Gill, 1954; Greenacre, 1954).

Silence as a Regression

Psychoanalytic literature from the 1950s onwards developed the thinking on silence. Evolving theories emphasised the importance of therapist silence for evoking transferences and listening to countertransference. The definition of transference and countertransference changed from being an obstacle to analysis, to an indispensable instrument and a crucial source of information about the therapist and client (Gabbard, 1995; Gill, 1982; Greenacre, 1968; Heinmann, 1950; Little, 1951; Racker, 1968). Silence was now fundamentally used for creating a therapeutic ambience that allowed regression to an early preverbal stage of infant development.

Progressive changes in the interpretations of silence can be attributed to Object Relations theory. Object Relations theorists focused on how pre-oedipal stages of human development are re-enacted in the supportive presence of the therapist (Fairburn, 1952; Winnicott, 1951). Many theorists believed that the therapist's silence created a longing for oneness with the mother for the client (Arlow, 1961; Greene, 1882; Khan, 1963; Nacht, 1963, 1964; Schulman, 1986; Serani, 2000; Shafii, 1973; Winnicott, 1971). At the breast, the dialogue between mother and child is mostly a silent one. Therefore, therapist silence was seen to create an opportunity for the preverbal relationship between mother and child to develop, creating the possibility for a reparative experience between therapist and client in the therapeutic relationship. These ideas and concepts are systematically discussed and reviewed in the following chapter.

Further Understanding of Therapist's Silence

From 1960 onwards the literature identifies four main theorists who exclusively explore aspects of therapist silence. The first theorist is Pressman (1961, 1961a) who expanded the meaning of therapists' silence in psychoanalysis, "whereas patient silence is usually a resistance, the analyst's silence creates the optimal milieu for the analytic work" (p. 168). Pressman systematically researched therapist silence dividing the therapeutic uses of silence into four major sections. First, he identified silence as a matrix that provides an ideal atmosphere within which clients' free association could take place. He then reviewed the multiple meanings of analyst silence to the client and thirdly described how analyst silence

could be a contra-indication.⁷ Finally, Pressman is the only theorist who noted forces that tend to disrupt the analyst's silence. Pressman's ideas are discussed and reviewed further in the following chapter.

In contrast, to Pressman, Zeligs (1960, 1961) specifically discussed the subtle role silence plays in the development of 'transference neurosis'⁸ and countertransference reactions and the consistent influence it has on the therapeutic relationship. Zeligs perceived silence to be a complex psychic state. Although he still viewed client silence as a resistance or defense, he added that the client's reactions, attitudes and interpretations depended on the underlying attitude of the therapist's use of silence. This is a good point as there is an assumption made by many authors that the therapist knows how to use silence well and is not plagued by using it in the same resistant ways as clients.

Similar to Zeligs, Brockbank (1970) believed that how the therapist dealt with the client's silent resistances depended on whether silence became a major symptom in the therapeutic process. Commenting on how the therapist's abilities to deal with the countertransference influenced treatment, Brockbank believed analyst countertransference revealed not only what the client was experiencing but also what the analyst was experiencing intra-psychically. He discussed how obsessive therapist silence affected the client through 'hypnotic suggestion', which may lead to reaction formation, adaptation, distancing and projection.⁹

Brockbank (1970) also spoke of the prudent use of silence by the therapist as one of the most potent tools of the analyst's therapeutic encounter with the client, a belief similar to that of Pressman's (1961). Brockbank believed that silence was becoming not only an intrapsychic but also an interpersonal phenomenon; however, intrapsychic and interpersonal silence could only be understood by taking into account realistic therapist and client reactions, the here and now, the meaning of external objects, intrapsychic conflicts and transference fantasies.

So far, much of the literature is scant, as it does not discuss the therapist's silence within the therapeutic hour in detail. However, Langs (1973, 1978) treated silence in psychotherapy fully and systematically. He valued analyst silence as a primary therapeutic tool for understanding the client and considered silence to be the most basic, undervalued and misunderstood of all interventions. He believed that silence is among the most difficult interventions for the therapist to make because the tendency is to apply more active interventions. Lang demonstrated therapeutic efficacy of therapists' verbal abstinence and defined silence into six

⁷ Contra-indication was when the therapist's use of silence either enforced or increased the client's defences or impeded upon the process of psychotherapy.

⁸ Transference neurosis is the client's emotional involvement with the therapist (Rycroft, 1995).

⁹ The technique of obsessive silence and suggestive interpretations can influence the client hypnotically. The client is placed in a state of hypnotic suggestibility; in this state, the client tends to give the therapist the material the therapist wants in a way that the therapist wants it (Brockbank, 1970).

basic principles that constitute the atmosphere of the psychotherapeutic setting and the therapist's way of being. These are:

1. Analyst is silent after greeting the client.
2. Analyst remains silent until he fully understands the implications of the client's dynamic conflicts.
3. Analyst is silent while he/she understands primary adaptive tasks, intrapsychic conflicts, ego strength and dysfunction, key unconscious fantasies and therapeutic context.
4. Analyst is silent if the client is working well.
5. Analyst is silent if he does not understand what is going on.
6. Analyst is silent when the client is silent and focuses on meaning of silence.

In considering these principles, is Langs suggesting that this is a prescriptive guide on when to be silent? There is no evidence that supports or measures the quality of whether these principles of therapist silence are useful or not. How then, do therapists assess the quality of their own silence?

In considering the above ideas on therapist silence, a noticeable shift occurs as discussion moves to how silence holds different meanings for both therapist and client. Controversy over therapists' silence appears as some theorists believed that silence could not only have a positive, but also a negative effect upon the client and therapeutic process (Arlow, 1961; Blos, 1972; Cheshire & Thomae, 1987; Gill, 1982; Glover, 1955; Greene, 1982; Greenspan, 1961, 1967; Leif, 1962; Schafer, 1983; Weiner, 1973; Zelig, 1977). Aull and Strelan (1967) decided to conduct clinical research on the above topic using several clinical case examples in which they recorded their own silences. Their clients reported that they experienced therapist silences in very different ways, either as gratification, welcomed abstention from intrusion, interference, protection, deprivation and as a refusal and/or inability of the analyst to help.

Does this point to a need for therapists to have an understanding of how each of their clients experience silence? Perhaps there is also a need to discuss and analyse the silence – if silence is a communication perhaps it should be analysed the way verbal communications are.

Silence as Communication

As relational perspectives of silence were introduced, silence was viewed as a productive communicative moment for both client and therapist providing insight into the psychotherapeutic process if properly explored. The relational perspective gave prominence to the re-experiencing of relational patterns in the treatment room. Lesser value was given to the analytic abstinence of the classical view. Silence was viewed as interplay between two people, facilitating transference and countertransference dynamics, the communication of feelings, fantasies; affect laden events and long forgotten repressed material and an integral

part of the psychotherapy process (Baerson, 1994; Balint, 1958; Friedman, 1980; Weisman, 1955).

The intersubjectively informed therapist views silence as a form of interaction and assumes that the therapist is making a statement to the patient through the silence. The interactive field is opened up by viewing silence as an activity of the therapist, rather than as an external tool that the therapist somehow applies as if he were not involved in the field. (Friedman, 1980, p. 23)

Within this intersubjective approach, Balint (1958) was significant in introducing a modern view of therapist silence. He saw the technique of silence as an acceptance of acting out in the therapeutic situation, as a valid means of communication without attempting to speedily organise it by interpretations. The therapist's use of silence was to bear the client's regression, meeting the client emotionally, no matter how primitive; this was viewed as the best possible way in working with the regressed client. Balint viewed silence as an analysable phenomenon, a powerful therapeutic force that may have negative and positive elements and effects.

Silence began to be seen as a requirement for healing to take place in the space provided by the therapist. Van Der Heide (1961) postulated that silence brings people together. Aull and Streat (1967) referred to the sharing of mutual and comfortable silence as having a preverbal function reminiscent of sleep. Nacht (1963) and Shafii (1973) believed that appropriate silence of therapist and client had a curative effect.

Sabbadini (1991) also considered silence to be a communicative process between client and therapist, an interpersonal phenomenon. In addition, he insisted on the therapist's use of silence for enhancing the understanding of the client's inner world. Silence is a multi-faceted tool used for attentive listening, a bridge, container and shield. Sabbadini (1991) emphasised the relationship between the verbal and non-verbal. He believed that words, like silences, may be used as forms of resistance in connecting to one's internal world and self. Like Sabbadini, Reik's (1968) later work also spoke of the "antinomic relationship" between speech and silence, observing meaningless speech and meaningful silences.

Trad (1993) felt that psychotherapy depended almost as much on the power of silence as the power of words. He believed silence was born from purposeful restraint, a holding that allows the client to fill the space between. Trad considered silence to serve three beneficial and purposeful principles within psychotherapy. Silence was a necessity to shared interpersonal experiences, client silence was used for self-revelation and the use of silence by both client and therapist was needed for self-reflection. When the therapist uses silence, it is as if the therapist penetrates the client's thoughts and feels the client's emotions causing the therapist to understand the client's dilemma and render appropriate interpretations (Trad, 1993). Trad's ideas are similar to those theorists who link the use of silence to the therapeutic technique of

empathy (Eagle, 2000; Levine, 1997; Kurtz, 1984; Schwaber, 1981a). Optimally, the use of silence creates a holding and containing that facilitates the therapist in sensing and experiencing the client, and in understanding the countertransference reactions.

In contrast to the traditional function of silence within classical psychoanalysis, Object Relations theorists suggested silence may be a 'holding process' and 'holding environment'. According to Khan (1963, 1974) Object Relations theorists influenced the therapist's function of holding and containing which, in contrast with analysts' traditional psychoanalytic function of interpretation, require silence. Sabbadini (1991) extended this idea and considered the silent space within a session as a form of container of words, words that for complex, over determined, unconscious reasons cannot be uttered.

Silence is like the colour white; although a white surface appears to be colourless, we know from physics that it consists of the sum total of all colours. This metaphor suggests that we could think of silence as a container of words, as a more or less transparent and fragile membrane. (Sabbadini, 1991, p. 232)

In addition, Bion (1967) offered psychotherapists the concept of 'containment' to describe the therapist's silence as a function of housing and registering the projected dimension of the client's experience. Like the classical idea of analytic abstinence, Bion suggested that the therapist must remain silent, an uncontaminated vessel for containment.

In contrast, Gale and Sanchez (2005) believed that silence was more intensely a part of language than what other theorists explanations suggested. They discussed the use of silence in psychotherapy from a philosophical viewpoint believing silence to be a component of speech that serves to provoke reparative introspection. Gale and Sanchez disagreed that silence communicates things that cannot be expressed verbally and at the same time believed silence mysteriously fostered a level of interaction which is somehow more profound than speech.

Unlike chatter or empty speech, silence frequently bears the existential characteristic of authenticity, including being with, and in this sense can be understood as a part of full speech. This gives it a particular value and significance in the therapeutic process, which aims to achieve full speech. (Gale & Sanchez, 2005, p. 216)

Beazley (1997) added that the therapist 'speaks' to the client through silence, and primarily communicates a sense of safety, security, and an invitation to explore, and ultimately share, inner thoughts and feelings. Like Beazley, Ogden (1994) believed that the therapist's silence can also be a form of interpretive action. This silence is the foundation for symbolic or imaginal experience; the client is given space without boundaries to explore their inner world. Although Beazley and Ogden do not specifically discuss the therapists' difficulties with silence, they do propose that the relationship occurs in an intersubjective field where each subjectivity affects the other. Therefore, therapists' difficulties in holding and using silence

may be influenced not only by their intrapsychic reality, but also by the client's intrapsychic reality and the interpersonal phenomenon.

There appears to be a gap in the literature discussing intersubjective silence. This is a key point, as due to what is happening in therapists, in terms of their own issues, one cannot assume that the therapist uses silence well and for the right reasons. How does the therapist rate or analyse the quality of his or her own silence? Is it holding, containing or countertransferential, etc? These unanswered questions are also evident in the next section on transpersonal silence.

Transpersonal Silence

Literature suggests that silence in relation to religion and spirituality has been well researched because silence appears to be an integral part of spiritual life (Elkins, 2006; Vasiliuk, 2005). However, the psychoanalytic literature lacks written evidence of silence in relation to psychotherapy and transpersonal silence. Ballou (1996), Coltart (1992), and Toth (1999) believed that the reality of silence as a transpersonal phenomenon can be and is, an effective tool within psychotherapeutic models of communication.

The psycho-spiritual context of silence within psychotherapy is a perspective that allows for an openness to emerge, the unconscious to speak and an experience of intimate connection with self, other and the universe (Moustakas, 1995). Transpersonal silence is a state of consciousness that transcends the ego level of consciousness. The literature reveals how outer and inner silence is seen to represent a 'state of being' that is achieved through the process of meditation, connecting with self and other at an unconscious level. Silence is also seen to be an important part of insight and enlightenment where verbalisation is discouraged and the ability to tolerate inner and outer silence is encouraged (Shafii, 1973, 1985).

Beazley (1997) discussed the psycho-spiritual connection in relation to the therapist's inner and outer speech and silence. To hear something being communicated from another person or from within ourselves, outer silence must first be achieved. He believed that inner silence is a psychological and spiritual posture that is difficult to achieve. Like Beazley, Levin (1989) postulated that in this age of communication, outer silence is improbable and inner silences impossible. Bruneau (1973, 1980) also stated that arriving at inner silence requires destroying the continuity of inner speech by going to the end of each thought.

An inner silence if held for a long time is a form of open listening and allows visualisations to become brighter, emotions clearer, and bodily sensations heightened (Garfat, 1993; Levin, 1989; Perls, Hefferline, & Goodman, 1965; Sabbadini, 1991; Sontang, 1966). In listening to the silence, there is a clearing of the field, an opening to a 'ground of silence' that returns us

to a sense of being. Bion (1967) discussed these ideas also but referred to outer silence being a container of words and inner silence when the container is empty.

The same may be said in the work of the psychotherapist. Listening to the client's outer speech and silence is only one channel the therapist must monitor. Attention to the therapist's own inner speech that perceives, hypothesises, and converses with the client's outer speech is another form of listening that the therapist must engage. How do psychotherapists manage to be still enough to create and listen to these concepts of outer and inner silence and beyond? How do we measure and evaluate such concepts?

The literature thus far does not adequately explore the possible limitations and restrictions a therapist may encounter when holding or using silence as a therapeutic technique. For this reason, the following chapter focuses on systematically reviewing the literature that speaks of the difficulties a therapist may experience in holding and using silence within the therapeutic relationship.

Conclusion

The meaning of silence has developed and changed over time. Early psychoanalytic literature discusses client silence as an intrapsychic phenomenon, interpreted as a resistance and transference reactions, while therapist silence has been viewed as a technique to unlock the client's silence, evoke transference and enable verbal communication. Over time, various theorists have come to understand silence as an intersubjective process of communication and experience between both the client and therapist with various meanings, including transpersonal.

In current psychotherapy practice, the appropriate use of therapists' silence is valued for enhancing the therapeutic relationship, holding and containing, and assisting the client and therapist in connecting with one's inner self at unconscious levels. Depending on whether silence is experienced as a help or a hindrance for both client and therapist, will influence the effectiveness of the therapeutic process and endeavour. This is discussed in the next chapter.

CHAPTER FOUR

USING SILENCE: THERAPISTS' DIFFICULTIES

Introduction

As discussed in the previous chapter, therapist silence provides the possibility for deep self-reflection and communication. Silence allows therapists the opportunity to observe and listen attentively to the spoken and unspoken, conscious and unconscious. This chapter investigates potential difficulties therapists may encounter when holding and using silence as a technique within the therapeutic relationship.

The literature reveals seven relevant factors that may influence and impact upon the therapist's ability to create, hold or use silence as a technique within the therapeutic process. These are: socialization and Westernized culture, gender related issues, developmental theory, abuse and trauma, health and illness, the therapist's personal and professional development and transference and countertransference constellations. The psychoanalytic literature in relation to these factors typically discusses the effects of silence within the therapeutic relationship in two contrasting ways. Silence can intra-psychically or interpersonally take on the form of being either an uncomfortable or comfortable, experience for both therapist and client¹⁰ (Balint, 1955; Brockbank, 1970; Davis, 1977; Nacht, 1964; Sabbadini, 1991; Serani, 2000; Zelig, 1961, 1977). It is not assumed that both therapist and client have a homogenous experience of silence.

The state of silence between any two human beings signifies and reflects many different psychic states and qualities of feelings. It might evidence agreement, disagreement, pleasure, displeasure, fear, anger or tranquillity. The silence could be a sign of contempt, mutual understanding and compassion. Or it might indicate emptiness and complete lack of affect. Human silences can radiate warmth or cast a chill. At one moment it may be laudatory and accepting; in the next it can be cutting and contemptuous. Silence may express poise, smugness, snobbishness, taciturnity, or humility. Silence may mean yes or no. It may be giving or receiving, object-directed or narcissistic. Silence may be the sign of defeat or the mark of mastery. (Zelig, 1961, p. 8)

Reading about these contrasting attitudes, I found myself wondering why some therapists find holding and using silence a comfortable experience, while others find silence uncomfortable and disturbing. To answer the research question posed at the start of this dissertation, I will discuss the uncomfortable and disturbing aspects evoked by silence, focussing on two of the seven factors mentioned above, developmental theory, and transference and countertransference constellations present in the therapeutic dyad. These two aspects were chosen because of their prominence in the literature. The first of these factors is discussed in this chapter.

¹⁰ Intrapsychic concept refers to the process occurring between two parts of the same mind, whereas, interpersonal concepts are concerned with how persons interact on one another (Rycroft, 1995).

Therapist Silence and Developmental Theory

Developmental theory is one way to understand therapists' difficulties in holding and using silence as a therapeutic technique. In this section, I briefly discuss the developmental phases that pertain to the difficulties in relation to silence. Although Freud, Winnicott, and Mahler did not specifically discuss the dynamics of therapist silence, they did discuss silence and the developmental stages and concerns with the process of attachment, separation, object loss and the fears of abandonment and retaliation. Following the introduction of ideas presented by these theorists, I will chronologically review other significant theorists who have developed and expanded upon initial theories, shifting the focus from childhood developmental theory to silence and its implications for clinical theory.

Prominent Developmental Theorists

Freud's (1901, 1966) psychosexual phases of development began with the oral phase (0-12 months), where if the mother is unavailable it is believed that the infant experiences anxiety in relation to the loss of the need-satisfying object. During the anal phase (1-3 years), the omnipotent oneness of the mother-infant changes to differentiate twoness and loss of the mother's love can become anxiety provoking and dangerous. In the phallic phase (3-6 years), Freud theorised about the fear of retaliation and punishment for the forbidden unconscious sexual and aggressive wishes for the primary love object.

Freud believed that later in life after external obstacles and threats of punishment are internalised into the personality (superego), the 'fear of conscience' forms in the perceived situation of danger (Freud, 1912, 1915). These situations trigger anxiety, signalling to the ego to defend against, eliminate or minimise danger. Therefore, defences such as the avoidance of silence protect the personality from intolerable anxiety. Although Freud interpreted the avoidance of silence as related to when a client becomes fixated in a psychosexual stage of development, I argue, this may also relate to therapist silence. Furthermore, Freudian theorists may view the therapist's avoidance of silence as related to a fear of female genitals or a castration fear (oedipal complex).

Winnicott (1896-1971) talked about 'potential space'. This is an intermediate area of experiencing which is necessary for the infant to initiate a relationship between themselves and the world, reality and fantasy (Winnicott, 1971). A fundamental tool for the child during this period of transition towards independence is the transitional object, which acts as a substitute for the comforting qualities of the mother and allows the child to let go of the earlier need for omnipotence.¹¹ The transitional object is seen to prevent the disillusionment of oneness (separation) happening too soon, as twoness may engender anxiety, resulting in feelings of loneliness, abandonment and death (Winnicott, 1951). From a Winnicottian perspective,

¹¹ Omnipotence is a characteristic of infant development, which usually occurs between the ages of 18 to 22 months. The child believes that they are all-powerful and that thoughts can of themselves, alter the world. All children believe in the omnipotence of thought and learn by experience of frustration to accept the reality principle (Rycroft, 1995).

avoiding silence may be due to preverbal anxiety where silence represents a disturbing force of separation.

Winnicott (1958, 1965) also theorised how the child's first experience of aloneness in the mother's presence develops the capacity (rather than fear) to be alone. The infant with weak ego organisation is naturally balanced by the reliable ego-support from the mother; the infant introjects the mother and in this way becomes able to be alone. In this way, aloneness does not imply solitude but a safe place to explore self in the company of a 'good enough' mother.¹² Deprived and abandoned children, who have a lack of physical contact and stimuli, produce an aloneness that is pathological and developmentally arrested. For Winnicott, these children would not develop a capacity to be alone due to the lack of initial connection with the 'good enough' mother.

In relation to the therapist being alone and allowing the client to be alone, assumptions are made that an individual's capacity to be alone is one of the most important signs of emotional maturity. It appears that Winnicott (1958) is trying to justify the paradox that the capacity to be alone is based on the experience of being alone in the presence of another, and that without a sufficiency of this experience, the capacity to be alone cannot develop. Winnicott (1965a) was able to see that silence was a necessary part of treatment because silence created a therapeutic atmosphere that allowed a client to regress to early stages of development in the supportive environment of the therapist. Winnicott (1958) described a mature silence as the "capacity to be alone" (p. 30). Although Winnicott does not relate this concept specifically to the therapist, it is an important factor that needs to be considered as the ramifications of this will influence and impact on the therapist's ability to be silent and to use silence as a therapeutic technique.

Mahler (1997-1985) discussed the anxiety of the separation-individuation¹³ process, which she related to four subphases (Mahler, 1972). The important one for this research is the rapprochement period (16-24 months). Mahler believed that the rapprochement crisis referred to conflicts in which infants work out their increased need for the mother while protecting their autonomy. Like Winnicott, Mahler believed the child uses a transitional object and the process of internalisation and ego identification with the primary care-giver to self-soothe and maintain safety.

¹² Winnicott (1971) postulated that the infant was able to experience a spontaneous, creative way of being; he named this the 'true self.' "This true self is primarily developed by a 'good enough' mother who responds and positively to the infants illusion of omnipotence and gives the infant the illusion that there is an external reality that corresponds to the infants own capacity to create" (Winnicott, 1971, p. 12). In contrast, if an infant is confined from exploring personal experiences and interference from external sources predominates, then the infant will display irritability and the false self develops. The false self develops from self-experience that consists mostly of adapting to and meeting the needs and wishes of others, creating a split from the 'true self.'

¹³ The separation process involved the psychological differentiation, distancing and disengagement from the primary care-giver whereas individuation meant intrapsychic autonomy (Mahler, 1972).

For some children either the overbearing quality or unavailability of the mother during the rapprochement crisis leads to the lack of separation. Separation, therefore, leads to ambivalence, anxiety and splitting.¹⁴ These childhood experiences impact upon the therapist's experience of silence within the therapeutic relationship as silence may represent separation anxiety. This is discussed in detail in the next section.

Whatever the theoretical persuasion, the common denominator discussed is object loss and separation anxiety. In addition, Freud discussed fear of retaliation and punishment. The discussion so far highlights the relevant parts of theory of Freud, Winnicott, and Mahler that later theorists refer to when describing the dynamics of silence within the therapeutic relationship. I now turn to theorists who discuss silence in terms of the fear of silence within the therapeutic relationship. While some theorists do refer specifically to the difficulties therapists encounter in being silent, most of the literature reviewed refers to silence from the clients' perspective. I have included this literature, as it is relevant to the research question in illustrating similarities that both client and therapist may face when encountering silence.

Silence as an Empty Space

In silence, early separation anxiety, terror of abandonment and object loss may be experienced. Silence in these situations can be symbolic in representing a form of emptiness.¹⁵ An empty space refers to loss, in that it cannot be defined in any psychological sense unless in relation to fullness. To be empty is to remove content or to have always had contents absent. Emptiness may characterise states of physical or emotional fatigue in which one feels drained, or feels that nothing is left, or of accompanying feelings of deprivation and emotional hunger (Kumin, 1978). Perhaps the therapist filling the therapeutic space with words is an attempt to repair inner emptiness.

A 'horrid empty space' is how Balint (1955) wrote about one kind of therapeutic silence. "The antithetical nature of the effect of silence strongly suggests that it can mobilize in us powerful and very primitive energies, which lead us back to primary object relationships" (Balint, 1955, p. 202). He talked about how we can meet different individuals who hate silence and are only happy in noisy and busy places, in contrast to those who adore and seek solitude and need it. Jung (1978) resonated with Balint, as he wrote, "Noise is welcomed because it drowns the inner instinctive warning as fear seeks noisy company and pandemonium to scare away the demons" (p. 389).

¹⁴ A process (defence mechanism) deriving from a preverbal time, before the infant can appreciate that its parents have good and bad qualities. The two year old child needs to organise their perceptions by assigning good and bad valences to everything in their world; the parent being good and the child being bad. Splitting can be very effective in reducing anxiety and maintaining self-esteem, however, always involves distortion (McWilliams, 1994).

¹⁵ In the case of regressive separation from whole objects, feelings of loneliness, despair, grief, isolation and the like are involved. In the case of separation involving an individual who is not fully differentiated from the object, the experience is one of fragmentation, emptiness, death and annihilation and impending loss of self (Ogden, 1994).

Silence as an empty space was also how Green (1974, 1975) viewed the initial existence of silence in the therapeutic process. He emphasised how silence could be coloured with affect that may represent fusion, destruction, absence, death or emptiness. To Green, the silent space was where the therapist and client shared, processed and worked through difficult transferences. The below clinical example illustrates Green's ideas.

I remember being with a client who had become silent. As the silence lengthened I felt an unbearable urge to fill the vacuum, to say something, without knowing what to say. In response to this I asked question after question, hoping to entice the client to speak. I noticed my anxiety and conflict, frustrated inwardly by the lack of response from my client. I gradually regressed more and more to primitive expressions of inner rage and merger. Through supervision I understood more about my intrapsychic conflict and the interpersonal interplay. I had experienced the client's silence as a powerful symbiotic relationship that called forth my countertransferential needs for fusion. In understanding this about my self I was then able to modify my way of being with the client.

Like Green, Toplin (1971) and Weiss (1997) also referred to silence as an 'absence' or 'empty' space. They made the connection between the attempts to fill the space by mother or child, to the parallel relationship of therapist and client. Examples of filling the space when silence is difficult are the child who creates a transitional object to fill the space, the client who fills the space with memories of the therapist; or the therapist who may need to fill the space with words, questions and interpretations. These theorists argued that the common denominator in filling these empty spaces seemed to be intolerance, ambiguity, uncertainty and not knowing. While they do not connect these to developmental theory, the driving force behind these concepts is anxiety.

In contrast to other theorists, Wilmer (1995) believed silence could be experienced as either danger or death. He believed that depending on an individual's life story, silence may be experienced as blissful, dangerous or deadly. Like Wilmer, Jung (1984) also described some silences as being dangerous or deadly.

If there were silence, fear would make people reflect, and there's no knowing what might then come to consciousness. More people are afraid of silence...The need for noise is almost insatiable, even though it becomes unbearable at times. "Deadly silence" – telling phrase! (Jung, 1984, p. 290)

Wilmer's (1995) work is relevant in providing insight into how and why therapists defend against silence. Silence may be a difficult experience if an individual is petrified of listening to unresolved feelings and experiences. This is of significance, for if the therapist struggles to be silent and self reflect, then he/she may be unable to hear another.

Wilmer (1995) also added to the understanding of silence by naming what he called 'unpunctuated speech.' This is where the stream of words flows together with "ands, buts and soon." Wilmer believed that clients try to cope with dangerous memories and feelings by

talking compulsively (unpunctuated speech) so that it seems that they leave no silence in their talking in which others can enter. This important link may also relate to therapists' difficulties with silence.

In contrast, to Balint, Green, Toplin and Weiss, subsequent theorists have interpreted silence as not just an absence or emptiness but a very full space. Kumin (1978) and Sabbadini (1991) described how emptiness is accompanied by intense affect, which is expressed as painful, heavy and intense fullness. In relation to silence being an empty space, this seems to be contradictory as the intra and interpersonal therapeutic space is filled with internalised objects and emotional feeling states. Perhaps just as emptiness may serve as a defence against disagreeable fullness; fullness may conversely serve as a defence against emptiness. Does empty always have to be negative? How does the therapist judge when silence is productive or destructive? When might an empty space be useful? Perhaps we could consider Bion's (1967) theories where outer silence can be a container of words and inner silence is the container when it is empty.

The above theorists link silence primarily to emptiness and intolerable feelings. Some of the theorists are limited in their findings, as only Balint (1955), Toplin (1971) and Weiss (1997) have named this as linked to primary Object Relations. Kumin (1978) and Sabbadini (1991) are alone in their thinking when they suggest that silence is a very full space. They have not considered that individuals may at times need an empty space, for example, in the therapeutic relationship or in meditation. In the next section, I discuss theorists who specifically link silence, anxiety, separation and object loss.

Silence: Separation and Object Loss Anxiety

Reik (1926, 1968) believed silence represented the loss of love and possibly even the loss of life, linking to Green's and Wilmer's ideas of deathly silence. However, Reik named this as silence taking an individual back to preverbal development, the proximity and touch of the original primary object identity. Therefore, silence becomes the place where in early childhood the small child can still freely express feelings and impulses. Reik believed that, "the therapist hears double as the client speaks; hearing unconscious voices chime in, which is facilitated by not only the client's voice but the therapist's own unconscious interruptions" (p. 6).

The unconscious feelings that arise in the silence however, may be so painful that the most meaningless things are said to escape the silence. Reik (1926, 1968) proposed that there is an anxiety or 'dim fear' in the therapist which causes the therapist to fill the room with words, interpretations and questions, the silence then ceases and the therapist sighs with relief. Silence from this perspective is seen to represent an indication of a threat or already present loss of love, which in turn has an effect that can be described as qualms of conscience or fear of castration. He specifically named how speech unites and silence is a force of separation. If

we take silence as communication can it not unite too? There is an assumption that words are not ambiguous or can contain shared meaning to unite— this is not always the case because language is arbitrary and it cannot be guaranteed that one person's meaning is understood by the other.

Nacht (1964) believed silence and language are integrative factors in the process of forming a therapeutic alliance. Like Reik (1926, 1968), he suggested that speech unites both client and therapist while silence forces separation, hence the transference. Nacht (1963) viewed therapist silence as a technique to help the client re-experience the perfect and total union of the pre-object phase of development. He discussed how silence between therapist and client promoted communication at an unconscious level of the pre-object phase of development. This pre-object phase was characterised by two opposing propensities. There is the urge to both separate and achieve complete union with the object. Nacht suggested this dual need is partially met in the silent, non-verbal relationship of the therapist-client.

True transference is first born in the verbal relationship and could not exist without it but I believe it is the non-verbal relationship which gives it substance and significant during the course of treatment. (Nacht, 1963, p. 300)

Weinberger (1961, 1964) offered an alternative view of silence. He proposed that a degree of loss of relationship with the mother experienced by the child between ages 18 months and 3 years results in the development of a 'triad of silence'. The triad consists of silence, masochism and depression. These symptoms can serve as a regression which increases 'narcissism, aggression, a sense of omnipotence and a distorted view of reality,' thus making it difficult for the therapist to use silence. Weinberger identified two types of silence, silence as the loss of an object and silence as a form of acting out.¹⁶

Developmental regression may occur in the silence. According to Cremerius (cited in Sabbadini, 1991), "silence is the form of communication characterizing primitive mother-infant relationships at the stage of subject and object fusion" (p. 230). Green (1978) and Greenberg (1991) used Cremerius's ideas and discussed how silence can be experienced as a preverbal form of communication, regressing to a safe or unsafe space, which may resemble in fantasy, the womb, cot, sleep or earlier experiences. Therefore, silence in the analytic hour, may be experienced by the therapist as a transferential primitive function. It appears that the therapist's use of silence may evoke not only the client's transference but also the therapist's transference; triggering anxiety and intolerable emotions that may connect back to the overwhelming early experiences of object loss and separation. This view of Green and Greenberg is supported by Wright (1991) who believed, the quality of our consciousness, is

¹⁶Silence as the loss of object is not a total loss of the mother, but an impingement of the relationship that causes a re-enactment in everyday life of the loss, likened to traumatic neurosis. Silence as a form of acting out, is an expression of affect, but a dominant way in which an individual relates to others (Weinberger, 1964).

determined by how the client or therapist experienced the original space of separation from the first object.

Like other theorists, Greene (1982) postulated that while silence may have a multiplicity of meanings specific to each individual; it is often associated with object loss and loss of love. Similar to Green, Jung, Reik and Wilmer, Greene felt silence to be unbearable and deadly. Greene specifically referred to very young children whose parents die. He believed that the immaturity of the child's ego at this young age was a severe impediment to the child working through the mourning process. He discussed how the impact of analytic silence has the potential for actualising these early loss experiences, which may be accompanied by painful and frightening affects and fantasies that both client and therapist may resist. Greene further discussed how in silence, the therapist must discard space-filling interpretations, questions, clichés and verbal automatisms.

Additionally, Greene (1982) described a gap within which symbolic expression becomes possible. This potential gap has been widely researched by other theorists who reviewed how symbols represent the experience of loss, separation and death, the possibility of experiencing intolerable mental pain (Bion, 1962; Ogden, 1985; Winnicott, 1951). Bion (1962) stated, "People exist who are so intolerant of pain and frustration (or in whom pain and frustration is so intolerable) that they feel the pain but will not suffer it and so cannot be said to discover it" (p. 9). The therapist's own intolerance of pain and frustration may be linked to feelings of loss, or yearning for union with the person lost, and may be revealed in the silence (Kurtz, 1984). Kurtz (1984) expanded Greene's ideas, believing that there is an opportunity for empathic connection and resonance as both therapist and client share the content of the silence.

Shafii's (1973, 1985) perspective differed from other theorists. He discussed silence and quiescence in relation to meditation, a controlled but deep regression in the service of the ego. In silent meditation, this controlled regression helps the individual re-experience union with his earlier love object on a preverbal level of psychosexual development. He believed that re-experiencing earlier cumulative trauma in the silence of meditation facilitates an individual's ability to deal with former traumatic experiences beyond verbalisation and cognitive awareness. This contributes to relative freedom from intra-psychic conflicts to experiencing a sense of internal stillness, peace and harmony.

Like Freud, Winnicott, and Mahler, Shafii (1973) strongly believed that the anxiety and fear of silence in childhood and adulthood is related to the fear of separation from the mother during the first few years of life. Shafii discussed the importance of children being reassured by their mother's voice. When the child is not reassured, the child will feel lonely and helpless; like

theorists that equated silence to an emptiness, silence in children, adults, clients or therapists minds, may equate to absence (Shafii, 1973).

Shafii (1973, 1985) was one of the few theorists who speculated on the dearth of studies pertaining to therapist's silence. He concluded that it was due to the repression of the fear of silence rooted in early separation anxieties (losing control) and the terror of abandonment.

While Reik (1968) and Nacht (1964) believed speech unites and silence separates, Caruth (1987) agreed that language binds but also gives simultaneous witness to our "awesome and terrifying separateness" (p. 57). Like other theorists, Caruth (1987) described how the infant is protected against the awareness of aloneness and separateness through the omnipotent fantasised oneness with the denial of the not Self mother who is experienced as within, around, or a part of themselves.

Caruth (1987) believed that throughout life, individuals struggle between the desire to return to that infantile, thoughtless and blissful merger and the opposing wish to escape from it (Ekstem & Caruth, 1965). She proposed that this is a transitional dilemma that affects all; the dialectic struggle between the need for the other and the need for self, the need for togetherness and intimacy and the need for privacy and autonomy. Language facilitates the resolution of this dialectic struggle, for language is a transitional phenomenon that arises out of separation and makes separation bearable. Caruth posited that language is therefore a kind of 'metaphoric teddy bear' that is carried around in the heart and head rather than in the arms. The child who is beginning to talk has advanced sufficiently to retain the image of the self and the mother in her absence. Thus, language becomes the symbol that is born of the absence of the object when accompanied by the presence of feelings of loss. In relating Caruth's theories to the therapist's difficulties in using silence, the over-use of words might perhaps be thought of as the therapist's attempt to bridge the chasm between self and object, which language confirms.

Caruth (1987) also believed silence might help an individual regress back to an earlier safe and comforting merger experience with the mother. Caruth's ideas link with those of Spitz (1945), who believed that silence occurs continually in external reality in which there is not a consistent caregiver. The result is an experience of emptiness, annihilation and even death. These ideas also link to Green, Jung and Wilmer, who discussed silence as emptiness, dangerous and deadly. If the therapist as a child has been unable to achieve healthy separation and individuation, moving from silent omnipotent oneness to the awareness of twoness with optimal frustration, one could say that words (metaphoric teddy bear) may be favoured over the emptiness of silence in the preverbal stage of infancy. The clinical vignette below illustrates Caruth's ideas where both the client and I have a shared experience of words becoming the transitional object (metaphoric teddy bear).

T1: I'm noticing how much we both are talking today.
C1: Yeah, I can't shut up (laughing).
T2: Words seem to comfort.
C2: Hmm...Yes, so yes, haven't really thought of that before.

Sabbadini (1991) insisted on the significance of therapists' use of silence and warned against premature words, interpretations or inadequate reactions. He believed that premature words and interruptions often stem from the therapist's own conscious or unconscious anxiety. Like Green and Greenberg, he postulated that silence and anxiety are closely related. Sabbadini reviewed the origin of the effect of silence, darkness and solitude from Freud's (1919) perspective of infantile anxiety from which the majority of human beings have never become quite free. Similar to Sabbadini, Fiumara (1977) believed that in avoiding the anxieties of separation and loss, which are experienced in the analysis of transference, the client or therapist might attempt to destroy the psychotherapeutic setting.

Beazley (1997) subsumed some of Winnicott's concepts, including the capacity to be alone, the concept of being alone together and the existence of an intermediate area.¹⁷ Beazley discussed the connection between these concepts and silence and examined Winnicott's (1965a) claim that in the development of the infant communication arises from silence; language acquisition is preceded by silence. Beazley proposed that as the verbal abilities of the child develop, communication is maintained at differing levels. If the child is exposed to a facilitating environment, three lines of communication develop, communication that is forever silent, communication that is explicit-indirect (communicative techniques like language) and communication in the intermediate or third (originated in the mother-child dyad and continues to be determined by the nature of the interpersonal relationship).

These first two communications seem concretely determined; however, the third is more ambiguous and evolving. The 'intermediate area' or 'the third' is most amenable to psychotherapy as this area may express silence or serve as the precursor of explicit communication. Like Winnicott, Beazley (1997) believed that an individual's ability to be alone is represented by the ability to contain or be comfortable in silence. He stated, "early pronounced solitude produces isolated individuals, being together produces alone persons" (p. 86). Although, Beazley does not specifically discuss the therapist, his findings are particularly important as the therapist's earlier developmental experiences and the 'capacity to be alone' with oneself and another, may factor in the therapist's capacity to communicate in silence.

¹⁷Existing between the mother and child dyad is an intermediate area that Winnicott (1971) describes as an, "experience between thumb and teddy bear between oral erotism and the true object" (p. 2). Between 4-12 months, an intermediate area between mother and child relationship, once established, gives way spatially to the infant acquiring transitional objects, symbolising the first true object, the mother. The intermediate area also called the 'third area' or potential space eventually develops into a place where the child experiences play, leading to later structuring of personal relationships, creativity, art and culture (Winnicott, 1971).

Conclusion

Analysis of the literature indicates that silence may cause the therapist to regress back to times of preverbal development, and the proximity of the original primary object. Therefore, silence within the therapeutic relationship for some therapists is seen to activate earlier primitive functioning. Here silence may be seen to trigger anxiety, painful affect and represent a threat of separation or overwhelming earlier experiences of object loss. The literature suggests that if the therapist has had difficulties with the earlier developmental process of separation and individuation then language could become a transitional phenomenon that makes separation bearable. Therefore, we can say that these object relations experienced by the therapist consciously or unconsciously will influence and affect the interpersonal process and may even destroy the therapeutic relationship. In the next chapter, I discuss how the therapist's transference and countertransference dynamics impact upon holding and using silence as a therapeutic technique.

CHAPTER FIVE

THERAPIST SILENCE: UNCONCIOUS PROCESSES

Introduction

Silence is a multi faceted phenomenon that takes on different meanings and interpretations depending on the immediate state of the transference and countertransference dynamics within the therapeutic situation. This chapter reviews significant factors that contribute towards understanding transference and countertransference dynamics in relation to the difficulties a therapist may encounter when experiencing silence. These factors include the influence of the therapist, therapists' narcissistic difficulties, the influence of the therapist's theoretical orientation, the influence of the client and silence in the space between.

Transference and Countertransference

In therapy two subjectivities intersect, the client's subjective reality and the therapist's subjective experience. The interplay of these subjectivities is highly influenced by transference and countertransference dynamics (Atwood & Stolorow, 1984; Bacal & Thompson, 1996). For the purpose of this dissertation, transference is understood as when an individual assigns feelings from a past relationship to a present relationship. Countertransference has two distinctive meanings, first the therapist's transference to the client, and second, the therapist's emotional attitude or reaction towards his client (Colman, 2001; Rycroft, 1995).

A therapist is situated in a countertransference position whether they are aware of it or not.¹⁸ Not understanding and using countertransference fully, may hinder therapists' effectiveness or prevent therapists from following the movements and experiences of their own 'psychical functioning' (Ehrenberg, 1985; Faimberg, 1992). As Faimberg (1992) noted "we cannot unravel what we as therapists fail to recognise" (p. 545).

Building on Ehrenberg and Faimberg's works, Stern (2002) believed that it is only through the awareness of, and within the context of transference and countertransference that the relationship between what can and cannot be said is meaningful. Stern suggested that the most significant part of language is sometimes, what it cannot speak. He paid particular attention to the difference between 'words' and 'wordlessness' and how language and silence interact within the psychotherapeutic process. He viewed the difference between words and their absence crucial, especially in understanding the transference and countertransference, conscious and unconscious dynamics.

¹⁸The countertransference position is ultimately the meeting point of intra-subjectivity, inter-subjectivity and metapsychology. The countertransference position is defined as not only the neurotic aspects of the therapist but all the psychical activity of the therapist intended to restore the history of the transference (Faimberg, 1992).

Furthermore, Stern (2002) elaborated on Winnicott's (1989), 'call for surrender.'¹⁹ He discussed how this 'call for surrender' is not verbally articulated and usually cannot be and should not be. He stressed how therapists must resist the temptation to speak, or even to formulate an experience in the privacy of their minds. By not formulating an experience, it may allow the therapist to be still enough to create an internal silence. If the therapist can achieve internal silence, then this allows for a deeper examination of the vicissitudes of the transference and countertransference dynamics.

The therapist's lack of awareness and correct use of countertransference influences silence within therapeutic relationship. To accept the idea that denial of, or resistance to, awareness of countertransference reactions can be detrimental to the therapeutic process, and that awareness presents us with options we do not have otherwise, we still face the question of how best to use this awareness once it is achieved. How can therapists use countertransference information to improve holding and using silence as a therapeutic technique to enhance professional practice?

The Influence of the Therapist

In this study, it is important to understand the therapist's contributions towards the avoidance of silence within the therapeutic situation. Over the course of therapy, clients re-enact in the transference all or many of the original uses and meanings of silence that have been accumulated or synthesised from different developmental levels. Unless therapists are correspondingly aware of the many meanings and uses of clients' silence, therapists, too, may unconsciously employ their original experiences of silence in the countertransference. Zelig (1960, 1961) postulated that these original qualities of silence within the therapeutic process derived from pre-genital levels, contribute to the preverbal and later verbal nature of the transference and countertransference. Zelig believed, the therapist's ability or inability to use silence may be a sign of ego regression or ego mastery and it may emanate from id, ego or superego. Although silence may be used consciously or unconsciously in all of these capacities, I wonder how the therapist knows when it is what?

The therapist's undealt with conflicts, underlying attitudes and feelings behind the use of silence, will impact upon the effectiveness and outcome of treatment. Zelig (1960, 1961) proposed that if the feeling behind the therapist's silence is consistently benevolent, it will greatly help the client with self assurance and self realisation. In contrast, if the therapist's silence denotes anxiety, fear, impatience, boredom, indifference or annoyance, this may be experienced by the client as anxious or uncomfortable silence, disapproval, rejection or condemnation.

¹⁹Winnicott (1989) suggested that 'surrender' is when the therapist is open to the intersubjective dynamics within the relationship. The therapist then can let go of words and connect to an inner and private experience, allowing fantasies to wash over, especially the shades and nuances that may be defining aspects of the intersubjective moment.

Racker (1968) discussed therapist's countertransference and stressed how the client's words and ideas may at times be introjected by the therapist and these introjects are used to gratify unconscious needs (cited in Zeligs, 1960, 1961). Like developmental theorists, Zeligs (1960, 1961) stressed that in such therapeutic situations client silences may be improperly dealt with by the therapist, as silence is experienced as, 'wilful retentiveness, emptiness or nothingness.' Although not specifically stated by Zeligs or Racker, avoiding silence may be evidence of a countertransference reaction in the therapist due to his or her primitive transferences and unconscious feelings of deprivation.

Silence is one of the most effective instruments for stimulating countertransference responses in the therapist (Arlow, 1991). In Arlow's (1991) experience, instances involving persistent countertransference identification disturbances and reactions are the most numerous and common.²⁰ The countertransference identification disturbance is the 'classic blind spot' of the therapist. This is the therapist's 'refusal' or inability to 'see' what the material is about, as the therapist does not want the client's material to remind him of his own unconscious conflicts. Both Eagle (2000) and Ehrenberg (1985) also viewed therapists' countertransference identifications, reactions and resistances as contaminating the therapeutic relationship.²¹

Although Arlow (1985) did not discuss the difficulties in using silence, he did highlight how therapists' inability to tolerate their own internal issues or conflicts impacts upon the therapeutic process. He believed that the therapist tends to defend against undealt with conflicts, attitudes and unbearable feelings and may avoid silence and justify this through various rationalisations.

Like other theorists, Faimberg (1992) believed that therapists might tend to avoid silence in listening to anything from the client that threatens to arouse displeasure in them. Faimberg noted how overcoming the resistance to hear something that arouses displeasure entails demanding psychical work on the part of both client and therapist. Yet she believed many enigmas posed by the transference might be resolved because the therapist discovers the beginnings of displeasure in the countertransference and follows the track that has been revealed. No matter what difficulty a therapist may experience within the therapeutic situation it is essential to be self-aware and examine how it potentially affects the use of silence, a principle that can also be applied to therapists' narcissistic sensitivities.

²⁰Identification is a defense whereby an individual extends his identity into someone else, unconsciously incorporating attributes or characteristics of another into one's own personality or fuses and confuses one's identity with someone else (Rycroft, 1995).

²¹Countertransference reactions include the therapist's transferences and emotional responses to the client's transferences that may be expressed overtly or covertly, as aspects of his or her therapeutic methods, techniques and procedures (Jacobs, 1986). Countertransference resistance or enactment is when the therapist acts out in a positive or negative way. Reich (1966) believed that repressed impulses and affect is stirred up in the therapist thus leading to real action, to over strong emotion or to the opposite, to rigid defences, blockages or blind spots.

Therapists' Narcissistic Difficulties

Little has been written on the specific subject of the meaning, importance and dynamic effects of the therapist's silence. Pressman (1961a) is the only theorist who discussed particular forces tending to disrupt therapists' silence. He believed the therapist's silence creates the optimal milieu for analytic work. However, there are certain chronic tendencies operating within every therapist and with respect to every client, which tend to interrupt this silence for reasons other than objective ones. Pressman distinguished these influences from acute and specific ones, such as would be operative in a particular therapist on a particular day or with respect to a particular client. He identified six relevant factors that impact on the therapist's ability to hold and use silence as a therapeutic technique. These include therapist's need for discharge, narcissistic supplies, to do psychotherapy, to fulfil a reaction-formation against sadism, the therapist's curiosity and the fear of the full development of the transference.

Like Pressman (1961a), other theorists emphasised the centrality of the therapist's narcissism and the impact of the therapist's vulnerabilities in countertransference (Bacal & Thompson, 1996; Gunther, 1978; Kohut, 1971, 1977, 1984; Wolf, 1988). Although these authors do not specifically relate silence to narcissism, their work illustrates Pressman's findings, providing insight into therapists' narcissism and why some therapists may encounter difficulties in holding and using silence.

Narcissistic issues can cause the therapist to react in a way that is detrimental to the therapeutic relationship (Kohler, 1985; Kohut, 1971; Pressman, 1961; Wolf, 1988). For example, therapists' need to do psychotherapy, to be the healer, and the inability to own their difficulties, self reflect and hear the client, may cause overactivity, as therapists are prone to filling the room with resistances and defenses. Pressman (1961a) proposed that therapists tend to make clever interpretations, more in the nature of satisfying their own narcissism than in the nature of observing the needs of the client. Kohut (1971) postulated that narcissistic countertransferences of the therapist interfere with the client's narcissistic transferences.²²

The therapist also has selfobject needs that are mobilised as a result of participating in the analytic process. Pressman (1961) was the first to propose that avoidance of silence was related to the therapist's need to be admired. Wolf (1980), Kohut (1971) and Kindler (1991) believed that every individual has at his or her core, a need to be mirrored or affirmed. The therapist's avoidance of silence can be related to the therapist's own narcissistic needs which make it difficult to tolerate a situation in which one is reduced to the seemingly passive role of being a mirror of the client's infantile narcissism. Therefore, one may subtly or openly, interfere with the establishment or the maintenance of the mirror transference.

²²Wolf (1988) and Kohler (1985) elaborated upon Kohut's concepts. They talked about 'selfobject' transferences and countertransferences. Selfobject transference refers to the client's self-restorative and self-sustaining responses from the therapist. Selfobject countertransference denotes the counterpart in the therapist of the selfobject transferences of the client.

Additionally, Pressman (1961a) theorised that avoidance of silence may be related to therapists assuming a narcissistic stance and condemning in the client what they cannot stand in themselves. Like Pressman, Arlow (1991) gave an example where the client wishes to be rescued and the wish of the therapist is to rescue. It has been by experience that when my clients are desperately needing or desiring to be rescued, I have a tendency to rescue. This reaction has more to do with my childhood experience of needing to be rescued and thus why I respond unhelpfully with reassuring content and discourse, avoiding silence and filling the space.

Like Arlow (1985), Ehrenberg (1985) also proposed that therapists can fail their clients through 'empathic' identification, the very response often equated with the overly caring therapist. She believed this might be about the avoidance of provoking client's anger, or awareness of other aspects of reactions of oneself or of other, which might be difficult, even traumatic to acknowledge, such as the full extent and depth of the client's actual pathology. Similar to other theorists, Grinberg (1997) believed that the transference can be feared by the therapist. Additionally, Caruth (1987) stated, "Silence may engender powerful, primitive and punitive countertransference reactions of merger and violence in the therapist's increasingly desperate need to breakout of the engulfing transference" (p. 61). The following case example illustrates my defence (avoiding silence) through empathic identification.

Jay was a young woman with narcissistic tendencies. In the 40th session, I began experiencing a rising tension in the space between us. I had assumed that Jay's archaic needs and their accompanying strong affects had begun to emerge as she began to regress into a self-object transference. I had already noticed in myself a tendency to be very active, talking obsessively and constantly reassuring Jay in my interventions, resulting in the following extract.

C1: You don't want to hear my painful feelings (shouting).

T1: That's not true.

C2: Then why are you trying to make everything better.

T2: I didn't realise I was doing that but I guess you are right; I am trying to avoid your feelings.

C3: How can we work together if you are afraid of feelings?

In retrospect, I understand this to be an unconscious need to reassure myself, an attempt to ward off the effect of her emerging intense affects upon me. The threatening and emerging feelings Jay projected, disturbed my equilibrium, owing to my unconscious need for an affirming self-object. My loss of self-regulation and defensive need to overly protect had its impact on Jay, resulting in her outbreak of narcissistic rage.

The problems of countertransference resistance as demonstrated in the above example are those forms of resistance to awareness of collusive involvements. Both Arlow (1991) and Ehrenberg (1985) paid particular interest to how therapist collusive involvement and assumptions influence their own countertransference experience involving identification. They discussed how the therapist who believes identification contributes to an ability to be

empathic, may not see the identification as dangerous or a possible countertransference issue.

The above clinical vignette also illustrates how clients may experience and be aware of, the therapist's process, which needs to be acknowledged (Schwaber, 1983b). Schwaber (1983b) shed light on this as a difficult experience for the therapist to acknowledge that the truth one believes about one's self is no more (though no less) 'real' than the client's view of the therapist; that all we can 'know' of ourselves is our own psychic reality. I will never forget an extremely difficult experience when working in clinical practice and a client said, "Why do you talk more than my last therapist?" At the time, I shrugged the comment off, as it was too difficult for me to hear and accept truth about myself. Hearing and accepting requires periods of understanding and working through of narcissistic sensitivities (Schwaber, 1981; Thompson, 1980, 1991).

The very nature of the psychoanalytic relationship is such that it inevitably impinges upon the analyst's narcissism. Countertransference, he believes, appears in the reactions, defensive or otherwise, which the analyst experiences due to such Impingement. (Gunther, 1978, p. 82)

In one particular study, researchers ascertained a high level of narcissistic injury among trainee psychologists (Halewood & Tribe, 2003). They hypothesised that if untreated, narcissistic issues in the therapist can interfere in the relationship with the client. As discussed above, this collusion makes it extremely difficult for therapists to let go and move past an external way of 'doing', to an internal and relational way of 'being', influencing the therapist's use of silence as a therapeutic technique (Halewood & Tribe, 2003; Sue et al., 1990). In addition to the therapist's narcissism, the therapist's orientation may affect the use of silence and impact upon the therapeutic relationship.

The Influence of the Therapist's Theoretical Orientation

Literature regarding therapists' difficulties with silence and therapists' theoretical orientation is limited. A key point raised however, is that the therapist's countertransference is influenced by the therapist's personal and theoretical orientation to psychotherapy (Schafer, 1983; Spence, 1987; Thompson, 1991; Wolf, 1983). Schwaber (1981, 1981a, 1983, 1983a, 1983b) emphasised the need for psychotherapists to understand how techniques and theories have a tendency to take precedence over the therapeutic relationship. As a result, therapists at times may view their clients' experiences and reality as distorted and their own experiences become universal truth.

A clinical vignette by Thompson (1991) demonstrated Schwaber's (1983) principles in terms of the intersubjective field, with emphasis on his own experience and input. He noticed his continual frustration with his client's silence and recognised the influence of his classical

training which regarded client silence as resistance. This aversive attitude caused Thompson at times, to match his client's silence with silence, and at other times to make excessive efforts to push the client to speak. This interfered with the intersubjective field and interfered with his capacity to empathise with the client. I corroborate with Schwaber's principles, as I initially trained in client-centred counselling using active interventions; silence was not considered a fundamental technique.

The experience of silence is related to the analysis of transference and countertransference dynamics and will differ according to the therapist's personal characteristics and theoretical orientation. Having discussed the therapist's characteristics that relate to difficulties with silence, I turn to how the influence of the client impacts upon the therapist's use of silence.

The Influence of the Client

One of the fundamental functions of the therapist's silence is to serve as a container for the self and object-representations, as well as the feelings connected with them. If the client has difficulty experiencing silence, the therapist needs to be aware and understand the process of projective identification as this in turn will affect the therapist's ability to hold and use silence, and the way one responds to the client. The psychoanalytic literature suggests that the therapist's avoidance of silence can be considered a countertransference reaction, understood as revealing or pointing to the client's psychological content. Via projective identification, the therapist is the recipient of both the client's internal object-representations and his/her own internal self-representations.²³

Sandler (1976, 1987) theorised that projective identification was the intrapsychic role-relationship, referring to the client and therapist interaction where each party tries to impose on the other. Racker (1968) discussed the above ideas as concordant and complementary identification.²⁴ In the clinical vignette below, I illustrate how I responded overtly to a client by talking too much so as to avoid silence, which I felt indicated only my problems or blind spots. After using self analysis to understand my particular response and attitude to the client, I realised that this was more about the client imposing upon me, than the other way round. Sandler (1976) suggested that very often the irrational response of the therapist may sometimes be regarded as a 'compromise-formation' between his/her own tendencies and a reflexive acceptance of the role which the client is forcing on them. My clinical example illustrates Racker's (1968) definition of concordant identification.

²³Numerous theorists have written about the therapeutic processing of projective identification and located the concept of projective identification in relation to other psychoanalytic concepts, such as projection, introjection, identification, internalisation, and externalisation (Bion, 1967; Heinmann, 1950; Ogden, 1982; Sandler, 1976). However, these concepts do not sufficiently explain the complexity of the dynamic and complicated unconscious interaction that occurs in the transference and countertransference.

²⁴Concordant identification is when the analyst identifies with the patient's ego and id. In complementary identification, the analyst identifies with the client's internal objects. Like Racker, McWilliams (2001) refers to concordant identification as either identical or very close to what one ordinarily intends by the term empathy and the term complementary identification refers to the analyst's response in which he or she takes on the role "assigned" to him or her by the patient.

Although I am not an unduly silent therapist, after two weeks of therapy I found myself talking more than usual with Trisha. I felt extremely anxious. After some reflection, I realised I was afraid that she would prematurely end therapy. I was talking more than usual to lower her anxiety levels and to avoid my own feelings around abandonment. Once I understood my behaviour, I felt relieved and began to allow for more space and silence. However, I noticed at once the urge to talk again and became aware how Trisha ended every sentence with an interrogation and indirect question. I brought this to her attention and she shared how she was quite unaware of it. I began to realise how much Trisha needed to have me reassure her by talking. She then remembered how she would feel extremely anxious as a child when her dad returned home from work. He was a very silent, stern and unengaging man and rarely acknowledged her. She shared how she would compulsively ask him many indirect questions in order to be reassured that her dad was not angry with her. Trisha was afraid of him but desperately needed his admiration and love. She told me that her dad had a habit of not listening and not responding; and how rejecting this was. Trisha realised that from early childhood she had developed the trick of asking questions without directly asking them. She was unaware that this had become part of her character, and this intensified in situations where she feared rejection and needed supplies of reassurance from authority figures.

This vignette demonstrates how the client evoked in me a response, which at first seemed to be only 'irrational' countertransference. The therapist is not always responsible for particular behaviours, as the client has a part to play in the relationship also. Ehrenberg (1985) and Feldman (1997) believed that sometimes therapists find themselves accepting client's projections as though they were truth when in actuality they do not apply. Therefore, difficulties in holding and using silence are not solely to do with therapists' intrapsychic dynamics, but also involve the intrapsychic dynamics of the client and the interpersonal interplay. However, some therapists may be more prone to certain roles and the proportion of contribution from the therapist side to the client may vary. In relation to avoiding silence, therapists need to think about to what roles they are more prone.

Therapists' difficulties with silence may not always be about concordant identification but rather complimentary identification (Racker, 1968). This complimentary position is where the therapist enacts the client's internalised objects; for example, the therapist is overly talkative, directive, overbearing and suffocating as he or she is acting out one of the client's primary-objects.

It is important to understand the difference between idiosyncratic and homogenous countertransferential responses with clients.²⁵ Weiss (1966) discussed how a client group or a particular client's intolerance of silence might place different demands upon therapists that must be met. Like Weiss, Jacobs (1986) and MacDougal (1979) pointed out that the use of ordinary psychotherapeutic techniques with specific clients who have, for instance suffered traumatic experiences in the preverbal period will be inappropriate, causing homogenous

²⁵Idiosyncratic countertransference is peculiarity of mind, temper or disposition in a person. Homogenous countertransference is when a specific client group, have a similar or uniformed nature, similarly influencing and impacting the therapist and therapeutic situation, e.g. narcissistic clients verses obsessive compulsive or neurotic clients verses borderline and psychotic clients (Deverson, 1999).

transference countertransference reactions as silence, is experienced as fresh trauma. There are parameters for the therapist in using silence, as the standard silent therapist approach is not appropriate for some clients.

Faimberg (1992) identified the relevance of clients' verbal and non-verbal communication in determining how the therapist listens to the client. In addition, Faimberg noted how clients' communication arouses in the therapist a form of psychical functioning, which must be analysed so as to distinguish what corresponds to the client from what corresponds to the therapist. Gabbard (1995), warned against the belief that in the concept of projective identification, the therapist is viewed as virtually empty and is simply a container for what the client is projecting. As discussed earlier in this chapter, the therapist's own dynamics also play a part.

The client may evoke responses in the therapist at different times. Potentially, clients who elicit the most personal reactions are the ones that also elicit the therapist's strongest defences against these reactions. Having reviewed both therapist and clients' intrapsychic dynamics in relation to difficulties with silence, it seems important to discuss interpersonal silence in the space between.

Silence in the Space Between

How the therapist learns how one mind speaks to another beyond words and in silence is discussed by Reik (1948), Picard (1953), Ogden (1994), and Winnicott (1971). Reik introduced the concept of learning to listen with the 'third ear'. He described this listening as a process that evokes all the senses of the conscious mind. He discussed how therapists must use their emotions and reactions to communicate with, decipher and understand the true meaning of the client's words and actions. Learning to listen, make meaning and work at a deeper unconscious level is of fundamental importance, hence the necessity of using silence as a technique.

Like Reik (1948), Picard (1953) hypothesised that when two people are talking to one another, a third is always present. "Silence is listening...the words are spoken as if it were from silence, from that third person and the listener receives more than the speaker is able to give, silence is the third speaker in such conversations" (Picard, 1953, p. 17). In the silence, the therapist, like the client, knows things without knowing that he knows them. The voice that speaks inside speaks low, but if one listens with a third ear, one hears not only what is expressed noisily but also what is whispered.

Reik (1948) discussed the importance of experiencing and using the transference and countertransference constellations. For example, listening with the 'third ear' catches what clients do not say, but think and feel. Likewise, listening with an 'inner ear' helps the therapist hear voices from within the self, which are otherwise not audible because they are drowned

out by the noise of conscious thought processes. The therapist's inability to listen to the 'third' and 'inner' ear, to be in touch with inner experiences, may affect the use of silence in the therapeutic process.

There was I, who thought I was a trained observer and yet, I did not recognise what was so obvious. What is a trained observer, I asked myself? He is a man who is trained to pay attention to certain things and to neglect others. He is a man who over pays attention to features he expects and remains in debt to others that escape his notice. (Reik, 1948, p. 80)

Similar to Reik (1948) and Picard (1953), Ogden (1994) contributed to understanding the avoidance of silence. Ogden described the interplay of three subjectivities; the therapist's, the client's and the "intersubjective analytic third", or simply "the analytic third". This is similar to Picard's ideas and Winnicott's (1971) concept of the "potential space." The analytic third constitutes the space between therapist and client. Ogden postulated that both therapist and client subjective states negotiate the 'third' area, it does not exist independent of the two subjectivities, but is a result of them. Therefore, this interpsychic interaction will differ in each therapeutic situation, which may be why difficulties with silence occur with some therapists and clients, and not others, e.g. trauma and addiction client groups (Briere, 1992; Herman, 1992).

Much of the psychoanalytic thinking to this point has primarily considered the implication of silence from either the client's or the therapist's perspective. While each of these two silences may carry a different set of assumptions regarding their meaning and use, there has been less discussion on the interactive qualities of the dyadic silence. This is discussed in the next chapter.

Conclusion

In this chapter, I consider the therapist's influence and theoretical orientations and how these impact upon the therapist's use of silence. Silence is one of the most effective instruments for stimulating countertransference responses in the therapist. Countertransference identification disturbances are seen to be a common blind spot of the therapist. Therapists' inability to tolerate their own internal issues or conflicts impacts upon the therapist's process as the therapist uses different defences against unbearable and intolerable feelings. In addition, the therapist's own narcissistic sensitivities can cause the therapist to be overactive reacting in a way that can be detrimental to the therapeutic relationship.

The therapist's avoidance of silence can also be considered as a countertransference reaction, which can be understood as virtually unerringly revealing or pointing to the client's psychological content, via projective identification. Importantly, therapists need to understand and learn how one mind speaks to another beyond words and in silence. The literature discusses how silence is the third speaker in such conversations, and this 'analytic third' constitutes the space between therapist and client. Learning to listen with the 'third ear,' make

meaning and work at a deeper unconscious level is of fundamental importance, hence the necessity of using silence as a technique. In the next chapter, I discuss and critique the conclusions drawn from the systematic literature.

CHAPTER SIX

CLINICAL RELEVANCE, LIMITATIONS and FURTHER RESEARCH

This dissertation explores why some psychotherapists may experience difficulty in holding and using silence as a therapeutic technique. Building on previous chapters, this chapter provides clinical discussions, limitations and recommendations for the therapist derived from the literature.

Silence as a Therapeutic Technique

The role and function of silence as a therapeutic technique has evolved over time. Therapist silence has moved from being a theory and a technique that unlocks client silence, evoking transferences and enabling verbal communication; to an intersubjective process of communication and experience between both the client and the therapist with various meanings.

I identify that a shared, mutual, or interactive silence has four major functions. Silence affords the client opportunity to explore inner thoughts and feelings; affords the therapist opportunity to explore inner thoughts and feelings; the therapist may experience and be invited to share in emotional experiences of the client; and silence helps the therapist to understand the interpersonal dynamics in the space between client and therapist.

One of the goals of psychotherapists is to use silence competently to facilitate safe communication, containment and deeper self-reflection, actualising early object relationships and experiences through understanding transferences and countertransference dynamics. This re-creates a reparative atmosphere for the client to re-internalise a good enough object and experience. The literature proposes that the 'homeostatic regulatory mechanisms' and affective exchanges between the mother and child proceed nonverbally. These same nonverbal interactions occur between the therapist and the client to facilitate in attachment, regulate affect and physiology and provide a sense of being understood. Silence facilitates in the observation and awareness of nonverbal cues of behaviour. Importantly, nonverbal cues not only express emotion but also regulate the body's physiology, emotions and behaviours of all interpersonal relatedness.

Silence has also been discussed in relation to spirituality and the transpersonal phenomenon. The psycho-spiritual context of silence within psychotherapy is a perspective that allows for an openness to emerge, the unconscious to speak and an experience of intimate connection with self, other and the universe. I question how therapists teach themselves and their clients, to claim the courage to let their unconscious speak, their subjective truth be created out of such silence and stillness?

What is missing in the literature is the discussion of how silence is always present and exists whether psychotherapists acknowledge it or not. Silence from this perspective is not connected to a theoretical orientation or used as a therapeutic technique, silence just is. "Silence is original and self-evident, like basic other phenomena; like love and loyalty and death and life itself...Silence is the firstborn of the basic phenomena" (Max Picard, 1953, p. 21). An idea requiring further research within psychotherapy is does silence contain everything within itself?

When thinking of therapist silence within the therapeutic relationship, there are two distinctions to consider. The first is that the therapist allows silence but there is no active use of it. Second, the therapist is aware of silence and actively uses it. When therapists allow and use silence they are in relationship with a theoretical set, like psychoanalysis or psychodynamic psychotherapy. Through extracting and synthesising data within this dissertation, I have discovered that silence cannot be wholly looked at from just the therapist's perspective. Silence of the therapist or client must be subsumed in the relational matrix, making the silence a product of the relationship. Silences become mutually, though at times unconsciously, agreed upon as part of the process of therapy. We could say that the space between is constructed within the session and serves as a container for words and silences of therapy, shared words, shared experience and shared silence. However, some theorists suggest that silence is the container. I wonder how therapists examine the quality of the container and whether, the space between or the silence is seen to be the container or both?

Silence: Help or Hindrance

Evidence confirms how essential it is, as therapists, to recognise that silence can be positively helpful or destructive and as insensitive or inappropriate as verbal interventions. Too long in the silence may leave the client in the abyss of their inner world; but filling the therapeutic space with words before the client fully experiences the content of the silent void may equate to the therapist committing an 'emotional theft' (Stern, 2002; Wilmer, 1995). This paradox poses more questions and the need for further research, as how do therapists know when to use silence and when not to? When is silence a help or a hindrance?

It is my observation that any use of silence requires sensitivity, tact and skill, and this applies to when therapists allow silence, actively use silence, or decide not to use silence. If silence is not skilfully and sensitively employed by the therapist, the client may experience the therapist's quietness, as distance, disinterest or disengagement, leading to breaches in the trust and safety of the therapeutic alliance (Lane, Koetting, & Bishop, 2002). What is crucial is that therapists recognise that believing in the theoretical value of and even the necessity for using silence is not the same as having the ability to use it so constructively. In this vein, knowing ones own limitations can prove to be the better part of wisdom.

Therapist Silence: Unconscious Processes

The evidence supports the view that the therapist's avoidance of silence may be associated with experiences of object loss and separation. What interests me is how the therapist's language becomes the 'metaphoric teddy bear' that is borne of the absence of the object when accompanied by the presence of feelings of loss. The reassuring voice, whether firstly the mother's voice, therapist's voice or client's voice, appears to protect the therapist against aloneness, making separation bearable. These ideas raise questions around silence and socialisation as a whole and what this means when social systems and organisations favour words over the emptiness of silence. What is also absent in the literature is the possibility of silence uniting over the emptiness of words.

Furthermore, the literature does not adequately discuss the possibilities of silence representing an intrusive fusion. If the child's experience of separation is more about an overbearing, controlling and intrusive presence, than object loss or separation anxiety, perhaps the therapist's over use of words has something to do with avoiding earlier preverbal silence where there was no space for self to exist. If we were to discuss silence from this perspective, maybe the therapist's difficulty with silence becomes more about a helpless, powerlessness and intrusive experience that makes autonomy impossible.

Whatever the constellation of development, research confirms that one of the most common barriers experienced within the therapeutic relationship, is the therapist's own unresolved conflicts that relate to unconscious, infantile anxieties (Greenberg, 2002; Jacobs, 1996; Thompson, 1980; Rosenfeld, 1987). I propose that the difficulties that therapists' experience with silence can be used to bring into awareness, draw attention to, and indicate such transferences.

To enhance the therapeutic relationship, the therapist may use the awareness of primitive transferences evoked by silence. Casement (1991) and Jacobs (1996) believed that therapists' awareness and use of controlled regression within themselves might enhance the connection and communication with the unconscious between client and therapist. Isakower (1963) discerningly pointed out the importance of the role of regression in the therapist. To communicate effectively, the minds of client and therapist must be in a state of temporary regression; a condition facilitated by the therapist's stance of expectant silence and evenly suspended attention. The therapist's controlled regression within, helps cross the boundary between the conscious (rational) thinking and the unconscious (irrational) thinking process (Casement, 1991; Greene, 1982; Isakower, 1963; Jacobs, 1996).

If the therapist is preoccupied with his or her own transferences, the regression may become more like that of the client, and the therapist's libido and energy becomes bound down in

problem solving (Aaron, 1974). In this situation, the therapist may have an unconscious wish for help, resenting the client for the demands made on him or herself.

It is fundamental that we not only focus on the therapist's issues with silence but also the client's difficulties with silence as the therapeutic situation is a dynamic bi-personal field in which shared unconscious fantasies operate simultaneously. In relation to difficult experiences with silence, both the therapist and client contribute to each aspect of the interaction. This interpersonal relatedness may make it difficult at times to evaluate and determine what belongs to the therapist, to that of the client. Each offers unique qualities, characteristics and patterns of response and involvement, generated through mutual interaction and determines the course and pattern of the therapeutic action specific to that therapeutic process and situation.

Therapists' difficulties with silence will inevitably be stimulated by different clients' idiosyncratic and homogenous transferences. The projective identification on the part of the client can reflect all kinds of unconscious conflicts and fantasies that can make it difficult for therapist to hold and use silence. These fantasies are often split off, denied and repressed by the client and experienced by the therapist as concordant or complimentary identification.

Furthermore, the client's intrapsychic difficulties may be similar to that of the therapist's (Bacal, & Thompson, 1996; Bolognini, 1997). More specifically, when clients project unwanted aspects of themselves on to the therapist and this corresponds to the therapist's unresolved issues, this may result in collusive and defensive behaviour where the therapist is unable to hold or use silence and contain the client's projections or experiences (Cooper, 2000; Feldman, 1997; Racker, 1989; Thompson, 1980).

Both client and therapist may attempt to avoid silence to avoid unresolved conflict, unbearable anxiety and pain (Symington, 1986, 1996). Through the mutual process of projective identification, the therapeutic situation revolves around resistances, non insightful symptom relief, inappropriate shared defences, enactments and gratifications (Ogden, 1994). Langs (1995) and Karlsson (2004) discussed how these often surface in the form of reverse projective identification, called 'therapeutic misalliances' in which the client is used as the container of the projected aspects of the therapist, rather than the other way round. Langs emphasised the destructivity in such a misalliance.

Being Aware of the Therapist's Narcissistic Sensitivities

Pressman (1961) is the only theorist who specifically illustrated how therapists' own narcissistic injuries can inhibit their ability and capacity to allow and use silence within the therapeutic relationship. This raises questions regarding the centrality of narcissistic reactions to the organisation of the therapist's personality. How does the therapist compensate for such

deficits and does the compensation at times involve filling the silence and not allowing for uncertainty or emptiness?

Although the literature reviewed does not suggest guidelines to improve the effectiveness of the therapist's use of silence, I believe it is essential that therapists understand their own narcissistic need to become 'the healer' not only of the client but also of one's self in the client. Closely linked with the therapist's need to heal is the desire to be the good self-object. It is my experience that these unspoken expectations may cause overactivity not only in the therapist but also within the therapeutic relationship.

Silence and the Unknown

As previously discussed, the need to fill silences in our lives can be conceptualised based on many theoretical viewpoints. While some clear distinctions and recommendations have been made, there appears to be an opening for further research within the psychoanalytic literature integrating therapists' difficulties with silence and the intolerance to the unknown. I propose that the use of therapeutic silence triggers and illuminates human difficulties in tolerating the unknown. It can be difficult not only in clinical practice, but in life, to hold and stay with the not knowing, during which feelings of ignorance, helplessness, powerlessness, fear, anxiety, frustration and anger may be present.

It appears that a fundamental tension exists between the basic human desire to know and the difficulty of not knowing (Gabbard, 1989; Grotstein, 1990; Kurtz, 1989). It is important to acknowledge how this tension may contribute to the therapist's difficulty in remaining silent. In some sense, psychotherapy emphasises knowing, learning and discovering what is not known.²⁶ Weiss (1997) drew attention to how "certainty has been the credo in psychotherapy, to make the unconscious conscious" (p. 61).²⁷ The therapist is confronted with the paradox of the need to value not knowing and the value of knowing enough. It could be argued that the verbal relationship between the therapist and client functions at its optimum only if a certain non-verbal relationship is present.

Internal and External Silence

After synthesising the data on transference, countertransference and the unconscious processes, I am interested in Bion (1967), Casement (1991), Reik (1948), Ogden (1994) and Winnicott's (1971) ideas in conceptualising psychoanalytic listening as not mere silence, but rather as an opening of an internal space in ourselves for the client. However, there is no substantial evidence as to the existence of this internal state. How is a concept like this measured and validated?

²⁶This is a common denominator in the Western world, to seek knowledge. Due to the scope of this research paper, I am unable to discuss this in more detail.

²⁷Westernized culture may be seen as a social system that esteems and is based on success, wealth, authority, independence and autonomy, skill and specialised knowledge (Freidson, 1994; Shweder & Bourne, 1984; Zohar, 1990, 1997). These external Westernized values may make it difficult for the therapist to hold and use silence and can be contradictory to what is valued in self development within psychotherapy.

As discussed in Chapter Four, Winnicott (1951) wrote how the 'internalized potential space' is based on a series of dialectical relationships between fantasy and reality. How do therapists know when they might be experiencing an interpersonal space between themselves and their clients, what is fantasy and what is reality? Green (1978) emphasised the loss of oneness as creating this space, while Ogden (1990) stressed the need for separation in order to develop this space. Possibly this explains why some therapists who experienced difficulties in developmentally separating, struggle in creating not only external silence but an internal space and stillness. Perhaps because this idea of the internal space is more conceptual than literal, it is harder to define, examine and make meaning of.

The recognition of the concept of internal space alerted me to how important it is that therapists understand the effectiveness of silence in creating external and internal spaces. Much of the developmental theory takes the position that there should be movement from the external to the internal to the internalised, from the object-representation to self-representation. In relation to silence, I wonder if we can apply the same ideas, that external silence is achieved before internal silence. From a transpersonal perspective, Beazley (1997) believed that outer silence is achieved first and inner silence is a psychological and spiritual posture that is more difficult to achieve. What evidence supports Beazley's hypothesis is unidentified.

Many questions remain unanswered. For example, how do therapists know if they are creating an effective external silence? How can an inner silence be actively created and maintained? If external silence is obtained without internal silence what influence does this have on the therapeutic process? What about the intersubjective experiences of silence, how do we measure and evaluate the quality of such silences? Little is written in relation to psychotherapeutic silence and these ideas and it may be that these questions cannot be answered or verified, as they are more conceptual than literal concepts. However, spiritual or religious views may offer contributions to the understanding of these ideas.

Therapists Development

Ultimately therapists' difficulties with silence are improved through the ability to self scrutinise. It is well documented that the use of the internal supervisor, the willingness to seek the counsel of others through personal therapy, supervision, exchanges with professional colleagues and on going training are fundamental methods in therapist's facilitating self awareness, development and growth as a professional practitioner (Bernstein & Glenn, 1988; Casement, 1991; Goldberg, 1997; Jacobs, 1996; Kanzer, 1979; Poland, 1986; Renik, 1996; Rosenblum, 1998; Symington, 1996).

One of the most important steps in the therapist learning silence is to learn to be alone with oneself (Winnicott, 1958, 1963). To develop therapists' capacity to use silence I wonder about the technique of meditation. It was Shafii (1973) that began this line of questioning on meditation within the therapeutic session. Inner silence may be seen to represent a 'state of being' that is achieved through the process of meditation, connecting with self and other at an unconscious level. The research in relation to how therapists' increase their capacity to hold and use silence through meditation is an area for further research.

Research Limitations

Little exists in the psychoanalytic literature specifically on the factors that disturb therapist silence. I wonder if such a gap within the literature symbolises an unconscious discomfort therapists have in dealing with such a complicated and conceptual phenomenon. In considering the relevant literature, little is mentioned regarding the therapist's feelings in relation to using silence as a therapeutic technique. Rather, the emphasis of the literature has been on silence and the therapist's developmental history and transference and countertransference constellations.

In addition to the research limitations mentioned in the methodology chapter, analysis of case studies can also offer further evidence on therapists and clients difficulties with silence. Although it has been important to find out what the existing literature states, transcripts and clinical vignettes could become the basic source material for further investigation. In addition, the effect of therapists' theoretical orientation on the use of silence could be explored further. Therapists could also be interviewed based on theoretical orientation.

My Development through this Study

My capacity to allow and use silence as a therapeutic technique and my ability to observe and make meaning of the interpersonal dynamics within the therapeutic relationship has undergone indicative development and change. I am more aware of the unconscious and making meaning out of all things that for some would be seen as trivial. Although I still have a way to go, this study has enhanced my capacity to use silence as a container, holding and tolerating more of the client's pain and my own. In clinical practice I am more able to self reflect and modify behaviour that hinders the progress of the therapeutic situation. I am now consciously aware of how my overactivity and lack of silence may be an indicator of my transferential and countertransferential reactions, my anxiety and unresolved personal factors.

Conclusion

Whether silence is used or not used by the therapist, it is a phenomenon that exists in and of itself. Therapist silence within the therapeutic relationship is a quality and fundamental technique that facilitates in communicating safety, understanding and containment. Silence is used to enhance and enable self exploration; providing a gateway that leads from the

conscious to the unconscious. Therapists' use of silence in this way is similar to preverbal levels of communication between mother and child and therefore allows for an external and internal space to be created in between both client and therapist.

The use of silence has a wealth of contrasting attitudes that impact both client and therapist, and the therapeutic relationship. This study has primarily emphasised the importance of how if either client or therapist have unresolved preverbal conflict this will in turn effect the therapist's ability and capacity to hold, allow and use silence and in this case words may become the primary vehicle of communication in the therapeutic setting.

Every sound made by the therapist is born out of silence, dies back into silence and during its life span, is surrounded by silence. To be able to use silence effectively in the therapeutic process, findings reveal that an important step is for therapist to learn to be alone with oneself in the silence. Silence is the element in which great things fashion themselves together. It is the uniqueness of this therapeutic dyadic silence that allows for and creates communication and holds the potential for a healing experience.

REFERENCES

- Aaron, R. (1974). The analyst's emotional life during work. *Journal of the American Psychoanalytic Association*, 22, 160-169.
- Abraham, K. (1919/1958). *The first pre-genital stage of the libido*. London: Hogarth Press.
- Arlow, J. (1961). Silence and the theory of technique. *Journal of American Psychoanalytic Association*, 9, 44-45.
- Arlow, J. (1985). The concept of psychic reality and related problems. *Journal of American Association*, 33, 521-535.
- Arlow, R. A. (1991). *Psychoanalysis: clinical theory and practice*. Madison, CT: International Universities Press.
- Atwood, G. E., & Stolorow, R. D. (1984). *Structures of subjectivity: Explorations in psychoanalytic phenomenology*. New Jersey: Analytic Press.
- Aull, G., & Strean, H. S. (1967). The analyst's silence. *The Psychoanalytic Forum*, 2, 72-85.
- Bacal, H. A., & Thomson, P. G. (1996). The psychoanalyst's self object needs and the effect of their frustration on the treatment: Progress in self psychology. *Journal of Psychoanalysis*, 12, 17-35.
- Baerson, A. (1994). *Silence and silent interventions: Unspoken communication in a long term therapy relationship*. New York: University Press.
- Balint, M. (1955). Friendly expanses-horrid empty spaces. *International Journal of Psychoanalysis*, 36, 225-241.
- Balint, M. (1958). The three areas of mind: Theoretical considerations. *The International Journal of Psychoanalysis*, 39, 328-340.
- Ballou, S. (1996). *An Existential-phenomenological historical enquiry into the awareness of silence as a transpersonal paradigm*. Un-published master's thesis, the Union Institute of Cincinnati, Ohio.
- Barkham, M., & Mellor-Clark, J. (2000). *Evidence based counselling and psychological therapies: Research and applications*. London. Routledge.
- Basch, M. F. (1983). Empathic Understanding: A review of the concept and some theoretical considerations. *Journal of the American Psychoanalytic Association*, 31(1), 101-126.
- Basch, M. F. (1988). *Understanding psychotherapy: The science behind the art*. New York: Basic Books.
- Beazley, S. (1997). *A theoretical model of non-activity in the therapeutic relationship*. Un-published master's thesis, Pepperdine University, New York.
- Bernstein, I., & Glenn, J. (1988). The child and adolescent, analyst's emotional reactions to His patients and their parents. *International Review of Psychoanalysis*, 15, 225-241.
- Bergler, E. (1938). On the resistance situation: The patient is silent. *Psychoanalytic Review*, 25, 170-186.
- Binder, J. L., & Strupp, H. H. (1984). *Psychotherapy in a new key*. New York: Basic Books.
- Bion, W. R. (1962). Learning from experience: *Psychoanalytic Forum*, 8, 113-128.

- Bion, W. R. (1967). Notes on memory and desire. *Psychoanalytic Forum*, 2, 271-280.
- Blos, P. (1972). Silence: A clinical exploration. *Psychoanalytic Quarterly*, 41, 348-368.
- Bolognini, S. (1997). Empathy and 'empathism'. *International Journal of Psychoanalysis*, 78, 279-293.
- Breuer, J., & Freud, S. (1895/1955). Studies in hysteria. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2, pp. 19-135). London: Hogarth Press.
- Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. London: Sage Publications.
- Brockbank, R. (1970). On the analysts silence in psychoanalysis: A synthesis of intrapsychic content and interpersonal manifestations. *International Journal of Psychoanalysis*, 51, 457-464.
- Bruneau, T. J. (1973). Communicative silences: Forms and functions. *Journal of Communication*, 23, 17-46.
- Bruneau, T. J. (1980). Chronemics and the verbal-nonverbal interface. In M. R. Key (Ed.), *The relationship of verbal and nonverbal communication* (pp. 101-117). New York: Mouton Publishers.
- Calogeras, R. C. (1966). Silence as a technical parameter in psychoanalysis. *International Journal of Psychoanalysis*, 18, 536-558.
- Caruth, E. G. (1987). Language in intimacy and isolation: Transitional dilemma, transformational resolution. *Journal of American Academy of Psychoanalysis*, 15, 39-49.
- Casement, P. J. (1991). *Learning from the patient*. New York: The Guilford Press.
- Cheshire, N., & Thomae, H. (1987). *Self, symptoms and psychotherapy*. New York: John Wiley.
- Colman, A. (2001). *Oxford dictionary of psychology*. New York. Oxford University Press.
- Coltart, N. (1991). The silent patient. *Psychoanalytic Dialogues*, 1(4), 439-453.
- Cooper, S. H. (2000). Mutual containment in the psychoanalytic situation. *Psychoanalytic Dialogues*, 10, 169-194.
- Davis, H. (1977). An empirical study of the meanings of silence occurring early in psychotherapy. *International Journal of Psychoanalysis*, 72, 132-144.
- Deverson, T. (1999). *The New Zealand mini dictionary*. Auckland: Oxford University Press.
- Eagle, M. N. (2000). A critical evaluation of current conceptions of transference and countertransference. *Psychoanalytic Psychology*, 17, 24-37.
- Ehrenberg, D. B. (1985). Countertransference resistance. *Contemporary Psychoanalysis*, 21, 563-575.
- Eissler, K. R. (1953). The effect of the structure of the ego on psychoanalytic technique. *Journal of the American Psychoanalytic Association*, 1, 104-143.
- Ekstein, R., & Caruth, E. (1965). From Eden to utopia. *American Journal of Psychoanalysis*, 22, 128-141.

- Elkins, D. (2006). *A qualitative study of silence as experienced by Christian psychotherapists*. Retrieved 3 October, 2007, from [www.http://gateway.uk.ovid.exproxy.aut.ac.nz](http://gateway.uk.ovid.exproxy.aut.ac.nz).
- Faimberg, H. (1992). The countertransference position and the countertransference. *International Journal of Psychoanalysis*, 73, 541-546.
- Fairburn, W. D. (1952). *Psychoanalytic studies of the personality*. London: Hogarth Press.
- Feldman, M. (1997). Projective identification: The analyst's involvement. *International Journal of Psychoanalysis*, 78, 227-241.
- Fenichel, O. (1939). Problems of psychoanalytic technique. *Psychoanalytic Quarterly*, 22, 102-111.
- Fenichel, O. (1941). *The psychoanalytic theory of neurosis*. New York: W.W. Norton.
- Ferenczi, S. (1916/1950). Silence is golden. In J. A. Suttie, (Ed. & Trans.), *Further contributions to the theory and technique of psychoanalysis* (pp. 250-252). London: Hogarth Press.
- Ferenczi, S., & Rank, O. (1923/1956). *The development of psychoanalysis*. In C. Newton, (Ed. & Trans.), *Contributions to the theory and technique of psychoanalysis* (pp. 360-369). New York: Dover.
- Fish, D. (1998). *Appreciating practice in the caring professions: Refocusing development and practitioner research*. Oxford: Butterworth Heinemann.
- Fish, D., & Twinn, S. (1997). *Quality clinical supervision in the health care profession*. Oxford: Butterworth Heinemann.
- Fiumara, G. C. (1977). The symbolic function, transference and psychic reality. *International Journal of Psychoanalysis*, 4, 171-180.
- Fleiss, R. (1949). Silence and verbalization: A supplement to the theory of the analytic rule. *International Journal of Psychoanalysis*, 6, 209-215.
- Freidman, R. (1980). Proto-rhythms: Nonverbal to language and musical acquisition. In M. R. Key (Ed.), *The relationship of verbal and nonverbal communication* (pp. 77-91). New York: Mouton Publishers.
- Freidson, E. (1994). *Professionalism reborn: Theory, prophecy and policy*. Chicago: University Press.
- Freud, S. (1901/1966). *The psychology of everyday life*, In A. Brill (Ed. & Trans.), *The basic writings of Sigmund Freud* (Vol 3, pp. 521-600). New York: The Modern Library.
- Freud, S. (1905/1953). Fragment of an analysis of a case of hysteria. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol 7, pp. 3-110). London: Hogarth Press.
- Freud, S. (1912/1953). The dynamics of transference. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol 12, pp. 209-253). London: Hogarth Press.
- Freud, S. (1913/1954). On beginning the treatment: Further recommendations in the technique of psychoanalysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol 12, pp.123-144). London: Hogarth Press.

- Freud, S. (1915/1953). The future prospects of psycho-analytic therapy. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol 11, pp. 139-151). London: Hogarth Press.
- Freud, S. (1919/1953). Beyond the pleasure principle. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol 18, pp. 3-64). London: Hogarth Press.
- Gabbard, G. O. (1989). On doing nothing in the psychoanalytic treatment of the refractory. *International Journal of Psychoanalysis*, 70, 527-534.
- Gabbard, G. O. (1995). Countertransference: The emerging common ground. *International Journal of Psychoanalytic*, 76, 475-485.
- Gale, J., & Sanchez, B. (2005). The meaning and function of silence in psychotherapy with particular reference to a therapeutic community treatment programme. *Psychoanalytic Psychotherapy*, 19(3), 205-220.
- Garfat, T. (1993). Listening to silence. The multigenerational influence of the work of Henry Maier. *Journal of Child and Youth Care*, 8(2), 195-210.
- Gill, M. (1954). Psychoanalysis and exploratory psychotherapy. *Journal of the American Psychoanalytic Association*, 2, 771-797.
- Gill, M. (1982). *Analysis of transference: Theory and technique*. New York: International Universities Press.
- Glover, E. (1928). *The technique of psychoanalysis*. New York: University Press.
- Glover, E. (1955). *The developing technique of psychoanalysis*. New York: University Press.
- Goldberg, P. (1989). Actively seeking the holding environment: Conscious and unconscious elements in the building of a therapeutic framework. *Contemporary Psychoanalysis*, 25, 448-476.
- Goodheart, C. (2004). Evidence based practice and the endeavor of psychotherapy. *The Independent Practitioner*, 24(1), 122-932.
- Green, A. (1974). Surface analysis and deep analysis: the role of the preconscious in psychoanalytical technique. *International Review of Psychoanalysis*, 1(4), 415-423.
- Green, A. (1975). The analyst, symbolization and absence in the analytic setting. *International Journal of Psychoanalysis*, 56, 1-22.
- Green, A. (1978). *Potential space in psychoanalysis: The object of the setting in between reality and fantasy*. Northvale, New Jersey: Jason Aronson.
- Greene, M. (1982). On the silence of the therapist and object loss. *International Journal of Psychoanalytic Psychotherapy*, 9, 183-200.
- Greenacre, P. (1954). The role of transference: Practical consideration in relation to psychoanalytic therapy. *Journal of the American Psychoanalytic Association*, 2, 671-684.
- Greenacre, P. (1968). The psychoanalytic process, transference, and acting out. *International Journal of Psychoanalysis*, 49, 211-218.
- Greenberg, J. (1991). *Oedipus and beyond*. Cambridge: Harvard University Press.
- Greenberg, J. (2002). Psychoanalytic goals, therapeutic tension and the analyst's tension.

- Psychoanalytic Quarterly*, 71, 651-678.
- Greenson, R. (1961). On the silence and sound of the analytic hour. *Journal of American Psychoanalytic Association*, 9, 79-84.
- Greenson, R. (1967/1985). *The technique and practice of psychoanalysis*. New York: International Universities Press.
- Grinberg, L. (1997). Is the transference feared by the psychoanalyst? *International Journal of Psychoanalysis*, 78, 1-14.
- Grotstein, J. S. (1990). Nothingness, meaninglessness, chaos, and the black hole: The importance of nothingness, meaninglessness, and chaos in psychoanalysis. *Contemporary Psychoanalysis*, 26, 257-290.
- Guba, G. (1990). *The paradigm dialogue*. California: Sage Publications.
- Gunther, M. S. (1978). The endangered Self: A contribution to the understanding of narcissistic determinants of countertransference. *Annual of Psychoanalysis*, 4, 255-278.
- Halewood, A., & Tribe, R. (2003). What is the prevalence of narcissistic injury among trainee counselling psychologists? *British Journal of Psychology*, 76, 87-103.
- Hammer, S., & Collinson, G. (1999). *Achieving evidence-based practice: A handbook for practitioners*. London: Bailliere Tindall.
- Heimann, P. (1950). On countertransference. *International Journal of Psychoanalysis*, 31, 81-84.
- Herman, J. (1992). *Trauma and recovery: From domestic abuse to political terror*. London: Basic Books.
- Hinselwood, R. D. (2002). *Evidence based psychoanalysis: Symptoms or relationships*. Retrieved 20 October, 2002, from [www.http://gateway.uk.ovid.exproxy.aut.ac.nz](http://gateway.uk.ovid.exproxy.aut.ac.nz).
- Isakower, O. (1963). *The analytic instrument*. New York: Psychoanalytic Institute.
- Jacobs, T. J. (1986). On countertransference enactments. *American Journal of Psychoanalysis Association*, 34, 289-307.
- Jacobs, T. J. (1996). The patient as instrument of change in the analyst. *Psychoanalytic Inquiry*, 16, 314-339.
- Jung, C. (1938/1978). Psychology and religion: West and East. In H. Read, M. Fordham, G. Adler, & R. F. C. Hull (Eds. & Trans.), *The collected works of C. G. Jung* (Vol 2, pp. 302-215). New York: Pantheon.
- Jung, C. (1928/1984). *The practice of psychotherapy*. In H. Read, M. Fordham, G. Adler & R. F. C. Hull (Eds. & Trans.), *The collected works of C. G. Jung* (Vol 16, pp. 104-122). New York: Pantheon.
- Kanzer, M. (1979). Developments in psychoanalytic technique. *Journal of American Psychoanalytic Association*, 27, 327-374.
- Karlsson, R. (2004). Collusions as interactive resistances and possible stepping stones out of impasses. *Psychoanalytic Psychology*, 21(4), 567-579.
- Khan, M. (1963). Silence as communication. *Bulletin of the Menninger Clinic*, 27, 300-313.

- Khan, M. (1974). *The privacy of the self*. New York: International University Press.
- Kindler, A. (1991). *Mirror transference and the need for confirmation*. New York: University Press.
- Kohler, L. (1985). *On self-object countertransference*. Madison CT: International University Press.
- Kohut, H. (1971). *The analysis of the self*. New York: International University Press.
- Kohut, H. (1977). *The restoration of the self*. New York: International University Press.
- Kohut, H. (1984). *How does analysis cure?* Chicago, IL: Chicago University Press.
- Kris, E. (1950). On the preconscious mental processes. *Psychoanalytic Quarterly*, 19, 540-560.
- Kris, E. (1956). On some vicissitudes of insight in psychoanalysis. *International Journal of Psychoanalysis*, 37, 445-455.
- Kumin, I. M. (1978). Emptiness and its relation to schizoid ego structure. *International Journal of Psychoanalysis*, 5, 207-216.
- Kurtz, S. A. (1984). On silence. *Psychoanalytic Review*, 71(2), 227-245.
- Kurtz, S. (1989). *The art of unknowing*. New Jersey: Jason Aronson.
- Lane, R., Koetting, M., & Bishop, J. (2002). Silence as communication in psychodynamic psychotherapy. *Peer Review Journal*, 22(7), 1091-1104.
- Langs, R. (1973). *The technique of psychoanalytic psychotherapy*. New York: Jason Aronson.
- Langs, R. (Ed.). (1978). Some communicative properties of the bi-personal field. In *Technique in Transition* (pp. 627-678). New York: Jason Aronson.
- Langs, R. (1995). Inner space: A spectacular voyage to the heart of identity. *Peer Review*, 52, 205-235.
- Leif, H. I. (1962). Silence as intervention in psychoanalytic. *American Journal of Psychoanalysis*, 22, 80-83.
- Levin, D. M. (1989). *The listening self: Personal growth, social change and the closure of metaphysics*. New York: Routledge.
- Levine, H. B. (1997). The capacity for countertransference. *Psychoanalytic Inquiry*, 17, 44-68.
- Levy, K. (1958). Silence in the analytic session. *International Journal of Psychoanalysis*, 39, 50-58.
- Little, M. (1951) Countertransference and the patient's response to it. *International Journal of Psychoanalysis*, 19, 199-216.
- Mahler, H. (1972). *Separation and individuation*. New York: Sage Publications.
- Maione, P. V., & Chenail, R. J. (1999). Qualitative inquiry in psychotherapy: Research on the common factors. In M. A. Hubble, B. L. Duncan & D. Miller (Eds.), *The heart and soul of change: The role of common factors on psychotherapy* (pp. 57-88). Washington DC: American Association Press.

- McWilliams, N. (2001). *Psychoanalytic diagnosis: Understanding the personality structure in the clinical process*. New York: The Guilford Press.
- MacDougal, J. (1979). *Primitive communication and the use of countertransference*. New York: Jason Aaronson.
- Maloney, J. C. (1947). The analyst remains silent. *Diseases of the Nervous System*, 8, 14-16.
- Meerloo, J. A. M. (1952). Free association, silence and the multiple function of speech. *Psychiatric Quarterly*, 26, 21-32.
- Menninger, K. (1958). *Theory of psychoanalytic technique*. New York: Basic Books.
- Moustakas, C. (1995). *Existential-phenomenological research methods*. Newbury: Sage Publications.
- Mulrow, C., & Cook, D. (1998). *Systematic reviews: Synthesis of best evidence for healthcare decisions*. Philadelphia: American College of Physicians.
- Nacht, S. (1963). The non-verbal relationship in psycho-analytic treatment. *International Journal of Psychoanalysis*, 44, 328-333.
- Nacht, S. (1964). Silence as an integrative factor. *International Journal of Psychoanalysis*, 45, 299-303.
- Novey, S. (1961). Further considerations on affect theory in psychoanalysis. *International Journal of Psychoanalysis*, 42, 21-31.
- Ogden, T. H. (1982). Projective identification and therapeutic technique. Northvale, New Jersey: Jason Aronson.
- Ogden, T. H. (1985). On potential space. *Journal of Psychoanalysis*, 66, 129-141.
- Ogden, T. H. (1994). The analytic third: Working with intersubjective clinical facts. *International Journal of Psychoanalysis*, 75, 3-20.
- Ogden, T. H. (1996). Reconsidering aspects of psychoanalytic technique. *Journal of Psychoanalysis*, 77, 883-889.
- Perls, F., Hefferline, R. F., & Goodman, P. (1965). *Gestalt therapy: Excitement and growth in human personality*. New York: Delta Books.
- Picard, M. (1953). *The world of silence*. Washington, DC: Regency Gateway.
- Poland, W. S. (1986). The analyst's words. *Psychoanalytic Quarterly*, 55, 244-272.
- Pressman, M. D. (1961). Silence in analysis. *Bulletin of the Philadelphia Association of Psychoanalysis*, 11, 101-115.
- Pressman, M. D. (1961a). On the analytic situation: The analyst is silent. *Bulletin of the Philadelphia Association of Psychoanalysis*, 11, 168-182.
- Racker, H. (1968). The meanings and uses of countertransference. *Psychoanalytic Quarterly*, 26, 303-357.
- Racker, H. (1989). Psychoanalytic technique and the analyst's unconscious masochism. In R. Lax (Ed.), *Essential papers on character neurosis treatment* (pp. 428-434). New York: University Press.
- Reed, J., & Ground, I. (1997). *Philosophy of nursing*. London: Arnold.

- Reich, A. (1966). On countertransference. *International Journal of Psychoanalysis*, 32, 25-31.
- Reik, T. (1926/1968). The psychological meaning of silence. *Psychoanalytic Review*, 55, 172-186.
- Reik, T. (1948). *Listening with the third ear: The inner experience of psychoanalysis*. New York: Noonday.
- Renik, O. (1996). The analyst's self-discovery. *Psychoanalytic Inquiry*, 16, 390-400.
- Rosenblum, S. (1998). Abstinence anonymity and the avoidance of self-disclosure. *Psychoanalytic Inquiry*, 18, 538-549.
- Rosenfeld, H. (1987). *Impasse and interpretation*. London: Tavistock.
- Roth, S. (1990). *Psychotherapy: The art of wooing nature*. Northvale, New Jersey: Jason Aronson.
- Rycroft, C. (1995). *A critical dictionary of psychoanalysis*. New York: Penguin.
- Sabbadini, A. (1991). Listening to silence. *British Journal of Psychotherapy*, 21(2), 229-240.
- Sandler, J. (1976). Countertransference and role-responsiveness. *International Journal of Psychoanalysis*, 3, 43-47.
- Sandler, J. (1987). The concept of projective identification. *Bulletin of the Anna Freud Centre*, 10(1), 33-49.
- Schafer, R. (1983). *The analytic attitude*. New York: Basic Books.
- Schaef, A. (1992). *Beyond therapy, beyond science: A new model for healing the whole person*. San Francisco: Harper Collin Publishers.
- Schulman, R. (1986). Relevance of the family to psychoanalytic theory. *Canadian Journal of Psychoanalysis*, 4, 195-198.
- Schwaber, E. A. (1981). Narcissism, self psychology, and the listening perspective. *Annual of Psychoanalysis*, 9, 115-132.
- Schwaber, E. A. (1981a). Empathy: A mode of analytic listening. *Psychoanalysis Inquiry*, 1, 357-392.
- Schwaber, E. A. (1983). Construction, reconstruction and the mode of clinical attunement. In A. Goldberg (Ed.), *The future of psychoanalysis* (pp. 273-291). New York: International Universities Press.
- Schwaber, E. A. (1983a). A particular perspective on analytic listening. *Journal of Psychoanalysis*, 38, 519-546.
- Schwaber, E. A. (1983b). Psychoanalytic listening and psychic reality. *International Journal of Psychoanalysis*, 10, 379-392.
- Shweder, R. A., & Bourne, E. J. (1984). *Does the concept of the person vary cross-culturally*. Cambridge: Cambridge University Press.
- Serani, D. (2000). Silence in the analytic space: Resistance or reverie. *Journal of Contemporary Psychoanalysis*, 36, 505-519.

- Shafii, M. (1973). Silence in the service of ego: Psychoanalytic study of meditation. *International Journal of Psychoanalysis*, 54, 434-443.
- Shafii, M (1985). *Freedom from the self: Sufism, meditation, and psychotherapy*. New York: Human Science Press.
- Sontang, S. (1966). *The aesthetics of silence*. New York: Farrar, Straus and Giroux.
- Spence, D. P. (1983). Ambiguity in everyday life. *Psychoanalytic Inquiry*, 3, 255-278.
- Spitz, R. A. (1945). *An inquiry into the genesis of psychiatric conditions in early childhood: A psychoanalytic study of the child*. New York: International University Press.
- Starcevic, V. (2003). Psychotherapy in the era of evidence-based medicine. *Journal of Australasian Psychiatry*, 11, 278-281.
- Stern, D. B. (2002). Words and wordlessness in the psychoanalytic situation. *Journal of American Psychoanalytic Association*, 50, 221-247.
- Sue, A., Derald, H., Wing, S., & David. P. (1990). *Counselling the culturally different: Theory and practice*: New York: John Wiley & Sons.
- Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York: Norton Library.
- Symington, N. (1986). *The analytic experience: Lectures from Tavistock*. London: Free Association.
- Symington, N. (1996). *The making of a psychotherapist*. London: Karnac.
- Thomson, P. G. (1980). On the receptive function of the analyst. *International Review of Psychoanalysis*, 7, 183-205.
- Thomson, P. G. (1991). Countertransference in an intersubjective perspective. In A. Goldberg (Ed.), *The evolution of self psychology: progress in self psychology* (Vol 7, pp. 7-92). Hillsdale, New Jersey: The Analytic Press.
- Toplin, M. (1971). On the beginning of a cohesive self: An application of the concept of transmuting internalization to the study of the transitional object and signal anxiety. *Journal of Psychoanalysis*, 26, 316-352.
- Toth, P. W. (1999). *The silent member in analytically orientated group psychotherapy and supportive group psychotherapy: A comparative study of the leadership styles utilized in the management of the silent member*. Un-published master's thesis, Hahnemann University: Philadelphia.
- Trad, P. V. (1993). Silence: The resounding experience. *American Journal of Psychotherapy*, 47(4), 167-170.
- Trindler, L., & Reynolds, S. (2000). *Evidence-based practice: A critical approach*. Oxford: Blackwell Science.
- Van Der Heide, C. (1961). Blank silence and the dream screen. *Journal of the American Psychoanalytic Association*, 9, 85-90.
- Vasiliuk. F. (2005). Prayer, silence and psychotherapy. *Peer Review Journal*, 1, 52-56.
- Weinberger, J. L. (1961). A syndrome of silence: Silence, masochism and depression. *Bulletin of the Philadelphia Association of Psycho-Analysis*, 11, 90-92.

- Weinberger, J. L. (1964). A triad of silence: Silence, masochism and depression. *International Journal of Psychoanalysis*, 45, 304-309.
- Weiner, N. D. (1973). Aposiopesis: A special type of silence. *Bulletin of the Philadelphia Association of Psychoanalysis*, 23, 281-287.
- Weisman, A. D. (1955). Silence in psychotherapy. *International Journal of Psychiatry*, 18, 241-260.
- Weiss, S. (1966). Clinical and theoretical aspects of, as if, characters. *Journal of the American Psychoanalytic Association*, 14, 569-590.
- Weiss, S. (1997). The empty space. *Journal of Psychoanalysis*, 25, 189-199.
- White, A., & Schmidt, K. (2005). Systematic literature reviews. *Complementary Therapies in Medicine*, 13, 54-60.
- Wilmer, H. (1995). Silence, something we really hear, which does not exist. *American Journal of Psychoanalysis*, 23, 723-730.
- Winnicott, D. W. (1951). *Transitional objects and transitional phenomena*. New York: Basic Books.
- Winnicott, D. W. (1958). *The Maturation processes and the facilitation environment*. New York: International Universities Press.
- Winnicott, D. W. (1958/1965). The capacity to be alone. *International Journal of Psychoanalysis*, 39, 416-420.
- Winnicott, D. W. (Ed.). (1963/1989). Communicating and not communicating leading to a study of certain opposites. In *The maturational processes and facilitating environment* (pp. 179-192). New York: International Universities Press.
- Winnicott, D. W. (1963/1989). Two notes on silence. In D. W. Winnicott, & C. Winnicott (Eds.), *Psychoanalytic explorations* (pp. 81-86). Cambridge, MA: Harvard University Press.
- Winnicott, D. W. (1971). *Playing and reality*. London: Tavistock.
- Wolf, E. S. (1980). Empathy and countertransference. In A. Goldberg (Ed.), *The future of psychoanalysis* (pp. 309-326). New York: International Universities Press.
- Wolf, E. S. (1988). *Treating the self*. New York: Guilford.
- Wright, K. (1991). *Vision and separation*. London: Free Association Books.
- Zeligs, M. A. (1960). The role of silence in transference and the psychoanalytic process. *International Journal of Psychoanalytic Association*, 41, 407-412.
- Zeligs, M. A. (1961). The psychology of silence: Its role in transference, countertransference and the psychoanalytic process. *Journal of the American Psychoanalytic Association*, 9, 7-43.
- Zeligs, M. A. (1977). Silence in psychoanalysis and psychotherapy. In B. B. Wolman (Ed.), *International Encyclopaedia of Psychiatry, Psychology, Psychoanalysis and Neurology* (Vol 10, pp. 233-234). New York: Van Nostrand Reinhold Co.
- Zohar, D. (1997). *Rewiring the corporate brain: Using the new science to rethink how we structure and lead organisations*. San Francisco: Berrett Koehler.

Zohar, D. (1990). *The quantum self: Human nature and consciousness defined by the new physics*. New York: Quill William Morrow.