How do Child and Adolescent Psychotherapists work with silent patients? An exploration of some meanings and functions of patient silence in sessions:

An interpretative phenomenological analysis

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Dedication

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Abstract

This study explores the experience of child psychotherapists that work with the silent child. I conducted semi-structured interviews with a purposive sample of four child and adolescent psychoanalytic psychotherapists, and used interpretative phenomenological analysis (IPA) to examine the unique meaning that participants attribute to their work with the silent child. Four superordinate themes emerged from the data: formulations of the silent child—'just different'; technique and cautious adaptation—'I needed to try something different'; the therapist's feelings; and the tension between the need for support, and resistance to accessing it.

This study aims to highlight the value of long-term work with the silent child, and strengthen understanding of the need for a mixed approach, which includes psychoanalytic technique and its cautious adaptation, to enliven the withdrawn child. As the first known qualitative study that investigates the experience of therapists working with silent patients, it reveals accounts of participants' experiences that working with the silent patient can be a long and painful process, but that psychoanalytically trained child psychotherapists have a good foundation for work of this kind. The child psychotherapist's skill of working with nonverbal communication based on infant observation is central, but flexibility is also required. A finding that was hitherto unexplored in the literature is the therapist's feelings of shame when working with the silent patient, tied to a feeling of being deskilled and the apparent lack of progress, which leads to difficulties in accessing the necessary supervisory support.

This study's findings can be used for future research and can hopefully benefit the clinical practice of child psychotherapy with the silent child.

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Introduction

Silence became a recognised clinical phenomenon in psychoanalysis in the last century (Liegner, 2003). The understanding and management of silence has been rather controversial, yielding varied and contradictory approaches. This topic seems to be gaining interest in the child and adolescent psychoanalytic psychotherapy field, judging from increasing publications on it in the last two decades, albeit mainly single-case reports and one thorough book, edited by Jeanne Magagna (2012) and dedicated to 'the Silent Child'. However, it has largely been a neglected research area (Acheson *et al.,* 2020). The literature gives lively and honest accounts of the disturbing countertransference in the work with this extremely challenging population, offering insightful thinking and some valuable and effective adaptations of the psychoanalytic technique. However, it has remained largely unintegrated, and the development of these techniques in the profession has been slow. Acheson *et al.* (2020) suggest that, to their knowledge, there has been no attempt to develop a coherent maturational framework for understanding and managing silence in adolescent therapy.

Against this backdrop, this study examines the experiences of psychoanalytic child psychotherapists who have worked with silent children. Using interpretative phenomenological analysis (IPA) as research method, it gathers in-depth retrospective accounts from a sample of participants to explore the meaning that child psychotherapists attach to their silent patients, as well as their own experiences with the silent patients. The study focuses on the individual's accounts, reflections, and emotions. The aim of this qualitative study is to provide insights into the factors at play in the psychotherapy of silent children that could have technical therapeutic implications within the Psychoanalytic Child Psychotherapy field.

The notion of 'silence' in therapy is key to this study, albeit difficult to define, as it is multidetermined. Furthermore, short periods of silence can probably be found in every treatment. Silence in a session can sometimes be a manifestation of thinking, a digestive pause, or it might indicate that the patient has taken in enough from the work for that day and is transitioning, in their mind, from being in to being outside of the session. However, I am interested in instances of therapy in which the silence becomes rather problematic, a predominant feature, is longstanding and intractable, or characterises the particular presentation of a patient.

One classical definition of silence in psychoanalysis can be found in Toth's (1996) dissertation 'Silence in Psychoanalysis: The analysand's perspective'. He uses Hinsie and Campbell's (1960) definition that characterises it as a 'withholding of response, information or free association which a patient resorts to at a point of anxiety or negative transference towards the therapist (...) in order to resist the therapeutic situation' (p. 679).

In the literature review, I will trace the evolution of the understanding of silence in psychoanalysis, starting from the one above, which sees silence in a negative light, to then open up into more recent views that allow for working with silence. Just to give an idea of the range of meanings and experiences that silence might underline within the psychoanalytical relationship, it is worth quoting Zelig (1960) at length:

> It might evidence agreement, disagreement, pleasure, displeasure, fear, anger or tranquility. The silence could be a sign of contentment, mutual understanding, and compassion. Or it might indicate emptiness and complete lack of affect. Human silence 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, snobbiness, taciturnity, or humility. Silence may mean yes or no. It may be giving or receiving, objected-directed or narcissistic. Silence may be the sign of defeat or the mark of mastery. (p. 8)

Zelig introduces the positive and negative manifestations of silence in a rather polarised way. However, it might remind the reader of the range of contradictory meanings that silence can manifest. His discussion can be seen as a precursor to the modern view of silence, which develops into a 'two-way process' (Balint, 1958; Coltart, 1991), acknowledging the influence of both patient and therapist on each other's silence. With this in mind, I would like the reader to hold onto a sense of inquiry and openness about silence as this study unfolds.

For purposes of clarity, I will sometimes refer to the phenomenon of silence, and at other times to the silent person, using the words ‘silent child’ or ‘silent patient’ interchangeably.

I will now elaborate on my research questions, which have developed over time. From the outset, I endeavoured to try to keep an open mind to allow me to gather the complexities, inherent contradictions, and internal tensions of the experience of working with a silent child. My main aim was to inform clinical practice in a meaningful way, anchored in my own clinical experience with this population.

I started with some preliminary literature searches and read broadly on silence and psychoanalysis. I was drawn to the meanings and functions of silence in its widest sense (Gale and Sanchez, 2005), particularly the paradox of the communicative and non-communicative aspects of silence, or ‘the language of silence’.

Early discussions in small groups facilitated by research supervisors clarified another area of interest which was the adaptation of technique when working with silent patients. I was interested in the dilemmas that participants might have

encountered in adapting their technique, as much as in the actual adaptations they may have made in the course of their work.

Finally, my experience of feeling isolated and disturbed—but also, in some cases and at times, deeply moved—sparked my curiosity about the emotional impact on other therapists working with silent patients. A main underlying interest was the journey of the therapist in their work with this population, how things might change over time, and how child psychotherapists (CPTs) learn from experiences informed by their countertransference.

From the outset, a premise was to remain as open-minded as possible to allow for unknowable matters to emerge with a clear focus.

I arrived at the following research questions:

1) What are the participants' thoughts about the meanings and functions of silence in their patients? Do they think there is meaning? If so, what sense do they make of it, and does it evolve throughout treatment?
2) What are their thoughts about their psychoanalytic technique—e.g. use of countertransference—what is helpful, do they face any dilemmas and are there adaptations of technique?
3) What is the emotional impact on the therapists of working with a silent child; how do they manage this, and what have they learnt from it?

Positionality as 'inside researcher'

As a psychoanalytically trained child psychotherapist, my psychoanalytic stance largely informs this research. The psychoanalytic tradition values disciplined subjectivity as a source of knowledge (McWilliams, 2013). With this in mind, I have tried to maintain an open mind of how my beliefs, experiences, thoughts and feelings might influence this research. Rather than trying to eliminate subjectivity, psychoanalysts try to name and make careful inferences from the consciously available subjective elements of our understanding of our experience (McWilliams, 2013). I have attempted to do this throughout the research and have been explicit in the discussion section. In addition, in line with the 'inside researcher' model, I value insider experience and understanding of actual clinical work, which might mitigate the potential for confusion of tongues between researchers and therapists.

Rationale for the choice of topic

I was inspired during my first year of clinical training in a CAMHS setting to undertake this study. There, I encountered three patients between the ages of 10-17 where silence was a significant feature in the therapy: an anxious and depressed female adolescent, and two latency boys who had lost their primary object and experienced neglect.

These young people could talk to some extent, and the silent feature was not part of the referral. They all used the silence in different ways and required different approaches. In two cases, I managed to adapt my technique and develop a therapeutic relationship, which allowed the work to progress, and the young people's mental health issues improved. In the case of the adolescent, however, after a year of

weekly work, and despite her regular attendance, the silence eventually defeated our precarious connection, and the work reached a natural end.

In contrast, one of the latency boys became my first intensive case after a year of therapy. He was severely traumatised and presented as dissociated. To begin with, I did not feel irritated, as I did with the adolescent. With this boy, I would drift off, and try to not fall asleep. He felt dead inside. As the therapy progressed, he became alive and eloquent, albeit non-verbally. Interestingly, as he became so engaging, I did not notice that he would usually not utter a single word during the entire session. It was my supervisor that helped me notice it. Later, it became clear that he imposed on himself not to talk. He wanted me to guess his mimicking and gestures. It is possible that this came from an early unmet need for synchronicity and full attention from the maternal object. When he relaxed and spoke, he would stop as soon as he realised. I only noticed the sadistic part of his personality, who enjoyed making me suffer, later. He eventually became more robust and managed to bear challenging interventions about this aspect of his personality. As a result, he gained some awareness of how he used his objects, which I hoped might give him some freedom and choice in his relationships. He also became freer to speak up.

My struggles with these cases sparked my curiosity about what colleagues made of working with such shutdown patients. I felt in the dark for a long time, puzzled, unaware of the suitability of the psychoanalytic method and whether helping them talk was part of my task. I also struggled to articulate what belonged to the young person and what belonged to me. Part of my motivation for this research was to get the help of colleagues' ‘digestive systems’ to make retrospective sense of my pre-symbolic experiences.

Overview of thesis

This research thesis begins with a presentation of the relevant literature on silence and psychoanalysis from Freud until now. A literature review and reflections on the rationale of the topic follows. It then moves on to explaining and detailing the IPA methodology. After that, the study analyses the data collected from participants' interviews and the resulting findings. A discussion of the findings follows, juxtaposing them to the existing literature, commenting on the strengths, potential and limitations of the study, reflecting on its clinical implications, and suggesting ideas for future research.

Background literature on silence and psychoanalytic child psychotherapy

Introduction

I will now comment on how I chose my literature, as I am aware that this may not seem clear to the reader. This may be because it was done in stages over a long period, mostly after data collection but before the data analysis, although there were some late additions.

First of all, it might be helpful for the reader, particularly if not from a psychoanalytical background, to clarify that psychoanalysis is a ‘broad church’ that includes many different approaches, although they are all connected by a close study of the works of Sigmund Freud, who was the founder of psychoanalysis. A detailed description of the differences within strands of psychoanalysis are beyond the scope of this study, but three main approaches stand out: Kleinian, the Independent Group, and the Anna Freudians (Robinson, n.d.). The Tavistock, the institution from which the present study stems, is mainly embedded within the Kleinian and post-Kleinian traditions. These distinctions, as any other modality, might be more or less important to the practicing child psychotherapist. Some child psychotherapists may train in one school of thought to then move to a different one, while others may integrate approaches and develop their theory and technique within one single tradition. In the interest of transparency, I should acknowledge that my theoretical approach is Kleinian, which I have found helpful in my work with patients. I am, however, open to being influenced by the patient's needs, working out with them what works, and develop my technique accordingly. This study aims to open up discussion and develop technique.

Initially, I started my literature review with a broad search about silence and psychoanalysis, which included mentions of Ferenczi, Balint's basic fault, Khan, and Nacht, who belong to the Independent Group. These authors are explicit in their pursuit of silence. I was then encouraged to look into Kleinian thinking, and to my surprise I found papers by Joseph (1982) and Steiner (1993) making references to silent patients. Silence was not the main topic of either of these papers, however, their capacity to grapple with the layers of complexity of silence illuminated my clinical experience, and I therefore decided to include them. Later on, Emanuel (2021) and Music (2021) published papers on techniques with traumatised children. Their innovations resonate with some of my findings, although they do not refer to silent children. What emerged from my research—both from the theoretical review and the findings—was that the roots of silence could be found in traumatic early experiences, although this might not always be the case, as Magagna (2012) warns us. Theoretically, as Balint (1958) clarifies, what might be underneath the silence is a 'basic fault'—a traumatic experience in pre-verbal life that remains pre-symbolic and therefore has no words. Both Emanuel and Music, who are involved in the Tavistock training, advocate for innovative ways of adapting Kleinian and post-Kleinian techniques. I believe that the evolution of technique is intrinsic to psychoanalysis in a broader sense, as evidenced in Freud's writings. This study's findings illustrate the Kleinian innovations.

Here I have tried to categorise the theories that I have used, which might provide some clarity, but it might also be a bit reductive. It is also important to acknowledge that my literature review is by no means exhaustive from any perspective. Many other relevant papers could have been included both from within and outside of the Kleinian tradition. I used what was available to me within a limited

time. I would like to signpost the reader to two relevant recent publications that came up after I had completed my literature review: ‘Silence and Silencing in Psychoanalysis’ (Dimitrijevic & Buchholz, 2021) and ‘Silence in Psychoanalytic theory and clinical work’ (Acheson and Avdi, 2023). The first is an entire book that fills a gap, as ‘there has historically been a lack of explicit debate within psychoanalytic theory as to how to understand and work with silence’ (Acheson, 2023, p. 154). The second is a review of mainly theoretical literature. Acheson (2023) concludes that:

> the lack of research in this area, and the lack of opportunity to draw on different forms of material in understanding this phenomenon, reflects the situation in which therapists find themselves when faced with silence in their patients, and highlights a collective ‘silence’ in the profession on how to further understand this form of communication (p. 154).

It is my hope that the present study contributes to this gap.

1.1 Silence and psychoanalysis

The literature on silence in therapy with children and adolescents is mainly limited to case studies (Acheson *et al*., 2010). In contrast, there is a large number of papers on silence in psychoanalysis with adults (Liegner, 2003). However, the literature on silence has remained largely unintegrated, lacking a coherent account (Acheson *et al*., 2010; Gale and Sanchez, 2005). Acheson *et al*. (2010) suggest that endeavours ‘to develop a conceptual framework to bring these ideas together are either outdated (Blos, 1972; Levy, 1958; Zeligs, 1960) or insufficient (Sabbadini, 1992)’ (p. 226). In addition, Liegner (2003) notes that there have been slow developments in terms of technique. In what follows, with the aid of Liegner (2003) and Bakalar (2012), I will present the development of psychoanalytic literature starting from Freud.

1.1.1 The classical view of working with the silent patient

Freud (1912; 1913) mainly understood silence as a resistance to the fundamental rule that the patient should ‘talk about anything that came to mind’, so as to enable ‘transference’ of feelings to the analyst. This became the traditional view of the silent patient, which remained for the first half of the last century (Bakalar, 2012). Liegner (2003) points out that although there were conceptualisations about the topic, little was accomplished regarding considerations of technique. The traditional technique encouraged analysts to interpret silences in order to help patients to resume talking. Following the publication of *Studies in hysteria* (Freud, 1893), Ferenci (1919) recommended meeting the patient’s silence with silence (Bakalar, 2012), which became the accepted practice, although Hermann (1920) noted that this intensified the silences (Liegner, 2003). Glover (1927) cautioned that, if not used appropriately, this type of intervention could be perceived as a counterattack. Liegner (2003) concludes that the classical management of silence, interpreted negatively, led to therapeutic failure, and that silent patients were considered unsuitable for psychoanalysis.

Knutson and Kristiansen (2015) explain that a disturbing feeling emerges when, as ‘listeners’, ‘the other person remains silent. Uncertainty often evokes fear: we are baffled when what we expect to happen does not happen (...) we lose our way and do not know “what to say”’ (p. 92). They also alert us to how, once the patient realises that their silence can exert power over the therapist, the therapist is left in a vulnerable position that could determine the course of the treatment: ‘The dialectics of wondering and its resolution is the field where insight and knowledge are gained. Feeling confusion and insecurity about “what I thought I knew” forces one to think, tune in, interpret, find words, and define one's experience’ (p. 28).

In my view, this formulation synthesises the trajectory of the development of how to work with silence, from classical to modern psychoanalysis, stemming from maturational concepts that use the negative and positive feelings of both patient and therapist, which I will now present.

1.1.2 Contemporary view of working with the silent patient

Bakalar (2012) refers to numerous authors writing in the second half of the previous century, including Khan (1963), Nacht (1963), and Zeligs (1960) who took a different approach to the fundamental rule when working with silent patients. They postulated that the root where the analytic work unfolds is embodied in understanding the silence itself (Bakalar, 2012).

Balint (1958) coined the term ‘basic fault’ to describe a deficit in the internal mother that may lead to silent periods during analytic sessions. Balint suggested that if there is a good-enough fit between what any particular baby needs and what his mother can provide in pre-verbal life, the baby has an experience of a good-enough world with trust and love. When the baby suffers a deficit of maternal love, emotional understanding and physical care, ill-formed feelings of anger around such a deficit may emerge. This part of the self is pre-symbolic and therefore has no words.

Bakalar (2012) postulates that the working through of the silence, being mentally present, and giving words to this experience are practices that can repair the ‘basic fault’*,* after which more traditional conflict analysis can take place. She reviews papers by Khan (1963) and Nacht (1963) and finds in them good representations of working at the level of the ‘basic fault’*.* Regarding the attitude of the analyst, Khan (1963) writes: ‘My role and function during those silences were to provide a sentient,

concentrated, alert attention. This attention had to be more than merely listening. It is listening with one's mind and body …' (p. 306).

Nacht (1963) postulates that these patients come to analysis to re-experience a union with another so as to repair the 'basic fault' (the self). This cannot occur if either analyst or patient is scared of closeness and silence. Nacht describes the attitude of the analyst as a 'deep understanding attitude'.

Bakalar (2012) compares Nacht's 'deep understanding attitude' with Bion's (1962) conception of 'K' (for 'knowledge'), which the latter explained in terms of how 'an emotional experience cannot be conceived of in isolation from a relationship' (p. 42). That is, in order to 'know' the patient, there is a need for lived experience.

Bakalar (2012) writes that Balint, Nacht, and Khan describe how the quality that the analyst must possess is the desire to 'know' the patient.

> It is the analyst's capacity to sit with the patient, to mentally take in the child's confusions, distress, thoughts, and unbearably painful feelings, to attempt to understand and sort them out, and then to speak to the patient about them, which constitutes Bion's notion of 'containment'. (p. 227)

About the contemporary understanding of the meanings of silence, Bakalar writes:

> We now understand that an individual's silence can have various dynamic meanings and may occur for reasons out of the person's awareness; or, the silence may be conscious, but the person inhibits verbalisation to defend against guilt, shame, or embarrassment; or silence may develop out of fear of verbally attacking or trying to seduce the analyst. (p. 222)

Balint (1958) considers that the silent patient in the analytic situation might be doing two different things: putting up resistance by running away from something, or running towards something, with creativity. In his words: 'Perhaps if we can change our approach – from considering the silence as a symptom of resistance to studying it

as a possible source of information – we may learn something about this area of the mind' (p. 338).

Bakalar (2012) warns us to be aware of these two distinct possibilities if we are to respond appropriately to the presence of the silent person.

1.1.3 Kleinian contributions

Further developments in the Kleinian tradition—including Joseph (1982), Steiner (1993), and Meltzer (1976)—provide clinical examples of the most ill silent patients, from which they derive helpful theories and technical developments. However, these authors do not focus on silence per se, as they see the silence as a manifestation of the disturbance that presents the technical difficulties they describe.

Joseph (1982) describes deadening silences in the analytical hour in the most disturbed and self-destructive patient as reflecting a pull towards the Freudian 'death instinct' and preventing contact with the analyst. She alerts us to a kind of patient that is stuck in masochistic ways of functioning, locating the life instincts in the analyst. She writes: 'They show a strong though frequently silent negative reaction, but this negative therapeutic reaction is only one part of a much broader and insidious picture' (p. 449).

Joseph also alerts us to the paradox of libidinal gratification and addictive nature in self-destructiveness, despite the concomitant pain. She emphasises that, to adequately address the underlying anxiety, it is crucial to distinguish between the patient's tendency to exploit their misery, and their genuine despair. She believes that it is necessary to first address their masochistic use of misery, which masks their real suffering. If this is not done, then these patients tend to respond to the analyst's interpretations with further silent mockery.

Joseph (1982) refers to Meltzer (1973), Rosenfeld (1971), and Steiner (1982) to situate this type of patient, which they describe as imprisoned by a part of the personality, while they can see that there is life outside this prison. She warns us that these patients may provoke the analyst to criticise them and then use this to beat themselves up. They may end up ‘caught up in this internal crushing and crushed, situation, and paralysis and deep gratification ensue’ (p. 453). Since the gratification is unconscious, it is difficult to help the patient gain awareness of its hold.

Illustrating the concept of ‘psychic retreat’, Steiner (1993) presents a case of an adult patient who, for months, stayed silent for a significant part of the sessions. He describes the patient's tendency to find an illusory refuge in a 'desert island where she sunbathes’ (p. 22). He explains how she idealises a safe and warm place, free from any concern, while in reality she creates a disabling, deadening, and arid place.

Steiner writes about the complexity of the use of the psychic retreat and its impact on the analyst:

> The refuge offered the patient an idealised haven from the terrifying situations around her and appeared to provide other sources of gratification. The perverse flavour was connected with the apparent lack of concern on the part of the patient and the evident pleasure and power she derived from the self-sufficiency of the retreat. The analyst, by contrast, feels extremely uncomfortable, being asked to carry the concern and yet knowing from his experience with the patient that whatever he does will be unsatisfactory. (p. 22)

Steiner (1993) refers to the psychic retreat as a pathological organisation that protected the patient from ‘paranoid-schizoid’ and ‘depressive’ anxieties. He writes, similarly to Joseph:

> It offered the comforts of withdrawal to a state which was neither fully alive nor quite dead, and yet something close to death, and relatively free of pain and anxiety. This state was idealised even though the patient knew she was cut off and out of touch with her feelings. I think that perverse sources of gratification were prominent and that these helped to keep her addicted to the relief which the refuge brought. (Steiner, 1993, pp. 23-24)

To continue with this line of thinking, I will now present some technical considerations from Meltzer (1976) that seem influential in some of the participant accounts that will be presented in the 'Findings' section. Meltzer introduces the helpful notions of 'temperature' and 'distance' as he examines some developments in the basic technical principles of psychoanalysis that emerged in his practice. He refers to how he conducts interpretations, rooting them in his countertransference. Meltzer notices how he modulates his voice to create an emotional environment, which he refers to in terms of 'temperature'. He also directs his interpretations, adjusting his tone to tune in to the different parts of the personality of his patient, trying to keep the appropriate 'distance'.

Referring to the musical deep and primitive roots of language to express states of mind, Meltzer develops this idea as follows:

> If one imagines that the speaking voice could be modulated through its entire range of musicality, this will provide a spectrum from monotone to full operatic splendour. (...) Its elements would be the ordinary ones of music: tone, rhythm, key, volume, and timbre. (p. 377)

He reflects on using his voice to help the patient reach a more balanced position by bringing him down a bit if he is too high or by enthusing him with his intonation should the patient be too low. Meltzer (1976) notes that the analyst can also modulate the 'distance' to the patient from moment to moment. He continues: 'An awareness of splitting processes in the patient makes it possible, especially if we take note of the language differences between various parts of his personality when they present themselves directly acting in the transference'. (p. 378)

1.1.4 Silence and child psychotherapy

I will now move on to present some background literature on the need to adapt child psychotherapy techniques when working with silent children, starting with some

thoughts from the pioneer child analyst, Melanie Klein (1930), on the importance of symbol-formation for child development. I will then present some more recent post-Kleinian developments, starting with Alvarez's (1992) influential concept of the enlivening object, as will emerge in the analysis of the data. I will finally turn to the most recent publications linked to the topic in a broader sense (Emanuel, 2021; Music, 2021).

Klein (1930) presents a four-year-old silent boy and emphasises how she temporarily adapted her technique. She writes:

> I would emphasise the fact that in Dick's case, I have modified my usual technique. In general, I do not interpret the material until it has found expression in various representations. In this case, however, where the capacity to represent it was almost entirely lacking, I found myself obliged to make my interpretations on the basis of my general knowledge, the representations in Dick's behaviour being relatively vague. Finding access in this way to his unconscious, I succeeded in activating anxiety and other affects. The representations then became fuller and I soon acquired a more solid foundation for the analysis, and so was able gradually to pass over to the technique that I generally employ in analysing little children. (pp. 228-229)

Interestingly, she initially seemed to interpret more rather than less. Klein started from a theoretical stance when the child was mostly deprived of means of communication. She was also trying to activate anxiety early on, which formed a basic principle of her technique.

More recent theoretical developments include neuroscience and body understanding, challenge existing traditional techniques and the prevalent idea 'to tackle the deepest anxiety in the patient as quickly as possible [which] is potentially anti-therapeutic, and for traumatised patients retriggering of their distress' (Emanuel, 2021, p. 394). Anne Alvarez (1992) agrees with Bion's concept of containing the child that can project his disturbance to the therapist. However, she feels the psychoanalytic technique needs something else to reach the extremely withdrawn child. She borrows

from child development research (Braselton *et al.*, 1974; Trevarthen, 1984; Stern, 1985) and their findings from observations of mothers that draw their babies to themselves and add something more to their interaction. Alvarez writes: ‘Mothers, I mean, function also as alerters, arousers and enliveners of their babies’ (p. 60). She adds:

> there is more to mothering than the passive and mechanistic concepts of adaptation and fit, or receptiveness would allow. Surely novelty, surprise, enjoyment and delight, in manageable quantities, play as vital a part in the infant's development as their more peaceful counterparts – structure, routine, familiarity, lullaby. (Alvarez, 1992, p. 63)

The mothers respected mutually-needed moments of separation and withdrawal, but they also initiated interaction, showing their genuine interest in their babies. Alvarez concludes that, like the mother, the therapist might need to claim, reclaim, and revitalise the most ill patients.

Emanuel (2021, p. 393) notes ‘that psychoanalysis has largely ignored the body. This is no longer tenable given’ that emotions originate in the body. He therefore advocates for enhanced recognition of body states and non-verbal communication in work with traumatised, abused, and neglected patients. ‘The essential starting point has to be to enable the patient to feel they are safe’ (p. 394), have some sense of agency, and follow their pace.

Similarly, Music integrates ‘neurobiology and understandings of the body, alongside psychoanalytic theory’ (2021, p. 357). He advocates for a more energising phase but applied with caution: ‘a slow “reboot” back into life and sparking, which needs to be actively facilitated by the therapist’ (p. 357). He continues: ‘to respark a life in which feelings can be felt again manageably. (...) slowly turning down danger signals, learning to trust in safeness, coming to know that danger is not as present as our nervous systems believe’ (p. 362).

These selected ideas support the findings, and I will therefore return to and build on them in the discussion below. In the next section, I will present the literature review on the topic in the area of child psychotherapy, and I will begin by explaining the method used to find these sources.

1.2 Literature review on silence and child psychotherapy

I searched the following concepts in databases.

Concept 1: "Child and adolescent psychotherapy" OR "Child psychotherapy" OR "Child analysis".

AND

Concept 2: silen* OR Quiet* OR Non£verbal* OR Mute* OR "Selective mutism" OR "Oral communication" OR "Speech disorders".

Forty-eight papers came up, including chapters of books and an entire book on the subject. I scanned and selected the most relevant papers to the research question and came up with more than twenty papers that I could mention to map out the literature.

The papers were mainly single-case reports on latency children, including Weinstein (2002), Allnutt (2010), Wolpe (2016), to name a few; and adolescents (Leira, 1995; Wilson, 1997; Berko, 2013; Della Rosa, 2015; Anagnostaki, 2013; Bakalar, 2012). A few included two or three single cases, for example Monzo (2015), Wolpe (2016), Leira (1995); all concerned the topic of working psychoanalytically with silent children or adolescents and were published in the last thirty years. There is also a seminal book, edited by the child and adolescent psychotherapist Magagna (2012), which covers multi-faceted work with silent children in different contexts and by different professionals, as well as two case studies.

Weinstein (2002) suggests that, until the beginning of the 21st century, the psychoanalytic literature on silence in children was relatively scarce, but mentions Friedman (1986), Pitlick (1994), and Yanof (1996) as examples bucking the trend. Twenty years later, there are a few more. However, papers do not always include the word 'silence' or a synonym in the title or keywords, which makes it hard to locate. This was the case in Allnutt's (2010) and Della Rosa's (2015) papers, despite the abstract clearly describing silence as a relevant feature in the therapies.

Some writers focus on selective mutism, such as Monzo *et al.,* (2015) and Berko (2013). Monzo *et al.* draw on six case studies written between 1977 and 2007 (Anthony, 1977; Dahl; 1983; Pitlick, 1994; Ratford, 1977; Piperno, 1997) and a book (d'Ostiani, 2007).

Quantitative studies were mainly absent, except Acheson *et al.*'s (2020) study on silence in depressed adolescents undergoing short-term psychoanalytic psychotherapy (STPP). They point out that silence as an aspect of psychoanalytic psychotherapy is a neglected research area. Their findings suggest that adolescents have more negative responses when their silences are met by silence. They conclude that further understanding the therapist's perspective might bring some light to understanding their interventions with their silent patients. My study then responds to this gap, as it could shed some light on the perspective of the child psychotherapist.

Magagna (2012) bases her edited book, entitled 'The silent child: communication without words', on her many years of experience as a child psychotherapist and supervisor on the subject of emotionally regressed children who entered the hospital in full retreat from the external world. The writers share their experiences of the tremendous challenges they faced in attuning in a lively way to a child that is so withdrawn (Magagna, 2012; Music, 2021). Magagna uses the model of

infant observation and countertransference to reach these withdrawn children and adolescents. It includes observing the minute details of the child's behaviour with all senses, with free-floating attention, and simultaneously becoming aware of the impact on the observer themselves. The authors describe how they work in the present moment, gathering the transference and countertransference to understand the dynamics of the muted child's emotional dilemma. This may imply feelings that have never been put into words before.

1.2.1 Single cases of child psychotherapy with silent patients

I will now briefly comment on four papers about single cases of intensive work with silent children, from psychoanalytic child psychotherapists and a psychoanalyst (Allnutt, 2010; Della Rosa, 2015; Anagtostaki, 2013, and Bakalar, 2012).

Allnutt (2010) presents a remarkable example of a finely-detailed infant observation combined with countertransference awareness, as the main communication channels with a latency girl who remained silent for a year. Her free associations reveal unconscious meanings that help her decipher and work with a child that is hard to reach. Della Rosa's (2015) detailed descriptions of her countertransference informs her understanding of the young person. Like the others, she struggled with her countertransference and realised that she could not use it classically.

Anagtostaki’s (2013) case study involves a three-year-long silence and she links her work with Nacht (1963). Bakalar (2012) presents a coherent literature review on the discourse of silence, and then proceeds to present a highly challenging adolescent boy that develops an erotic transference with her and is silent for four months of his five-times-a-week analysis. This paper is published in Magagna’s edited

book on silent children. In this latter paper, I found that returning to the theory was anchoring amid such unsettling passions, and the creative application of theoretical concepts felt illuminating.

I will now present what I have found in the literature regarding the reasons for these children’s silence or mutism.

1.2.2 Origins of silence

Most writers agree that silence is multi-determined. Magagna *et al.* (2012) and Monzo *et al.* (2015) both suggest that the child retreats into a non-thinking, non-talking, 'mutism of the mind' (Monzo, 2015) in the context of complex family relationships. The extreme cases may reflect intergenerational silences and the child's withdrawal from the unbearable pain of 'family secrets’ (Magagna, 2012). Monzo *et al.* (2015) add that selective mutism occurs when speaking has become fraught with conflict and aggression and thus becomes dangerous. Magagna describes this phenomenon in terms of a child who feels terrified and retreats from unbearable external or internal emotionally or physically turbulent situations. She adds that: ‘Not *all* the families of these non-speaking children had severe family difficulties, and it remains a mystery as to why these particular children found it so difficult to stay connected to life’ (Magagna, 2012, p. 34).

Magagna and Bakalar (2012) use the concept of a ‘basic fault’ (Balint, 1968) to explore possible origins in early infancy of the emotional bridge between baby and parents breaking. They describe this as a ‘shutting-down place’ in their personality development, which the child might retreat to when he/she faces a crisis later in life.

Monzo *et al*. (2015) suggest that the early mother-infant relationship, which might be impaired by depression, trauma, or mental illness, impacts the establishment

of reciprocity and containing object relations. Given that this is the context in which the child develops its speaking capacity, this could also be damaged.

Wolpe (2016) uses the concept of the ‘speaking object’ (Meltzer *et al.,* 1975) to explain the necessity of an external maternal object that talks to the baby, a function that is internalised over time, and the child can then talk to itself and, later on, think with words. Wolpe suggests that this develops within a good early-object relationship and emphasises the importance of musicality in the mother's speech as a structure where meaning develops over time. He reminds us of how the capacity to symbolise is connected to the achievement of the ‘depressive position’, as conceived by Klein, in terms of being able to separate from concrete objects and achieve mental representation and abstraction. Along the same lines, Bakalar (2012) argues that some patients with more primitive ways of thinking are unable to differentiate words from actual deeds, in a so-called ‘symbolic equation’ (Segal, 1981), and are therefore unable to verbalise these thoughts to their therapist.

Joseph (1982) describes her impression of these kinds of patients, who as infants:

> have not just turned away from frustrations or jealousies or envies into a withdrawn state, nor have they been able to rage and yell at their objects. I think they have withdrawn into a secret world of violence, where part of the self has been turned against another part, parts of the body being identified with parts of the offending object (…) It seems to me that instead of moving forward and using real relationships, contact with people or bodies as infants, they retreated apparently into themselves and lived out their relationships in this sexualised way, in fantasy or fantasy expressed in violent bodily activity. This deeply masochistic state, then, has a hold on the patient, that is much stronger than the pull towards human relationships. (Joseph, 1982, p. 457)

Furthermore, Magagna (2012) categorises five different states of mind that could underline the silence, ranging from various stages of disconnection to achieving

full connection with the other: giving-up; going-away; adhesive identification, and hatred, followed by persecution and loving unity.

1.2.3 Psychoanalytic technique with the silent child and dilemmas

This project is embedded in psychoanalytic thinking overall, but while conducting the interviews, some basic concepts emerged in the participants' accounts that also came up in different parts of the literature. I think it important to outline a few key concepts, as this thesis could be read by a larger audience outside the psychoanalytic child psychotherapy profession.

1.2.3.1 The psychoanalytic attitude

The analyst's attitude of 'evenly suspended attention' or 'free-floating attention' is a key psychoanalytic idea that was first formulated by Freud (1912), and later developed by Wilfred Bion. Bion (1897-1979) is an extremely influential psychoanalyst in the training both of psychoanalysts and child psychotherapists and is mentioned in the above literature as well as in the study participants' accounts. He developed some of Freud's and Klein's theories, all of which are most influential in the Kleinian strand of the Tavistock training.

Bion developed Freud's early formulation and wrote, in a letter to Lou Andreas-Salomé: 'Freud suggested his method ['evenly suspended attention' or 'free-floating attention'] of achieving a state of mind which would give advantages that would compensate for obscurity when the object investigated was peculiarly obscure. He speaks of blinding himself artificially'. (Bion, 1970, p. 43)

Using the poet John Keats's (1795-1821) concept of ‘negative capability’[1] Bion advocated for the abandonment of 'memory and desire' as a method to achieve artificial blinding. He saw it as essential to the psychoanalyst to develop an attitude to observe. He wrote: ‘A certain class of patient feels “possessed” by or imprisoned “in” the mind of the analyst if he considers the analyst desires something relative to him – his presence, or his cure, or his welfare’ (p. 42).

In this way, Bion aspired to train the mind to remain open, in an unhurried state, and to achieve an attitude of passive receptivity that would allow space to get to know the patient as authentically as possible.

1.2.3.2 Infant observation

Infant observation is another fundamental aspect that appears in the literature review, the findings, and the discussion sections, and is a cornerstone of the child psychotherapy training, so I think it merits some explanatory notes.

Esther Bick (1962), a child analyst pioneer, developed the method of infant observation, which has formed part of the child psychotherapy training at the Tavistock since its inception in 1948, and was later incorporated as a pre-clinical requirement. Since 1960, infant observation has been included in other psychoanalytic trainings, including the Institute of Psychoanalysis.

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[1] Several things dovetailed in my mind, and at once it struck me what quality went to form a Man of Achievement. ... – I mean Negative Capability, that is, when a man is capable of being in uncertainties, mysteries, doubts, without irritability reaching after fact and reason’ (Keats, 2002). Bamford (2005) clarifies that ‘It is not that Keats does not want to know; he wants to know in a different, purer way. He aspires to a more direct access to reality’.

Bick and Harris (1980) comment on how demanding this module is in terms of both time and effort but found that students came to value it highly due to the knowledge and skills gained in this process.

The method involves, as explained by Bick (1980), once-weekly home visits to observe an infant, from birth until the end of their second year of life. The recording of detailed observations done after the observation allows the observer to be present with ‘free-floating attention’, which is discussed in a small seminar group.

Harris (1976) explains some of the skills that therapists-to-be gain from infant observation, which are also key in the work with the silent child, as follows:

> The infant-observer attitude helps the aspiring analyst to take not only the words, but also the details of the patient’s total demeanour and behaviour into account: to read between the words and to discern the nature of the experience which is being conveyed or avoided. It can help him to wait until he gathers from his own response to the patient some intuition of what may be happening. If he cannot bear this period of uncertainty and confusion, he is likely to pre-empt the emergence of the emotional experience in the patient by explaining it first. (pp. 229-230)

Harris highlights the essential learning of the required attitude when observing pre-verbal and minute communication, including the capacity to stay with painful experiences, build up understanding over time, and resist premature conclusions. These skills become essential in the work with the silent patient, as we will see in the participants’ accounts.

1.2.3.3 Countertransference

Another key tool in psychoanalytic practice is ‘countertransference’. It was initially a controversial concept established by Freud in 1910 as the undesirable unconscious feelings stirred up in the analyst by the patient, and it was understood to interfere with the process. Heiman (1950) developed the concept to include all the feelings that the

analyst experiences during the analytic session and changed the prevalent negative view of it, seeing countertransference as helpful.

Pick (1985) addresses the complexities of this concept and explains how the feelings that the patient projects into the analyst will undoubtedly trigger the analyst's feelings, being interconnected. She argues that it is part of the work for the analyst—using Bion's terms—to have an 'emotional experience' of and be impacted by the patient. She suggests the analyst observes their responses to the patient and tries to work through the impact of the responses on themselves, which will inform their interpretations. She concludes that the experience is as powerful for the analyst as it is for the patient:

> To suggest that we are not affected by the destructiveness of the patient or by the patient's painful efforts to reach us would represent not neutrality but falseness or imperviousness. It is the issue of how the analyst allows himself to have the experience, digest it, formulate it, and communicate it as an interpretation that I address. (p. 8)

I will now return to the four case studies with a focus on technique, mainly concerning countertransference. Della Rosa (2015), Allnut (2010), Anagnostaki (2013) and Bakalar (2012) present the development of their technique when faced with different kinds of prolonged silences, which last from 12 months (Allnut) up to three years (Anagnostaki). They all emphasise how much more they needed to rely on the infant observation method, their countertransference, and their creativity (Magagna *et al*., 2012; Della Rosa, 2015; Allnutt, 2010; Anagnostaki, 2013) when trying to reach these withdrawn children and adolescents.

Allnut (2010) writes: 'My countertransference was the only guide I had in an atmosphere that was otherwise impenetrable' (p. 36). Magagna (2012) agrees that the countertransference experience is the basis of communication with silent patients.

Rustin (2001) writes about how she uses her countertransference to 'get through' to two patients who would not talk to her about themselves. She describes:

> Since neither of them could talk to me about themselves… I had to experience in the countertransference, in my own emotions in the sessions and my thinking about them between the sessions, the intolerable feelings which their way of life was designed to hold at bay and which their growing relationship with me acquainted me with directly. (p. 274)

Rustin describes the impact of this work on her and how she struggles to find ways to use her countertransference to help the child. She emphasises the necessity of external and internal support for the therapist to pursue such intricate work, and the technical dilemmas when the established ways of working seem 'useless' with non-verbal children with a history of maltreatment and abandonment. She vividly illustrates the 'deadness' she experienced with this boy as follows:

> The sort of boredom and emptiness one faces in sessions with silent, passive patients like this is a chilling challenge to one's equanimity. Too little anger about the waste of a life will lead to a deadly collision, an enacted abandonment of the live child, too free an expression of it to frozen terror in the patient, whose belief is that the life in him was responsible for the loss of his mother – she could not cope with him, he was too much for her; the only hope of holding on to someone is to be an inoffensive mouse. (p. 283)

Della Rosa (2015) poses the critical dilemma of using the countertransference so that her easily-persecuted patient would find it helpful. With her patient, it was helpful to keep the transference in mind without addressing it explicitly. She writes: 'During the first year, I found the best I could do was observe and make some, often failed, attempts at interpreting the countertransference experience' (p. 37).

1.2.3.4 Challenges in the work, progress and creativity

These therapists convey the feeling of constant failure and suggest the importance of learning to remain silent and not show any excitement at the minor indications of progress, as the child cannot allow the therapist or herself to experience any pleasure.

The writers share their experiences of the tremendous challenges they faced in trying to remain receptive, with free-floating attention to a child that is so withdrawn (Della Rosa, 2015; Allnutt, 2010; Anagnostaki, 2013). In the most challenging cases the silence contains the terror of the baby without the presence of an emotionally attuned and containing parent. Magagna *et al.* (2012) suggest the treatment aims not to get the child to speak but—without exerting any pressure—to gradually understand and tackle the emotional dilemma. She holds that the therapist has to attend to the countertransference and work out what belongs to the child's communication and what is triggered by them in the therapists. Joseph (1998) writes: 'in work with children, the therapist is liable to be drawn into some kind of acting in; … sensitivity to this is an essential aspect of the work; … perhaps the crucial element in the setting itself is the therapist's state of mind'. (p. 366)

Several authors, including Bakalar (2012) and Allnutt (2010), alert us to the impact of relentless and insidious silence on the therapist, which could result in interventions that could humiliate the child.

It is interesting to see how these therapists find a way into the silence and, significantly, how they recover a receptive state of mind. Bakalar brought her crochet to the sessions. This was her way to relax, remain available, and she also thought this lifted the pressure on the patient to talk. Her patient responded with fury. Bakalar reflected, with the help of Klein's (1975) ideas, on the young person's phantasy of absolute control of the other as a manic defence against feelings of helplessness and loss.

Bakalar's (2012) idea to bring the crochet was inspired by what Symington (1983) referred to as the 'act of freedom' upon realising one is under the patient's

control. Symington suggests that once the analyst can find a moment of internal freedom, they can take an independent stance or action concerning the patient.

Allnutt (2010) used role-play, which she notes allowed for the accumulation of shared moments and understanding of the meaning of silent communication rather than meeting with defensive control. She draws ideas from Alvarez (1992), such as ‘reclamation’, which refers to the mother's active role in engaging her baby in an enlivening way.

An interesting aspect that comes up clearly in these vivid accounts is that none of them knew that their patients would be silent when the work was set up, as during the assessment phase the patients presented different degrees of verbalising their worries (Della Rosa, 2015; Allnutt, 2010).

All the above authors struggled with their own feelings when finding themselves in the void with an absent other. The patient's early experience of being 'let down' is quickly mirrored in the therapist's countertransference (Della Rosa, 2015), and they all thoughtfully link the early histories of catastrophic changes in the child that seemed to be re-evoked (Della Rosa, 2015; Allnutt, 2010; Anagnostaki, 2013).

In Allnutt and Anagnostaki, the re-experience of the traumatic situation emerges due to an early 'mistake' linked with the setting or contract. This seems to precipitate the dramatic change in the young person to become relentlessly silent. These two cases reach a satisfactory ending in which discussions became possible, either about the early change in the therapy, or the long subsequent silence.

Several challenges have already been mentioned, but I will summarise a few more. Della Rosa (2015) reflects on her experience of her thinking at times being inhibited due to the robust projections of fear of parasitic thinking of and relating to her silent patient. The challenge is to monitor such paralysing projections to keep on

thinking. Similarly, Anagnostaki (2013) points out the difficulty in her attempts to maintain her capacity to think through the silence, and writes about the 'silent cure' instead of the 'talking cure’. Anagnostaki conveys the difficulty of not knowing if the therapy is going in the right direction, and the challenge of constantly receiving aggressive attacks.

All writers talk about the problematic doubts and frustrations that the therapist undergoes amid deafening silence: questioning their role, their ability, and the value of their work (Anagnostaki, 2013). They also account for the difficulty in interpreting the patient's aggression without being experienced as retaliatory (Della Rosa, 2015). In addition, the therapist struggles to find a place where she would not be masochistic or the child humiliated (Allnutt, 2010). Allnutt writes: 'Playing roles helped bring something out into the open without masochism on my part or humiliation on Julia's part’ (p. 41).

1.2.3.5 The importance of multidisciplinary work

Magagna (2012) believes in the importance of the work with the multidisciplinary team and the family, who are embarking on a journey that requires them to develop and find words for their experiences with the silent child. Anagnostaki (2013) suggests the help she received from a social worker who was providing parent support prevented a premature termination of the therapy.

In contrast to the standard view, which considers the child must be sufficiently physically fit to start therapy, Magagna suggests that any child is a suitable candidate for psychotherapy, at any stage of illness. She argues that a silent child is terrified of his predicament and requires attentive, empathetic thoughtfulness and psychical care, similarly to a new-born baby.

Methodology

2.1 Rationale for the use of IPA

This study requires in-depth examination of complex and subjective experiences and therefore a qualitative methodology was deemed more suitable. My study follows the interpretative phenomenological (IPA) framework as it explores the meaning that therapists give to their experiences of working with silent patients, and the impact it has had on themselves.

While I was interested in the therapists' personal experience, which included their countertransference and their perspectives on the work, this was originally a way to get into the experience of the silent patients. I was therefore concerned about the validity of second-hand accounts. Smith *et al.* (2009) point out that human and health science researchers have an ultimate interest in attending to the experiences of others, which encompasses third-person data. IPA research is aware of several ways that research differs from experience and offers steps to realise such a project (Smith *et al.*, 2009). In addition, since accessing the experience of silent patients might prove difficult due to the nature of the silence, accessing their experience through the interpretation of their therapists might provide potential for enriched understanding, whilst there are limitations.

However, the study took on a life of its own, and I became more interested in the therapist perspective, and its value for the profession. I therefore chose IPA as the qualitative methodology for this study, as it was concerned with subjective lived experiences within a specific context. IPA acknowledges that individuals' experiences and meaning can only be accessed through the researcher’s interpretation of the participants’ accounts – double hermeneutic - (Smith *et al.*, 2009, p. 3). Furthermore, as a psychoanalytic psychotherapist, I highly value disciplined subjectivity as a source

of knowledge (McWilliams, 2013) as said above.

The question arises about the choice of IPA over other methodologies for this study. Thematic analysis (TA) would have given less importance to participants' and researcher's subjectivity—thus not valuing double hermeneutics, which matches the importance that psychoanalysis gives to unconscious communications which includes my countertransference, an essential tool as a psychoanalytic child psychotherapist that I wanted to use. In addition, I discounted TA due to its focus on generalisation rather than on the specific experiences of the particular individual that were needed for my study. IPA was deemed more appropriate due to being ideographic and aiming to explore in detail individuals' experiences and motivations.

Narrative analysis (NA) would have been less suitable as it is more concerned with how participants recount their stories rather than the meaning they gave to their experiences (Willig, 2013). Moreover, NA does not seek out similarities and shared experiences which is part of the phenomenology strand of IPA, nor includes the double hermeneutic, explained above. For all of these reasons, IPA was deemed the most suitable method.

2.2 Ethics

The study needed ethical approval from the Tavistock Research Ethics Committee (TREC) (Appendix A), since I set out to solely recruit child and adolescent psychotherapists registered to the Association of Child Psychotherapy. I submitted the proposal and public documents (Appendices B, C, D, and E). Due to the outbreak of Covid-19, I adapted my proposal to undertake the interviews online. After receiving approval, I proceeded with the recruitment process.

During recruitment, each potential participant contacted me via email, I provided an information sheet explaining the key aspects of the research and the consent form. Being in my third year of psychotherapy training, I was well-prepared to conduct the interviews in open manner and build a rapport with the participants. I followed my participants' pace and took cues from them to ensure they felt at ease, particularly when exploring sensitive issues. Since I was interviewing colleagues, I took an informal and friendly stance. The questions were open, and I followed the participant's lead and pace. They chose what they wanted to discuss about the presented topic.

Since the study was about professional experience, and the participants were all fully qualified, they would be familiar with this method of enquiry and would be able to look after themselves. I therefore did not anticipate that the interviews would trigger unmanageable emotional responses. There was, however, a plan to contact my supervisor should this be needed.

Finally, being aware of my own needs as a researcher was also important, particularly since this was my first experience interviewing participants, and I felt rather anxious about the process. The nature of the recruitment process meant that the interviews were naturally spread over time, allowing enough time to process each of them before moving on to the next. Personal therapy, research group, peers, and research supervision were major supports utilised to tackle any emotional difficulties brought up by the research process.

I will now provide some ethical considerations from the relational dimension. I carefully considered the operational definition of 'the silent patient', and the wording that I used in the leaflet to recruit participants.

I was interested in the enigmatic and contradictory nature of silence, and the potential formulations of ‘silence’ and 'the silent patient'. Assuming a psychoanalytic stance from the outset, I made the deliberate decision to provide broad guidelines regarding the silent patient in the leaflet, to allow participants to self-select using their own explicit or implicit definitions. The key was that I asked for therapists who had experience with this work and that they found it interesting. This was important to me as I wanted to ensure that I recruited a sample of participants who had an emotional experience of working with a silent patient of significance to them; that it had the potential to become lively—and not just theoretical—in their minds. I was cautious—following a psychoanalytic approach—to limit contamination of the potential associations they might have or what might emerge in the interview, all of which was part of my study. I hoped this might allow some more unconscious and unprocessed thoughts, closer to their genuine experience, to emerge in the interview.

At the same time, from the outset I set it up so that the interview schedule would be sent two weeks before the interview. The reason for this was two-fold: I wanted to give the participants some time to consider the interview questions to help them bring back into their minds as much of the range and detail of their work with silent patients as they could, so as to make it as available to them in the actual interview as it could be. I also thought it might provide participants with some predictability, to mitigate anxiety levels. In this way, I provided clear expectations that could help to create a safe structure to put participants at ease. I think that the psychoanalytic method relies on a balance between a clear and reliable setting within which free thinking can emerge over time. These were the principles that I applied. Furthermore, the questions were formulated in an open way, which I hoped would provide a framework without being directive or prescriptive. Furthermore, participants were free to choose whether

to read the questions in advance or not. Half of the participants mentioned they had not read the questions. These were the more experienced therapists who may have felt more confident and comfortable with letting their mind do the work in the present (more akin to the 'free association' method).

I recognise that providing the questions in advance may have impacted the data to some extent. For example, one participant mentioned ‘not being an expert’ on the topic of ‘silence’ and having read about the meanings of silence, which I had not anticipated. She started from a more theoretical position, but soon relaxed and then managed to speak from her emotional experience. In her case, the data was influenced, but to a minimal degree.

2.3 Conducting IPA

2.3.1 Research sample

I collected data from child and adolescent psychotherapists with previous or current experience of working with silent patients. Participants were purposely selected to allow a defined group for whom the research problem had relevance and personal significance (Pietkiewicz and Smith, 2014).

IPA studies usually have a small number of participants. I recruited and interviewed a small and relatively homogenous sample of therapists (four). The small number of participants generally fits well within the idiographic focus of IPA (Smith *et al.,* 2009). There was slight concern that it might, however, fall below the standards of the doctorate setting. In the end, we settled on keeping the sample to four, due to the impact of the pandemic on students working in the NHS, and the competing demands to complete the clinical part of the training.

2.3.2 Inclusion/exclusion criteria

I defined a set of inclusion and exclusion criteria to ensure a purposive sample for the study. The recruitment criteria included being a member of the Association of Child Psychotherapists (ACP). This limited participants to a selective pool of highly-trained professionals from five recognised training schools in the UK, potentially including both trainees, qualified, and retired members. The members could have been from different cultural backgrounds, and English could have been their second language.

Given the already selective pool of potential participants, having too many exclusion criteria were deemed unnecessary. I considered including participants living outside the UK, as that might provide richer outcomes, but the ethical considerations were too complex, and I decided against that.

Participants needed to have worked regularly (weekly or more) with at least one silent child or young person for at least one year. Participants had to acknowledge that silence was a salient feature of the therapy when they contacted me. Due to the differing definitions of silent patients within the field, and it being my intention to recruit varied experiences of silent patients, I set some operational definitions as guidance but kept them quite open, stating that silent patients might include children and adolescents who display selective mutism or speech delay outside the therapy. They would demonstrate this within the therapy and have remained silent for a great part of their therapy. It might also include patients who normally engage in everyday conversation outside therapy but who become silent for long periods within therapy sessions. I hoped to make sure to recruit a purposive sample with some variation of experiences.

2.3.3 Recruitment

I published a research poster in the ACP newsletter and bulletin in July and August 2020 to recruit suitable participants.

Five interested participants initially came forward between July and September 2020. However, one did not pursue it after the initial enquiry. I declined the last interested participant as their expression of interest coincided with the research panel agreement that four people would suffice. I took the time to explain this in an email and the potential participant understood.

Three people sent me their signed consent to participate in the research. I approached a senior clinician that met the criteria as I was interested in capturing various experiences. She accepted to participate in my research.

I did not have to manage any ethical concerns related to withdrawal, as none of the participants withdrew during the study.

2.3.4 The participants

Four female therapists participated in this study. I did not ask them to fill out a demographic questionnaire before the interview. On reflection, I think it would have been helpful to do so, as the lack of this information impacted on my assumptions. However, I deemed this information irrelevant to the topic at the time. There was no male participant, which possibly reflects the disproportionate gender-representation within the profession. All participants were middle-age to retirement-age adults who had worked with at least one silent child or adolescent at least once-weekly for at least a year. Participants were of homogenous ethnicity and race, mainly Caucasian from a range of British and European backgrounds. My ethnic origin is Latin-American. This

limits the cultural backgrounds and experiences included in the study to mainly Western.

I was originally interested in recruiting participants from all five UK training schools to reflect a variety of psychoanalytic approaches. However, I came to de-prioritise this and became more interested in the therapist's live emotional experience of being with their silent patient, rather than in differences in theoretical background. Three participants were Tavistock-trained and one was from the Northern School, which I am aware is Tavistock-influenced in its orientation. However, this provided a bit of heterogeneity within the sample, which I appreciated. I assume that the psychoanalytic orientation of the sample ended up being more Kleinian and post-Kleinian. I did not ask the participants about their orientation directly, and in most cases their use of theory was more implicit than explicit, except from one participant who drew on a range of Kleinian authors. However, I do not know how they might identify, and have, personally, some reservations about these categorisations. It is a fact, however, that I did not have any participants from the Independent Group, which I assume could have provided quite a different viewpoint, perhaps offering, e.g., a Winnicottian perspective (see Table 1 for details).

I am nevertheless satisfied with the findings and think that the homogeneity of the sample provided an in-depth examination of working with silent patients within a Kleinian perspective, in most cases implicitly, but grounded in the clinical material. I thought this was a testament to the British tradition as a whole, stemming from Sigmund Freud's clinically-led work, as taught in the infant-observation module, work discussion, and clinical supervision across all five child-psychotherapy schools and also in psychoanalytic adult training.

The silent patients had different ethnicities, were of both genders, and ranged between 11-16 years of age. Some were silent from the start of the therapy for long periods, and were also silent outside of therapy. One patient was silent for a limited amount of the therapy and was talking outside of therapy. Two silent patients had diagnoses: an autistic young man and a young woman in 'pervasive retreat' (see Table 2 for details).

Table 1: Participants' details

Name*	Gender	Qualifications	Employment	Training location	Current or past work**
Sarah	Female	Senior	Retired/Trainer	In London	During training
Betty	Female	Qualified	CAMHS	Outside London	Current work
Hannah	Female	Newly qualified	CAMHS	In London	During training
Claudia	Female	Senior	Supervisor	In London	During training

Note: * Pseudonyms given due to confidentiality.
** This refers to the clinical work with the silent patient that was presented in the interview.

Table 2: Participants' silent patients' characteristics

Therapist's name	Gender	Age	Background	Type of silence	Diagnosis?
Sarah	Female	11	Adopted	Only in therapy	No
Betty	Male	14	Adopted	In and outside therapy	Autism

Hannah	Female	14	Early attachment difficulties	In and outside therapy	No
Claudia	Female	14	Sudden migration (Asian)	In and outside therapy	Pervasive retreat

2.3.5 Data collection

Semi-structured interviews were used to collect data, allowing the therapists to share in-depth accounts of their experiences of working with silent patients.

2.3.5.1 The interview schedule

The interview schedule (see Appendix E) consisted of six open questions. I asked participants about their work with silent patients, their understanding of the meaning of the silences, and about change over time.

Prompts included enquiries about technical considerations, dilemmas, and adaptation of technique. The last two questions explored how participants felt the silence impacted them, their coping mechanisms, and their learning experience.

2.3.5.2 Conducting the interviews

I conducted a trial interview with a fellow trainee, to practice the technical aspects and help me feel more at ease and available to the participants.

Two weeks before each interview, I emailed the interview schedule to the participants so they could prepare for the interview if they wanted. Before beginning each interview, I explained the structure, gave some time for any questions, and then proceeded to read the first question.

I conducted the interviews between July and September 2020 via Zoom—a virtual platform. I kept the interview schedule in mind but followed participants' accounts which naturally responded the questions. This flexible approach allowed the participants to find their flow and provided me with interesting accounts. Smith *et al.* (2009) argue that IPA is committed to a degree of open-mindedness to data collection and thus encourages the researcher to try to suspend personal preconceptions when conducting interviews.

Each interview took around 50 minutes. The interviews naturally reached an ending, and I allowed some time to bring what turned out to be stimulating and moving encounters to a close, thanked the participants, and addressed any further questions.

2.3.5.3 Transcription of interviews

I transcribed each interview 'verbatim', which took several work hours, and immersed myself in my participants' experiences.

2.3.6 Data analysis

I used the six steps suggested as guidance, rather than a rigid methodology (Smith *et al.* 2009).

2.3.6.1 Reading and re-reading

Listening to each recording to gauge the emotional intensity, I was aware of my countertransference -emotional responses- to the data, particularly when participants' accounts chimed with my challenging experiences of working with silent patients.

2.3.6.2 Initial noting

I continued the analysis, making exploratory comments on every transcript. I noted the participants' use of language throughout the interviews, including pauses, silences, repetitions, and contradictions. I used printed transcriptions and then passed this to a computer to be able to share the full analysis with my supervisor.

2.3.6.3 Developing emergent themes

I then developed emergent themes around the descriptive and interpretative meaning of each interview. I wrote down concepts that encapsulated my interpretation of the psychological meaning of the participants' descriptions throughout the interviews.

2.3.6.4 Moving to the next case

I followed the same thorough procedure for each participant before moving on to the next, to ensure rigorous analysis. I then realised I had jumped one step and had to go back through all the transcripts.

2.3.6.5 Connections across themes

I then searched connections among emergent themes by listing them and then grouping related themes. Following Smith *et al.*'s (2009) suggestion, I printed out the typed list of themes and cut up the list, so each theme was on a separate piece of paper. I then used a large table and moved the themes around. The number of emerging themes was up to 15, and the number of superordinate themes was approximately 14. I then created a table of superordinate themes for each participant, with the themes under each. I annotated each theme with the line on which it is located,

along with keywords from the participant to remind me of the source of the theme to ensure I had not moved away from the data (Appendix G).

2.3.6.6 Patterns across cases

The final stage involved looking for superordinate themes across all four cases. To do this, I started by identifying the major themes of each interview. To facilitate the identification of patterns within the data, I colour-coded each connection between one major theme and another. As suggested by the IPA guidelines, I visually scanned these patterns, identified connections across the cases and drew a table of themes for the group by ordering them in a sequence, showing how themes are nested within superordinate themes and illustrating the theme with each participant's quotes (Appendix H).

In the end, I identified four overarching superordinate themes-found in the accounts of all participants- with three to five subordinate themes to represent my interpretation of the participants' reflections of their experiences. I then constructed a table of each theme as the basis for the subsequent analysis write-up (see master table of themes for the group in the 'Findings' section).

2.4 Methodological reflexivity

Researchers undertaking qualitative studies inevitably influence the outcome and are thus encouraged to use reflexivity to identify personal beliefs that may incidentally affect the research (Delve, 2022).

In line with these principles, I used a reflective journal, clinical supervision, research supervision and personal therapy to reflect on my experience with silent patients. Firstly, I included in my proposal how I had become interested in the topic

and wrote the details of this in a reflective journal. Since the beginning of my training, I worked with three patients that remained silent for considerable periods. I struggled with the work and wanted to find answers to several questions, some of which were not fully formed. Since I was genuinely interested in other child psychotherapists' experiences, and to avoid biases, I formulated the prompts with open questions and ran them by my research supervisor.

Clinical supervision was where my interest emerged, and it facilitated awareness of my professional experience. One of the three cases was my first intensive case.[2] Supervision made me aware of how I did not notice the lack of verbal language when the child became lively and engaged in non-verbal communication. It also helped me notice that I was unaware of my own non-verbal responses, which seemed attuned and were important in terms of technique.

Personal therapy helped me understand the personal reasons for my interest in the topic, coming from experiences of silence in my childhood. Moreover, I came full circle when I eventually realised the topic's connection with my background as a dance-movement psychotherapist, a field that relies on non-verbal communication, and prioritises the body and movement.

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[2] A training case involves three-times-a-week therapy for at least a year or two, and once-weekly supervision throughout the treatment.

I must have had several assumptions and expectations about the topic from my experiences of which I was not fully aware. My expectation of the findings included the potential for struggle surrounding the work with silent patients. As time went on, I could identify more assumptions that may influence the analysis and I tried to 'bracket' (Smith *et al*., 2009, p. 13), or put to one side, those thoughts.

An important component of my reflexivity practice was my awareness of a rather vague definition of the 'silent patient'. This aspect is linked to the fact that I was recruiting participants and their patients. I was aware that there was a limited pool of potential participants—as mentioned above—and my interest lay in recruiting therapists that felt they had a significant experience with the silent population, however defined, as long as it matched the quite open inclusive criteria. In practice, I had to manage the tension between my definition of silent patient and the participants' definitions, which I felt impacted on two participants in different ways. In both instances, I remained reflective and tried to provide a containing stance. For example, one participant presented a case on the autistic spectrum. I noticed a slight change in my tone of voice that gave away my initial disappointment, which immediately impacted the participant, who then justified that the patient was capable of being verbal. I then adjusted my non-verbal response to remain open, and the participant settled back and continued. Afterwards, I reflected on whether I should have included

autism as an exclusion criterion. Retrospectively, I still decided against it, since this participant's reflections of her experience were rich and pertinent to my study. In addition, she was the only participant trained in a non-London-based school, which provided some diversity to my sample.

Another relevant aspect is my position as an 'insider researcher', being a child psychotherapist in training, and then qualifying during the write-up of the thesis. ‘Insider research’ has been described as research that is undertaken within an organisation, group, or community of which the researcher is also a member (Trowler, 2011). This position makes me face methodological and ethical dilemmas.

A key challenge included awareness of the potential conflicts of my dual role as a trainee and researcher within the same context. There were different relational dynamics when I was interviewing and analysing the data of someone more senior than me, which was different to when I interviewed someone closer to my stage of professional development. The tensions in my dual role as researcher and trainee therapist were exacerbated when faced with a highly experienced therapist. I had to resist positioning myself as a student that wanted to take everything at face value. I used certain strategies to minimise these challenges, as mentioned above. On the other hand, there were also advantages. As an insider researcher I share a language, knowledge, ethical values, and understanding of the theory and practice of child psychotherapy, all of which assist my capacity to obtain an accurate understanding, which someone who was not already deeply embedded and involved might not find possible.

In addition, my experience of working with silent patients resulted in multiple connections with the participants as revealed during the interviews. Given that the participants had felt much on their own in their experiences, the interview experience

of having a lively and genuinely interested listener allowed us to build a rapport. The participants shared honest and rich material and seemed to appreciate the study as a valuable space for themselves. I was, however, worried about whether I should have been more neutral.

My interest in the topic together with personal, cultural and clinical experiences also enriched my ability to engage in the analysis of rich accounts of each participant, but, at times, it may have also influenced it. To address these concerns, I paused and reflected whenever I felt connected to my participants' accounts.

Data analysis was a challenging stage, being a novice researcher using IPA for the first time. I used the handbook of Smith *et al.* (2009) as a guide, which I found incredibly helpful. I experienced a genuine appreciation for the participants' contributions, and I wanted to do justice to each participant while trying to interpret them. In line with IPA guidelines, the analysis conducted for my study aimed towards a double-hermeneutical foundation of my interpretation including my countertransference of participants' accounts of their experiences and countertransference. I was preoccupied with being too descriptive, a common experience among novice researchers (Smith *et al.*, 2009). To address this, I made several attempts, supported by supervision, a supervision group, and a colleague, which helped with the triangulation of the data analysis. It is important that the results of this study are not seen as certainties but as interpretations (Smith *et al.*, 2009), and diverse researchers could make dissimilar interpretations. My previous personal and professional experiences with silent patients may have impacted my findings, as is inevitable, despite all efforts. However, this is also an enriching aspect recognised by IPA research.

2.5 Quality and validity

The quality and validity of qualitative research require different criteria from quantitative research (e.g. validity and reliability) for its evaluation. Yardley (2000) has produced guidelines to assess qualitative research, recommended by Smith *et al.* (2009). Yardley suggests four broad principles. First, *Sensitivity to context* included a relevant literature review; engaging closely with the particular experience of the participants; a carefully designed interview schedule; interviews conducted with high sensitivity and skill that collect rich data; diligent data analysis, and findings' claims grounded in the data obtained, with a considerable number of verbatim extracts from the participants to support each argument (Smith *et al.*, 2009). *Commitment and rigour* were sustained by a high degree of attentiveness to each participant during the research, and careful analysis of each case, which follows the IPA method systematically. *Transparency and coherence* were maintained by clearly presenting each stage of the research process in the study's write-up. Finally, the *impact and importance,* focused on the potential clinical benefit of its findings and future research.

Findings

Four main themes emerged from the analysis of the data, each of which came up in all four of the interviews (see table below). I describe these themes in detail and include extracts from the interviews to illustrate convergent and divergent views.

Master table for themes for the group

A. **Formulations of the silent child and the silences:**
   1. Silent children as active communicators: *'just different'*
   2. Silence as ambiguous: *'you don't know the silent child'*
   3. '*All* [silent children] *are different'*, and silence can evolve
   4. Silence as masking different feelings: *'it was a child who was very angry'*

B. **Technique and cautious adaptation**
   1. *'Infant observation as key to any silent work'*
   2. *'I was always interested'*
   3. It is *'a bit like a master class in countertransference'*
   4. Cautiously active: '*I have to try something different'*
   5. '*I don't know if you call it the psychoanalytic method or not'*

C. **Therapist's feelings**
   1. '*It's all your fault that the child is not talking'*
   2. 'Y*ou get very angry that the child is not talking to you'*
   3. '*I do feel quite on my own, actually'*
   4. Grief and learning

D. The tension between the necessity for support and its resistance

1. ‘*It did not feel comfortable bringing the silent patient to supervision’*
2. The internalisation of good objects as key to overcoming difficulties
3. Working with the network as essential

3.1 Theme One: Formulations of the silent child and the silences

3.1.1 The silent child as active communicator: *‘just different'*

All four therapists articulated that the silent patients did communicate, even when the message was an unwillingness to relate. The patients varied in their desire to connect to life.

They compared silent patients with talking patients, the latter being, implicitly, the norm. Initially, the main problem to overcome was the unmet expectation of a patient who 'talks’. Once the therapists came to terms with the child that does not talk, other ways of communication emerged.

All participants concluded that the silent patient is ‘different’ from their speaking counterparts. Betty used words such as 'just' and 'actually', which conveyed a moment of realisation. Her hesitations suggested that her adaptation to this patient was still ongoing, as she presented current work:

> *It's very hard for me to have an expectation of him to do much more () than he's already doing, and () I don't know if that's because ( ) somewhere I believe that actually, he's trying, and he's engaged with it but (   ) (...) ( ) this is very different kind of work to that of children who can speak, you know, maybe well, just communicate more readily in the room. I think, I don’t know, I think we’re in different territories to that (   ) umm ( ) so ( ) I think I’m (...).* (Betty, lines 309-320)[3]

[3] A bracketed small empty space () within quotes indicates that there was a pause.
A bracketed bigger empty space (   ) within quotes indicates that there was a longer silence.

Hannah equally implied the need for a phase of adaptation to come to the realisation that this population is '*just different'*. She presented two adolescent girls from her training, completed in recent years prior to the interview.

Sarah contributed with an increased awareness that what matters is the authenticity of the communication, whether silent or verbal. She described a journey of finding the essence of the communication, namely the willingness or unwillingness to connect:

> *actually, the words are not so important to communicate, but sometimes they are actually a hindrance. Even when you got an adolescent who uses his words, how much they are a defence as much as a connection. So, I think it really taught me to be quiet (), enjoying silences and not seeing them as me losing connection. And if I have lost connection, what's the quality of my lostness of connection because that's different.* (Sarah, lines 409-414)

Presenting a very unwell child, Claudia described the potential for nuanced communication without words:

> *So all these things we think 'oh the child is just not speaking to me', all these things we can think but the mind is always speaking, you know, the mind is speaking 'I'm gone to the claustrum, and I'm not in the world', or the mind can start coming to life, and you see the hands doing this* [fists]*, or this* [opening hands] *or this* [pushing hands]*, and you can start interpreting, umm the hands 'frightened', 'holding the self safely'', wanting to 'push me away', there's a whole language of hands.* (Claudia, lines 184-191)

3.1.2 Silence as ambiguous: *'you don't know the silent child'*

The therapists expressed how hard it was for them to decipher the silent communication due to its ambiguous nature and, therefore, how hard it is to get to know the silent child: '*this is the thing about silence, isn't it? that it's so hard to say absolutely that this is what is happening'* (Hannah, line 111).

Betty and Sarah also conveyed a phase of bewilderment that went on for different lengths of time, depending on how unwell the young people were:

> *…she could not speak to me because she was too angry about something, and I did not know what it was, so, I had lots of ideas in my own head, you know for*

example was it because she was getting very attached to me and she knew it would come to an end, was it because of something about me reminded her of her birth mother? (Sarah, lines 73-78)

Betty added the complexity of even knowing if the child was agreeable to the therapy, raising an ethical dilemma regarding consent for therapy with this population.

Eeehh () eee, it was his adopted parents who really wanted him to come, ( ) they ( ) wanted him to be able to ( ) they said learn how to communicate ( ) better ( ) and ( ) I was never entirely sure what the boy himself thought, why he might've wanted to come, and when I try to explore this with him, ( ) the kind of response I would get was, ( ) yes, I want to come, but he couldn't say why really. Eeehhh, but because he was indicating he wanted to, ( ) and I felt he wanted to, ( ) (...), ( ) ummm ( ) I offered it. (Betty, lines 56-66)

Claudia described the minimal communication that comes across through gestures. She expressed her awareness of the limitations of this kind of interaction as the gesture without context can easily be misunderstood:

I think it was giving her the meaning more than whatever words I would say, which could have been completely inaccurate because I did not know her as it were, you don't know the silent child; you just know a tiny, tiny fraction of their personality, that comes across through gesture. (Claudia, lines 97-101)

The therapists implied that getting to know the silent patient is a long-term commitment as it involves a reticent communicator developing the desire to open up and be known. Building trust seems particularly challenging with this population. The therapists reported how they used their minds to make sense of silent communications, which they sometimes transmitted verbally to the child or kept in their minds as an internal dialogue, depending on what they thought the patient needed. Claudia, as presented, warned us that these interpretations might be entirely wrong, particularly in the early stages of the therapy. However, they conveyed that what mattered was the therapist’s intention.

3.1.3 *'All* [silent patients] *are different'*, and the silence can evolve

All participants agreed that silent patients also differ from one another. The participants seemed to be grappling at different interview stages with how to formulate 'the silent patient'. This might have reflected their journeys of trying to understand this particular population.

> *…right ( ) well there are two kinds of silent patients, you know there's the silent patient who hasn't developed language, who's communicating through gesture and play (…) the child just didn't develop language. (…) and there's the other kind of silent child who's ummm umm you know, latency age child who's speaking at school, but comes to therapy and is silent for part of the therapy. (...) And then there's the, you know, silence of the anorexic nervosa. But then there's a third kind of patient (…) withdrawn completely from the world, from family, friends, staff and they're just living in a hospital bed, not moving, not speaking, not eating, you know, they are like alive, but dead, living in a claustrum* (Claudia, lines 1- 21)

Claudia provided a comprehensive framework to describe the vast universe of the silent child, which she must have developed over time. She divided this population into three main categories. One spoke to silence as a deficit, perhaps resulting from the absence of language. There might be a willingness to communicate in other ways when language is not available. This seems different from deliberate silence, when language is available, such as in selective mutism and/or anorexia nervosa. The third category describes a more unwell child that had completely shut down. She used Meltzer's (1992) concept of the 'claustrum' to describe the entirely withdrawn child.

Hannah added an interesting philosophical dimension, as she questioned the possibility of thought without words: '*Umm, but I, I was thinking about this in relation to your research and thinking about how interesting it is that you might not have speech, but you have thought, you know, does thought ever stop, thought isn't silent'.* (Hannah, lines 84-87)

The participants also conveyed a message of hope as they offered examples in which the silent child eventually developed. Hannah highlighted the importance of creating a space in the mind for different ways of communication. However, her hesitance conveyed the difficulty in doing this. She might once again have been pointing to the fact that verbal language dominates our limited understanding of communication. Hannah used the model of pre-verbal children to illustrate the importance of play in their communication:

> *…when you work with very small children, well they have not got language, they still can let you know how they are, or what might be going on internally, and I think with my first patient she was able to do that even though she did not have words, even though she was silent, because,* [hesitant] *yoouur research question is about silence as in spoken words, that's how I understood it, but patients communicate with us in so many other ways, it's not just about opening their mouths to speak.* (Hannah, lines 126-133)

She finished the above idea with an interesting but apparently contradictory point: '*it was not silent even though she did not speak*' (Hannah, line 133). I wonder if she spoke to the difference in the room's environment when one is with a child who readily communicates in non-verbal ways. One might forget they are not using words.

Claudia reported detailed observations of a range of silent gestures that expressed positive and negative feelings within a relationship. She focused on different body parts, demonstrating the potential richness of non-verbal communication if one pays considerable attention—skills she had gained in the Infant Observation module. Here are her descriptions of the communication of eyes:

> *So I look at the eyes, and I see, from the minute I see somebody, ( ) (..) if the eyes can greet me, in which case I might think that there's curiosity and interest in me, if I see the eyes just being any other place, I would think that I'm a dangerous presence, that I have turned into a bad object or that I always was a bad object, ( ) but if somebody is looking at the world and then turns away when I arrive, as Tanika did when she, she got better, I could imagine that they've identified with me leaving between the sessions, unconsciously, identified with the aggressor who's abandoned her and that I am to feel the experience of what it is like to be alone and isolated without somebody*

interested in me. So, there are many different interpretations, just linked with where the eyes are. (Claudia, lines 149-161)

Claudia weaved in psychoanalytic theory, such as Klein's (1946) ‘part object’ concept and Anna Freud's (1992) defence mechanism of ‘identification with the aggressor’. Betty, on the other hand, referred to a positive change in the silent communication of one of her patients, which developed over a long period:

I think the silence has changed since then, ( ) (…) () again I still feel as if I’m waiting, () but ( ) it also feels like allowing space ( ) because eventually ( ) I get like a little what feels like a cluster of () words () like a conversation, he’ll say something, ( ) gives me a thought that is in his mind ( ) and () (...) But now the fact that if we wait long enough. Something does come to his mind feels quite significant () (…) () he'll say something that will enable me to ( ) have a thought about it ( ) it feels quite, you know, like something like one thought could connect with another ( ) and produce a bit more to say ( ) and that feels very (...) different from the ( ) you know if I go back, to, with the ball ( ) for example, (...) it could feel very repetitive () it does feel like development [excitement in her voice] *you know ( ) and so the silence now, more recently, ( ) feels like it’s a kind of ( ) uummhh ( ) maybe we’re both sat anticipating that the thought would come.* (Betty, lines 220- 244)

Betty conveyed a sense of hard-won development, patiently nurtured over a long time. Her genuine excitement spoke to her commitment and well-deserved pleasure at witnessing a child's mind that started to open up and connect. The different quality of Betty's waiting seemed to turn from disconnection to a possibility of a creative connection of two minds that can produce thoughts together.

Hannah articulated the difference in the silence between her two silent patients:

…her silence was a very different silence in that it was umm probably uuuh a bit more () of a symptom of how unwell she was, umm, but I think it was a bit more complicated than that, I mean, I thought a lot about it since, it almost ( ) felt as though she had not any words, almost like an absence of (…) (Hannah, lines 53-56)

Hannah spoke about the impact of this experience and how it remained with her for a long time. The difficulty in making sense of the silent communication seemed

to provoke enduring curiosity, which may have been part of Hannah's motivations to participate in the research.

This theme attempts to capture the underlying formulations that the participants seemed to be grappling with at different levels of consciousness, to define the universe of the silent child. They all seemed to be presenting their work from a framework they had in their minds, either implicit or explicit.

3.1.4 Silence as masking different feelings: '*it was a child who was very angry'*

Participants reported a variety of feelings underlying the silences. Hannah and Claudia described 'angry' children. Hannah commented on a young person who, as she described, seemed more in control of what she was doing:

> *I suppose the first girl I thought of it much more, well I used the word 'defiance', but it's also you know, there were so many things in her silence that were, you know, it was hostile, it was aggressive, it was you know, it was ummm, you know, refusal you know, and I said earlier about it being much more of a conscious decision to, you know, keep her mouth closed and not let something out, you know, she had control over her mouth.* (Hannah, lines 102-108)

Claudia presented a young person who turned the anger inwards. She alerted us to the common problem of confusing this silent child with a 'victim', when something more active might, sometimes, be going on underneath. She helpfully explained the underlying dynamic that can lead to the repression of angry feelings:

> *So that's one of the problems with silent children is you think 'poor child', and actually, that might be completely wrong as* [names renowned supervisor] *helped me to understand (...) it wasn't 'poor child' some of the times, it was, you know, and it wasn't persecuted child, it was a child who was very angry and didn't have ways, didn't have safe containers, containing objects to express anger, so part of silence (...), which is the attack, can't go to the object externally, hasn't been able to go, because it's not safe for some reason, so it turns in.* (Claudia, lines 121-130)

On the other hand, Betty and Sarah were uncertain about experiencing their patients as angry. Betty questioned herself:

I don't think that I have felt particularly ignored by him () I don't feel as if I have been particularly shut down by him (   ) and ( ) or have I and can I let myself know about it? ( ) or is it that actually, no he hasn't shut me out, this is just ( ) this is how it is we're not at the point of where maybe more negative communication can be there ( ) what do you have to have first before ( ) you can reach something that, can feel, that there is something more negative? (Betty, lines 321-329)

Sarah, on the other hand, began by believing her patient was angry with her, while as the work progressed, she thought she had got this wrong:

…she must be angry with me, she turned her back on me, she's not speaking to me, stiff, but I realised it was fear, as you get it in an infant. It was not anger at all, it was fear. (Sarah, lines 432-434)

This theme highlights that the therapists had varying degrees of clarity in their ideas, informed by their feelings, which probably depended on experience. They agreed that the silences have a meaning that varies from patient to patient and can change and evolve within each patient over time.

3.2 Theme Two: Technique and cautious adaptation

This theme starts with the key techniques that the therapists found helpful in working with silent children within the psychoanalytic model. The participants also drew attention to the need to adapt the psychoanalytic technique to meet the silent patient, whom they viewed, as described above, as 'different' from the speaking patients. They seemed to experience the adaptation of technique as necessary but problematic. Initially, the non-speaking child challenged the psychoanalytically-trained therapist, perhaps due to the importance of language in psychoanalysis. Despite the participants experiencing an urgent need to adapt the technique, they remained vigilant regarding the impact on their patients. Another main concern seemed connected to how far from

the classical technique it was safe to go while still belonging within the psychoanalytical profession.

3.2.1 *'Infant observation as key to any silent work'*

The therapists emphasised the importance of noticing the minute communications of the body—skills gained in the Infant Observation module—for work with the silent child: '*My way of working would be to use the non-verbal like in baby observation, use the eyes, the body, the hands, and talk about what I think it's saying about their state of mind'* (Claudia, line 73).

Claudia gave clear examples of her observation of each body part, looking for expression. Below is what follows her description of the communication of the hands:

> *…the hands, and I think ummm we know from sexually abused children, that the hands can speak something that the mouth has been forbidden by the superego or by abusers to speak, so the mouth may not be able to do anything, but the hands can point, or show, you know, when the completely dead child starts doing this* [fists] *you realise they're using some of Esther Bick's idea of holding itself together, 'oh my goodness there's a beginning of an ego now!' They come to the world and they can say 'I'm scared' with their hands.* (Claudia, line 175-184)

The extract presented earlier conveys the richness of the observation to details. Claudia provided different meanings to the different expressions of the hands. Claudia's excitement is demonstrated here at the realisation of a moment when this silent patient shifted from a state of withdrawal to what Claudia calls the beginning of an 'ego', using Freud's (1923) 'structural' model of the mind as id, ego, and superego. She also uses Esther Bick's (1968) concept of the 'second skin' which describes the infant's use of muscular tension to hold the self together in the absence of maternal containment.

Betty was more implicit about the importance of infant observation, as she referred to observation in a more general sense: '*using what we've got available, which is a lot of observation'* (Betty, line 425-426). She, however, provided several examples throughout the interview that showed her use of detailed observation, as learnt in the Infant Observation module:

> *I provided him with these strips of different colour plasticines like this, and he moved them together into a big ball, like a big brown ball really and, so for a long time at first he would roll this ball* [her voice turns monotonous] *of plasticine and would smooth the surface of it and then after a while would put that down and would go to the soft brown ball, ordinary ball, but which was in his box, and he would kind of do a bit similar with that, holding it in his hand and then he would bounce it on the floor, but it would just stay with him, and this went on...* (Betty, lines 110-119)

Betty's observation conveyed a very insular boy. It is important to note that this was a boy on the autistic spectrum. I noticed that her intonation turned monotonous and flat, which conveyed to me some boredom. This made me wonder if she was actually working very hard to remain alive and interested to compensate a child that may have felt lifeless.

Hannah first evoked the hard work such detailed observation entails: '*it's very much doing your baby observation again, you know, watching what the baby is doing, it's such fine detail'* (Hannah, line 511-512). She then articulated the possible impact on the young person who may have missed such an intimate connection: '*so having me notice even the tiny little things that might change was probably quite painful for her at one level, you know, but also necessary as well'* (Hannah, lines 200-202).

Hannah told of how she gathered knowledge about her patient, using infant observation skills, until the moment came when she started offering a narrative that created a meaningful connection, which began to unlock this patient. In Hannah's words:

> *I started to talk to her about () how important it was for her to make her mark* [she coughs]*, and for people to see her, umm and you know, to see the person that she was and, that enabled her to start to talk to me about what her name meant.* (Hannah, lines 306-309)

Sarah added a sense of pride as she recognised the importance of infant observation, which appeared to represent a key milestone in her professional identity and belonging, '*I've realised why they say the most important tool for a child psychotherapist is the infant observation'* (Sarah, line 39). She then used her observation skills to describe the moment when her patient started to show signs of wanting to connect with her again: '*I get a look, that was the first thing I got when it* [the silent period)] *was about to end, her body language changed a little bit, she unravelled a bit, you know, and turned towards me a little bit'* (Sarah, lines 220-222).

The participants conveyed a sense of achievement in developing such fine, detailed, demanding observation skills, which supported their belonging to the psychoanalytical profession. This seemed to compensate for the lack of other helpful psychoanalytic techniques to work with this population.

3.2.2 *'I was always interested'*

The participants described the importance of waiting with an unhurried but interested state of mind that provided the silent patient space to develop. They conveyed a gradual understanding of the patients' communication as they got to know them, and their ability to eventually provide them with a narrative. They were all referring, explicitly or implicitly, to the concept of the psychoanalytic attitude, as introduced by Freud, and then developed by Bion. In Claudia's words, first inspired by Freud: '*So, one needs to have "evenly suspended attention", curiosity, interest'* (Claudia, lines 223-225). Claudia then added a conceptualisation influenced by Bion, when she

described an '*inner state of reverie, and you wait until the thought arrives to you'* (Claudia, line 238). They spoke about the importance to wait for the interpretations to emerge, implying the need to resist premature interventions. In Betty's words: '*I felt that I had to sit and be with that and I was always interested'* (Betty, line 26-27). Betty implied the idea of the therapist as a mother of an infant, and this came up for all participants: '*Infants () need somebody to be with them () an interested mind'* (Betty, lines 30-31).

Hannah humorously implicitly referred to Bion's well-known paradox of being in a state 'without memory or desire': '*we are meant to not know and* [she laughs] *even though we all struggle with it'* (Hannah, line 112-113), referring to Bion's idea of being born with an innate impulse to want to *Know*; with an urge to understand and make sense of our relationships. After commenting on the usual pattern of her patient's behaviour Hannah explained how she created a hypothesis alongside her patient: '*I wonder if that is what is going to happen today, and I have to maybe wait and see* [the rhythm of her speech slows down, giving space]'. (Hannah, lines 345-346)

Here, Hannah also made the point of developing the knowledge of her patient until she got in touch with their essence. Similarly, Sarah talked about remaining open to something *truthful* to emerge, as Bion advices: '*I then thought right I'm going to speak when, (…) interpretations come out of your mouth'* (Sarah, lines 167-169). She also referred to Bion as *'the best teacher for this kind of thing'.*

The participants waited until they felt they had something genuine to say. Additionally, they were at different stages of thinking about how much was appropriate to give back to their patients. Another complexity regarding to how much to give was Betty's examples of finding herself increasing the frequency of the sessions from once to twice weekly. She questioned why, as in her previous experience the increased

sessions resulted in less use of the overall time. From a slightly different angle, Claudia added the idea of the common problem of the therapist's wish for more—for example, more words—and the therapist's excitement when there are signs of development as the main cause of an impasse. She explained that the silent child feels robbed of their achievement and retreats at this fragile stage. However, as the silent child becomes more robust, they eventually grow able to let their therapist take some pleasure in their development. The participants all indicated the need to restrain their wishes in different ways. Claudia referred to the analysis[4] as key to resolving personal issues that might get on the way.

3.2.3 It is *'a bit like a master class in countertransference'*

The participants commented on their reliance on their countertransference to help themselves understand what might be going on in the silent communication. They all spoke about its effect on them in one way or other. Hannah experienced her patient's silence as an absence. The patient was a late adoptee and Hannah linked the experience of her silence to what it may have been like in her early life: '*something was missing, that she couldn't speak to them and, but I also think she had to give me an experience of how perhaps it had been for her as a younger child?'.* (Hannah, lines 57- 58)

Hannah sighed and laughed, adding a clear quality of exasperation with the hard work involved in almost entirely relying on non-verbal cues, referring to the work

[4] The child psychotherapy training requires undergoing three/four-times weekly psychoanalysis for at least the duration of the 4-year training.

with the silent child as: '*uuhh you know it's a bit like a master class in countertransference* [she laughs] *really*' (Hannah, lines 176-177).

Betty and Sarah picked up something from the young person that was not expressed in words; however, it was not clear how they reached their conclusion: '*it's not out there in a sense, ( ) but there is a sense of fragility*' (Betty, line 176). Sarah, after describing how she assumed a foetal position, says: '*the more I looked into my countertransference, the more I saw her as a baby*' (Sarah, lines 149-50).

Claudia referred to *body-countertransference* and emphasised the importance of the visceral countertransference experiences in the therapist's body: '*I would feel something very devastatingly tired in my body at moments when aggression was being expressed and felt but not being expressed in any visible way*' (Claudia, lines 111-113).

Everyone agreed on the silent child's having a significant emotional impact on themselves. There was, however, great difficulty in articulating the felt experience of their silent patients. This might be connected to the additional inherent difficulty in articulating a non-verbal experience. They all rely on their emotional experience with the silent patient to inform their understanding of the patient, and subsequent technique.

3.2.4 Cautiously active: '*I have to try something different*'

An important theme that emerged was the need to adapt the technique. The participants seemed to frame their work with the silent patient within the traditional psychoanalytic method to a certain extent. The psychoanalytic stance of *evenly*

suspended attention and being in a state *without memory or desire*, as described above, seemed particularly helpful for this kind of child. However, at times, some participants seemed to recount that they intuitively, but not always knowingly, shifted into an active role. Claudia seemed confident and in control of the adjustments to her technique, having found a way to keep the psychoanalytic sentiment by using *free associations*:

> *Mind you, but when you're working with the silent child who for almost a year is not speaking to the world (…) when they are pervasively retreating, I did in fact had free associations (…), which led me to create stories and find poems (…) or make up things, on the spot also, so that I had something that was interesting* (*…) they could choose to turn to me or not.* (Claudia, line 239-249)

They all seemed to think that part of what was needed was to revitalise the silent child by taking an active role, which sometimes happened unconsciously. There were worries about the implications of such pro-activeness though, should they intrude. Overall, they expressed how hard they worked and how carefully they fine-tuned. At times, it felt like a necessary trial-and-error exercise: '*I would ask him about external things (…) my feeling was that "I've interrupted something" (…*). *I was playing with my own technique'* (Betty, lines 278-285). There was a sense of a desperate attempt to use the limited input the silent child provided in Hannah's mind: '*commenting on any communication, anything that she did, without it being too intrusive'* (Hannah, lines 192-193). Sarah conveyed the dilemma of '*when do I say it and when do I not?'* (Sarah, line 99), and added: '*I might have said, ummm, (…) something like, I think you need to be silent and I am going to be here because I'm going to think about you, and I kind of knew she knew that really'* (Sarah, lines 163-164). It seemed that Sarah sensed she may have said something unnecessary here.

The therapists paid attention to the impact of taking a more active role with the patient and adjusted their technique accordingly. This seemed part of necessary

learning. They all seemed worried about imposing, intruding, interrupting, or interfering by taking a more active role, which brought them away from the more neutral psychoanalytic stance.

Interestingly, for two participants, a major change into an active role took place intuitively, partially due to circumstances, which led to opening previously unknown territories, resulting in positive change. In Betty's case, it was the first lock-down during the pandemic that caused a break in the therapy. When the young person eventually agreed to a phone session, the excruciating silence led Betty to ask questions about his external reality. The child shared he had been watching a soap opera, but a character was missing, and it was not the same without it. The moving parallel with their experience of unexpected separation allowed an unprecedented experience of connection and thinking, in displacement, about their separation.

Hannah had to do an outcome measure with her patient as part of her team's practice. When she did this, she discovered her patient 'cheated' in the answers. This instilled in her patient a desire to talk, which Hannah skilfully steered to meaningful discussions about trust.

They also referred to the *unconscious* in one way or another. Betty observes '*I didn't always know what I was doing'* (Betty, line 35). Hannah states: '*I don't think I knew what I was doing or if I did know. The great thing about our job is that there are two people in the room that communicate unconsciously'* (Hannah, line 406). Sarah commented: '*it's totally unconscious'* (Sarah, line 250). They referred to their unconscious to articulate their awareness of not always being fully conscious of their technique. They seemed to be talking about the power of the unconscious too, a fundamental idea in psychoanalysis. Hannah added the importance of undergoing analysis as part of the training to ensure safe practice when working with the

unconscious. Claudia provided a more positive spin when she referred to using 'free associations'—a quintessentially psychoanalytic technique—that is grounded on the analyst's capacity to connect with his or her unconscious in relation to the patient, and offer comments coming from that place.

Another aspect of a more proactive technique was the therapist's non-verbal communication. Again, there were various levels of awareness of what they might have been doing. Betty wondered whether her genuine excitement had come across in her body language when her patient, after a long process of 'painstaking work' finally let her in, allowing for a moment of connection between them: *'a lot of it would have been in my body language I guess () yes you know looking at him and woooh throwing it back'* (Betty, lines 268-269). Betty's intuitive response reminded me of the responsiveness that well-supported attuned mothers/carers have with their babies, when they are not always aware of what they are doing. Hannah demonstrated her intuitive adaptation to her patient in the intonation of her voice, which was noticeable during the interview. This might have been how she unknowingly modulated her voice with her patient. She did not refer to this explicitly, and I wonder if she might have adapted it intuitively, not fully conscious of it.

Claudia emphasised how she would modulate her voice and referred to Meltzer's (1976) concept of the importance of talking to the different parts of the personalities in different tones of voice.

> *I would talk about their relationship to me, being, not liking my words, or liking my words, not the meaning but more the sound of my voice probably (…) many patients (…) are really listening more to the tone of voice.* (Claudia, lines 77-81)

Furthermore, she used it in an 'enlivening' way (Alvarez, 1992) when needed: '*The psychotherapist's understanding voice is boring, you got to have lots more spark in it'.* (Claudia, lines 388-390)

This theme speaks to the complexities that the participants encountered when adapting the psychoanalytic technique to the needs of their silent patients. It seemed key to finding the balance between resisting personal wishes of giving too much while being in tune and providing the necessary vitality. They used the characteristically psychoanalytic stance of remaining open and curious. Some, knowingly or unknowingly, added Meltzer's (1976) development of the talking to the different parts of the personality with a different tone of voice, which included Alvarez's (1992) concept of the 'enlivening object'.

3.2.5 Preoccupation with their professional identity: '*I don't know if you call it the psychoanalytic method or not'*

The therapists seemed to be grappling with how far they could diverge from the traditional psychoanalytic method and still belong to the profession. The tension between classical psychoanalytic training and the practice that moved away from psychoanalysis seemed problematic. Most of the participants entertained these considerations openly: '*I don't know if you call it the psychoanalytic method or not, but I have to say that it worked. So, I do what works'* (Claudia, lines 252-253).

Claudia referred to this as a concern, but compensated with scientific rigour. She spoke of evidence in the work that backed up the necessary adaptations described above. She provided detailed examples, and linked them with theory that made her claims convincing. Betty provided another example around preoccupations with belonging to the psychoanalytic profession, as she kept coming back to concerns about negative transference throughout the interview: '*I feel that ( ) there is quite an emphasis in the training on ( ) like working with the negative transference'* (Betty, line 423).

She seemed concerned with this concept, which, in her experience, did not seem to fit with the work with her silent patients. This seemed to fill her with some doubts about the method. Hannah, as mentioned above, recounted her journey which began with questioning whether non-speaking patients could legitimately receive a *'talking therapy'*. She referred to the problem of making interpretations, another quintessential psychoanalytic technique: '*trying to make an interpretation, it's probably so much more difficult? because you don't have language spoken by the patient'* (Hannah, lines 463-464). Later on, however, she returned to this topic with hope, as she realised that her interpretations were fewer, but more authentic: '*My interpretations were much more tentative umm, but maybe when they came, they were a bit purer'* (Hannah, lines 465-466).

On the other hand, Sarah found solace in the infant observation method, which grounded her place within psychoanalysis: '*because I saw I am in a place, which is very much in psychoanalysis, I know this place, it is called Infant Observation'* (Sarah, lines 243-244).

There was an underlying theme regarding their belonging and professional identity within psychoanalysis. There were concerns about how much they could adapt the technique and still belong to the profession. Some of the participants seemed to feel more a part of the profession with a stronger sense of belonging than others, as well as feeling they are able to take part in different ways. They also seemed to address these preoccupations differently, perhaps finding different positions or roles, which seemed fluid within the psychoanalytic 'family', such as pioneer, protegee, scapegoat, or rebel.

3.3 Theme Three: Therapist's feelings

3.3.1 '*It's all your fault that the child is not talking'*

A recurring theme in the interviews was the experience of excessively painful feelings of incompetence. The therapists held that the work with the silent patient involved facing difficult emotions about their professional competency due to the child's reluctance to talk: *'I felt ( ) a bit frustrated, but it has been more with ( ) myself about ohh what do I need to do?'* (Betty, lines 310-311). In Hannah's words: '…*made me feel sort of incompetent ooor that I needed to try harder'* (Hannah, lines 148-149). In Claudia's words: '*the team thinks you're an incompetent therapist'* (Claudia, line 358).

Most of them explicitly mentioned a tendency to blame themselves, particularly when trainees. For example, Hannah commented: *'when you're a trainee because umm, you know, () there is a sense in which umm it's something about you, that's* [laughs] *preventing the patient from speaking'* (Hannah, lines 137-9). Sarah remarked: '*I've done something really wrong, you know, like trainees often* do' (Sarah, lines 83-84).

Interestingly, three out of the four participants referred to silent work that occurred during training. However, in other parts of the interview, they also pointed out that these feelings remained even when they were very experienced. For example: '*it does not feel as a trainee, even as a very experienced therapist, it did not feel comfortable bringing the silent patient to supervision'* (Claudia, lines 340-342).

The participants' experience spectrum was quite wide, but they all spoke to these feelings.

3.3.2 Anger and its defences: '*You get very angry that the child is not talking to you'*

The participants were brave to talk about undesirable feelings in themselves. Hannah and Claudia were both referring to work that had taken place during their training, where they had regular supervision, analysis, and other help that formed a robust support network. This may have aided their capacity to openly speak about negative feelings. For instance, Hannah humorously expressed a genuine wish '*to get rid of*' the '*bad'* patient and exchange it for a '*better'* one: ***'****there was a part of me that wanted to get rid of both of these patients'* (Hannah, line 450).

Claudia drew attention to harsh judgements that can come from anywhere when working with the silent child, engendering resentment in the therapist: '*if only you were a better therapist, certainly this child would feel free to talk with you (...), why isn't this child talking to me, I'm working so hard, I've given them so much understanding'* (Claudia, lines 357-361).

Interestingly, she pointed out that the 'accusations' also come from oneself, as the therapist may run out of patience performing such a demanding job.

In contrast, Betty's work was current. She was a qualified therapist in the public sector without regular supervision for this particular case, or adequate overall support. She enquired if her sympathetic attitude towards her silent patient might be a defence against overwhelming pain that could interfere with her ability to continue with such taxing work: '*I wonder if it's harder for me to be open to the negative transference () (...) () how on earth do I keep going on with it?'* (Betty, lines 395-397).

The participants' honesty and willingness to consider their feelings moved me. I think that the stark difference in support between being in training and post-qualification raises an important issue that requires further consideration.

3.3.3 ‘*I do feel quite on my own, actually’*

The therapists conveyed that working with the silent patient was a lonely experience, due to the limited feedback. The silent patient was often in a withdrawn state and reaching them involved a sustained effort that sometimes seemed akin to resurrecting them. In this absent state of mind, these children could not become partners in the work. The overriding feeling of isolation in the therapists was as if they were abandoned in the room.

Betty went deep into her experience during the interview, and she realised she felt lonely, which seemed a new idea for her. She appreciated that the work with the silent child was less recognised in her place of work, and easily dismissed due to the ‘not talking’ aspect. She reflected on the general feeling of isolation when working in the public sector, too, and an idea of the potential benefits of private work for this population emerged as an alternative:

> [with very honest voice] *and it’s, I guess it’s, it’s not the kind of work that lots of people might be very keen to do either and or maybe are not interested in, I don’t know* [laugh] *ummm () I wonder yeah I did wonder what it would be like if it wasn’t CAMHS work for example, if it was ( ) umm private work because, () I think lots of people, () (…) certainly within the service ( ) would not offer therapy to a child like him, you know, he does not speak in the room, I had that, you know, from people that met him. So, in that sense probably yeah, I probably do feel a little bit on my own with it () yeah ().* (Betty, lines 368-379)

Betty also spoke about feeling ‘silenced’ in her team and seemed to find some resolve to find her voice going forward. Hannah added the limited feedback that therapists receive from the silent patient, which makes it harder to know if they are developing:

> *…well (sighs), I suppose it’s just about getting to know your patient. Umm, in a way that, () you know is, you know, it’s a bit like, you’ve got a, you’re trying to work it out a bit on your own in a way, you know, what is the feedback () that you get () from a silent patient, you don’t get an awful lot of feedback from a silent patient* [laugh], *you definitely don’t get a confirmation of them saying something back to you, which is the equivalent of, you’re onto something there or, you know, that feels about right, you know, I mean, those moments are quite*

> *rare, but uhh when that does happen, (...) what might be beyond words that lets you know that some things are shifting.* (Hannah, lines 220-230)

Hannah conveyed how hard it is not to get any confirmation from the patient. Betty told me towards the end of the interview that she was expecting some feedback from the supportive school. This seemed to give her some hope that all the effort had been worthwhile, but that she needed some external confirmation. Sarah acknowledged the loneliness of this particular work and the need for company:

> *I felt I was not alone in the room, and I think, when you are working with a silent patient, the most important thing is that you don't feel you are alone in the room, you know, that you've got your analyst, you're this and that, lots of characters and experiences that you've got that are concretely sitting next to you all around it, because it is a very lonely experience. When people are lonely, they can't think.* (Sarah, lines 130-136)

Claudia referred to the beginning of the work, and her role seemed akin to a detective looking for minimal clues or signs of life that are unnoticeable to the untrained eye:

> *…I would be looking () at () would be ( ) whether I have any sign if they are actually listening to me, anywhere in the body, because when you are in that completely pervasive retreat, you cocoon and not even almost no responding to sound, I think sound might be actually the first thing they respond to, but you don't have any verbal, any physical experience that they're hearing (…)* (Claudia, lines 168-174)

This description shows an extreme example of total unresponsiveness. Claudia wondered about what the first sign of coming back to life might be and looked for a response to sound in the body.

Predominantly, the participants emphasised an impoverished experience with an unresponsive patient, which significantly impacted them. They showed enormous dedication and commitment to keep the therapy going, as they seemed to be holding in their minds the potential for developing a relationship.

3.3.4 Mourning and learning

There were feelings of loss and grief in the participants about the limitations in themselves and their silent patients. Betty seemed to be grieving her patient's interpersonal limitations resulting in few opportunities for connection, exchange, sharing, and togetherness. Her voice was full of loss and pain as she spoke: *'To get something, ( ) more reciprocal going between us, ( ) I did not feel we got there in that work, really'* (Betty, lines 37-39).

Hannah reflected on how she came to terms with having a 'not-ideal' patient. She conveyed a realisation of having had an assumption that equated a good patient with a talking patient. Her honesty paid off as she developed a capacity to work with the silence over time. In a truthful Bionian way, she concluded that the silent patient is *'just different'*. These words captured the transformation she experienced:

> *I quite like a patient who's going to come and talk to me* [laugh] *as if that's easier, when actually it's just different, now I know it's just different, still communication being made by the patient, it is just not with words, it's in other ways.* (Hannah, lines 452-454)

Sarah also talked about her learning with the silent child. She reported being aware of being a *'talker'* and initially struggling with having to be silent. However, sticking to '*sitting in there'* led her to find something quite enlightening about the silence:

> *I learnt to stay with it (…) I'm the kind of person that would (…) do it* [talk] *(…) I did not have any interruptions, so yeah, I can say this any time I like (..) I ended up finding it (…) spacious.* (Sarah, lines 180-185)

Claudia reflected on the potential loss of an idealised identity as *'the main healer'* perhaps common among care professionals, which in turn gave way to a more realistic view of the professional self as part of a team: '*I'm more aware of the necessity*

of working with the system around the child and not thinking of myself as the guardian, you know, the saviour' (Claudia, lines 422-424).

The participants opened up and shared turbulent experiences with the silent child that involved mourning the absence of the 'ideal' patient and, equally, the absence of being the 'ideal' therapist. In a truly Kleinian (1940) spirit, they seemed to reach the 'depressive position', which allowed them to, in a Bionian sense, learn from experience and do their best.

3.4 Theme Four: Tension between the need for support and its resistance

3.4.1 '*It did not feel comfortable, bringing the silent patient to supervision'*

Hannah and Claudia referred back to their experience in training, where each member of the group takes turns to present a piece of work in a seminar group about five times a year.[5] They both implied a performative element as a barrier due to the wish to impress the seminar group and leader and the painful exposing process of learning, to be a beginner and not knowing. In their experience, these familiar feelings seemed to intensify when presenting the silent child:

> *…my experience as a trainee psychotherapist (…) people would not want to bring a silent patient to a seminar when it was their turn to present, because it's so embarrassing and you think everyone is going to see me, making, fumbling around with my interpretations, and so they will bring any other patient but the silent patient.* (Claudia, lines 315-320)

Claudia suggested that the lack of regular supervision of the silent child could have a detrimental impact on the development of the profession within this particular

[5] The presentation entails a write-up that the trainee composes after the session, by memory. The therapist describes her observations of the patient's demeanour, actions, interactions, and the sequence of the events in as much detail as possible.

population: *'So so it's very painful and awkward to let people see your work with the silent patient, so that's partly why we're behind in terms of technique'* (Claudia, lines 348-350).

Hannah and Betty pointed out how hard they found doing a write-up for supervision. Hannah conveyed the excruciating process:

> *…when you're a trainee and you're in a group seminar, umm, you know, I'm sure we've all, you know, you have or everyone has an experience of wanting to show their best work* [laugh]*, and, you know, if you're presenting a silent patient, you know, you don't really have an awful lot to write about, about what they say, you know, so you know, your write up is is so reliant on your observational skills, umm, you know, and, remembering, you know, what you've noticed, what you've felt, what you commented, what you might have not commented on.* (Hannah, lines 183-190)

Betty, who had not managed to take the silent patient to supervision regularly—having less provision for this as a qualified therapist than those in training—seemed to imply that perhaps a more informal kind of supervision might be helpful. She also shared regrets and doubts about her work due to the lack of regular supervision:

> *Yeah, yeah, well I think I think one of the things that is challenging is, ( ), you know, how do you, it's much harder for example to write the session to take to supervision, and yet I can speak about him, I could probably speak about him to you for ages* [laugh], *you know, ummm, but then ( ) what I guess () that makes me think what gets missed then.* (Betty, lines 330-336)

The participants tried to articulate the difficulty of remembering when most of the communication was non-verbal. It seems much harder to register and sequence the events in the mind. Some of the communication might pass unnoticed and remain unconscious, which demands a much harder job to attempt to decipher in order to be able to write about it. Hannah and Claudia both commented on the exposing experience of presenting the silent child in seminar groups; the need to be brave to present their work with the silent child, and its benefits as the child (and therapist) develop.

3.4.2 Support and the internalisation of good objects as key to overcoming difficulties

Predominantly, the therapists spoke about the need for support to work with the silent child. Paradoxically, three participants expressed great difficulty in seeking support, as mentioned. Sarah referred to the importance of the internalisation of 'good objects', as described by Klein. This seems to constitute an antidote to the feelings of loneliness with the silent child—the only way she could keep thinking: '*So, although it was a difficult period, my network, my structure around me, the parents,* [names her training school]*, the supervision all helped me and my past experience with my infant observation'* (Sarah, lines 123-125).

In addition, she used a metaphor of an explorer to convey the importance of the experience:

> *…it was to realise that I was not alone, that I had my support network. The support that you have and the supervision. Hopefully the family, the parents of the child you're working with, so that they trust you. And the fact that you've been there, not in that particular part before, but that you've been the explorer before in your infant observation.* (Sarah, lines 386-390)

Similarly, Claudia referred to the internalisation of 'good objects', including her mentors and overall training. She highlighted the importance of a previous experience of having helped a silent child:

> *I think what I probably was really helped by was Dr Meltzer, Herbert Rosenfeld talking about having some faith in the psychoanalytic method, and hope that the psychoanalytic method has some value and in helping, in understanding these children, and I think, probably I did not have much faith in the beginning with the first child, which was I think Tenika, was probably one of the first children, and I think once one sees it working, and the person developing, once you've seen with one child, you can have more faith in yourself and the psychoanalytic method, I think, the worst thing is when you haven't been in this journey, for the first time, I think the worst thing is that, and not knowing if the psychoanalytic method has any value in this, () with children like this, umm,*

> *once you have faith and hope in your good objects internally, that you've internalised your supervisors and your analyst.* (Claudia, lines 398- 412)

Claudia, following her reflections from training, referred to an exceptional seminar supervisor that potently helped trainees to bring the 'uncomfortable' patients:

> *I remember Isca Wittenberg insisting that we didn't just bring the talking patients or the playing patients, so that was a very good supervisor with who pulled out of our repertoire of patients we could bring and had us bring things we did not feel comfortable with, and it does not feel as a trainee, even as a very experienced therapist, it did not feel comfortable bringing the silent patient to supervision.* (Claudia, lines 335-342)

Hannah referred to having good supervision and felt well supported. She used the seminar group in her training school and service supervisor:

> *I suppose I got good supervision for both of these patients. (...) uuhh it was my service supervisor who really helped me with her, you know, and I, I suppose in many ways it was, ummm () her reminding me of my baby observation and trying to remember, you know, all the ways in which you learn how to observe what's happening, and how it might make you feel or noticing, maybe, how someone else is feeling, (...) and that was hugely helpful.* (Hannah, lines 170-177)

Betty longed for the support she lacked, as already described above. All the participants agreed on the need for regular supervision as essential for the work with the silent patient.

3.4.3 Working with the network as challenging but essential

The participants highlighted the necessity to work with the network. Betty and Sarah commented on the considerable work with the parents before the psychotherapy started. Betty explained the work the care-holder did with the parents to help them gain a more realistic expectations of their adopted son, which meant that they managed to transfer him to a more suitable educational environment where he settled well.

The participants also spoke about the regular reviews with the parents, which seemed key in developing a trusting relationship. This helped build a partnership with the parents, which supported the continuity of the therapy. Betty commented how her patient's mother seemed to play an important role in helping her son to return to therapy after an unexpected long break during lock-down when the patient refused tele-analysis: '*his mum was very worried about him being in his bedroom a lot and you know, she wanted him to talk, so I think she pushed it as well'* (Betty, lines 200-2002).

Similarly, Sarah referred to the family's key role in helping overcome the crisis when her patient became silent: '*If I had the same problem with a family that was less engaged (…) it would have been much trickier'* (Sarah, lines 121-123).

Hannah had a patient transferred due to the mother's interference with the previous psychotherapist, which posed the challenge of how to work with such a mother: '*Her mum can be like this, you're either awful and have to be sacked or you're idealised and wonderful umm () even though it's problematic if you know what I mean, being idealised is better than being sacked'* (Hannah, lines 207-208).

She managed to keep the young person in therapy, building a relationship of trust and mutual respect with the mother *'I did what I said I would do (...) I was warm and friendly but quite boundary'* (Hannah, lines 218-219). This seems to well-summarise some of the qualities that child psychotherapists aim to develop during training.

Claudia identified gaining awareness of the need to work with the entire system as a significant insight. She highlighted the work within the network of professionals and justified her conviction about parent work as follows: '*Every symptom is a function of the child's personality linked with the family relationships internalised by the child and the ongoing external relationships'* (Claudia, lines 283-285).

All the participants agreed on the importance of the work with the whole network. Claudia clearly stated that everyone has to change. It takes *'the whole village'* to nurture growth and positive change.

Discussion

The aims of this study have been to investigate the experience, reflections, and dilemmas of child psychotherapists working with silent children, including their sense of the meanings and functions of silence in sessions. Based on the identified themes analysed above, this discussion is organised under four general topics found in the study: 1) cautious formulations and long-term work; 2) 'waiting' and being cautiously active; 3) 'the need to be brave to use supervision', and 4) the therapist's feelings.

4.1 Cautious formulations and a long-term commitment

Most of the participants sometimes struggled to formulate their work with the silent patient. Throughout the interviews, this was conveyed in frequent hesitations, sighs, and silences. Some participants struggled to articulate their thoughts, which may be explained by the fact they were trying to talk about their first and/or second silent patient for the first time. Even more experienced participants chose to speak about the first silent patient they worked with during their training, despite this being several years before, which I had not expected. I assumed that the participants would bring a recent case, and I wondered why they would bring cases from training. I wonder if this may have to do with the power of first experiences, and the intensity of the training, which may stay with us for life.

Another layer might be that the struggle to communicate during interviews may reflect a parallel process between the therapists and their patients. The interviews' emotional impact on me was powerful too. On the one hand, their dedication moved me; on the other, I sometimes felt overwhelmed by the extent of the therapy experience that was left unsymbolised. This reminded me of my previous painful

experience with my silent patients. I wondered how much of this was being triggered. The difficulties conveyed so vividly perhaps reflect the ambiguity and impenetrability of some silences, which is recognised in the literature (Allnutt, 2010). Rustin (2001) emphasises the necessity of external and internal support for the therapist to pursue such intricate work. Undertaking this study is partially an attempt to contribute to the support needed to metabolise these raw clinical experiences.

In my search to give voice to the range of characteristics that made some silent patients so hard to formulate, I found Klein's (1930) description of Dick extremely helpful. This silent boy spoke sparingly in an unintelligible way, did not play, was devoid of affects, had no contact with his environment, lacked a wish to communicate and be understood but seemed at times to be deliberately oppositional.

These complexities resonate with my experience of working with a most challenging child, and I think it captures some of the characteristics of the silent patients of the participants' too.

4.1.1 Is talking the aim of therapy? Is communication without words as valid as verbal communication?

It might seem tendentious to pose these questions, given that child psychotherapists are trained to observe infants who communicate primitive states of mind non-verbally. However, child psychotherapists are aware of how difficult a task this is. With this in mind, I noticed the participants in this sample courageously revealed the different feelings they had in mind, allowing their contradictory feelings and thoughts to emerge. Some participants spoke explicitly about the aim of the therapy and the common mistake of understanding it as 'to talk'. This view seemed to be linked with the participants' deep-seated preoccupations with whether communication without words

was as valid as verbal language was, despite the emphasis on infant observation and on the countertransference in our training. Knutson and Kristiansen (2015) point out that the silent patient presents a dilemma to the psychoanalytically trained therapist as spoken word is considered a primary tool. Although this might be partially true for adult psychoanalysts, it is not the whole story since they also make use of infant observation skills and countertransference. This view, however, fits with part of the participants' accounts, perhaps alerting us to an important contradiction that might need further consideration. Some participants reported that their supervisors reminded them of the infant observation method as a fundamental technique in their work with silent patients, which they found incredibly helpful.

Another underlying aspect that may influence the participants' apparent initial preference for verbal communication could be our personal experience of undergoing analysis, which relies to a certain extent—albeit not exclusively—on words.

Some participants referred to so-called 'talking therapy', which in my view poses an additional problematic dimension to elucidate. I had myself questioned whether child psychotherapy was considered a ‘talking therapy’, possibly in the face of feeling so deskilled with my silent patient. There might be different opinions here, which might be a debate worth exploring. If one believes that child psychotherapy is a 'talking cure', then the silent patient would not be suitable. Anagtostaki (2013) wonders how the therapy with 10-year-old Phoebe turned into ‘silent cure’ rather than ‘talking cure’, as she puts it, providing an example of this assumption in the literature. Importantly, however, just like the participants from the study, this did not prevent Anagtostaki from working with this child.

These dilemmas resonated with me, and I found it helpful that some participants acknowledged these contradictions.

In the same vein, but from a wider perspective, one of the participants commented that the 'non-talking' children referred to her clinic were often rejected by the CAMHS multidisciplinary team as they were deemed unsuitable for ‘talking therapy’. She noted that most of the other professionals in her team would not volunteer to take on a ‘silent child’. It would be important to explore if this attitude may reflect a wider mental health services attitude and how child psychotherapists could be more vocal about a willingness to work with these patients, given adequate support and a realistic time frame.

However, there was a sense that there may be other reasons to ‘reject’ silent patients' referrals, as some generic CAMHS clinicians, including perhaps some child psychotherapists, may not feel equipped to work with this population, as acknowledged in the literature (Emanuel, 2021). In addition, there is the difficulty of the long-term commitment in highly pressurised services that press for quick turnovers.

Referring to the complexity of the patients referred to CAMHS nowadays, Emanuel (2021) postulates that child psychotherapists must sometimes change their usual techniques, including some that might be unfamiliar, and predominantly those that directly tackle body states. He argues that this would make therapists feel better equipped and less demoralised by their task and concludes by raising the importance of allowing ‘our views to evolve in the light of new understanding and thus learn from experience’ (p. 399). I hope this study can make a small contribution in this direction.

These internal and external debates regarding the method's suitability for silent patients, and how to respond to silence, are widely reflected on in the literature since Freud, albeit with a focus on adults. These are still relevant topics, as demonstrated by the participants’ preoccupations, and mine, too. It might be important to consider

the age of the participants' patients, who were latent children or adolescents. Child psychotherapists who work with younger children would perhaps expect more play than words, but it is not always the case that a child can play either. As mentioned above, Klein's (1930) case, Dick, is a good example of a non-playing child.

The participants also mentioned the parents' wish for the therapy to help the child talk, which is usually echoed by the professionals involved. Some participants highlighted the potential problem of a premature ending, as the parents often lost patience with the slow progress and long duration of the therapy. This led to reflections on the importance of working with the network, to encourage more realistic expectations and support the long-term commitment. The literature widely reflects this point (Anagtostaki, 2013; Magagna, 2012).

Over time, the participants adjusted, learned, and developed a way of working with their silent patients. As they came to appreciate communication without words, their perception of verbal language as a more 'proper' channel for communication seemed to shift. They also reflected on the limitations that verbal language could present, as recognised in by Harris (1976): 'In work with adults one can so much more easily be misled by the *apparent* meaning of the words than in the work with children' (p. 229). Levitt (2001) speaks to the same sentiment when she suggests that silence speaks louder than words. And even Freud (1905) suggests the powerful means of body language: 'He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his fingertips; betrayal oozes out of him at every pore' (p. 77-78).

Klein (1930) also denies that talking was the aim of the therapy with Dick, a silent boy. In her words:

> The unusual difficulty I had to contend with in the analysis was not his defective capacity for speech. In the play-technique, (...) we can, to a great extent, dispense with verbal associations. (…) Our material can be derived (as it has to be in the case of children inhibited in play) from the symbolism revealed in details of his general behaviour. (p. 224)

She here invokes the developmental achievement of communicating through play, from which verbal communications can evolve. I find Klein's eloquence extremely helpful here as she clarifies that, in very shutdown children, the difficulty lies not in the lack of verbal communication but in the lack of a willingness to communicate. It seems that everyone agrees that this kind of child requires some adaptation of technique, at least temporarily.

One participant warned of the danger of focusing on talking, which may lead to an impasse, due to the therapist's excitement when the child speaks for the first time, which is also acknowledged by Allnutt (2010) and Della Rosa (2015). She claimed this might lead to regression, as the child, in this fragile state, feels robbed of their development. As the child becomes more robust, he would be able to share the pleasure of his development with the therapist. The therapist of silent children requires great patience, as it may be a long unrewarding journey before they can experience any pleasure.

The study participants and the literature seem to agree that working with silent patients constitutes an arduous journey as the silence contains in the most challenging cases the terror of the baby without the presence of an emotionally attuned and containing parent (Magagna, 2012). Some participants acknowledged the importance of experience, which builds faith in one's capacity and the psychoanalytic method. However, they also emphasised the importance of ongoing support, even for experienced therapists. The child psychotherapists interviewed stuck with these patients despite feeling deskilled and incompetent for some time. Yet over time, these

participants found ways to revitalise themselves and their intricate patients in ways I found a real testimony to their commitment and vocation.

4.1.2 A long-term commitment

The participants saw their work with the silent child as a slow process requiring a long-term commitment.

The patients' backgrounds included family breakdown, neglect, parental mental health problems, and complex circumstances around migration. This meant, in many cases, multiple and intergenerational traumas, abandonment, loss, and being uprooted, which, in the most extreme cases, led to psychic death. The fact that these young people suffered early attachment disruptions might explain their high levels of disturbance and the necessity for long-term work.

The early attachment disruptions of the patients could mean an absence of consistent containing objects. Emanuel (2021) argues that: 'it would be true to say that another essence of trauma is a serious deficit of containment – the lack of equipment to help make sense of an emotional experience which renders the person helpless and overwhelmed' (p. 388).

This, however, did not mean seeing the young people as victims only, a common mistake that Claudia flagged. She explained the important distinction between a 'poor' child and an 'angry' child, which she understood with the help of her experienced supervisor and recognised in the literature (Joseph, 1982). Furthermore, she reflected on the aetiology of anger that cannot be expressed, linked to the idea of the absence of containing objects, which resulted in turning inward.

The participants grappled with the silent patient for a long time before finding a way that felt right for each particular patient, as we will see next, in the context of dilemmas around technique.

4.2 ‘*Waiting*’ and being cautiously active

4.2.1 *‘The need to do something different’*

The tensions regarding the adaptation of technique seemed present in the participants' minds and is widely recognised in the psychoanalytic literature. All the participants conveyed the need to do something ‘different’, ‘play with their technique’, or ‘let their mind do the work’. All of which involves an element of trusting themselves and their training. This connects with ideas that some referred to experience, it being the hardest when working with the silent patient for the first time, not knowing if the psychoanalytic method works with this population, or if one is a capable therapist.

This connects with another aspect that some participants made explicit regarding the need to internalise the good objects of the training experience that the participant could reach to withstand the work's loneliness with an emotionally absent patient. Furthermore, Sarah linked the difficulty to think when feeling lonely, and it being imperative to reach out to external and internal resources to re-establish the therapist's capacity to think helpfully to do the work as recognised by Rustin (2001).

The silent child seemed to flummox the participants, perhaps due to the therapist being less familiar with non-verbal patients. The participants expressed the anxiety of not knowing how to work with the silent patient. Hannah reflected with humour about the tension of following Bion’s aspiration to sustain an open mind with the unknown, and how hard this actually is in practice.

Some participants spoke of a phase that involved doing 'something different' that could lead to more psychoanalytically recognisable work. Similarly, Klein (1930) refers to a temporary adaptation of technique, mainly in the initial phase:

> Once access to the Ucs has been gained and the degree of anxiety has been diminished, play activities, speech associations and all the other modes of representation begin to make their appearance, alongside the ego-development which is made possible by the analytic work. (p. 224)

The participants shared a similar progression, which might, in their examples, take a long time. Here an important question emerges whether there is a need for a blended approach in this therapy, or if the adaptations are only temporary, as Klein suggested. This could be an aspect for further research. Importantly, Emanuel (2021) argues that there is sometimes a need for adapting our techniques.

4.2.2 The value of the psychoanalytic method

Most participants questioned the psychoanalytic method, put it to the test and seemed to find genuine value as well as limitations. They all started from a place deeply rooted in psychoanalysis, given their training.

4.2.2.1 *'Infant observation plus'*

All participants began with infant observation as a way to establish contact with the silent child, but it was not straightforward. Supervision reminded the participants of this crucial skill. The only person who did not explicitly refer to infant observation had been unable to access supervision, however, she clearly used these skills.

The participants described the use of '*infant observation plus*', as coined by Sarah, meaning observation accompanied by commentary. This felt very valuable to all of them and is also recognised by Magagna (2012) and Allnutt (2010).

Klein (1930) refers to how in the analysis with a silent boy she had to start from 'the fundamental obstacle of establishing contact with him', which is what the participants showed by using 'infant observation plus'. This might be akin to Music's (2021) idea of an initial 'safening' phase.

Most participants also considered infant observation a cornerstone for this particular work, showing implicit or explicit pride in having developed these skills during their training. The pride might be linked to the fact that infant observation embodies the particular contribution of the child psychotherapy profession to the field of psychoanalysis (Bick and Harris, 1987).

4.2.2.2 Being cautiously active

The participants expressed the need to adapt their psychoanalytic technique, but not without hesitation. There was a sense of trial and error—some seemed to need to free themselves up to find their particular way of working. The participants showed rigour in examining the impact of the adaptation of the technique on the patient. Claudia referred to ultimately becoming more active, and justified this with the phrase 'I do what works', following a long psychoanalytic scientific tradition of developing the technique grounded on clinical observation. Similarly, Music (2021) advocates for the therapist's need for caution and courage for genuine transformations to occur in the patient.

Participants' worries about interfering, interrupting, or being intrusive led them to be cautious about becoming active. Alvarez (1992) indicates this preoccupation when comparing the therapist's interventions with maternal interventions that stimulate curiosity, interest, and attention, rather than intrusive interferences. Claudia states that she eventually actively interests the silent patient with stories, toys, and free

associations, to which the literature also refers (Allnutt, 2010; Magagna, 2012; Bakalar, 2012). She added the sensitive approach to allow the patient to turn to her if they wanted to, similar to Meltzer's following description:

> (...) we can also modify the distance by not addressing the part concerned in our formulation at all, but, rather, talking about that part to another, or by ruminating aloud in the presence of the patient, leaving it to his choice to listen or ignore. (p. 378)

There were also concerns about their belonging to the psychoanalytic profession if they departed from the classical approach, a preoccupation widely recognised and present in the latest ACP conference (2022). Delegates at the conference explored the search for identity in the profession in modern times and questioned if it is about survival, adaptation, or betrayal. However, Sheila Miller (2022, ACP conference) made a point about a profession that has been ever-evolving since the outset. Klein (1930) talks directly about adapting her psychoanalytic technique when working with a silent boy in an early paper and recent theoretical developments (Emanuel, 2021; Music, 2021) show also the evolving nature of the psychoanalytic method to date.

4.2.2.3 The importance of fine-tuning

The participants spoke about the importance of fine-tuning with the patient: the fine balance between waiting with a curious mind and knowing when they needed to take an active role to draw the patient towards them.

Hannah spoke of a 'dance' that she and her patient developed as they got to know each other over time. Brazelton (1974) referred to 'the dance of reciprocity' to describe the 'steps' the mother and baby would take in their respective turns. Hannah's patient's initial routine developed over time, and Hannah got to learn it. In her words:

> *(...) there sometimes is a bit of a dance in the room, isn't there? and then the dance gets repeated, you know, and you get to know the steps in the dance, and I suppose I got to know that she she needed time, you know, and she needed things to be set up in a way, and almost part of the dance was knowing that that I would comment on what she does, 'so you're back, and it looks like you're going to do another sticker, I wonder if that is what is going to happen today, and I have to maybe wait and see, I have to wait and see what colours might be on the sticker', so I was giving her a sort of dialogue, even though it is one-sided, she it it was what happened, you know, and that was part of the therapy.* (Hannah, lines 340-348)

This moving example combines Bion's containment and something more in the quality of Hannah's overall response, giving back a sense of something that was built together over time, while getting to know each other. There are clear and predictable roles, yet there is also space for new developments. Hannah here provides a beautiful example of a containing structure of a thinking mind that enables another mind to emerge in its own time.

Claudia advocated for the importance of the therapist's voice having a spark and musicality to tune in with the patient. Meltzer (1976) debates whether the musicality of the voice is a matter of personal style or technique. Claudia clearly postulated this as an essential technique, particularly with the silent, shutdown patient. She demonstrated beautiful moments during the interview when she modulated her voice providing warmth, care, and comfort. This may be linked with the 'safening' that Music (2021) postulates. Meltzer (1976) adds that: 'by modulating these musical elements, we can control the emotionality of the voice and thus what I mean by the temperature of our communication (...), variously heightening or dampening this atmosphere' (p. 378).

4.2.2.4 Part of the therapist’s technique seems unconscious

There were some aspects of the technique that the participants could not formulate in detail, such as their body language—possibly lacking ‘emotional literacy’ in this domain (term used by Davids, 2022). Davids defines ‘emotional literacy’ as awareness, which can develop. The participants acknowledged that part of their communication is unconscious as recognised by Freud (1915): ‘It is a very remarkable thing that the Unconscious of one human being can react upon that of another, without passing through the Conscious’ (p. 194).

Another seemingly underlying unconscious preoccupation was the possibility of harming the patient. The rationale for undergoing analysis during training is to ensure safe practice, something that Hannah addressed in the interview.

Similarly, Claudia highlighted that *'the greatest impasse with the silent child is in the countertransference*', which she stated can only be resolved in the therapist’s own analysis. Meltzer warns against the danger of acting out in the countertransference:

> where does ingenuity end and acting-in-the-countertransference begin? I am of course claiming that I want my freedom in order to enrich the process and not for its own sake: to increase my pleasure in the work, etc. But we know well from Freud the serious limitations and distortions that the unconscious countertransference can introduce, and that this manifests itself in the analyst, (...), through difficulty in interposing thought between impulse and action. (Meltzer, 1976, p. 379)

Meltzer also links these ideas to Freud's preoccupation with how to prevent 'wild analysis'. Meltzer talks about the importance of knowing what we are doing in terms of the development of technique, proposing that:

> …if we wish to free the analyst for the sake of enriching the communication (...), then we must examine and formulate and evaluate what we actually find ourselves doing to see if guiding principles can be formulated in lieu of constricting rules of conduct. (p. 379)

This research has made some inroads to explore what the participating therapists remember they are doing, to the extent that they are conscious. Future research could build on these findings. Perhaps video recordings could aid in seeing what the therapists do in terms of body language and the impact this has on the patient, just as child development researchers have done with mothers and their babies. However, this would need to be carefully and sensitively thought through. Psychoanalysis has historically resisted such exposing methods as they could be experienced as invasive by both patient and therapist and could be potentially damaging. Therefore, considerable thought would have to go into the particular dyad of patient and therapist to see if this could be done helpfully, being mindful of the fragile states of such patients and their relationship. There might be other innovative ways of complementing our capacity to capture what is happening in the consulting room, which could have further implications on training.

When thinking about using the tone of voice, Claudia commented that *'all therapists should take a drama course'*. However, I wonder if whole-body expression is not equally important. Betty commented that she thought she communicated her delight about her patient's eventual ability to connect with her, *'possibly with my whole body'*. This may show the need for language to describe what therapists do with their body language. Therapists could also learn about non-verbal communication from child development research. Stern (1985), for example, offers the concept of 'affect attunement' to describe the performance of a mother's behaviours towards her baby. The mother responds with different levels of energy in her demeanour, and the quality of her non-verbal communication includes facial expressions, tone of voice, and gestures. She conveys her understanding of her baby's inner state (after reading the

infant's feeling state from the overt behaviour) in such a way that these feelings are mutually shared.

4.2.2.5 Pre-symbolic state

Some participants spoke of a part of the personality that lacks symbolisation as the main difficulty that needs to be reached, which, as Claudia commented, is not unique to silent patients. Klein (1930) recognises that Dick was unable to symbolise, and Emanuel (2021) writes as follows:

> Preverbal memory is likely to be only encoded in implicit memory. Part of our work in therapy is to try and help the person move from implicit emotional and procedural memory to more explicit memories, which hopefully can be integrated into the person's autobiographical explicit memory, placing it in the past rather than living with it happening in the now, again and again. (p. 385)

4.3 *'The need to be brave'* to use supervision

Another aspect that emerged was the great emotional difficulty most participants encountered in accessing supervision. This might be the most original outcome of my study, which is not present in the literature as far as I know. There are implications for training and the need for support post-qualification.

The participants expressed experiencing intense negative feelings, including questioning their professional competency and feelings of shame. This complicated their ability to seek help, and one participant almost entirely avoided seeking it. This left her with difficult feelings about the quality of her work—had she missed something important?—despite noticing developments in the child.

Writing up the clinical material of such limited verbal expression provided another challenge, which is also not acknowledged in the literature. Hannah spoke to the difficulty of noticing the non-verbal communication, something more akin to an

infant observation: *'You're constantly struggling with yourself, aren't you? In those situations when you're trying to notice constantly'* (Hannah, lines 227-228).

Another aspect that some participants voiced was the conflict entailed in the performative aspect of seminar supervision groups. The desire to impress versus the need for help, and thus the shameful experience of exposing work that made them feel incompetent when the descriptions were more about oneself, and one can be seen '*fumbling with the technique'*.

Betty, who had not had regular supervision, used the interview as a place to reflect on the challenges of the work. As I asked her what she had learnt, Betty acknowledged she was still working this out and realised that she felt '*silenced'* as the team did not value the work with the silent patient. In her words:

> *Umm mm () ummm mm I feel that () to be honest, I feel that, () you know I can't sit here and say () 'Oh, I've learnt this this and this () I feel that even by having this conversation with you () that maybe is more about realising something that it's not very well acknowledged about this work and as you just said, you have to wait for this tiny shifts and it's kind of painstaking work that isn't really seen, nor talked about that much, you know* [laugh] *() ummmm () I think () it's been very helpful to be able to sit and talk like this and it's making me think 'oh that's something to learn but () actually () maybe what I could be thinking about is () how do I get an opportunity to get more of this with this kind of work more discussion, more, whether supervision or you know, there's something about () maybe umm () trying to make sure that there is not too much isolation, I think, you know it'sss () I don't think this is acknowledged you see, I don't think it's acknowledged more broadly ( ) how how hard the work is and then () it is well for me () I think I just carry it a bit, you know, ( ) and then () I'm a bit silenced by it, you know, and I don't kind of find a place to speak, speak about it in the service I work in.* (Betty, lines 400-419)

Betty here provides a full reflection on the complexities of this work. Some of these aspects have already been explored in the first section of this chapter, but she makes other points. For example, she finds her voice and, later on in the interview she decides to become more proactive in seeking spaces for informal or formal discussions among her team and beyond, so as to benefit her work with these children

and advocate for this population to not fall through the net. She was among the first to volunteer for this research project, which shows her readiness to use opportunities.

She commented about the difficulty of taking this work to supervision, partially due to the harder write-ups. Yet she acknowledged the contradiction of being able to talk about the case for a long time, and frequently remembering what had taken place after the session. Although only one participant raised this point, I wonder if alternative ways of supervision, such as peer supervision and other informal spaces, might facilitate more discussion of this population.

It is important to note that Betty's silent patients were capable of play, which would have provided her with clearer material, unlike the children who neither talk nor play. Hannah commented on children that play, that often she did not notice they were not talking when they were playing, which resonates with my experience.

The participants suggested ideas for overcoming the difficulty of accessing supervision, such as the need to be brave from a more personal perspective and the importance of seminar supervisors with a genuine interest in non-talking and non-playing patients, to encourage trainees to bring such cases. These are also innovative points that are not present in the literature. This two-fold approach could support the development of the technique with the silent patient. One participant pointed out the detrimental consequences of infrequent sharing of the work with the silent child, which, in her view, has led to a lack of development in technique with this population, as recognised by Acheson (2020) and Liegner (2003). It might be helpful to further promote the discussion of the work with silent patients within the profession to advance the development of the technique with this population.

To summarise the conditions under which clinical supervision can be most helpful: The findings suggest that clinical supervision is paramount for this work, yet

there is a danger of practitioners falling silent about their silent patients due to feelings of being unskilled, ashamed, and incompetent.

Flexibility regarding the format of the presentation—e.g. oral or written—or a combination of both, may also promote more presentations as participants mentioned how excruciating they found it to try to do write-ups of sessions, but that they were able to 'talk for hours'. It seems to me paramount that supervisors convey a sympathetic stance, sensitivity, and patience that communicates a truthful understanding of the painful feelings that supervisees may experience when presenting 'not good work'. A participant re-enacted a tone of voice of her supervisor that sounded critical, or even shaming. It seems that the holistic approach of the supervisor, including verbal and non-verbal communication, proves crucial to ensuring a safe environment for the therapist who is finding a way to the silent child. This, in turn, echoes what the silent patient requires from the therapist. In addition, therapists must be brave enough to expose their unfinished work, tolerate feelings of incompetence, 'not knowing' and dependency, and find creative ways of voicing the work. During the training, the internalisation of a good object supported their work with the silent patient and would potentially also aid their capacity to use supervision.

4.4 Therapist’s feelings

The participants also spoke about the impact on themselves of working with silent patients and their countertransference. Feelings of loneliness, isolation, and incompetence emerged powerfully and are widely acknowledged in the literature (Allnutt, 2010; Della Rosa, 2015; Bakalar, 2012; Music, 2021). Betty seemed the most isolated, and I wondered if being the only one who was presenting current work as a qualified child psychotherapist might have partly explained this. This is an important

finding for the profession and requires further exploration regarding the support that qualified child psychotherapists might need to continue their development.

Music (2021) adds the challenge of remaining ‘psychologically alive with people who easily slip out of our minds’, which resonates with my experience. He continues: ‘with such children, I can feel incompetent, bored, resistant, sorry for myself, fed-up. I sometimes wonder if I am in the wrong business altogether. Time passed slowly (...), and with some children each second can feel like an eternity’ (p. 367).

Most participants referred to self-blaming in work with the silent patient and beyond as a common characteristic among trainees that may carry into post-qualification life. Therapists experienced desperation in their failed attempts to make contact with these patients. With some desperation in her voice, Hannah conveyed her *'need for help'* to be able to make a shift in herself to find a different way of engaging with the reluctant patient. This links with Joseph’s (1998) point that the therapist’s state of mind is crucial. Emanuel (2021) suggests that: ‘using the bio-psychosocial model of the neuroscience of trauma (...) can enable those around the child to take things less personally, be less blaming, and enable children to have their expectations of hostile rejecting world not confirmed (...)’ (p. 399).

All participants eventually found their way to establish an emotional relationship as they reached the point of feeling comfortable with the silence and being alongside it—an opening rather than a closing attitude. Towards the end of the interview, participants conveyed genuine pride, and a sense of authority and clarity emerged in their voices as they had achieved a depth of understanding. For example, Hannah shared: *‘I made a choice to engage with it with words, so as to not be silent back, which would’ve not helped these two young women’* (Hannah, lines 487-488).

All the participants spoke about very distressing feelings. I felt honoured and privileged that they trusted me to tell their stories in such an honest way. Their genuine commitment to their patients was unwavering. They examined themselves rigorously. Still, they also managed to free themselves up into those moments of true connection where surprising meaningful contact took place. At other times it was more a gradual increase of contact, and it eventually seemed that all the hard work was worthwhile. I felt moved by witnessing their authentic delight in their well-deserved achievements.

4.5 Strengths, potential and limitations of the study

This study constitutes a beginning of an exploration into a vast topic. However, it has several strengths and considerable potential. As my first qualitative research, the study has aimed to explore the lived experiences of child psychotherapists who have worked with silent patients, using a reflective design. Using semi-structured interviews, I collected rich first-hand and second-hand relevant data on a matter that may be difficult to gain direct access to, due to the nature of silence. This allowed in-depth examination into the therapists' understanding of their experiences with silent patients.

The study does not provide generalisability due to the idiographic nature of IPA. However, the sample of interviewed participants was purposive, relevant, and homogenous enough, as suggested by the high level of similarity between participants' accounts, which guarantees a high-quality IPA study. The commonalities of the participants' accounts allowed for the emergence of a series of robust and meaningful themes with potential clinical and educational implications. This is a strength of this project.

Regarding the limitations of this project, from a broader perspective, one could argue that its being topic-driven renders it reductive. Evidence of this view might be

found in the fact that some relevant case studies and clinical material found in the literature search did not focus on 'silence', despite this being a salient feature. Psychoanalysts endeavour to understand human experience in its fullest complexities. I must admit that the present study's focus caused conflict in me, due to its potentially narrow scope. However, the participants' rich and complex accounts, as well as the literature reviewed, provided me with faith that it might be possible to have a focus, as required for research purposes, and still retain the complexities of the phenomenon of silence. My intention was neither to pay tribute to silence nor make a condemnation of it, but to begin to explore and understand it. I started my research thinking about 'silence' as a general clinical phenomenon. However, during the data analysis, I realised that there was not such a thing as 'silence', but a 'silent person', as it is so context dependent and relational. My hope was to examine the 'silent patient' from as many angles as possible of the therapist's perspective, to provide a full picture of their complexities and potential.

From a narrower perspective, it is clear that the sample for this study is small. As such, it gives a narrow representation of child psychotherapists, for example, in terms of ethnicity and gender—as it only included Caucasian female participants from Western cultures. Future research on the topic could include a bigger sample of participants with bigger variations of experiences, races, cultural backgrounds, classes, and genders. This would help provide a deeper and wider knowledge of the phenomena and test whether the results of this study apply to wider and diverse groups of psychoanalytic child psychotherapists.

It may be important to remind the reader that this study deliberately set out to explore the experiences of psychoanalytic child psychotherapists who belong to the Association of Child Psychotherapy (ACP). It would be interesting to explore the

experiences of clinicians from other modalities who have worked with young silent people, as this could provide a multidisciplinary understanding of the phenomena involved. For example, I believe there is much to learn from the arts psychotherapists whose mediums are non-verbal creative expressions. Magagna (2012) suggests that in non-speaking young people engaged in creative activities, silent thinking occurs while drawing and sculpting long before these young people open their mouths to speak to anyone in a group. I would be equally interested in therapies that include contact with nature.

Another characteristic of this study is its focus on individual therapy. Magagna argues that creative groups 'can function as a container for the not-speaking young people's unconscious, unprocessed emotional states' (p. xxv). I would be curious about the benefits of group settings for silent patients.

Another area of interest for future research would be to gather a broader or narrower intersectionality of patients. Whilst extending the study toward 'the universal', it would be imperative to continue to highlight 'the particular': an important element in IPA. There could be a focus on different diagnoses or particular groups, such as silence in autistic children, children with eating disorders, selective mutism, foster- or adopted children, children with depression or anxiety, etc.

An obvious area for future research would be to undertake a study directly from the silent patients' perspective, perhaps after completing therapy, but this would imply complex ethical considerations.

The cultural meanings of silence for patients and therapists would also be an area of interest that falls outside the scope of the current research.

Regarding the present study's potential, I would be interested in sharing the findings by writing a paper for the journal of the child psychotherapy profession,

making a presentation in my current CAMHS service and psychotherapy NHS trust-wide group, and perhaps at a future Association of Child Psychotherapy conference.

The data analysis, aided by my previous clinical experience on the topic, resulted in rich findings that could allow therapists to enhance their understanding of key aspects of working with silent patients. It could stimulate researchers to continue to investigate the phenomenon by extending or narrowing the inclusion criteria suggested above. Finally, it could provide clinicians, researchers, educators and other professionals with additional knowledge for treatments and interventions.

Conclusions

I will attempt to summarise some ideas for clinical practitioners to hold in mind, both individually and in their professional networks.

- This study indicates that psychoanalytically-trained child and adolescent psychotherapists (CAPTs) have a good foundation for working with silent patients, which is based on infant observation, countertransference, and the psychoanalytic receptive attitude. These skills, however, are not enough and the data suggests that flexibility to adapt technique when this is needed is also paramount.
- The findings suggest that 'infant-observation plus', which includes tuned-in commentary or interpretations combined with the use of countertransference, is fundamental. The receptivity to accept the different kinds of communications and signalling from deadness, desperation, and aggression must be received, tolerated, and made sense of.
- It is essential to find the right 'temperature and distance' (Meltzer, 1976) through musicality of the voice and body/gestures/facial expressions to respond to the different parts of the personality as they are expressed in the moment-to-moment of the therapy.
- The work with the silent patient is a long-term commitment. The therapist must develop a capacity to wait and be alongside the child to get to know the patient over time and to learn the steps of the dance/duet ('dance of reciprocity' Braselton, 1974).

- Predictability, structure, consistency, boundaries, and warmth are all important qualities to offer a reliable setting where trust can be built over time, but the process cannot be rushed. These same qualities are important to build trusting relationships with the parents/carers to support long-term therapy.
- The capacity to finely attune to the child, finding the right balance between a receptive and active '*enlivening'* (Alvarez, 1992) position with voice and body that has a 'spark' (Music, 2021) helps to gradually wake up the patient, and allow them to reconnect with life. One participant suggested that all therapists could benefit from a drama course.
- It is important to be able to differentiate between an 'angry' child and a 'poor' child who is truly suffering. The source of this knowledge may be found in the body's countertransference and the therapist must therefore develop a capacity to not repress difficult feelings such as anger.
- It is important to understand that there could be a stronghold in an internal dynamic of self-deprecation and 'crushing' within the silent patient, and that the therapist might be drawn to act out and 'criticise'. It is crucial to differentiate between the part of the patient that might be exploiting their suffering from the part of the patient that is actually in despair. In the first instance, the patient might end up mocking the therapist's compassion. This part of the patient needs to be noticed for the true suffering part to find proper holding (Joseph, 1982).
- A great part of the work takes place within the therapist's countertransference. This is the emotional work of deep transformation which allows for a true emotional experience to take place with the silent patient. From that place, the right words/interpretations can emerge, giving voice to the child's longstanding internal dilemmas. This can generate positive authentic shifts in the child.

- Another way of looking at the transformation would, in Klein's words, be the shift from the schizoid-paranoid position to the depressive position. The silent patient may feel persecuted and fragile, requiring urgent work that allows a shift to be able to receive something good from the therapist that can nourish and sustain the self from the inside. This requires long-term hard work, as the data shows.
- It is important to note that the therapist cannot do this demanding and draining work alone. It requires the support of a robust and thoughtful supervisor as much as the team and network, including the parents. Therefore, working with the parents and the network is crucial to avoid re-enactments of unhelpful familiar patterns that may lead to premature endings.
- The findings of this research remind us of the importance of continuing to develop theories that account for the difficult experiences and technical difficulties of working with silent patients so that we can learn from experience, skill ourselves up, and become useful to this hard-to-reach population. The problem of how to work with silent patients should be ours and not theirs, and we therefore need to keep learning from each other and develop our technique to best meet their needs.

References

Acheson, R; Verdenhalven, N.; Avdi, E. and Midgley, N. (2020). Exploring silence in short-term psychoanalytic psychotherapy with adolescents with depression. *Journal of Child Psychotherapy, 46*(2), 224-240.

Anagnostaki, L. (2013). Beyond silence: working with Phoebe. *Journal of Child Psychotherapy, 39*(2), 156-161.

Allnutt, L. (2010). Light and movement: making contact with a traumatised and embattled latency girl. *Journal of Child Psychotherapy*, *36*(1), 33-47.

Alvarez, A. (1992). *Life is company: Psychoanalytic psychotherapy with autistic, borderline, deprived and abused children.* Tavistock/ Routledge.

Bakalar, N. (2012). Countertransference in the psychoanalysis of a silent adolescent boy. In J. Magagna (Ed.), *The silent child: Communication without words.* Routledge.

Balint, M. (1958). The three areas of the mind-theoretical considerations. *International Journal of Psychoanalysis*, 39, 328-340.

Bick, E. (1968). The experience of the skin in early object relations. *International Journal of Psychoanalysis*, 49, 484-486.

Bick, E. (1962). Notes on Infant Observation in Psychoanalytic training. In M. Harris

& E. Bick (Eds.), *Collected papers of Martha Harris and Esther Bick.* The Roland Harris Education Trust, 1987.

Bick, E. & Harris, M. (1987). *Collected papers of Martha Harris and Esther Bick.* The Roland Harris Education Trust.

Bick, E. & Harris, M. (1980). Bion's conception of a psychoanalytic attitude: An obituary appreciation of the work of W. R. Bion. In *Collected papers of Martha Harris and Esther Bick.* The Roland Harris Education Trust, 1987.

Bion, W. R. (1959). Attacks on linking. In *Second Thought.* William Heinemann Medical Books Limited.

Bion, W. R. (1962). *Learning from Experience.* William Heinemann. [Reprinted Karnac, 1984].

Bion, W. R. (1965). *Transformations.* William Heinemann. [Reprinted Karnac, 1984].

Bion, W. R. (1970). Opacity of memory and desire. *Attention and interpretation.* Basic Books. [Reprinted Rowman & Littlefield, 2004].

Blos, P. (1972). Silence: A clinical exploration. *The Psychoanalytic Quarterly, 41*(3), 348-363. https://doi.org/10.1080/21674086.1972.11926602.

Braselton, T., Koslowski, B. & Main, M. (1974). The origins of reciprocity: the early mother-infant interaction. In: M. Lewis & L. Rosenblum (Eds.), *The effect of the infant on its caregiver.* Wiley.

Delve. Ho, L., & Limpaecher, A. (2022b, February 25). *The Importance of Reflexivity in Qualitative Research. Essential Guide to Coding Qualitative Data.* https://delvetool.com/blog/reflexivity.

Della Rosa, E. (2015). The problem of knowledge in psychotherapy with an adolescent girl: reflections on a patient's difficulty in thinking and issues of therapeutic

technique. *Journal of Child Psychotherapy, 41*(2), 162-178.

Douglas, H., (2001). *Solihull Approach resource pack: The first five years.* Jill Rogers Associates Limited.

Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. In: C. Willig & W. S. Rogers (Eds.), *The Sage handbook of qualitative research in psychology.* Sage, 2017.

Emanuel, R. (2021). Changing minds and evolving views: a bio-psycho-social model of the impact of trauma and its implications for clinical work. *Journal of Child Psychotherapy, 47*(3), 376-401, DOI: 10.1080/0075417X.2021.2013927

Ferenczi, S. (1919). On the technique of psychoanalysis. In J. Rickman (Ed.), *Further contributions to the theory and technique of psychoanalysis*. Hogarth Press, 1950.

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

Freud, S. (1893). The psychotherapy of hysteria. *Standard Edition*, *2*, 255- 305. Hogarth Press.

Freud, S. (1905). Fragment of an Analysis of a Case of Hysteria (1905 [1901]). *Standard Edition, 7*, 1-122.

Freud, S. (1910). The future prospects of psychoanalytic therapy. *Standard Edition*, 11, 139-152. Hogarth Press.

Freud, S. (1912). Recommendations to Physician practicing psychoanalysis. *Standard Edition*, 12, 109-120. Hogarth Press.

Freud, S. (1912). The dynamics of the transference. *Standard Edition, 12*, 99-108. Hogarth Press, SE.012.0097A.

Freud, S. (1913). On the beginning of treatment. Further recommendations in the

technique of psychoanalysis. *Standard Edition, 12,* 123- 144. Hogarth Press. SE.012.0121A.

Freud, S. (1914). Remembering, repeating and working through. Further recommendations in the technique of psychoanalysis II. *Standard Edition, 12*, 145- 156. Hogarth Press.

Freud, S. (1915). The Unconscious. *Standard Edition, 14*, 159-190. Hogarth Press.

Freud, S. (1923). The ego and the id. *Standard Edition, 19*, 19-27.

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, DOI: 10.1080/02668730500238218.

Glover, E. (1927). Lectures on technique in psychoanalysis, part I. *International Journal of Psychoanalysis, 8*, 311-338.

Harris, M. (1976). The contribution of observation of mother-infant interaction and development to the equipment of a psychoanalyst or psychoanalytic psychotherapist. In M. Harris & E. Bick (Eds.), *Collected papers of Martha Harris and Esther Bick.* The Roland Harris Education Trust, 1987, 225-239.

Heimann, P. (1950). On countertransference. *International Journal of Psychoanalysis, 31*, 81–84. IJP.031.0081A.

Hermann, I. (1920). *Die Psychoanalyse als Method.* International Psychoanalytic Verlag.

Hinsie, Leland, E. and Campbell, R. (1960). Psychiatric dictionary [by] Leland E. Hinsie and Robert Jean Campbell. New York: Oxford University Press.

Joseph, B. (1982). Addiction to near-death. *International Journal of Psychoanalysis*,

63, 449–457. IJP.063.0449a.

Joseph, B. (1998). Thinking about a playroom. *Journal of Child Psychotherapy, 24*(3), 359-366.

Keats, J. (1795-1821). Selected Letters. In: Robert Gittings (Ed.), Oxford University Press, 2002.

Bamford, C. (2005). Negative Capability, *Parabola, 30*(2).

Khan, M. (1963). Silence as communication. *Bulletin of the Menninger Clinic, 27*, 300-317.

Klein, M. (1930). The importance of symbol-formation in the development of the ego. In *Love, guilt and reparation and other works 1921-1945.* The Free Press.

Klein, M. (1940). Mourning and its relation to manic-depressive states. In *Love, guilt and reparation and other works 1921-1945.* The Free Press.

Klein, M. (1946). Notes on some schizoid mechanisms. In *Envy and gratitude and other works 1946-1963.* Vintage.

Klein, M. (1975). *Envy and gratitude and other works 1946- 1963.* Vintage, 1997.

Knutson, H. V. and Kristiansen, A. (2015). Varieties of silence: Understanding different forms and functions of silence in a psychotherapeutic setting. *Contemporary Psychoanalysis, 51*, 1-31.

Lask, B. (2012). The sound of silence. In J. Magagna (Ed.), *The silent child: Communication without words.* Routledge.

Leira, T. (1995). Silence and communication: Nonverbal dialogue and therapeutic action. The *Scandinavian Psychoanalytic Review, 18*(1), 41-65. DOI:10.1080/01062301.1995.10592330.

Levitt, H. (2001). Sounds of silence in psychotherapy: The categorisation of clients' pauses. *Psychotherapy Research, 11*(3), 295-309. DOI: 10.1080/713663985.

Levy, K. (1958). Silent in the analytic session. The *International Journal of Psychoanalysis*, 39(1), 50-58.

Liegner, E. (2003). The silent patient. *Modern Psychoanalysis, 28*(1), 69-86.

Magagna, J. (2012). Communicating without words. In J. Magagna (Ed.). *The silent child: Communication without words.* Routledge.

McWilliams, N. (2013). Psychoanalysis and research: some reflections and opinions. *Psychoanalytic Review, 100*(6).

Meltzer, D. (1973). *Sexual states of mind.* Clunie Press. ZBK.139.0001A.

Meltzer, D., Bremmer, J., Hoxter, S., Weddell, D. and Wittenberg, I. (1975). *Explorations in autism: A psycho-analytical study.* Karnac.

Meltzer, D. (1976). Temperature and distance as technical dimensions of interpretation. In *Sincerity and other works: Collected papers of Donald Meltzer.* Routledge, 1994.

Meltzer, D. (1992). *The claustrum: An investigation of claustrophobic phenomena.* The Harris Meltzer Trust. [Revised edition, 2018].

Meltzer, D. (1998). *The apprehension of beauty: the role of aesthetic conflict in development, violence and art.* The Clunie Press.

Monzo, M. P., Micotti, S., Rashid, S. (2015). The mutism of the mind: child and family therapists at work with children and families suffering with selective mutism. *Journal of Child Psychotherapy, 41*(1), 22-43.

Music, G. (2021). Resparking from flatness: new thoughts on shut-down states after trauma and neglect. *Journal of Child Psychotherapy, 47(*3), 357-375, DOI: 10.1080/0075417X.2021.2018482

Nacht, S. (1963). The non-verbal relationship in psycho-analytic treatment. *International Journal of Psychoanalysis, 44*, 334-339.

Pick, I. B. (1985). Working through in the countertransference. *International Journal of Psycho-analysis, 66*, 157-167. IJP.066.0157a.

Pietkiewicz, I. & Smith, J.A. (2014). A Practical Guide to Using Interpretative Phenomenological Analysis in Qualitative Research Psychology. *Psychological Journal, 20,* 7-14.

Robinson, K. (n.d.). *A brief history of the British psychoanalytical society*. Institute of Psychoanalysis.https://psychoanalysis.org.uk/sites/default/files/documents/pages/history_of_the_bps_by_ken_robinson_0.pdf

Rosenfeld, H. (1971). A clinical approach to the psychoanalytic theory of the life and death instincts: An investigation into the aggressive aspects of narcissism. *International Journal of Psychoanalysis, 52*, 169- 178. IJP.052.0169A.

Rustin, M. (2001). The therapist with her back against the wall. *Journal of Child Psychotherapy, 27*(3), 273-284.

Sabbadini, A. (1992). Listening to silence. *Scandinavian Psychoanalytic Review, 15*(1), 27-36. https://doi.org/10.1080/01062301.1992.10592268.

Segal, H. (1998). The importance of symbol-formation in the development of the ego- in context. *Journal of Child Psychotherapy, 24*(3), 349-357. DOI: 10.1080/00754179808414823.

Symington, N. (1983). The analyst's act of freedom as agent of therapeutic change. *International Journal of Psychoanalysis, 10*, 283-291.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method and research.* SAGE Publications.

Steiner, J. (1993). Psychic retreats: a clinical illustration 1. *In Psychic retreats.*

Pathological Organizations in Psychotic, Neurotic and Borderline Patients. Routledge. DOI:10.4324/9780203359839.

Steiner, J. (1982). Perverse relationships between parts of the self: A clinical illustration. *International Journal of Psychoanalysis, 63*, 241-252. IJP.063.0241A.

Stern, D. N. (1985). *The interpersonal world of the infant.* Basic Books.

Toth, P. W. (1996). *Silence in psychoanalysis: The analysand's perspective*. The Union Institute ProQuest Dissertations Publishing. 9620952.

Trevarthen, C. (1984). Emotions in infancy: regulators of contacts and relationships with persons. In K. Scherer & P. Ekman (Eds.), *Approaches to emotions*, Erlbaum.

Trowler, P. (2011). *Researching your own institution: Higher education.* Retrieved from http://www.bera.ac.uk/resources/researching-your-own-institution-higher-education.

Tustin, F. (1981). *Autistic states in children.* Routledge.

Weinstein, L. (2002). Language, Transference, and the Developmental Context in Child Analysis, *The Psychoanalytic Study of the Child, 57(*1), 355-373, DOI: 10.1080/00797308.2002.11800699

Wilson P. (2000). Castaway's Corner. *Clinical Child Psychology and Psychiatry*, *5*(3):457-462. DOI:10.1177/1359104500005003014

Berko, Z. (2013). "Psychic Twins": A psycho-dynamically informed treatment of a selectively mute adolescent and her mother. *Journal of Infant, Child, and Adolescent Psychotherapy, 12(*4), 307-320, DOI: 10.1080/15289168.2013.850390

Willig, C. (2013). *Introducing qualitative research in psychology.* McGraw-Hill

education.

Wolpe, E. (2016). Thoughts about the internalised speaking object: psychoanalytic psychotherapy with children of delayed verbal development. *Journal of Child Psychotherapy, 42*(1), 30-44.

Zeligs, M. A. (1960). The role of silence in transference, countertransference, and the psychoanalytic process. *The international journal of psychoanalysis,* 41, 407-412.

Appendices

Appendix A: Notice of ethical approval (including ethical amendments)

March 10, 2020 10:24 AM
Subject: Ethics Application

Dear Maria,

I am writing to inform you that your application has been reviewed by the Assessors and I can confirm that your research ethics application has not been approved at this stage. Please see attached letter regarding your TREC application.

The following comments have been raised:

Condition	Comments	How have the conditions been met?
1. Data Storage	To clarify if data will be held, encrypted, in mobile device, or elsewhere (question 26, has ticked that data will be stored in UEL secure server)	
2. Data Collection	Questionnaire to participants requests information on referral and background of patients. Is this necessary? How will it be ensured that participants only release data in a 'need to know' basis?	
3. Data Collection for Participants Abroad	Student states that participants from abroad will be included, I presume via zoom. Which countries? Consideration needs to be given to data issues in relation to this.	

Your supervisor/research lead is responsible for guiding you through the ethical approval process; and with this in mind, **you are strongly advised to discuss your application with your supervisor and/or the course lead.** In the meantime you MAY NOT begin to undertake your research work at this stage.

Regards,

Paru
Mrs Paru Jeram
Quality Assurance Officer
(Research Degrees and Research Ethics)

From: Maria Eugenia Valdivia Rossel
Sent: 24 March 2020 19:29
To: Paru Jeram
Subject: Re: Ethics Application

Dear Paru

I hope this finds you well and safe.

We have worked really hard to try to get this by today - to respect the deadline. Please find enclosed the corrected versions following the feedback and below the way I've addressed the issues raised.

My supervisor, Margaret Lush, has emailed you earlier on regarding her electronic signature. I hope given the current circumstances there could be an alternative. Please let us know either way.

I would also really appreciate if you could acknowledge receipt of this email.

Condition	Comments	How have the conditions been met?
1. Data Storage	To clarify if data will be held, encrypted, in mobile device, or elsewhere (question 26, has ticked that data will be stored in UEL secure server)	Question 26: I have unticked that data will be stored in UEL secure server as I am an Essex student.
2. Data Collection	Questionnaire to participants requests information on referral and background of patients. Is this necessary? How will it be ensured that participants only release data in a 'need to know' basis?	I have removed the request on referral and background of patients, as you suggested this is not necessary.
3. Data Collection for Participants Abroad	Student states that participants from abroad will be included, I presume via zoom. Which countries? Consideration needs to be given to data issues in relation to this.	I am not including participants from abroad to keep it simple. I believe I will have enough participants from within the UK.

Best wishes,

Maria Eugenia

From: Academic Quality **Sent:** Monday, March 30, 2020 10:57 AM **Subject:** FW: Ethics Application

Dear Maria

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee (TREC) **your application has been approved. This means you can proceed with your research.**

Please note that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me.

May I take this opportunity of wishing you every success with your research.

Regards,

Paru

Mrs Paru Jeram

Senior Quality Assurance Officer

Sent: 14 April 2020 10:51
To: Academic Quality

Dear Mrs Jeram

I hope this finds you well.

I would like to thank you for these good news. Following my supervisor's advice regarding the current guidance due to COVID-19, I have highlighted the option of video-link interview via Zoom in the TREC form and other documents with an explanation of the current situation. Please see 'change to doctoral research protocol' enclosed and the other documents.

Best wishes,
Maria Eugenia Valdivia

23.04.22

Dear Maria

I can confirm that I have received your updated TREC documentation in light of the current crisis and that the changes have been approved. You may proceed with your research.

For information governance purposes and in line with the Trust policies, please be advised that in order to conduct research/interviews using online videoconferencing you must contact TEL (copied) to set up a zoom account. With regards to privacy, please ensure that meetings with yourself and your participants are conducting in a safe environment and that confidentiality is maintained.

Kind regards,

Paru
Mrs Paru Jeram
Senior Quality Assurance Officer
(Research Degrees and Research Ethics)

Appendix B: Participant information sheet

Researcher: Maria Eugenia Valdivia

Study Title: How do Child and Adolescent Psychotherapists (CPTs) work with silent patients? An exploration of some meanings and functions of patients' silence in sessions. An interpretative phenomenological analysis.

I would like to invite you to take part in a research study. Please take time to read the following information carefully. Ask questions if anything you read is not clear or would like more information. Take time to decide whether or not to take part.

What's the study about?

This study will explore your thinking and ideas about the work you have done with children and young people that were silent in sessions in a significant way. I am interested in hearing about your experience with silent children that stayed with you and stimulated your thinking. I am interested in the impact of their silence on you, your reflections of how you adapted your technique if you did, what did you use when verbal communication was not the predominant channel of your patient. I am also interested in how you understood the perhaps different silences and moments of silence at different stages of the therapeutic process, the challenges in engaging them, and perhaps a bit about the journey alongside these patients, how the work develop -if it did-, or if it did not, what sense you made of it. I hope to build a picture of a small group of Child and Adolescent Psychotherapists' experiences and gather your views of working with this cohort, including the approach you take to silence, and the dilemmas and technical considerations you came across.

What is the purpose of the study?

It is for me to qualify in the Doctorate in Child & Adolescent Psychoanalytic Psychotherapy at the Tavistock and Portman Clinic in conjunction with University of Essex.

Do I have to take part?

No, participation in the study is entirely voluntary. However, your contribution would be invaluable. If you do agree to take part, you can change your mind without giving me a reason at any point either during participation or up to two weeks after participation and all data collected from or about you would be destroyed immediately. After this it is likely that data will have been processed and it will no longer be possible to withdraw it.

Where a participant is a student of our University, the offer to participate or choosing to decline will have no direct impact on your assessment or learning experience.

What will happen if I take part?

If you agree to participate, I will arrange a convenient time to interview you in the Tavistock Centre (or on Zoom) on one occasion. (Please note that the interview options available will depend on public health policies due to COVID-19).

The interview would be a semi-structured questionnaire, which would last approximately one hour, and will take place between … and … 2020.

I would send you the questions in advance so that you could read through them if you choose. The interview would be tape recorded and transcribed by myself. The tapes will be stored securely and labeled with a pseudonym from the outset to keep your identity strictly confidential.
All data will be held securely in accordance with the University of Essex Data Protection Policy and will be kept for up to 10 years after the study (tape recordings will be destroyed as soon as they have been typed up: likely in less than a year).

The documented results of the study would form my doctoral thesis, and may become an academic paper and/or published in relevant academic articles and/or presentations. Direct quotes from interviews may be used in this paper but using pseudonyms would anonymise these.

What are the possible disadvantages and risks of taking part?
This is a relatively small profession, as such, there is a risk some identifying features may be discoverable, however, every effort will be taken to ensure confidentiality.
There are also limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

Am I eligible?
To be eligible for this study you would need to be a member of the ACP and have worked regularly (on a weekly basis or more) with at least one silent child or young person for at least one year.

What are the possible benefits of taking part?
I hope that participating in this study would be an opportunity for you to reflect on the challenges of this important work. Your contribution would certainly be invaluable not only in helping me to gain my qualification, but in the potential knowledge that this research project may make available to the profession.

Contact Details
If you have any questions or would like to discuss possible participation further, you can contact me on MariaEugenia.Valdivia@slam.nhs.uk. Alternatively, any concerns or further questions can be directed to my supervisor: Margaret Lush (mlush@tavi-port.nhs.uk) or Dean of Postgraduate Studies at the Tavistock: Brian Rock (brock@tavi-port.nhs.uk).

If you have any concerns about the conduct of the researcher or any other aspect of this research project, you should contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

This research project has been formally approved by the Tavistock and Portman Trust Research Ethics Committee.

General Data Protection Regulation (2018) arrangements

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom.
I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for not more than 3 years after the study has finished.
Your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.
You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

Appendix C: Consent form

Researcher: Maria Eugenia Valdivia

Course: Prof Doc Psychoanalytic child and adolescent psychotherapy

Study Title: How do Child and Adolescent Psychotherapists (CPTs) work with silent patients? An exploration of some meanings and functions of patients' silence in sessions. An interpretative phenomenological analysis.

Please tick boxes that apply to you and sign bellow the statements.

1) I _____________________________ (name) confirm that I have read and understood the participant information sheet for the research study. ☐

2) I _____________________________ (name) confirm that I would like to take part in the tape recorded interview (face to face or video-link using Zoom platform)* and understand that you intend to use interview conversation as described in the participant information sheet received. ☐

3) I _____________________________ (name) confirm that I understand that my participation is voluntarily and that I am free to withdraw at any point during my participation in the study and up to two weeks after my participation without giving a reason. ☐

4) I _________________________________ (name) grant permission for the data to be used in the process of completing a Prof Doc degree, including dissertation and any other future publication.

5) I _____________________________ (name) understand that arrangements will be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations. ☐

6) I _____________________________ (name) understand that due to the small sample size of participants and their defining features, there are limitations of confidentiality. The level of anonymity can be discussed with the researcher on research write-up and dissemination process. Options will be available on the level of anonymity/identification in a publication. ☐

Signed: .... Date: ....

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* The interview options available will depend on public health policies due to COVID-19.

If you would like to discuss any of the above with me further before making your decision or if you have any questions, concerns or would like more clarification please make a note here or email me on mariaeugenia.valdivia@slam.nhs.uk and I will contact you.

Appendix D: Poster

Working with silent patients

Seeking Child and Adolescent Psychotherapists to take part in a doctoral research study.

Have you worked with a child and/or young person who was silent in sessions in a significant way? Did you come across dilemmas and technical considerations you would like to talk about? If so, I would like to speak with you about possibly taking part in my research project.

Who I am?

I am Maria Eugenia Valdivia, a third year student on the Child and Adolescent Psychoanalytic Psychotherapy Doctoral Training (M80) at the Tavistock and Portman NHS Trust.

Could you help?

This study is open to all ACP members who have worked with a patient who remained silent in sessions for considerable periods. Preferably the work would have gone on for at least a year. I am planning to recruit between six and eight participants.

Getting involved

Participation is through one interview lasting one hour by Zoom (with or without video), audio recorded. All participants' details will be made anonymous.

If you are interested in hearing more about the study or wish to discuss taking part in the interview, please contact me (the researcher) at: palomavaldivia@hotmail.com

The project is being supervised by **Dr Margaret Lush**.

This project has been approved by The Tavistock and Portman Research Ethics Committee (TREC).

Appendix E: Interview schedule

The Tavistock and Portman NHS

NHS Foundation Trust

24-08-20

Semi-structured interview schedule for child and adolescent psychotherapists working with silent patients

Research title: How do Child and Adolescent Psychotherapists (CPTs) work with silent patients? An exploration of some meanings and functions of patients' silence in sessions. An interpretative phenomenological analysis.

Themes and possible prompts

The work and meanings of silence

- Can you tell me about some child or adolescent psychotherapy work you've carried out with silent patients that you found interesting?

- How did you understand some of the meanings of the silence?
(Did you think the meaning of the silence changed over the course of treatment? If so, how did you understand this?)

Technique and progress

- Did you come across any technical dilemmas or considerations?

- Did you alter your approach in the treatment in response to change in dynamics?
(In what way, if at all, do you think the work developed?)

Clinician's Experience

- What was the impact of the silence on you?
(For example, sometimes you might feel it's quite deadening, or it might be different)

- What do you think were the most challenging aspects to the work?
(How did you manage them? For example, did you seek support/supervision?)
(What did you learn?)

Appendix F: Example of transcript analysis

70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98	P3: I mean I think the dad was from that country and was a tribal leader in that country and part of the commitment to being part of that tribe is that you take infants from the country to give them a better life, but these three did not have a better life and were brought into a family where there was quite a lot of disturbance I think, you know, mum had her own MH probs and there was an allegation that their older adolescent had been sexually abused by the adopted dad and very disturbed family set up and my patient umm, I think showed me in the only way she could, how how uhh it had been for her, but I also think, I mean it's interesting isn't it, how silence can shift, it's not the same thing all the time, I mean, I had thought and, you know, still think that she was ummmm almost like on the edge of being a bit psychotic? Mmm, you know, not in uuhhh sort of, profoundly overt way, in that she had some strange ideas that you could have thought of them being a bit delusional but more that she had like quite a lot of negative symptoms of almost like so depressed that she could dip into something without and you know speech was one of them. Mmm, but I, I was thinking about this in relation to your research and thinking about how interesting it is that you might not have speech but you have thought, you know, does thought ever stop, thought isn't silent and I mean (giggles a bit) I was reading about this (giggling as if she had been cheating, about to confess something) in thinking about volunteering because umm you know, do I know enough about silence, what does it mean in the room, it's a bit like what I said already, does it change, the meaning? **You need someone to help you with it** because in the room silence is it can be so **paralysing** (passion is coming through), especially with adolescents because most of them, won't, // young people, who, maybe the first girl did a bit more, she used art and would decorate her box so there was something that I could engage with, she was doing something even though she was not speaking whilst the second older adolescent girl, // was absent, there were so many things that were absent, speech was just one of these things, it felt like she came and, uhhh, she just, **there was something empty**? Trying to access what she	Family responding to complicated cultural expectations A very disturbed family set up Allegation of sexual abuse from the adopted dad to the eldest brother Depression What does psychotic mean? Lots of umm, hard to articulate an extreme experience of absence? Lots of things were absent to this YP Perhaps on the edge to getting mad? Or of completedly shutting down? Has taken her participation to this research very seriously Has thought about this research Questions speech and thought Philosophical question: can you think without words? She has been reading about the topic, some ideas coming from outside her mind Sense of ideas that are not coming from her immediate experience giggling as if she had been cheating, about to confess something questions her expertise with regards to the topic she needed help, does that disqualify her as an 'expert'? Tone of voice gets more intense suggests some desperation, 'help!', (don't leave me alone with this, it's too much?). Silence can be paralysing Despair comes across the tone of voice Staccato before more fluency Hard when there is nothing to engage with	Negative impact of cultural practices on family formation Disturbed family Depressed girl T's struggle to communicate an experience of nothingness Absent girl Shut down girl T's experience of a girl on the edge of breaking down? Philosophical questioning of the possibility of thought without words Doubts her expertise T's underlying anxieties about this work? Desperate therapist (needs urgent help) Silence as paralysing Hard when there is nothing to engage with Art as a medium to communicate The need of something to engage with They are all different Shuts down child	Child's background impact on the therapist

99 100	might have been thinking or what might have been going on was sooo difficult; probably the second example was more difficult than the first.	Use of art as helpful The need for the T of something to engage with -w the SP Comparison between a 'deadened' patient and a patient that does not speak but does something Absent/empty/deadened patient/child more like the 'pervasively retreat'? Some sense of protest in her voice, complain Hermetic patient like a closed oyster Some patients more difficult than others (they are all not the same, they are all different).	Child that communicates without words more hopeful	'They are all different'
	R: Ok, so you have touched into….			
	Next question, I think you've already told me, the meanings of silence, would you like to summarise..			
101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117	P3: Well, what I sort of thought of since, and I suppose in many ways these two girls are quite good examples of how silence is different, I suppose the first girl I thought of it much more, well I used the word defiance, but it's also you know, there were so many things in her silence that were, you know, it was hostile, it was aggressive, it was you know, it was ummm, you know, refusal you know, and I said earlier about it being much more of a conscious decision to, you know, keep her mouth closed and not let something out, you know, she had control over her mouth, whereas I think with the second girl, it was much more, a symptom of her illness, of her, I mean maybe they both, I mean this is the thing about silence, isn't it that it's so hard to say absolutely that this is what is happening umm, because it seems as though it's ummm the whole thing about psychotherapy is that we are meant to not know and (laugh) even though we all struggle with it, you know, we all are programmed in a way to want to know and want to understand, to want to find reasons and want to have explanations, and // what's wonderful about psychotherapy is that we're trying to understand what the meaning might be for the silence and it's a bit like we're working it out as we go along and **it shifts and changes.**	Silence is different Silence as defiance Silence is complex Silence communicating negative feelings Aggressive silence Conscious vs unconscious silences (spectrum) How much control does the person have over the silence? 'I mean maybe they both'- contradiction It's so hard to define such complex thing as silence So hard to know, to be 100% sure of what's happening with the silent child. If they don't speak, you can only speculate. Refers to/Acknowledges paradox between being trained to be in the 'unknown' vs human's nature of wanting to know Important to keep the tension between unknown nature of silence vs thrive to try to know Towards the end her voice becomes livelier – sharing her passion for psychotherapy Psychotherapy as a rewarding profession Silence's meaning as ever-changing	Silence has different meanings Silence as a complex phenomenon Silence can communicate negative emotions Unclear about how much control the YP has over her silence Hard to know the silent child Inherent paradox in silence as communication Unknown nature of silence T's commitment to try to understand The joy of trying to work out the silence Silence meaning as ever-changing	Multiple meanings of silence Deliberate vs undeliberate silence Ambiguous nature of silence

Appendix G: Example of table of super-ordinate themes and themes for one participant

Themes	Page/line	Key words
Meanings of silence Silence has different meanings	1.2-3	I think their silences were very different and had an impact on me in a different way
Silence as defence	1.6	her silence was (…) like a defence,
Silence as defiance	1.4-5	her silence was more a sort of defiance
Silence as refusal	1.5	like a refusal to engage
Level of control of the silences	1.6	, but I think she had a bit more control over it
Fear of attachment underlying the silence	1.8-9	I think there was a fear (…) she would get attach to me
Silence as defiance	1.19	her silence was very much uuhhmm I'm not going to do what you want me to do
Silence as a symptom of mental illness	3.54	a symptom of how unwell she was
Different silences	3.53	**her** silence was **a very different silence**
Tension in defining silence	3.55	a bit more complicated than that
Silence due to absence of words	3.56	she had not any words
Silence to convey early non-symbolised experiences?	3.58	she had to give me an experience of perhaps how it'd been for her as a younger child?, uhh she was an adopted,
Silence as loss/grief	3.56	it almost felt as though she had not any words almost like an absence of words **something was missing,** that she couldn't speak them
Shut down state of mind	4.83-84	she could dip into something without and you know speech was one of them.
Silence as an empty state of mind	5.96-98	the second older adolescent girl, // was absent, there were so many things that were absent, speech was just one of these things, it felt like she came and, uhhh, she just, there was something empty?
Shuts down child as more problematic	5.100	probably the second example was more difficult than the first
Silence has different meanings	5.102	these two girls are quite good examples of how silence is different
Silence as a complex phenomenon	5.104	there were so many things in her silence

Silence can communicate negative emotions	6.105	it was hostile, it was aggressive, it was you know, it was ummm, you know, refusal
Unclear about level of control YP has over her silence	6.107-109	she had control over her mouth, whereas I think with the second girl, it was much more, a symptom of her illness, of her, I mean maybe they both,
Silence meaning as ever-changing	6.117	it shifts and changes.
Angry silence	6.122	, howw angry her silence felt,
Silence as rejection of the new therapist	12.254	I'm not going to make a relationship with you
Silence as a defence to keep self-safe	13.275	it's dangerous if you if you speak, uhh certain things happen.

Background of these silent children Intergenerational interpersonal difficulties	1.11 1.14 1.16	she had a very difficult relationship with her mum she (the mum) had a lot of interpersonal difficulties their relationship had been fraud for years
Family history of MH issues	1.11	her mum um had also been a patient
Mother's difficulties impacted previous therapy negatively	1.17-18	her mum fell out often with therapists and had fallen out with the previous child psychotherapist, so the case had been transferred to me
Neglect	2.41-42	long history of neglect in the family
Family secrets	2.43-44	mother had her own MH probs, the children were by three different fathers, umm and my patient's father **she did not know who her father was**
P's chronic hidden self-harm	2.39-40	she'd been secretly taking the tablets over quite a long period of time
Multiple losses	3.60	she was **an infant** when she was adopted from another country
Disturbed family	3.65-66	the brother's disturbance was so profound from a very early age, aggressive and violent
Silenced child	4.67	my patient took the silent quiet position
Absent maternal object	3.62-64	another older adolescent that had been adopted from the same country who was brought over to look after the two infants
Disturbed family	4.76	very disturbed family set up
Depressed girl	4.82-83	she had like quite a lot of negative symptoms of almost like so depressed
Patient felt obliged to attend therapy	12.248	She felt forced
Traumatic event	16.354-5	one of the dates that was quite often written was the day of the fire

Silence as a rare phenomena among adolescents	21.474	whereas for these two girls it was, you know, that was that was what they brought in a way

Appendix H: Sample of themes for the group with quotes

A) Ever-changing meanings of silence *(from unwillingness to willingness to communicate/ connect? More or less conscious/control)*

1. *Silence as masking difficult feelings such as anger*

Claudia: when aggression was (…) felt but not being expressed in any visible way line 5.111-3

some of the times, (…), it was a child who was very angry
line 5.125-8

Betty: what do you have to have first before you can reach something that, can
line 10.327-9

feel, that there is something more negative

Hannah: how angry her silence felt
line 6.122

it was hostile, it was aggressive, it was you know, it was ummm, you know, refusal line 6.105

Sarah: she was obviously quite annoyed and quite cross
line 2.53

2. *Silence as fear/feeling persecuted*

Claudia: if I see the eyes just being any other place, I would think that I'm a dangerous
line 6.149-61

presence, that I have turned into a bad object or that I always was a bad object

if you open your mouth not only can sound come out, but there's an anxiety that stuff can come inside you
line 8.196-8

Betty: it did not feel particularly anxiety provoking line 6.182

Hannah: I think there was a fear (…) she would get attach to me
line 1.8-9

it's dangerous if you if you speak, uhh certain things happen line 13.275

Sarah: it was fear line 11.434

3. *Silence as abandoning*

Claudia: but if somebody is looking at the world and then turns away when I arrive
line 6.149-61

as Tanika did when she, she got better. I could imagine that they're identified w me leaving between the sessions unconsciously, identified with the aggressor who's abandoned, and that I am to feel the experience of what it is like to be alone and isolated without somebody interested in me.

Betty: he would not eehh speak on the phone or do a video call (during lock-down)
line 6.190-1

Hannah: her silence was more a sort of defiance like a refusal to engage
line 1.4-5

I'm not going to make a relationship with you line 12.254
Sarah: go to her seat and lie down and go to sleep sometimes or pretending to be asleep line 2.60-1
she turned her back so I could not see her face
line 2.62-3

4. *All silences are different and change*

Claudia: So there are many different interpretations, just linked w where the eyes are
line 6.161
all different underneath these symptoms line 1.25
Betty: the silence has changed since then
line 7.220-1
that feels quite different from the you know if I go back
line 7.238
Hannah: I think their silences were very different
line 1.2-3
It shifts and changes
line 6.117
Sarah: It's different with autistic, it's different with this, it's different with that
line 10.414

5. *Silence always communicates from connection to disconnection*

Claudia: we think 'oh the child is just not speaking to me' but the mind is always communicating
line 7.185
The mind is speaking 'I'm gone to the claustrum and I'm not in the world', or the mind can start coming to life
line 7.187
Betty: he is engaged with it but, this is very different kind of work to that of children who can speak
line 10.317
it's not out there in a sense, (pause) but there is a sense of fragility line 6.176

Appendix I: Key to presentation of the quotes

- Quotes are followed by the participant's pseudonym, and line number from which the quote was obtained within the transcript. For example (Betty, lines 309-320) refers to Betty, line 29 from her transcript.
- Bracketed ellipses (...) within the quotes indicate that some material has been removed.
- Added material to indicate what participants are referring to have been denoted in square brackets [ ].
- A bracketed small empty space () within quotes indicate that there was a pause.
- A bracketed bigger empty space (   ) within quotes indicate that there was a longer silence.