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THERAPISTS' PERCEPTION OF SILENCE DURING PSYCHOTHERAPY SESSIONS

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THERAPISTS' PERCEPTION OF SILENCE DURING PSYCHOTHERAPY SESSIONS

Therapistlerin Psikoterapi Seanslarındaki Sessizlik Algısı

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TABLE OF CONTENTS

List of Figures

List of Tables

List of Appendices

Abstract

The aim of this study is to explore the therapists' perception of silence during the psychotherapy process, identify its personal and professional correlates for psychotherapists who live and practice therapy in Turkey. Within this framework, the relationship between therapists' perception of silence and certain demographic characteristics (e.g. age, gender) and professional characteristics (e.g. theoretical orientation, level of experience) were explored. Further, the association of counter-transferential experiences of the therapists with the perception of silence was investigated.

The research was carried out with the survey package over Internet. The study included 129 participants, who were professionals practicing psychotherapy in Turkey. A Silence Perception Questionnaire for Therapists (SPQ-T) was designed and used by the researcher to assess therapists' perception of silence inside and outside the psychotherapy setting. Counter-transferential experiences were assessed using Countertransference Questionnaire (CTQ) developed by Betan et al. (2005) with an instruction to focus on a client whose silences were noteworthy.

There was no specific hypothesis for this study. However, on the basis of the literature, it was expected that silence perception of the therapists would vary and that the more negatively perceived silence would have associations with negative countertransference reactions, such as feeling inadequate, overwhelmed, helpless or anxious; whereas the more productive perception of silence would have associations with positive or protective countertransference reactions.

The results of the first part of the study showed that SPQ-T was a reliable tool for the assessment of silence perception for therapists with a coherent component structure, having both negative and positive attributes: Discomfort / Negativity, Anxiety / Urge to End, Appreciation and Self-Reference. Similarly, the results also showed that the Turkish version of CTQ was a reliable tool for the assessment of countertransference reactions, with seven countertransference factors identified: Inadequate / Disengaged, Overengaged / Protective, Hostile / Mistreated, Erotic / Sexualized, Overwhelmed, Anxious / Fearful and Special.

The second part of the study investigated the professional and demographic correlates of therapists' silence perception and their countertransference reactions toward a silent client. The investigated correlates were Age, Education, Theoretical Orientation, Work Setting, Client Population, Number of Clients, Level of Experience, and the overall areas of Difficulties. The results showed that with all the components of SPQ-T except Self-Reference and with all CTQ factors, the correlations indicated a decrease as the age and experience increased. Additionally, it was also observed that BA graduate as well as the therapists who worked with Just Child –Adolescent had higher means in all components of SPQ-T as well as for all factors of CTQ. Additionally, therapists who worked with Insight-oriented / Expressive theoretical orientation also had higher means for all four CTQ factors. Specifically, therapists who worked with Just Child - Adolescents perceived clients' silence as anxiety provoking and had an urge to end it, and reported feeling significantly more overwhelmed and more anxious / fearful with their silent clients when compared with the therapists working with Just Adult or Mixed client populations. The results also showed that the PhD graduates had a significantly lower Anxious / Fearful countertransference towards a silent client as compared to BA graduates when level of experience is controlled and the therapists with Insight-oriented / Expressive theoretical orientation felt significantly more Overengaged / Protective in their countertransference reactions towards their silent clients when compared to therapists working with other theoretical orientations.

With regard to associations between components of therapists' perception of silence and their countertransference reactions toward silent clients, two points were observed. First, negative components of SPQ-T, Discomfort / Negativity and Anxiety / Urge to End as well as Self-Reference were all significantly and positively correlated with negative countertransference feelings of Inadequate / Disengaged, Hostile / Mistreated, Anxious / Fearful as well as countertransference reaction of Special. Second, the SPQ-T component Appreciation which included a positive regard for silence as well as an overly welcome or attributing too many meanings to silence was only associated with countertransference feelings of Overengaged /

Protective, which suggested that for this population, this attribute related more to the latter.

The significant correlations between CTQ factors, certain professional factors and the components of SPQ-T suggested that the therapist's perception of silence as well as professional characteristics such as level of experience, theoretical orientation and client population might predict their counter-transferential reactions. Third part of the study included further analyses to assess this predictability. The results showed that SPQ-T component Anxiety / Urge to End was a strong predictor of both of the CTQ factors Inadequate / Disengaged and Anxious / Fearful. Similarly, SPQ-T component Discomfort / Negativity was a predictor of both of the CTQ factors Overwhelmed and Overengaged / Protective. Having Insight-oriented / Expressive Theoretical orientation was a predictor only for CTQ factor Overengaged / Protective. Therapist's level of experience and SPQ-T componentSelf-Reference were both predictors only for CTQ factor Anxious / Fearful but for no other factors. Similarly, Total Number of Difficulties and Working with Just Child-Adolescent Clients were predictors only for the CTQ factor Overwhelmed, but not for any other CTQ factors. SPQ-T component Appreciation was also a predictor only for Overengaged / Protective CTQ factor. Daily Silence Preference was not a predictor for any of the CTQ factors.

The findings were further discussed for theoretical and clinical implications along with the limitations of the study and suggestions for future research.

Keywords: psychotherapy, silence, countertransference.

Özet

Bu çalışmanın amacı Türkiye'de yaşayan ve çalışmakta olan terapistlerin psikoterapi süreçlerindeki sessizlik algısını araştırmak ve bu algının terapistlerin kişisel ve profesyonel özellikleriyle ilişkisini incelemektir. Bu çerçevede terapistlerin sessizlik algısı ile demografik (yaş, cinsiyet gibi) ve profesyonel (teorik yönelim, deneyim düzeyi gibi) bazı özellikleri ve sessizlik karşısındaki karşı aktarım deneyimleri ile ilişkisi araştırılmıştır.

Araştırma internet üzerinden bir anket çalışması ile yürütülmüştür. Türkiye'de psikoterapi alanına çalışan 129 terapist bu araştırmaya katılmıştır. Terapistlerin hem seans içinde hem de dışında sessizlik algısını ölçmeye yönelik Terapistler için Sessizlik Algısı Ölçeği (SPQ-T) tasarlanmış ve bu araştırmada kullanılmıştır. Sessiz bir danışana karşı deneyimlenen karşı aktarım deneyimlerini ölçmeye yönelik olarak da Betan et al. (2005)tarafından geliştirilmiş Karşı Aktarım Ölçeği (CTQ) kullanılmıştır.

Bu araştırmanın spesifik bir hipotezi yoktur. Ancak, literatüre bağlı olarak, terapistlerin sessizlik algısının değişken olduğu ve olumsuz anlamlar yüklenen sessizlik algısının yine negatif karşı aktarım deneyimleriyle, olumlu algılanan sessizlik ile de daha pozitif karşı aktarım deneyimleriyle ilgisi olacağı düşünülmüştür.

Bu çalışmanın birinci kısmının sonuçlarına göre, SPQ-T terapistlerin sessizlik algısını ölçen, güvenilir ve hem negatif hem de pozitif anlamlar içeren tutarlı bir faktör yapısına ait bir araçtır. Faktörler, Sıkıntı / Olumsuzluk, Endişe / SonlandırmaİhtiyacI, Değer Atfetme, Kendiyle Alakalı olarak tanımlanmıştır. Benzer şekilde, sonuçlar Karşı Aktarım Ölçeğinin Türkçe versiyonun da karşı aktarım deneyimlerini ölçebilen güvenilir bir araç olduğunu göstermiştir. Bu Ölçek için de 7 faktör tespit edilmiştir: Yetersiz / Kopuk, Aşırı bağlı / Korumacı, Düşmanca / Kötü muamele edilen, Erotik / Cinsel Çekim, Boğulmuş, Endişeli / Korkutucu ve Özel.

Bu çalışmanın ikinci kısmında terapistlerin sessizlik algısı, karşı aktarım deneyimleri ile demografik ve profesyonel özellikleri arasındaki ilişkiler

araştırılmıştır. Araştırılan özellikler Yaş, Eğitim Durumu, Teorik Yönelim, Çalışılan Kurum, Danışan Popülasyonu, Haftalık Danışan Sayısı, Deneyim Düzeyi ve Çalışılan Problem Sayısıdır. Araştırma sonuçları, Kendiyle Alakalı haricindeki tüm sessizlik algısı faktörleri ve tüm Karşı Aktarım faktörlerinin , yaş ve deneyim arttıkça düştüğünü göstermiştir. BA mezunu olan ve Sadece Çocuk ve Ergen ile çalışan terapistlerin tüm Sessizlik Algısı ve Karşı Aktarım faktörlerinin kendi alanlarındaki diğerlerine göre daha yüksek olduğu gözlemlenmiştir. Ayrıca, İç görü odaklı teorik yönelimli terapistlerin tüm Karşı Aktarım faktörlerinin de diğerlerine göre daha yüksek olduğu gözlemlenmiştir. Araştırma sonuçları, Sadece Çocuk ve Ergen ile çalışan terapistlerin Sadece Yetişkin veya Karışık Popülasyonla çalışan terapistlere göre sessiz danışanları ile Endişe / Sonlandırma İhtiyacı duydukları ve Boğulmuş hissettiklerini göstermektedir. Sonuçlar ayrıca, Doktora mezunu terapistlerin BA mezunu olanlara göre, deneyim düzeyi kontrol edildiğinde de, sessiz danışanlarına karşı daha az Endişeli / Korkutucu hissettiklerini, İç görü odaklı teorik yönelimli terapistlerin de diğer teorik yönelimli terapistlere göre daha Aşırı bağlı / Korumacı hissettiklerini göstermektedir.

Terapistlerin sessizlik algısı ile sessiz danışanlarına karşı hissettikleri karşı aktarım deneyimleri arasındaki ilişkiye bakıldığında, iki sonuç gözlemlenmiştir. İlk olarak, negatif anlam içeren Sessizlik Algısı faktörleri Sıkıntı / Olumsuzluk, Endişe / Sonlandırma İhtiyacı, ile Kendiyle Alakalı faktörü, negatif tepkiler içeren Karşı Aktarım faktörleri Yetersiz / Kopuk, Düşmanca / Kötü muamele edilen ve Endişeli / Korkutucu ile Özel faktörleri arasında anlamlı ve pozitif bir ilişki olduğu gözlemlenmiştir. İkinci olarak, Değer Atfetme sessizlik faktörünün sadece Aşırı bağlı / Korumacı Karşı Aktarım faktörü ile anlamlı ve pozitif ilişkilendiği gözlemlenmiştir. Bu faktörün hem sessizliğe karşı pozitif bir anlam yüklerken bazen azla değer de atfedebileceği düşünülmüş ve bulunan sonuçların bu düşünceyi doğrular olduğu görülmektedir.

Anlamlı bulunan bu ilişkiler değerlendirildiğinde, terapistlerin sessizlik algısı ile deneyim düzeyi, teorik yönelimleri ve danışan popülasyonu gibi profesyonel özelliklerinin sessiz danışanlarına karşı hissedebilecekleri karşı aktarım deneyimlerini öngörebileceği düşünülmüştür. Bu çalışmanın üçüncü kısmı

bu öngörülebilirliği araştırmaya yönelik regresyon analizlerini içermektedir. Bu analizlerin sonuçlarına göre, Sessizlik Algısı faktörü Endişe / Sonlandırma İhtiyacı, Karşı Aktarım faktörleri Yetersiz / Kopuk, ve Endişeli / Korkutucu için belirleyicidir. Benzer şekilde, Sessizlik Algısı faktörüYetersiz / Kopuk, Karşı Aktarım faktörleri Boğulmuş ve Aşırı bağlı / Korumacı için belirleyicidir. İç görü odaklı teorik yönelimli terapist olmak sadece Karşı Aktarım faktörü Aşırı bağlı / Korumacı için belirleyicidir. Terapistlerin deneyim düzeyi ile Sessizlik Algısı faktörü Kendiyle Alakalı, Karşı Aktarım faktörü Endişeli / Korkutucu için belirleyici bulunmuştur. Çalışılan problem sayısı ile Sadece Çocuk ve Ergen ile çalışmak Karşı Aktarım faktörü Boğulmuş için belirleyici bulunmuştur. Terapistlerin seans dışındaki sessizlik algısını ölçmeye yönelik olan Günlük Sessizlik Algısı hiçbir Karşı Aktarım faktörü için belirleyici bulunmamıştır.

Araştırmanın bulguları teorik ve klinik açıdan tartışılmış, gelecek araştırmalar için öneriler sunulmuştur.

Anahtar Kelimeler: psikoterapi, sessizlik, karşı aktarım

CHAPTER 1
INTRODUCTION

1.1. WHAT IS SILENCE? A DEFINITION AND ITS DUAL NATURE

Emotional moments in life are frequently experienced in silence; whether they may be positive such as joy, enlightenment, peacefulness, being in love, or negative such as feelings of grief, loneliness (Shafii, 1973). At other times, silence can be ambivalent (Reik, 1968; Shafii, 1973); it may represent yes or no (Serani, 2000), be a sign of disapproval or approval (Reik, 1968), may say all or reveal none (Serani, 2000). Silence can be interpreted as a sign of sympathy, contentment and compassion or as an expression of intense hostility (Zeligs, 1961). One can be silent with another over an agreement when they understand each other well or conversely, silence may be a sign of hostility when such understanding is missing (Reik, 1968). Silence may indicate emptiness, complete lack of affect, void, nothingness, as well as death and annihilation; and as such communicate deep anxiety, intra-psychic suffering and autistic withdrawal (Lane et al., 2002; Weissman, 1955; Zeligs, 1961). Yet it can also indicate eternity, truth, wisdom and strength (Weissman, 1955; Zeligs, 1961); and subsequently relate to feelings including joy, excitement and gratitude (Lane et al., 2002).

Apart from having different and at times opposing meanings, silence can also serve many different functions (Zeligs, 1961). Silence may be giving or receiving, object-directed or narcissistic (Brewer, 1894; Zeligs, 1961) and can facilitate preverbal form of communication (Lane et al., 2002). Silence could be a bridge, a container, a shield and a sign of alertness (Lane et al., 2002). Silence may conceal inappropriate thoughts and feelings as well as protect against external stimuli (Zeligs, 1961). It is easier to deny or repress thoughts if they only exist in silence (Loewenstein, 1956; Zeligs, 1961). On a physiological level, after physical or psychic trauma, there is silence through loss of consciousness so that the traumatic event is not experienced or remembered (Lorenz, 1955; Zeligs, 1961). Conversely, silence can be linked with heightened sensory acuity in a state of

alertness, where its role is strategic, aggressive or defensive, as in fight or flight situation (Lorenz, 1955; Zeligs, 1961).

Silence is usually considered in relation to speech. One sometimes speaks because one cannot be silent or vice versa. Sometimes, the unexpressed may be more audible in silence (Reik, 1968). Speech may at times be meaningless or empty, and silence more authentic and promoting being-with (Gale & Sanchez, 2005).

Culturally, silence may be highly regarded and idealized in some societies, whereas it may be considered an indisposition where talking is socially desired (Ronningstam, 2006). In some cultures silence may be a passive expression of discontent (Saunders, 1985). In some other cultures, silence is linked to hostility and exclusion, equated with treating someone as if he/she does not exist (Ronningstam, 2006). Silence can serve to protect personal boundaries, and may be valued in some cultures, but may be perceived as impolite, insulting and hostile in others (Ronningstam, 2006; Sifianou, 1997).

In Turkish culture, although talkativeness is a desired and appropriate quality, especially in friendly exchanges, knowing when to be silent is also a required attribute; which is summarized in a well-known saying popular in Turkey: "If words are silver, silence is golden" (Zeyrek, 2001). Silence in Turkish culture is usually used to communicate; and knowing when to be silent is a sign of competence. As such, silence is not seen as lack of speech, but rather an appropriate amount of it in a particular context (Sifianou, 1997; Zeyrek, 2001).

Whenever there is an interaction between individuals, what is said as well as not said are both communicative. At times, what is not said may even reveal more than words can. Despite that however, the phenomenon of silence, due to its highly subjective and culturally varying nature, has not been studied much.

1.2. RELEVANCE AND IMPORTANCE OF SILENCE IN PSYCHOTHERAPY

Arthur Schnabel has famously quoted: "The notes I handle no better than many pianists. But the pauses between the notes – ah, that is where the art resides."

Similarly, in psychotherapy, the most important thing may not be what is said, but maybe recognizing what speech conceals and what silence reveals (Reik, 1968).

There is not much research on silence in psychotherapy (Gale & Sanchez, 2005; Goldstein Ferber, 2004) and the classical psychoanalytic understanding of the meaning and function of silence is quite limited (Gale & Sanchez, 2005).

Earlier contributions in literature emphasize the necessity of the client to overcome his silence by the help of the therapist and express his thoughts and fantasies in words for the psychoanalytic work to be possible (Lane et al., 2002). As such, silence was seen as inhibiting and withholding, a transference resistance, or maladaptive regression (Lane et al., 2002; Shafii, 1973). Gradually, emphasis in the literature has shifted, and besides being defensive, silence is also seen as a way to communicate within the therapeutic setting and a psychic state serving a variety of ego processes (Arlow, 1961; Blos, 1972; Bollas, 1996; Brockbank, 1970; Greenson, 1961; Khan, 1963; Lane et al., 2002; Langs, 1976; Liegner, 1971; Loomie, 1961;Shafii, 1973; Zeligs, 1961).

Following this dual and opposing nature of silence, therapists are warned of positive and negative consequences of silence in psychotherapy (Basch & Basch, 1980; Blos, 1972; Gill, 1984; Greenson, 1966; Ladany et al., 2004; Moursund, 1993; Reik, 1968). On one hand, allowing for silence can enhance the therapeutic relationship and process by communicating to the clients that they are being supported and understood; and as such ensure trust for the ones who were not allowed to sit silent with their feelings (Ladany et al., 2004). It can be a powerful instrument for the therapist, to understand the client, and his/her conflicts, defenses, interpersonal style, and functioning. This understanding can greatly facilitate the therapeutic encounter as well as communicate important psychodynamic information (Lane et al., 2002). On the other hand, silence can hinder therapy when it withholds negative feelings such as anger and hostility, especially for clients who come from families that have used silence destructively (Ladany et al., 2004).

The distinction between silence as unproductive and negative (such as resistance) and silence as productive and positive (such as communicating and protecting) has implications in the therapeutic encounter (Ronningstam, 2006).

Understanding the meaning and function of silence and finding a balance between silence and speech is valuable, even crucial, in therapy (Wheeler Vega, 2013). While it is beneficial to interpret silence when it is defensive, the protective silence that aims at integration and authenticity of the self requires a different technical approach, where attention and exploration is more sensitive and gradual (Ronningstam, 2006).

Furthermore, although therapeutic interventions are mostly through verbal language, some clients cannot be understood, assured and/or soothed on spoken language only. Clients with conflicts stemming from pre-verbal phase of development may need silent forms of intervention (Lane et al., 2002; Strean, 1969).

Silence in the analytic space can also take on many different shades and tones for each client and for each therapist individually and as a dyad. It may encompass layers of thoughts and affects (Serani, 2000). Clients uniquely relate to speech and silence, which then further influences the way they form therapeutic alliance and process (Ronningstam, 2006). Therapist's own cultural background and own relationship to silence in the presence of another may also affect the understanding of silence within the therapeutic setting (Ronningstam, 2006).

1.3. PERCEPTION OF SILENCE AS UNPRODUCTIVE

Following the definition of psychoanalysis as talking cure, silence encountered by the client has been seen as an enemy to therapeutic success (Arlow, 1961). As such, silence is a way of maintaining distance, avoiding attachment, or communicating (Del Monte, 1995; Gale & Sanchez, 2005; Goldstein Ferber, 2004; Meerloo, 1975), especially if it has been a useful means of adaptation to emotional stress during childhood, which may be due to different conflicts: the threat of positive feelings in stimulating situations; the fear of separation, annihilation, or domination; or the conflict over oral masochistic impulses (Blos, 1972; Shafii, 1973; Weismann, 1955).

Several unconscious destructive purposes of silence are also reported by

contemporary authors (Bravesmith, 2012). The silent client may endanger the therapeutic relationship by keeping the analyst isolated and deprived (Bravesmith, 2012); or by withholding communication to form a kind of attack out of anger (Bravesmith, 2012; Coltart, 1992; Sontag, 1969), or by failing to communicate (Bravesmith, 2012; Winnicott, 1965). In cases of failure in communication, it is difficult for the therapist to identify what is going on in a client; it may be that the client cannot communicate affect (Bravesmith, 2012; Khan, 1974), or the client is possessed by split unconscious (Bravesmith, 2012; Coltart, 1992; Jung, 1954). As such, until some internal communication occurs within silence, the client finds it almost impossible to communicate with the analyst (Bravesmith, 2012).

Silence may also represent a developmental arrest, and disclose client's early disturbed or lost relationship with primary other (Kahn, 1963;Ronningstam, 2006;Weinberger, 1964).

1.3.1. Silence as Defense

1.3.1.1. Resistance

Silence was mostly interpreted as resistance and defense (Freud, 1912) and regarded as a frame deviation (Gale & Sanchez, 2005; Langs, 1992), implying distrust on the part of the client and subsequently disruption in the therapeutic encounter (Gale & Sanchez, 2005). Silence as resistance meant either an inhibition of speech in general or a difficulty in communication during the treatment, stopping the free flow of association (Levy, 1958). The resisting component of silence may be due to the fear of the client that the therapist may not be sensitive to his/her needs and is not trustable (Hadda, 1991), or it may simply be a resistance towards insight and/or change (Kurz, 1984; Ronningstam, 2006).

Silence as a transference resistance, may be a repetition of very specific and highly charged experiences in childhood, where the child had been silent usually due to overwhelming state of sexual excitement (Greenacre, 1954; Zeligs, 1961). Those silences can also be in the service of discharge (Zeligs, 1961).

1.3.1.2. Repression

Silence in the therapeutic relationship may involve repressed feelings, fantasies, and various underlying psychic forces (Blos, 1972), which is analyzable. The client may be silent to avoid a particular subject, or to organize feelings and thoughts that are confusing and difficult to put into words (Benjamin, 1981; Lane et al., 2002). The therapist's counter-transferential reactions to silence are of great assistance in understanding some aspects of the repressed material. There are fantasies which live behind silent events that need to be put into words in order to facilitate communication, reality testing, clarity, and, above all psychic growth (Blos, 1972; Loewenstein, 1956).

Similar to and inspired by speech as discharge of affect (Abraham, 1925; Ferenczi, 1916; 1950; Gale & Sanchez, 2005) corresponding to different psychosexual stages of development, physical-erotic nature of silence is also described (Fliess, 1949). In this context, silence is seen as an unconscious defense against this discharge from oral, anal or phallic stages of psychosexual development (Gale & Sanchez, 2005); and mostly a sign of anal retentiveness / obsessional neuroticism**,** holding, hoarding, and keeping all the feelings within (Bergler, 1938; Ferenczi, 1916; Fuller & Crowther, 1998; Gale & Sanchez, 2005; Reich, 1934; Zeligs, 1961).

1.3.1.3. Regression

During treatment, a special form of temporary, recurrent interruption of speech, a blank silence (Heide, 1961) may happen, which can be defined as a temporary regression of the ego, when confusing preverbal experiences may get re-enacted (Arlow, 1961), and for which verbal expression is not available (Lane et al., 2002).

The disruptions in speech in the regressive states may be a consequence of unconscious forces operating in the service of the id, or in the service of the ego in averting anxiety stemming from the id or the superego (Arlow 1961). As such,

silence represents an overactive unconscious, unassimilated, unprocessed material (Coltart, 1992; Lane et al., 2002). The client's regression may be symbolized in fantasy as being in the womb, or being in a sleep state (Lane et al., 2002).

A silent regressive state may also be indicative of alteration of object relations (Heide, 1961). It might, represent fusion with the object in a blissful narcissistic sleep, where the client seem to have no thoughts or conscious withholding of thoughts or fantasy (Heide, 1961; Shafii 1973).

1.3.1.4. Acting-out

Client's silence may constitute a form of acting out, a common tool used by clients to keep the therapist wondering (Altman, 1957; Hoedemaker, 1960; Zeligs, 1961). The meaning of the client's silence eventually gets revealed (Blos, 1972; Zeligs, 1961). As such, silence may be the client's way to deal with the anxiety from unconscious conflicts, by transforming it to a conscious one in the therapeutic relationship (Sabbadini, 1991; Lane et al., 2002). Silence then, acts as censorship not to say anything aggressive, punishing or of sexual content as they would be considered wrong (Lane et al., 2002).

Several clinical cases are reported in literature as examples of this form of experience of silence by the therapists and associated countertransference reactions, where silence was an act and like other forms of act may communicate feelings or may provide discharge of feelings at times when verbal expression of such feelings was not available or possible. As such, silence may communicate a traumatic life experience of a client (Blos, 1972; Khan, 1963); how others are kept distant (Blos, 1972; Greenson, 1961); or a claim for the wasted pleasure of childhood, and his unconscious wish to live more than the therapist, in a way silencing him forever (Zeligs, 1961).

1.3.1.5. Dissociation

Silence may represent personal isolation in search for identity (Winnicott, 1965), particularly when it relates to the treatment of severe emotional childhood trauma (Fuller & Crowther, 1998; Wilson, 1963).

These clients distance themselves from relationships in search for self- care. This search eventually results in dissociation during which the psyche attacks itself (Fuller & Crowther, 1998; Kalsched, 1996).

The trauma when it gets reenacted in the transference relationship represents an intrusion to the client's self; and the client's silence ensures staying within psychic boundaries (Fuller & Crowther, 1998; Wilson, 1963). As such, silent client keeps the analyst out (Fuller & Crowther, 1998).

1.3.1.6. Reaction Formation

Client's silence can be a reaction formation to the pleasure of communication. In such cases, the communication is longed for by the client, but also felt as seductive and anxiety provoking. Thus, the urge to communicate might be defensively transformed into its opposite that is the urge to keep silent (Levy, 1958).

1.3.1.7. Omnipotent Control of Affect

Silence may communicate shame, anger, fear, anxiety, withdrawal or lack of emotion in the client (Arlow, 1961; Lane et al., 2002; Levy, 1958; Liegner, 1971). Silence may manifest from the fear of being exposed when the client feels demanding or sadistic (Coltart, 1991; Lane et al., 2002; Ronningstam, 2006).

Overwhelming, painful emotions are usually concealed (Lewis, 1971; Ronningstam, 2006; Tangney, 1996) and cause withdrawal from interpersonal relationships to avoid any exposure (Arlow, 1961; Coltart, 1991; Morrison, 1984; 1989; Ronningstam, 2006; Schore, 2003). As such, silence provides a protective

layer with omnipotent control of the affects, aiming at grandiose self-sufficiency where closeness means intrusion from others and is frightening. As such, it serves to regulate self-esteem and maintain inner control (Modell, 1975; 1976; 1980; Ronningstam, 2006; Weinberger, 1964), and protect a precious core of authentic existence from destruction (Kurtz, 1984; Lane et al., 2002). Furthermore, several studies of solitude and isolation highlight the dilemma in narcissistic relationships: a state of not being able to be with the object and without it at the same time (Erlich, 1998; Ronningstam, 2006) or a state that represents a pre-verbal level of affect organization (Killingmo, 1990; Ronningstam, 2006).

1.3.2. Silence as a Symptom

Another perspective that regards silence as unproductive is its portrayal as a symptom that relates to masochism and depression (Weinberger, 1964). For masochistic and depressed clients, silence represents a reunion with the love object in a suffering state (Arlow, 1961). Silence expresses the loss of a unique and close relationship with the mother during childhood, perhaps due to the birth of a younger sibling, mother's illness or something else. In the absence of a substitute or compensation for this loss, any disappointment of the client's narcissistic demands for acceptance and love is expressed through silence, as there are no words to convey the pain of this loss or the feeling of inadequacy. Masochism is manifested in aggressiveness directed at oneself, while depression is suffering in silence and emotional withdrawal (Weinberger, 1964). On the one hand, these symptoms prevent the possibility of another loss and further injury. On the other hand, in a passive and unconscious manner, silence restores the lost relationship with the mother. It is not silence per se that these clients wish for, but the merger experience with the therapist as a projected, archaic mother image (Anagnostaki, 2013; Olinick, 1982).

Schizoid individuals are defined with their defensive state of withdrawal into fantasy in silence (McWilliams, 2011). Despite their withdrawal, they are attuned to the subjective experience of others and are in fact more overwhelmed by

the acute awareness of affect rather than absence of it. Their withdrawal and silence serve to hide their conscious rich inner worlds (McWilliams, 2011). They crave closeness; yet fear the engulfment when the other comes close (McWilliams, 2011). For many schizoid individuals, speaking is unconsciously linked to object seeking that provokes the anxiety of engulfment; thus is voiced through withdrawal and silence (Cooper, 2012).

Silence is also considered to be indicative of psychopathology as a conversive symptom, namely aphonia, indicated when a person loses his/her voice. This symptom might appear when the client had been unable to assert him/herself, or seeks attention (Gale & Sanchez, 2005; Rycroft, 1988). In a clinical case described by Rycroft (1968), a woman client had hysterical aphonia, as a form of sulking (Gale & Sanchez, 2005).

1.3.3. Silence in the Service of the Id

Following Freud's structural theory of mind, Pressman (1961a) proposed a classification of silence on the basis of the psychic structures that it originates from: id, ego, and superego. Within the id, the wish may be derived from the oral, anal, or phallic levels, so do the categories of silence (Blos, 1972; Fliess, 1949; Zeligs, 1961).

Oral silence resembles mutism with complete lack of affect. It resembles mutism and gives an impression that the client has suddenly absented him/herself. In this state, the client shows no sign of struggle or conflict, and directly or symbolically informs of an erotogenic occurrence (Fliess, 1949). It is a regressive state, where the individual appears to lose speech because he/she has temporarily become an infant. In this type of silence, the client discharges strivings for primal identification with the primary object (including oral-libidinal and oral aggressive strivings) within transference with the therapist, with a demand of mutual incorporation of both subject and object. As such, the therapist is ingested; he/she has ceased to exist for the moment as an object (Fliess, 1949).

Anal silence is inhibited speech, occurring at odd places in the grammatical

structure, giving the impression that the speaker is no longer capable of supplying the missing thought and seems to be in distress. It is a struggle for or against verbalization and regressive affect is controlled through silence. The silence appears involuntary; speech appears to occur spontaneously against an almost physical resistance, and as such resembles the original rage-response of the child to an enema (Fliess, 1949).

In contrast, phallic silence is a form of silence, where the client appears engrossed in his thinking rather than any absence of thoughts (Fliess, 1949; Zeligs, 1961). It resembles silence punctuating an ordinary conversation. After such silence, usually when the client speaks again, there usually a change of subject where the latter is less affective (Fliess, 1949).

Destructive tendencies also find expression in silence, and at the deepest level, the anxiety of silence is death / castration anxiety (Reik, 1968).

1.3.4. Silence in the Service of Superego

Client's silence is usually seen as an ego function (Freud, 1936; Reich, 1934) as could be exemplified by the defensive uses of silence outlined above. However, superego can also be a factor in some cases of silence alongside ego's contribution (Levy, 1958). The conscious wish of the ego to co-operate can be opposed by the superego and provoke a silence. This may be a re-enactment of prohibition on talking, imposed as a child or an act of censorship (Levy, 1958). During therapy, when ego's wish to cooperate within the therapeutic alliance is opposed by the superego, silence could be provoked in the form of punishment against guilt (Arlow, 1961), paralyzing the client's will for recovery (Levy, 1958).

1.3.5. Silence as Separation and Avoidance of Attachment

Behind the fear of silence, there might be an unconscious fear of losing the love object (Reik, 1968). Silence, when awake or in dreams might symbolize death or unconscious identification with the dead (Freud, 1913; Zeligs, 1961).

Concepts of separation and individuation develop in children in early stages of their lives (Mahler, 1965), when fear and anxiety in the absence/ separation of mother also emerges (Bowlby, 1960; Shafii, 1973). Without assurance by the mother's voice, the child feels lonely, helpless and abandoned (Fraiberg, 1950; Shafii, 1973). Silence in the child's mind is equated with absence (Shafii, 1973).

Mental representations and metacognitive functioning of clients with a history of trauma and abuse are incoherent and poor (Fuller & Crowther, 1998; Main, 1991; Patrick et al., 1994). As such, these clients cannot understand their silence. These clients' capacity for thought and vision is severely compromised because of the fear of what they would know and see (Fuller & Crowther, 1998).

Attachment research shows that rejecting attitude of mother is associated with avoidant behavior in the infant (Fuller & Crowther, 1998; Main & Goldwyn, 1984; Main & Weston, 1982); which further suggests that the significance of client's silence can be an avoidance of the therapist, especially if the client has experienced rejection from the attachment figure in early childhood. Through silence, the client tries to protect him/herself, and is unaware of feelings of anger and resentment against the rejecting attachment figure. As such, these clients usually have difficulty remembering childhood memories and if they do, they usually idealize the rejecting figure. The client yearns for attachment but cannot commit oneself to one, resulting in a paralysis of thinking and feeling. In such state, client is unable to explain his state to the therapist in words (Fuller & Crowther, 1998).

1.4. PERCEPTION OF SILENCE AS PRODUCTIVE

While the classical analytic view of silence was related to intrapsychic conflicts and defense, there were other theorists, who took a different view and saw silence as communicative and an integral part of the psychotherapeutic process (Blos, 1972; Weismann, 1955), which can be productive and valuable (Ronningstam, 2006;Wheeler Vega, 2013).

The client's silence may be an indication of adaptive functioning and psychological health (Lane et al., 2002; Shafii, 1973). In both philosophy and religious studies, silence has been linked to psychological insight and self-discovery, transformation towards a more authentic self and relationships (Brown, 1993; Hadot, 1987; Gale & Sanchez, 2005).

Similarly, within the context of therapy, silence can cultivate self-attentiveness, self-introspection, self-awareness (Gampel, 1993; Goldstein Ferber, 2004). It provides the client with a profound potential space to reflect upon experiences, internalize interpretations and develop a capacity to be alone **(**Gale & Sanchez, 2005). A client's silence may also communicate interpersonal experience (Editorial, 1993; Lane et al., 2002), which might lead to insight both on the side of the therapist and the client, an experience described as dense internal experiencing (Bollas, 1996; Lane et al., 2002).

Silence is also identified with feelings of acceptance, appreciation, and understanding (Lane et al., 2002; Liegner, 1971); and the client may feel pleased and free to remain silent, which sometimes leads to a resolution of resistance rather than be a resistance in itself (Lane et al., 2002).

1.4.1. Silence as Communication

Silence can be an essential part of speech (Balint, 1958; Gale & Sanchez, 2005; Lacan, 1977) and can be a form of communication (Greenson, 1961; Loewenstein, 1961; Serani, 2000; Walderhorn, 1959). It may have multiple meanings (Gale & Sanchez, 2005; Hill, 2002), and sometimes can be more profound than speech as a kind of no-word language (Coltart, 1992; Del Monte, 1995; Gale & Sanchez, 2005; Van der Linden, 1995). It may also be a process toward verbalization (Lowenstein, 1956).

Beyond the view of silence as being a component to speech or another language replacing speech, silence in the analytic space may also be communicative through an unconscious reenactment of a historical event, or a projective identification. It can serve as a much-needed space, and an invitation for greater

compassion in search for maintaining integrity (Greenson, 1961; Serani, 2000).

1.4.2. Silence as Space for Insight and Creative Processes

Analytic views on the meaning of insight agree that it is a consequence of integrative ego tendencies (Kris, 1956). Insight and integration need not be verbal, reach awareness and/or have cognitive manifestations. Insight is often experienced on a preverbal level, which helps the development of feelings of security, wholeness, oneness and integration (Shafii, 1973).

Silence can be a state where creative processes are allowed to take place (Bravesmith, 2012; Shafii, 1973). In silence, the internal subjective world is free of compromise as it would be in the objective world and as such, creative processes can take place (Bravesmith, 2012). Deeply unconscious processes occur in silence and stillness before reaching a state of symbolization, which is needed for explicit communication (Bravesmith, 2012).

During sessions, the client's silence and speech occur in a pattern, where the therapist and the client try to discover an integrative connection between silence, often experienced as nothingness, and speech, often experienced as suffocating (Bravesmith, 2012). This process, the transcendent function (Jung, 1958) is an unconscious cooperation of silence and speech as opposites, in an act of internal creation for new associations or disclosure, or at times producing insight or interpretation both for the client and the therapist (Bravesmith, 2012). During silence, the client can process what has been said both intellectually and emotionally (Bravesmith, 2012).

1.4.3. Silence as Co-creation

Psychoanalysts (Balint, 1958; Green, 1979; Ogden, 1994; Winnicott, 1965) have approaches that mention the creation of a "third", which incorporate principles similar to the transcendent function.

Winnicott (1965) attempts to explore outcomes of opposing concepts of

communicating and not communicating, i.e. speech and silence (Winnicott, 1965), as well as having other ideas in his thinking that relates to linking opposites to create a third, transitional phenomena, where objective and subjective elements meet to create new ones in another (Bravesmith, 2012; Winnicott, 1971).

Ogden (1994) writes about the analytic third similar to Jung (1958)'s living third thing, linking opposites, where the analytic third is described as intersubjectively co-generated experience of the analytic pair and as such is the present moment of the past (Ogden, 1994). The analytic third becomes accessible to the analyst through the analyst's experience of 'his own' reveries, forms of mental activity, which may look like narcissistic self-absorption, distractedness, compulsive rumination, and daydreaming in silence (Ogden, 1994), but in fact rather is in the service of understanding and addressing the transference–countertransference for the therapeutic activity.

Green (1979) also presents his idea of tertiary processes connecting the primary and the secondary (Bravesmith, 2012). Balint (1958) presents his theory of three areas of the mind, where the third area of mind relates to creation where there is no external object and the individual on his own silently creates new syntheses out of his self (Bravesmith, 2012). Creative processes, scientific discoveries, mathematical and philosophical explorations, development of insight and understanding as well as mental and physical illness in the early stages of life and the spontaneous recovery from them all belong to this level (Balint, 1958; Shafii, 1973).

1.5. TRANSFERENTIAL MEANINGS OF SILENCE

Silence plays a phenomenological role in the development of the transference, countertransference and on the maintenance of the therapeutic alliance (Zeligs, 1961). Silence can be a part of ego processes, unconscious transference fantasies, re-enacting object relations of the client (Lane et al., 2002).

1.5.1. Silence Leading to Individuation, Growth and Capacity to Be Alone

Silence can be a part of an active developmental process or therapeutic transition (Balint, 1958; Lane et al., 2002; Ronningstam, 2006) and a deep regression in the service of ego, leading the client to re-experience union with his earlier love object on the preverbal level of psychosexual development (Nacht, 1964; Shafii, 1973), phase of basic trust and a protective shell of warmth (Lane et al., 2002; Shafii, 1973). Silence can provide a relatively safe place for the client to work and resolve what is bothering or tormenting him (Balint, 1958; Kurz, 1984; Lane et al., 2002). Silence can facilitate protection and recognition of the authentic self (Gabbard, 1992; Ronningstam, 2006; Shafii, 1973).

It is further emphasized that it is important for the client during the therapeutic process, to experience a yearning for union where there is no subject-object duality (Anagnostaki, 2013; Nacht, 1963). Within the safety provided by the therapeutic setting, the client can regress where he/she can communicate without words, in a kind of bodily transmission of affect (Anagnostaki, 2013; Gabbard & Lester, 1998). In symbiotic fusion with the therapist and through a dependent/containing kind of transference (Leira, 1995; Modell, 1990), the client re-enacts unconscious memories and fantasies of early childhood relationship with the primary caretaker (Khan, 1963; Lane et al., 2002). Within silence, the client recollects, integrates, and works through the elements of early attachment (Khan, 1963; Lane et al., 2002; Leira, 1995), develops emotional depth and greater autonomy (Ronningstam, 2006; Wheeler Vega, 2013), and completes the process of growth and individuation necessary for final separation (Anagnostaki, 2013; Nacht, 1963). Similar to a preverbal fantasy of fusion and subsequent disruption of it by attaining speech in early childhood, the client's moments of silence represent a perfect union between self and object, the client and the therapist, promoting integration and development of the self (Lane et al., 2002; Nacht, 1964).

1.5.2. Silence as Relationship to the Object

The client's silence also can function as a way of forming an object relationship, which is an important expression of the transference (Lane et al., 2002; Zeligs, 1961). The enactment of this object relationship in silence can give the client an opportunity to share the emotional experience of his fantasies. Same enactment can help to induce countertransference responses in the therapist of what the client wishes the therapist to feel and recognize, and as such, create empathy (Arlow, 1961; Kris, 1952; Wheeler Vega, 2013; Zeligs, 1961)**.**

Within the relationship between the therapist and the client, silence can take on several meanings depending on the self-states of the client and the therapist at a particular time during therapy (Wheeler Vega, 2013)**.** As such, the situation is said to be analytically not silent although it verbally is, as silences may hold engagement and activity in the internal object worlds of both the client and the therapist (Wheeler Vega, 2013). Conversely, there may be other cases when the client is analytically silent although verbally not, preventing the therapist from communicating with the client's internal objects (Wheeler Vega, 2013). As such, verbal but not analytical silence helps to increase both the client's and the therapist's communication with their own internal worlds as well as with each other. Finding an optimal balance between internal and external silence may indeed help to create a new healthy object relationship for the client, connected but not invasive (Wheeler Vega, 2013).

1.6. COUNTERTRANSFERENCE REACTIONS TOWARDS SILENCE

Silence can stimulate strong countertransference reactions in the therapist as well as increase the therapist's sensitivity to those reactions. As such, countertransference is heightened during silent periods (Fuller & Crowther, 1998). Understanding these countertransference reactions is essential to understand the meaning of silence (Blos, 1972; Fuller & Crowther, 1998; Gabbard, 1992; Ladany et al., 2004; Ronningstam, 2006; Zeligs, 1961).

During silence, as boundaries become blurred, what is being projected by the silent patient can cause strong and at times uncomfortable counter-transferential feelings in the therapist (Fuller & Crowther, 1998). These sometimes turn into subsequent enactments on the part of the therapist. This process may be in the service of client's defense (Arlow, 1961) as when the silence is filled in by the therapist as a result of strong countertransference reactions, the client can feel that he is not responsible for what he has been thinking and about to say. By stimulating projection, client can disown his own thoughts and feelings because it is the analyst who said it, not the client (Arlow, 1961).

Silence may provoke loneliness, confusion and inadequacy in the therapist, causing technical problems, one of which may be to reveal more than what he/she would normally do (Fuller & Crowther, 1998).

Conversely, for the therapist, silence may also provide relief from the client's words, especially when the client is engaged in an unreal conversation of a defensive complying nature (Bravesmith, 2012).

Furthermore, during the client's silence, the therapist, having only his countertransference reactions at hand, can become more attuned to those feelings and be creative on how to use them the understand the client (Fuller & Crowther, 1998).

The therapist's silence can also be a kind of countertransference reaction (Brockbank, 1970), which may subsequently cause the client's silence (Lane et al., 2002). In this context, the client tries to conform and fit to the expectations of the silent therapist. Investigation of the client's and the therapist's intra-psychic conflicts and transference fantasies, and their interplay can help to reveal the meanings of silence in those cases (Brockbank, 1970; Lane et al., 2002).

Silence possesses meanings frequently related to feelings of anxiety concerning hiding and possible exposure of an unconscious fantasy on the part of the client. (Lane et al., 2002). Similarly, client's silence may affect the therapist to become anxious, confused, overwhelmed, seduced, or inadequate (Ladany et al., 2004; Zeligs, 1961), arouse feelings of anger, self-reproach, or frustration, which interfere with the therapeutic work (Blos, 1972; Pressman, 1961a; 1961b; Zeligs,

1961).

During prolonged silences, as also during incessant speech, the therapist may feel frustrated and distressed. The stress may be due to a sense of nothingness or intense emotions that the client is projecting (Bravesmith, 2012).

Silent clients project the need for containment, which they then deny. The therapist is then left to carry this need, and as such feel helpless, inadequate and mistreated in their therapeutic identity (Fuller & Crowther, 1998).

Feelings of discomfort, avoidance of positive emotional involvement; including destructive fantasies are also reported among countertransference reactions with silent clients (Fuller & Crowther, 1998). Brown (1987) describes the experience with a silent client who has a history of parental abuse, as severely uncomfortable and anxiety provoking for the therapist (Lane et al., 2002). Gilhooley (1995) writes about a client whose silence aroused tension, an irresistible desire to flee, and feelings of being dead, being trapped, emptiness, hopelessness and inadequacy (Lane et al., 2002). In another case, Bravesmith (2012) presents a case where client's silence is often treated with disapproval from the superego. Because only words are valued, silence reflected the client's feeling that she was inadequate, which was then projected onto the therapist (Bravesmith, 2012).

Fuller & Crowther (1998) mention silent clients as conveying blankness, inhibition, shame and fear through their silence and how that may create despair and frustration in the therapist when they cannot get these clients verbalize those feelings. Therapists are overwhelmed with feelings of helplessness, suspicion, and inadequacy and impulses to reject their clients and often dread their arrival (Fuller & Crowther, 1998). Therapists may interpret a client's silence with self-sufficiency and miss their vulnerability to boundary disturbances, experienced and witnessed psychic annihilation (Fuller & Crowther, 1998).

Therapists may tend to fill the client's silence with their own thoughts and personal preoccupations, and as such lose touch with the client (Blos, 1972; Ladany et al., 2004).

Silent clients can put the therapists at a technical dilemma: whether to attempt to match or to challenge the client's silence, especially when silence

conveys a demand for a self-object (Fuller & Crowther, 1998; Siegel, 1996). In such cases, allowing prolonged silence could be experienced by the client as neglectful and withholding, but attempting interaction could feel intrusive and demanding. Such tension can create a double bind for the therapeutic dyad, as well as cause a variety of feelings including discomfort, inadequacy and helplessness (Fuller & Crowther, 1998). If the therapist fails its function as a self-object, the client gets disappointed and stays in silent hostility, which in turn provokes feelings of hostility in the therapist and leaves him exhausted and indifferent. As such, the therapist gets inhibited about understanding the client's silence (Fuller & Crowther, 1998).

Silence may induce a process of empathy in the analyst (Arlow, 1961). It is also reported that therapists are actively engaged in the therapeutic work during silences with variety of activities such as observing clients, communicating empathy and interest, conceptualizing therapeutic interactions, examining their countertransference reactions, and trying not to distract the silent client (Ladany et al., 2004). However, attributing too much meaning to silence may also lead to over-engagement or over-protection or even intrusion of the therapist toward their silent clients.

1.7. THE CURRENT STUDY

In the literature, both unproductive and productive perceptions of silence are reported. The transferential meaning of the silence is usually uniquely considered for each client. Still, reported counter-transferential reactions towards a silent client usually revolve around inadequacy / helplessness and annihilation. These might be related to the meaning that is ascribed to the silence of a client that could be determined by the personal, professional, and cultural characteristics of the therapist as well as the dynamics of the client.

The aim of this study is to explore the perception of silence during the psychotherapy process and identify its personal and professional correlates for psychotherapists who live and practice therapy in Turkey. Within this framework,

the relationship between therapists' perception of silence and certain demographic characteristics (e.g. age, gender) and professional characteristics (e.g. theoretical orientation, level of experience) were explored. Further, the association of counter-transferential experiences of the therapists with the perception of silence was investigated.

There was no specific hypothesis for this study. However, the study aimed to explore the perception of silence by a sample of psychotherapists in Turkey. On the basis of the literature, it was expected that silence perception of the therapists would vary according to different kinds and meanings of silence, whether it was communicating a defensive attitude, was perceived as anxiety, discomfort or it was perceived as a more positive event including appreciation of silence as a tool to understand and develop an empathic attitude towards the client, or as a way to create space for development, insight and creativity for the client, therapist and the therapeutic relationship between them.

This study also aimed to identify the components of silence perception that might affect counter-transferential reactions toward silent clients. Following the clinical case examples reported in the literature, it was expected that the more negatively perceived silence would have associations with negative countertransference reactions, such as feeling inadequate, overwhelmed, helpless or anxious; whereas the more productive perception of silence would have association with positive or protective countertransference reactions.

CHAPTER 2
METHOD

Participants were professionals practicing psychotherapy in Turkey. A Silence Perception Questionnaire for Therapists (SPQ-T) was designed and used by the researcher to assess therapists' perception of silence inside and outside the psychotherapy setting. Counter-transferential experiences were assessed using Countertransference Questionnaire developed by Betan et al. (2005) with an instruction to focus on a client whose silences were noteworthy.

2.1. PARTICIPANTS

The participants of this study were psychotherapists practicing in Turkey with no other restrictions. Of the 132 therapists who participated to the study, 129 completed the first part of the survey that included questions about silence perception. Of these 129 eligible participants, 100 completed the second part of the survey, which included counter-transferential reactions to their particularly silent clients and therefore were eligible for further analysis.

Of the 129 participants, 119 (92.2%) were women and 10 (7.2%) were men. The age of the participants ranged from 24 to 57 (M = 33.28, SD = 8.028). Regarding marital status, 59 (45.7%) were married, 58 (45%) were single, 9 (7%) were divorced, 3 (2.3%) were categorized as other. Further, 36 (27.9%) had child and 93 (72.1 %) had no child.

In terms of educational level, 4 (3.1%) of the participants were BA graduates, 34 (26.4%) were MA students, 62 (48.1%) were MA graduates, 12 (9.3%) were PhD students, and 17 (13.2%) were PhD graduates.

In terms of professional title, 101 (78%) of the participants defined themselves as Psychotherapist and/or Clinical Psychologist. The remaining 18 (22%) participants reported to have additional titles as Counselor, Psychoanalyst and/or Psychiatrist. In regard to theoretical orientation, 82 (63.6%) of the participants had a single theoretical orientation and 47 (36.4%) had multiple theoretical orientations. Of the 82 therapists with a single orientation, majority (71%) adhered to a Psychodynamic orientation. The remaining 30% identified their orientation as Cognitive-Behavioral, Humanistic or Other (e.g. Client-focused, EMDR, Schema Therapy). On the other hand, of the 47 therapists with multiple theoretical orientation, more than half of them (57%) reported combinations of Psychodynamic Orientation with Cognitive-Behavioral, Humanistic, Systemic and/or Other approaches; whereas the remaining 43% reported combinations of Humanistic, Cognitive-Behavioral, Solution-focused and/or Other. The theoretical orientation of the participants were categorized into three as (1) Insight-oriented / Expressive, which included Psychodynamic, Psychoanalytic and Humanistic

orientations; (2) Behavior-oriented/ Supportive, which included orientations such as Cognitive-Behavioral, Solution-Focused, Systemic and (3) Mixed, which included participants who adhered to multiple theoretical orientations from both of the above mentioned categories. With respect to this categorization, 70 (54.3%) of the participants had Insight-oriented / Expressive, 25 (19.4%) had Behavior-oriented/ Supportive, 34 (26.4%) had Mixed theoretical orientation.

In terms of work place, 69 (53.5%) worked in private practice, 34 (26.4%) in an institution (e.g. university, municipality), and 26 (20.2%) in both private practice and an institution. With regard to population, 63 (48.8%) worked with just adults, 23 (17.8%) worked with just children and adolescents, 41 (31.8%) worked with a mixed population, and 2 of the participants reported that they worked only with couples and families.

Participants' weekly number of clients ranged between 1 and 60 (M = 13.43, SD = 10.84) and their years of experience varied between 1 and 33 (M = 7.21, SD = 7.21). Their self-assessed level of experience on a 5-point scale ranged between 1 and 5, with a mean of 3.09 (SD = 1.07).

In terms of perceived difficulties while working with clients, 83 (64%) of the participants reported that they had difficulty with risk of harm to self or others, 33 (26%) with impulsivity, 32 (25%) with anger, 28 (22%) with narcissistic injuries, 27 (21%) with loss and grief, 16 (12%) with erotic transference, 9 (7%) with separation-individuation issues, and 6 (5%) with trust and commitment issues. Total number of difficulties of the participants out of these 13 above listed categories ranged between 1 and 6, with a mean of 3 and a standard deviation of 1.

In terms of health issues, only 1 (0.8%) participant reported having a physical health issue, whereas 128 (99.2%) reported none. Similarly, in terms of psychological health, only 2 (1.6%) of the participants reported having an issue, and 127 (98.4%) reported none.

2.2. INSTRUMENTS

2.2.1. Demographic Information Form

Demographic InformationForm (See Appendix B) was administered to gather data about the background characteristics of the participants, and included questions about the participants' age, gender, education level, marital and child status, health conditions as well as professional characteristics such as work place, client population, theoretical orientation, years and level of experience, and areas of perceived difficulties.

2.2.2. Silence Perception Questionnaire for Therapists (SPQ-T)

Silence Perception Questionnaire for Therapists (SPQ-T) is a self-report questionnaire designed by the researchers, to assess therapists' perception of silence both during their psychotherapy sessions and in their daily private life (See Appendix C). The participants were asked to evaluate the self-applicability of each item on a 5-point Likert Scale. Initially, 70 items were formulated by the researcher and supervisor on the basis of the clinical, theoretical and empirical literature on silence during psychotherapy sessions. Three experienced clinicians reviewed the item set for comprehensiveness and clarity. Since this is the first study to use the scale, a Principal Components Analysis was conducted to identify the different dimensions of silence perception. Internal consistency of the whole scale as well as any possible components were calculated. Results of these analyses and the final component structure of the scale will be presented in the Results section in detail. The reliability and validity of SPQ-T were supported by the results of the current study.

2.2.3. Countertransference Questionnaire for Therapists (CTQ)

Countertransference Questionnaire (CTQ) is a 79-item self-report questionnaire, developed to assess countertransference patterns in psychotherapy for both clinical and research purposes (Betan et al., 2005). The items measure a wide range of thoughts, feelings and behaviors expressed by therapists toward their clients. As advised by the developers of the scale, the instructions could be revised asking the therapists to consider a specific client. In this study, the instructions guided the participants to consider a client whose silences were noteworthy, and asked to evaluate the self-applicability of each item on a 5-point Likert Scale (See Appendix D).

The items were translated to Turkish by the researcher, and then back translated by two independent translators. Two experts reviewed all the translations.

In this study, a Principal Components Analysis was conducted to identify and confirm the different dimensions of countertransference reactions of therapists toward their particularly silent clients. The current study provided support for the reliability and validity of the Turkish version of CTQ-79. Results of the analyses and the final component structure of the scale will be presented in the Results section in detail.

2.3. PROCEDURE

Ethics approval was received from the Ethics Committee Board of Istanbul Bilgi University to start the data collection process. All data was gathered via an online survey software (www.surveymonkey.com). The link to the survey was shared via e-mail and social media.

Participants were initially presented an Informed Consent Form (Appendix A) that briefly explained the aim and the subject of the study, informed the participants about the confidentiality of the data, and their right to quit at any point. The form also informed the participants that further information could be reached via researcher's email in case they had any questions and/or concerns about their

participation. Upon their approval of the Informed Consent Form, the instruments listed above were presented in the same order to the participants. It took approximately 20 minutes to complete the survey.

CHAPTER 3
RESULTS

The results are presented in three parts: 1. Scale Development and Adaptation, 2. Correlates of Therapists' Silence Perception, and 3. Factors that Predict the Counter-transferential Reaction to a Silent Client.

Part 1 includes Principal Component Analysis and internal consistency analyses for both Silence Perception Questionnaire for Therapists (SPQ-T) and Countertransference Questionnaire (CTQ-TR). Part 2 includes correlations and mean comparisons that investigate the relationship of background characteristics with silence perception and countertransference reactions to silence. Part 3 includes regression analyses to determine the factors that predict counter-transferential reaction toward a silent client.

3.1. SCALE DEVELOPMENT AND ADAPTATION

In this section the development and adaptation processes, Principal Component Analyses and reliability analyses of the Silence Perception Questionnaire for Therapists (SPQ-T) and Countertransference Questionnaire (CTQ-TR) will be reported.

3.1.1. Silence Perception Questionnaire for Therapists (SPQ-T)

SPQ-T consisted of 70 items, 59 of which address a therapist's perception of silence during psychotherapy sessions and 11 of which address a therapist's perception of silence in daily private life. Separate analyses were conducted for these two parts of the questionnaire, as the component structure and the reliability

coefficients were not meaningful and significant when these two parts were evaluated together.

For the 59 items of SPQ-T that were related to the therapists' perception of silence during psychotherapy sessions, an item screening was conducted that included an exploration of means, variances and covariances. It was observed that 10 of these 59 items had low common variance with the rest of the items and they were phrased conditionally, indicating that a change in attitude towards silence was due to the specific client and process conditions (e.g. I feel more anxious when a client of the opposite-sex becomes silent). These items (Items 4, 17, 18, 22, 38, 45, 51, 55, 57, 60) were excluded from further analyses since high or low ratings of them were related to the condition rather than a more inclusive sense of silence perception.

The remaining 49 in-session SPQ-T items were also evaluated via descriptive statistics and inter-item correlations. In addition to the 11 items reported above, 8 more items were eliminated (Items 3, 7, 10, 12, 21, 31, 35, 43) due to floor-ceiling effect, high kurtosis levels, and/or low levels of common variance.

A preliminary Principal Component Analysis (PCA) was conducted using the remaining 41 SPQ-T items. A PCA was preferred since there was no hypothesized latent construct, and the sole aim of the procedure was to reduce the correlated items to internally consistent components.

Prior to the analyses, the factorability of the sample and data were checked. The Kaiser-Meyer-Olkin measure of sampling adequacy was found to be .864, indicating that the sample and data were adequate for analysis. Bartlett's test of sphericity was significant ($\chi 2(820) = 2704.85$, $p < .001$), suggesting that the correlation matrix was factorable stating the overall significance of all the correlations within the correlation matrix. The inspection of the anti-image correlation matrix and initial communalities further confirmed that the data with all 41 SPQ-T items was suitable for analysis.

Initially, 9 components with eigenvalues greater than 1 were extracted. Based on the percentage of variance explained by each component, four-component and five-component solutions were examined that accounted for 48% and 51% of

the variance, respectively. In order to simplify the resulting structure, Varimax was selected as the method of rotation. The cut-off score for factor loadings were identified as 0.50. The four-component solution was preferred over the five-factor solution, since the latter resulted in an additional component that consisted of only 2 items with satisfactory factor loading; and the additional variance accounted for by the five-component solution was only marginal whereas the four-component solution was more interpretable.

A total of 12 items were eliminated due to their lower than 0.50 factor loadings and/or cross-loadings. The remaining 29 items constituted a theoretically and statistically sound 4-component structure. Table 1 presents the pattern matrix of item-factor loadings of the SPQ-T. Item listing in Turkish could be found in Appendix C.

Table 1 Item-Factor Loadings of SPQ-T

Silence Component and Item	Loading
Silence Component 1 Discomfort / Negativity	
24. I feel disappointed during silence in sessions.	0.713
20. Silence in sessions make me angry.	0.696
59. I feel inhibited during silence in sessions.	0.683
23. Silence in sessions frightens me.	0.677
48. When there are short silences in sessions, I feel uncomfortable.	0.624
11. When there is silence in session, I feel unsuccessful and/or incompetent.	0.583
6. I feel physical discomfort during silence in sessions (e.g. muscle contraction, headache etc.)	0.572
42. I feel embarrassed during silence in sessions.	0.556
66. Silence in session makes me feel guilty.	0.539
8. When a client is silent, I think something is wrong.	0.528
Silence Component 2 Anxiety / Urge to End	
39. When there is silence in session, I think I am the one to start talking.	0.721

34. When a client becomes silent, I feel like immediately breaking it by saying something.	0.699
25. When a client becomes silent, I think he/she expects an answer / reaction from me.	0.675
65. I become anxious as silences become frequent in sessions.	0.643
44. As the silence extends, I become more anxious.	0.641
36. When a client becomes silent, I encourage him/her to speak.	0.639
61. Silence during sessions never makes me feel uncomfortable.	-0.6
29. I feel in a void during silence in sessions.	0.553
27. Silence in sessions makes me anxious.	0.542
Silence Component 3 Appreciation	
46. Silences during sessions make me happy.	0.748
63. I feel I can better understand my client's internal world during silence.	0.692
26. Silences in sessions comfort me.	0.679
56. I feel the need for silence during sessions.	0.675
9. When a client becomes silent, I think s/he is absorbing what we've talked about.	0.541
15. There is silence in almost all my sessions.	0.505
Silence Component 4 Self-Reference	
68. When a client becomes silent, I think s/he is offended with me.	0.712
50. When a client becomes silent, I think s/he is mad at me.	0.646
53. When a client becomes silent, I think s/he is hiding something from me.	0.561
2. When a client becomes silent, I think s/he feels embarrassed with me.	0.542

The first component included 10 items that indicated negative feelings towards (e.g. I feel disappointed during silence in sessions) and/or discomfort with silence (e.g. I feel physical discomfort during silence in sessions) in the session. On the basis of content, the component was labeled "Discomfort / Negativity." The second component included 9 items that referred to heightened anxiety during

silences (e.g. As the silence extends, I become more anxious) and/or an urge to end the silence (e.g. When a client becomes silent, I feel like immediately breaking it by saying something). Thus, this component was labeled "Anxiety / Urge to End". The third component was composed of 6 items that reflected a sense of positive regard for silence (e.g. Silences during sessions make me happy) as well as an appreciation of it as a therapeutically productive moment (e.g. When a client becomes silent, I think he/she is absorbing what we've talked about). In order to reflect both aspects, the component was labeled as "Appreciation." The final component was composed of 4 items in which the reason for silences was attributed to the therapist (e.g. When a client becomes silent, I think he/she is mad at me). Thus, the component was named as "Self-Reference." Items that constitute each component are summarized in Table 2.

Table 2 Internal Consistency Coefficients for Silence Components

Component	No. of Items	Items	Cronbach's alpha
Discomfort / Negativity	10	6, 8, 11, 20, 23, 24, 42, 48, 59, 66	0.89
Anxiety / Urge to End	9	25, 27, 29, 34, 36, 39, 44, 61, 65	0.89
Appreciation	6	46, 63, 26, 56, 9, 15	0.76
Self-Reference	4	68, 50, 53, 2	0.67

Internal consistency for each of the four components was examined using Cronbach's alpha (see Table 2). First three components, Discomfort / Negativity, Anxiety / Urge to End and Appreciation had high internal consistency as indicated by Cronbach's alphas of .76 and .89. Only the fourth component, Self-Reference, had a minimally acceptable internal consistency. Considering that the Self-Reference component has 4 items, the alpha of .67 was deemed acceptable.

Component scores were calculated by taking the mean of the items that constituted the component. The descriptive statistics of the component scores are presented in Table 3. In order to depict the distribution of each component, boxplots

are presented in Figure 1. Both the descriptive statistics and boxplots indicate that Discomfort / Negativity and Self-Reference has quite low means and ranges for this sample, whereas Anxiety / Urge to End and Appreciation demonstrate a rather dispersed distribution with moderate means.

Table 3 Descriptive Statistics for Component Scores

Component	Min.	Max.	Mean	SD
Discomfort/Negativity	1.0	3.3	1.53	0.52
Anxiety and Urge to End	1.0	4.4	2.33	0.69
Appreciation	1.2	4	2.52	0.61
Self-Reference	1.0	3	1.60	0.51

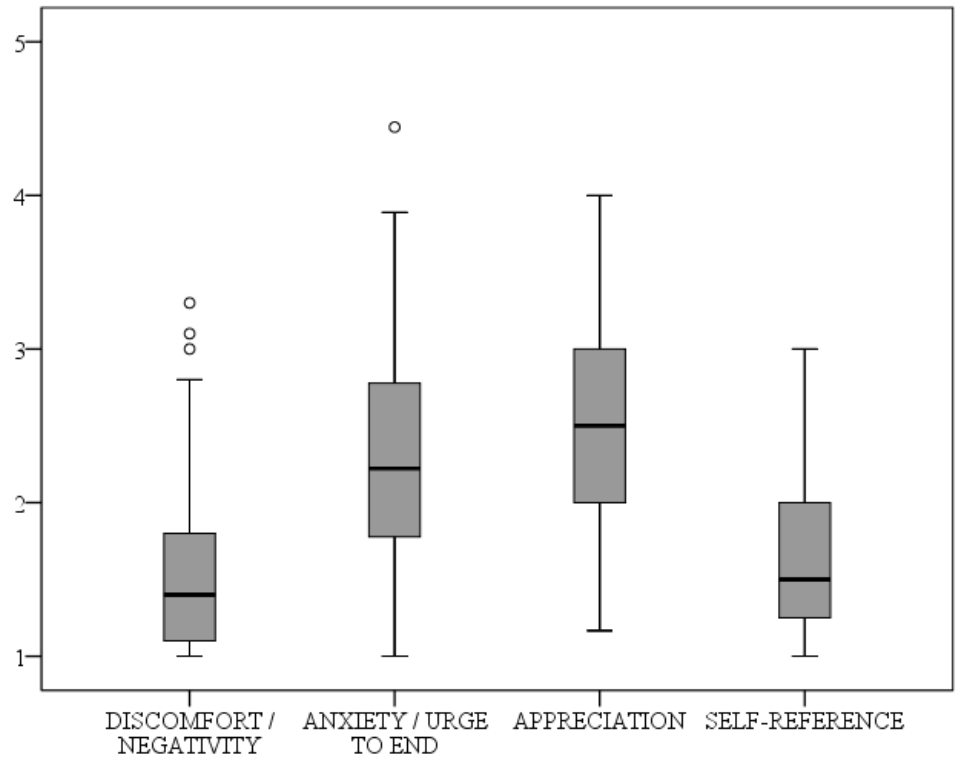

Figure 1 Boxplot Distribution Chart of Silence Components

As mentioned above, 11 of the initial SPQ-T items addressed the therapist's perception of silence outside the session, in their daily life (e.g. In my daily life,

when I'm around someone remaining silent bothers me). An item screening that included an exploration of means, variances and covariances was also conducted for these 11 items (Items 1, 16, 32, 40, 41, 47, 62, 64, 67, 69, 70). Inter-item and item-total correlations indicated that these items indicated a unified attribute rather than a multi-dimensional one, which is labeled as Daily Silence Preference. Thus, the internal consistency analyses were performed for all the items. One item (Item 62) was excluded since its exclusion increased the Cronbach's alpha by .004 points. The remaining 10 items had a Cronbach's alpha of .691, indicating a marginally acceptable reliability. A scale score was computed by taking the mean of the 10 items; higher scores indicating that the therapist prefers and/or likes silence in daily life. The descriptive statistics are presented in Table 4.

Table 4 Descriptive Statistics of Daily Silence Preference Scale

	Min.	Max.	Mean	SD
Daily Silence Preference	1.6	4.3	3.22	0.52

3.1.2. The Adaptation and Psychometric Properties of Countertransference Questionnaire (CTQ)

As mentioned in the Method section, Countertransference Questionnaire (CTQ), which includes 79 items, was translated to Turkish and presented to participants with an instruction to think of a particular client whose silence was noteworthy. Item listing of both Turkish and English versions of CTQ are presented in Appendix C.

Since this is the first study to use CTQ with a sample of Turkish therapists and with the instruction of silent client, an Exploratory Factor Analysis was conducted to be able to (1) identify the factor structure that fits the current data best and (2) compare this factor structure with the two already existing and slightly different factor structures reported in the manual for the questionnaire prior to any publication (Conklin & Westen, 2005) and in the paper by Betan et al. (2005).

The questionnaire was first administered to a random sample of 181 psychiatrists and clinical psychologists in North America who completed the questionnaire with a randomly selected client in their care. In the manual (Conklin & Westen, 2005), 8 factors, labeled as Hostile / Mistreated, Helpless / Inadequate, Positive / Satisfying, Parental / Protective, Overwhelmed / Disorganized, Special / Overinvolved, Sexualized and Disengaged, were reported. In the published paper on the same data, again an 8-factorstructure was reported by excluding 14 items that were included in the manual and including 5 items that were excluded. In the resulting factor structure, some items that were listed in the Hostile / Mistreated factor in the manual were incorporated into Overwhelmed / Disorganized, and the former was renamed as Criticized / Mistreated. Except for 2 items, all other items that were included in the analyses remained in the same factor as in the manual. Another minor change was that the factor Positive / Satisfying was renamed as Positive.

As mentioned in the Method section, among the 129 participants who completed the first part of the survey, only 100 of them completed the second part of the survey, which included the Turkish version of CTQ. The analyses that will be presented further were conducted on data from these 100 participants.

Initially, item screening was carried out, and then Principal Component Analyses were conducted with Promax as the Rotation method. In order for the final factor structures to be comparable, these methods were directly adopted from the original scale development study (Betan et al., 2005; Conklin & Westen, 2005).

As a result of the item screening, 11 items (Items 19, 20, 24, 41, 43, 44, 46, 62, 70, 72, 88) were eliminated due to quite low means, and high skewness and/or kurtosis. Based on the preliminary factoring with the remaining 68 items, 5 more items (Items 28, 29, 39, 45, 55) were excluded due to low loadings on all factors or moderate multiple loadings on 3 or more factors.

The final factor analysis was conducted using Principal Component Analysis as the extraction and Promax as the Rotation method to assess the factor structure of the remaining 63 CTQ items. The Kaiser-Meyer-Olkin measure of sampling adequacy was found to be 0.772, and Bartlett’s test of sphericity was

significant ($\chi 2$ (1953) = 5232.87, $p < 0.001$), both suggesting that the data of this sample was factorable. Anti-image correlation matrix and communalities further confirmed that items shared reasonable variance for factor analysis. On the basis of eigenvalues and variance explained, and also on the number of factors in previous studies, 7-factor and 8-factor solutions were examined. The 7-factor solution, explaining 62% of the total variance, provided the most interpretable solution. 7 items (Items 1, 2, 3, 32, 48, 49, 57, 66) were excluded from the final factor structure due to lower than 0.4 factor loadings and/or multiple loadings. Remaining 55 items met the criteria of contributing to a simple 7-factor structure with a primary factor loading of 0.4 or above. Table 5 presents the pattern matrix of item-factor loadings of the CTQ. Total item listing of both Turkish and English version of CTQ can be found in Appendix D.

Table 5 Item-Factor Loadings of CTQ

Countertransference Factor and Item	Loading
Countertransference Factor 1 Inadequate / Disengaged	
58. I think or fantasize about ending the treatment.	0.914
54. I think s/he might do better with another therapist or in a different kind of therapy.	0.889
9. I don't feel fully engaged in sessions with him/her.	0.887
16. I feel bored in sessions with him/her.	0.875
22. I feel frustrated in sessions with him/her.	0.827
5. I wish I had never taken him/her on as a patient.	0.817
52. I feel hopeless working with him/her.	0.812
59. I feel like my hands have been tied or that I have been put in an impossible bind.	0.808
68. I feel less successful helping him/her than other patients.	0.806
36. I feel incompetent or inadequate working with him/her.	0.803
31. I feel I am failing to help him/her or I worry that I won't be able to help him/her.	0.775

75. I watch the clock with him/her more than with my other patients.	0.756
25. My mind often wanders to things other than what s/he is talking about.	0.687
38. I feel interchangeable—that I could be anyone to him/her.	0.652
13. I dread sessions with him/her.	0.614
10. I feel confused in sessions with him/her.	0.6
8. I feel annoyed in sessions with him/her.	0.596
Countertransference Factor 2 Overengaged / Protective	
42. I feel like I want to protect him/her.	0.858
21. I wish I could give him/her what others never could.	0.835
23. S/he makes me feel good about myself.	0.783
65. I like him/her very much.	0.77
74. S/he is one of my favorite patients.	0.741
4. I feel compassion for him/her.	0.74
64. I have warm, almost parental feelings toward him/her.	0.73
7. If s/he were not my patient, I could imagine being friends with him/her.	0.664
47. I feel nurturant toward him/her.	0.63
40. I feel like I understand him/her.	0.613
14. I feel angry at people in his/her life.	0.585
19. I look forward to sessions with him/her.	0.557
53. I feel pleased or satisfied after sessions with him/her.	0.494
Countertransference Factor 3 Hostile / Mistreated	
60. When checking my phone messages, I feel anxiety or dread that there will be one from him/her.	0.831
11. I don’t trust what s/he’s telling me.	0.694
33. I feel used or manipulated by him/her.	0.673
37. I find myself being controlling with him/her.	0.663
12. I feel criticized by him/her.	0.559
15. I feel angry at him/her.	0.531
27. I get enraged at him/her.	0.466

6. I feel dismissed or devalued.	0.454
63. I feel unappreciated by him/her.	0.41
Countertransference Factor 4 Erotic / Sexualized	
17. I feel sexually attracted to him/her.	0.894
56. I find myself being flirtatious with him/her.	0.884
61. I feel sexual tension in the room.	0.833
Countertransference Factor 5 Overwhelmed	
51. I feel overwhelmed by his/her needs.	0.769
73. I find myself discussing him/her more with colleagues or supervisors than my other patients.	0.583
79. I talk about him/her with my spouse or significant other more than my other patients.	0.568
77. More than with most patients, I feel like I've been pulled into things that I didn't realize until after the session was over.	0.493
26. I feel overwhelmed by his/her strong emotions.	0.427
Countertransference Factor 6 Anxious / Fearful	
35. S/he frightens me.	0.818
34. I feel I am "walking on eggshells" around him/her, afraid that if I say the wrong thing s/he will explode, fall apart, or walk out.	0.66
30. I feel anxious working with him/her.	0.415
Countertransference Factor 7 Special	
71. I disclose my feelings with him/her more than with other patients.	0.701
50. I tell him/her I love him/her.	0.631
76. I self-disclose more about my personal life with him/her than with my other patients.	0.605
69. I do things for him/her, or go the extra mile for him/her, in ways that I don't do for other patients.	0.599
67. I end sessions overtime with him/her more than with my other patients.	0.485

The first factor included 17 items that indicated feelings of inadequacy or

incompetence with a silent client (e.g. I feel incompetent or inadequate working with him/her) and/or detachment during silence in session (e.g. I don't feel fully engaged in sessions with him/her). On the basis of content, the factor was labeled "Inadequate / Disengaged". The second factor included 13 items that described wishes to protect and nurture (e.g. I feel like I want to protect him/her) and/or feelings of being overly engaged with the client during silences (e.g. I wish I could give him/her what others never could). Thus, this factor was labeled "Overengaged / Protective". The third factor was composed of 9 items that reflected a sense of being devalued or unappreciated by the client during silence in sessions (e.g. I feel dismissed or devalued) as well as a sense of hostility or anger (e.g. I feel angry at him/her). In order to reflect these aspects, the factor was labeled as "Hostile / Mistreated". The fourth factor was composed of 3 items, which described sexual feelings or a sexual tension during silence (e.g. I feel sexually attracted to him/her). Therefore, the factor was named as "Erotic / Sexualized". The fifth factor included 5 items that indicated feelings of dread and being overwhelmed (e.g.I feel overwhelmed by his/her needs). Thus, this component was labeled "Overwhelmed". The sixth factor included 3 items that indicated feelings of anxiety (e.g.I feel anxious working with him/her) as well as and fear (e.g.S/he frightens me). On the basis of this content, this component was labeled "Anxious / Fearful". The seventh factor included 5 items that described a sense of seeing the client as special (e.g.I do things for him/her, or go the extra mile for him/her, in ways that I don't do for other clients). Based on this content, this factor was labeled "Special". Items that constitute each factor are summarized in Table 6.

Table 6 Internal Consistency Coefficients for Countertransference Factors

Factor	No. of Items	Items	Cronbach's alpha
Inadequate / Disengaged	17	5, 8, 9, 10, 13, 16, 22, 25, 31, 36, 38, 52, 54, 58, 59, 68, 75	0.954
Overengaged / Protective	13	4, 7, 14, 19, 21, 23, 40, 42, 47, 53, 64, 65, 74	0.918
Hostile / Mistreated	9	6, 11, 12, 15, 27, 33, 37, 60, 63	0.876
Erotic / Sexualized	3	17, 56, 61	0.889
Overwhelmed	5	26, 51, 73, 77, 79	0.808
Anxious / Fearful	3	30, 34, 35	0.848
Special	5	50, 67, 69, 71, 76	0.715

Internal consistency for each of the seven factors was examined using Cronbach's alpha (see Table 6). All seven factors, had high internal consistency as indicated by Cronbach's alphas that range between .715 and .954.

When the seven-factor structure presented here is compared to the eight-factor structure of the previous study by Betan et al. (2005), the factors Erotic / Sexualized, Overwhelmed and Special stayed the same. The factors Parental / Protective and Positive / Satisfying were regrouped under Overengaged / Protective in the current study. Similarly, most of the items constituting the factor Inadequate / Helpless and factor Disengaged were also regrouped under Inadequate / Disengaged in the current study. Finally, a new factor Anxious / Fearful appeared in the present study which constituted items that related to counter-transferential feelings of anxiety and fear which were listed under three different factors in the previous study: Overwhelmed/ Disorganized, Hostile / Mistreated, and Helpless / Inadequate.

Factor scores were calculated by taking the mean of the items that constitute the factor (See Table 7). In order to depict the distribution of each factor, boxplots

are presented in Figure 2. It should be noted that the highest mean was of the second factor, Overengaged / Protective. Inadequate / Disengaged, Overwhelmed and Anxious / Fearful countertransference reactions also yielded a reasonable mean and variance for further analyses. On the other hand, Hostile / Mistreated and Special countertransference reactions towards a silent client were reported as quite low for the majority of the sample. Erotic / Sexualized Countertransference scores did not even provide a distribution; approximately 95% of the sample yielded mean scores between 1 and 2. Thus, these 3 factors were excluded from further analyses.

Table 7 Descriptive Statistics for Countertransference Factors

Countertransference Factor	No. of items	Min.	Max.	Mean	SD
Inadequate / Disengaged	17	1	4.88	1.78	0.74
Overengaged / Protective	13	1	4.46	2.48	0.77
Hostile/Mistreated	9	1	4.22	1.53	0.57
Erotic / Sexualized	3	1	4.67	1.19	0.5
Overwhelmed	5	1	4.2	1.76	0.68
Anxious / Fearful	3	1	4.33	1.84	0.83
Special	5	1	3.2	1.44	0.50

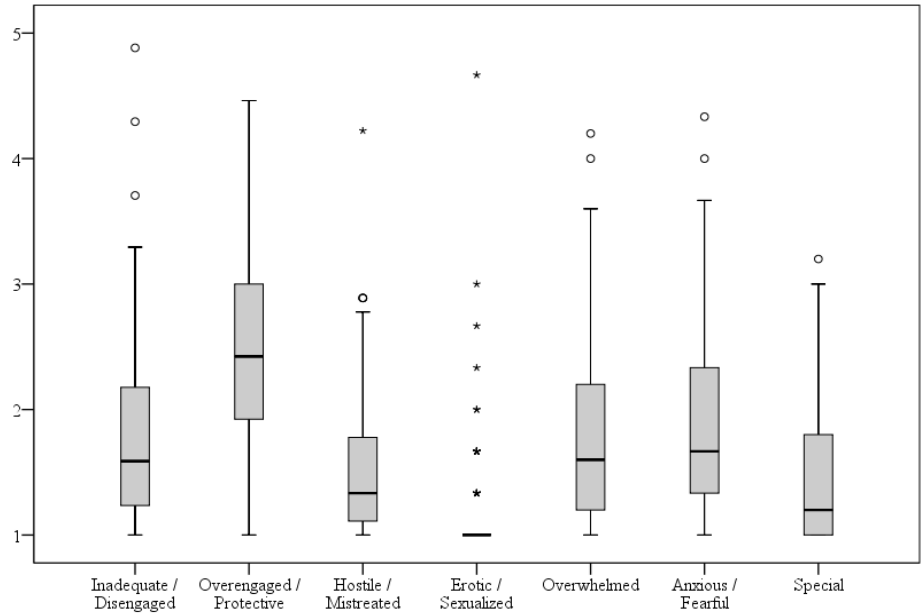

Figure 2 Boxplot Distribution Chart of Countertransference Factors

3.2. CORRELATES OF SILENCE PERCEPTION AND COUNTERTRANSFERENCE

In this section, the associations between demographic and professional characteristics of the therapists and the attitudes and reactions towards silence in sessions and countertransference with a silent client were examined. Since valid responses for CTQ were available for 100 participants, the analyses in this section were conducted with data from these participants.

3.2.1. Silence Perception and Demographic and Professional Characteristics of the Therapists

Data on therapists' Age, Years of Experience, Education, Theoretical Orientation, Work Setting, Client Population, Number of Clients, Level of Experience, and the overall areas of Difficulties they experience in practice were collected in this study. Since this is the first study on silence perception, all these

characteristics were examined in terms of their associations with the components derived from the Silence Perception Questionnaire for Therapists.

For continuous variables such as age, number of clients, correlation coefficients were calculated and reported. Since there were issues with normality of the distribution and since the self-assessed level of experience was a single-item rating over 5, Spearman correlation was preferred. All correlation coefficients are presented in Table 8.

Table 8 Spearman Correlation Coefficients between Demographic and Professional Characteristics and Components of SPQ-T

	Age	Years of Experience	Level of Experience	No. of Clients	No. of Difficulties
Discomfort /Negativity	-.293**	-.326**	-.354**	-.248*	.350**
Anxiety / Urge to End	-.279**	-.275**	-.337**	-.260**	.288**
Appreciation	-.233*	-.285**	-.169	-.288**	.299**
Self-Reference	.001	-.048	-.116	.012	.211*

* Correlation is significant at the 0.05 level (two tailed)

** Correlation is significant at the 0.01 level (two tailed)

Silence components Discomfort / Negativity, Anxiety / Urge to End and Appreciation were found to be negatively correlated with Age ($r(100) = -.293$, $p < .01$; $r(100) = -.279$, $p < .01$; $r(100) = -.233$, $p < .05$ respectively), Years of Experience ($r(100) = -.326$, $p < .01$; $r(100) = -.275$, $p < .01$; $r(100) = -.285$, $p < .01$ respectively), Number of Clients ($r(100) = -.248$, $p < .05$; $r(100) = -.279$, $p < .01$; $r(100) = -.233$, $p < .01$ respectively); and positively correlated with Total Number of Difficulties ($r(100) =.350$, $p < .01$; $r(100) = .288$, $p < .01$; $r(100) = .299$, $p < .01$ respectively at weak but significant levels. Silence component Self-Reference was not significantly correlated with any of the variables except with Total Number of Difficulties at a weak level ($r(100) = .211$, $p < .05$). Age, Years of Experience and self-assessed Level of Experience were strongly inter-related and yielded similar correlations with silence components. The initial examination of the

correlations demonstrated that self-assessed Level of Experience has slightly stronger correlations with negative aspects of silence perception, Discomfort /Negativity and Anxiety / Urge to End ($r(100) = -.354$, $p < .01$; $r(100) = -.337$, $p < .01$ respectively). On the other hand, the relatively objective report of Years of Experience had a significant negative correlation with Appreciation of silence, whereas self-assessed Level of Experience did not. Overall, the correlations indicate a decrease in all aspects of silence in sessions, except Self-Reference, as the age and experience increases.

In order to investigate the associations between the categorical variables, which are Education, Theoretical Orientation, Work Setting, and Client Population, and components of SPQ-T, a Multivariate Analyses of Variance was conducted. A multivariate test was selected since the Silence Perception components were inter-related. The categories of Education variable were reduced to 3 categories with comparable sizes -BA Graduate (29%), MA Graduate (45%) and PhD Student and Graduate (26%)- to be included in Multivariate Analysis of Variance, without violating the assumption of homogeneity of variance. In addition, since there were only two therapists who reported working with just couples and adolescents, they were excluded from the comparisons. Descriptive statistics for each variable are presented in Table 9.

Table 9 Descriptive statistics for variables Education, Theoretical Orientation, Work Setting, and Client Population

	Discomfort / Negativity		Anxiety / Urge to End		Appreciation		Self-Reference	
	M	SD	M	SD	M	SD	M	SD
Education								
BA Graduate	1.73	.56	2.54	.73	2.66	.72	1.67	.56
MA Graduate	1.51	.47	2.31	.65	2.51	.58	1.62	.50
PhD Student & Graduate	1.35	.49	2.11	.69	2.42	.59	1.47	.47
Orientation								
Insight-oriented / Expressive	1.62	.51	2.37	.67	2.62	.63	1.70	.52
Behavior-oriented / Supportive	1.42	.49	2.26	.69	2.43	.68	1.39	.41
Mixed	1.45	.55	2.29	.77	2.45	.57	1.53	.53
Work Setting								
Private Practice	1.57	.50	2.41	.71	2.63	.58	1.59	.48
Institution	1.54	.59	2.28	.73	2.43	.62	1.52	.48
Both Private & Institution	1.45	.48	2.21	.64	2.46	.70	1.67	.61
Client Population								
Just Adult	1.57	.50	2.32	.64	2.57	.63	1.58	.54
Just Child-Adolescent	1.73	.51	2.74	.68	2.63	.64	1.72	.46
Mixed	1.36	.53	2.07	.71	2.45	.62	1.58	.52

A Multivariate Analyses of Variance was conducted with Education, Theoretical Orientation, Work Setting and Client Population as independent variables and four Silence components Discomfort / Negativity, Anxiety / Urge to End, Appreciation, and Self-Reference as dependent variables. None of the multivariate tests were found to be significant.

On the other hand, univariate tests revealed that there was a significant association between Client Population and Anxiety / Urge to End, $F(2,89) = 5.537$,

p = 0.005, *partial η2* = 0.111. It was observed that therapists who work with a Mixed population of clients had the lowest level of Anxiety / Urge to End (M = 2.07, SD = 0.71) regarding silence in sessions; and therapists who work with Just Children and Adolescents had the highest (M = 2.74, SD = 0.68). Follow up tests via Tukey's HSD confirms that the difference between these two groups is statistically significant. The therapists who were working with Adults (M = 2.32, SD = 0.64) yielded a mean rating that falls between these categories, and the differences between them were not significantly significant.

Daily Silence Preference did not demonstrate any significant correlations or mean differences with any of the variables listed above.

3.2.2. Countertransference with Silent Client and Demographic and Professional Characteristics of the Therapists

The associations between demographic and professional characteristics of the therapists and countertransference with silent clients were also examined. Since this is the first study to examine the correlates of countertransference with silence perception, all characteristics were examined in terms of their associations with the factors derived from the Countertransference Questionnaire.

For continuous variables such as age, number of clients, correlation coefficients were calculated and reported. Since there were issues with normality of the distribution and since the self-assessed level of experience was a single-item rating over 5, Spearman correlation was preferred. All correlation coefficients are presented in Table 10.

Table 10 Spearman Correlation Coefficients between Demographic and Professional Characteristics and Countertransference Factors of CTQ-TR

	Age	Years of Experience	Level of Experience	No. of Clients	No. of Difficulties
Inadequate / Disengaged	-.173	-.140	-.207*	-.099	.337**
Overengaged/ Protective	-.244*	-.267**	-.247*	-.136	.308**
Hostile/ Mistreated	-.222*	-.160	-.267**	-.010	.398**
Erotic / Sexualized	-.126	-.087	-.056	-.034	.422**
Overwhelmed	-.213*	-.206*	-.220*	-.088	.383**
Anxious / Fearful	-.298**	-.282**	-.376**	-.146	.297**
Special	-.051	-.114	-.093	.012	.219

* Correlation is significant at the 0.05 level (two tailed)

** Correlation is significant at the 0.01 level (two tailed)

As could be seen in Table 10, most of the correlations that are significant are weak to moderate and the characteristic that demonstrates the strongest associations with all counter-transferential reactions is the total number of session-related Difficulties experienced by the therapist. The overall Difficulty experienced by the therapist is positively and significantly correlated with all types of countertransference with a silent client, except Special ($r(100) = .337$, $p < .01$ with Inadequate / Disengaged; $r(100) = .308$, $p < .01$ with Overengaged/ Protective; $r(100) = .398$, $p < .01$ with Hostile/ Mistreated; $r(100) = .422$, $p < .01$ with Erotic / Sexualized; $r(100) = .383$, $p < .01$ with Overwhelmed; $r(100) = .297$, $p < .01$ with

Anxious / Fearful). Number of clients, on the other hand, had no significant relationship with any of the CTQ factors. Age and Level of Experience demonstrated a similar pattern of weak yet significant correlations that increase in age and experience indicated a decrease in the countertransference reactions of feeling Overengaged / Protective ($r(100) = -.244$, $p < .05$; $r(100) = -.247$, $p < .05$ respectively), Hostile / Mistreated ($r(100) = -.222$, $p < .05$; $r(100) = -.267$, $p < .01$ respectively), Overwhelmed ($r(100) = -.213$, $p < .05$; $r(100) = -.220$, $p < .05$ respectively) and Anxious / Fearful ($r(100) = -.298$, $p < .01$; $r(100) = -.376$, $p < .01$ respectively). Years of Experience also has weak yet significant negative correlations with CTQ factors of Overengaged / Protective ($r(100) = -.267$, $p < .01$), Overwhelmed ($r(100) = -.206$, $p < .05$), and Anxious / Fearful ($r(100) = -.282$, $p < .01$), but not with Hostile / Mistreated.

A Multivariate Analysis of Variance was conducted with the variables Education, Theoretical Orientation, Work Setting, and Client Population as independent variables and four Countertransference factors, Inadequate / Disengaged, Overengaged / Protective, Overwhelmed, and Anxious / Fearful as dependent variables. As also mentioned before, because reported Hostile / Mistreated and Special countertransference reactions towards a silent client were quite low for the majority of the sample, and Erotic / Sexualized Countertransference scores did not provide a distribution, these factors were excluded from the multivariate analyses (See Figure 2). Descriptive statistics for each variable are presented in Table 11.

Table 11 Descriptive statistics for Education, Theoretical Orientation, Work Setting, and Client Population

	Inadequate/ Disengaged		Overengaged/ Protective		Overwhelmed		Anxious/ Fearful	
	M	SD	M	SD	M	SD	M	SD
Education								
BA Graduate	1.91	.75	2.74	.82	1.97	.79	2.15	.96
MA Graduate	1.78	.71	2.43	.80	1.72	.68	1.86	.81
PhD Student & Graduate	1.64	.78	2.26	.59	1.60	.50	1.47	.55
Orientation								
Insight-oriented / Expressive	1.85	.73	2.70	.84	1.82	.71	2.00	.84
Behavior-oriented / Supportive	1.59	.70	2.34	.57	1.61	.61	1.61	.83
Mixed	1.79	.78	2.14	.62	1.76	.67	1.70	.78
Work Setting								
Private Practice	1.84	.79	2.56	.77	1.91	.80	2.01	.85
Institution	1.66	.65	2.38	.67	1.70	.52	1.64	.82
Both Private & Institution	1.79	.72	2.41	.88	1.55	.51	1.73	.77
Client Population								
Just Adult	1.79	.71	2.52	.84	1.68	.67	1.82	.83
Just Child-Adolescent	1.97	.72	2.43	.66	2.21	.77	2.38	1.01
Mixed	1.65	.81	2.44	.75	1.60	.47	1.54	.54

The multivariate test was significant for Client Population, *Wilks' Λ* = 0.784, $F(8,172) = 3.047$, $p = 0.003$, *partial η2* = 0.118**,** indicating a difference in the Countertransference with a silent client with regard to Client population. The univariate F tests showed that there was a significant difference between these categories for Countertransference factors Overwhelmed, $F(2,89) = 7.595$, $p = 0.001$, *partial η2* = 0.146; and Anxious / Fearful, $F(2,89) = 7.001$, $p = 0.002$, *partial η2* = 0.136. Follow-up tests by Tukey's HSD demonstrated that therapists who were

seeing Just Children and Adolescents reported to be significantly more Overwhelmed (M = 2.21, SD = 0.77) and more Anxious / Fearful (M = 2.38, SD = 1.01) with a silent client as compared to therapist working with Just Adults (M = 1.68, SD = 0.67 for Overwhelmed; M = 1.82, SD = 0.83 for Anxious / Fearful) and Mixed populations (M = 1.60, SD = 0.47 for Overwhelmed; M = 1.54, SD = 0.54 for Anxious / Fearful).

Further, although the multivariate tests were not significant for Education and Theoretical Orientation, univariate effects were observed. For Education, Anxious / Fearful countertransference reaction was significant, $F(2,89) = 3.489$, $p = 0.035$, *partial η2* = 0.073. Post-hoc tests demonstrated that the PhD group had a significantly lower Anxious / Fearful countertransference towards a silent client (M = 1.47, SD = 0.55) as compared to BA Graduates (M = 2.15, SD = 0.96). MA Graduates (M = 1.86, SD = 0.81) were in-between and not significantly different from these groups.

With regard to theoretical orientation, the univariate test for the CTQ factor Overengaged / Protective was found to be significant, $F(2,89) = 3.542$, $p = 0.033$, *partial η2* = 0.074. Insight-oriented / Expressive therapists had the highest level of Overengaged / Protective countertransference reaction towards silent clients (M = 2.70, SD = .84), followed by the Behavior-oriented / Supportive (M = 2.34, SD = .57), and Mixed orientation (M = 2.14, SD = .62). Post-hoc tests confirmed that the Insight-oriented / Expressive and Mixed orientation groups were significantly different from each other.

3.2.3. The Association between Silence Perception and Countertransference with a Silent Client

In order to examine the association between Silence Perception and Countertransference with silent clients, the correlations between factors of both scales were inspected. Pearson correlation coefficients are reported in Table 12. All factors are included, yet the coefficients for the Hostile/ Mistreated, Erotic /

Sexualized and Special CTQ factors should be cautiously considered due to their problematic distributions.

Table 12 Pearson Correlation Coefficients between Silence Perception Components of SPQ-T and Countertransference Factors of CTQ- TR

		Silence Components			
		Discomfort/ Negativity	Anxiety / Urge to End	Appreciation	Self-Reference
Countertransference Factors	Inadequate / Disengaged	.545**	.623**	-.093	.364**
	Overengaged / Protective	.218*	.185	.413**	.245*
	Hostile/ Mistreated	.454**	.491**	.046	.463**
	Erotic / Sexualized	.176	.120	.169	.118
	Overwhelmed	.393**	.362**	.184	.272**
	Anxious / Fearful	.459**	.519**	-.020	.409**
	Special	.392**	.324**	.156	.432**

* Correlation is significant at the 0.05 level (two tailed)

** Correlation is significant at the 0.01 level (two tailed)

As can be seen in Table 12, all the significant correlations are positive and show weak to strong relationships between Countertransference factors toward a silent client and the Silence components. CTQ factors of Inadequate / Disengaged, Overwhelmed and Anxious / Fearful are all significantly correlated with all the silence components except Appreciation. Similar patterns of association are also obtained for Hostile / Mistreated and Special but these should be considered cautiously due to their problematic distributions. It can also be observed that Silence component Appreciation is only significantly correlated with CTQ factor Overengaged / Protective and that Overengaged / Protective has weak correlations with the rest of the silence components. The results also demonstrate that the strongest correlation is between CTQ factor Inadequate / Disengaged and Silence component Anxiety / Urge to End.

3.3. FACTORS THAT PREDICT COUNTER-TRANSFERENTIAL REACTION TOWARD A SILENT CLIENT

Analyses conducted above showed that four CTQ factors of Inadequate / Disengaged, Overengaged / Protective, Overwhelmed and Anxious / Fearful had meaningful distributions and significant correlations with Daily Silence Preference as well as several different variables. On the basis of these, for each of these four CTQ factors, a separate stepwise regression analysis was preformed to observe which variables predict each CTQ factor along with their comparative effects.

Following the preliminary analyses presented above, Theoretical Orientation, Client Population, Level of Experience, Total Number of Difficulties and four Silence components as well as Daily Silence Preference were included in the regression analyses as independent variables. The variables Theoretical Orientation and Client Population were defined as binary variables where the value of 1 meant Insight-oriented / Expressive for Theoretical Orientation and Just working with Child and Adolescents for Client Population, and the value of 0 meant otherwise. The variable Level of Experience is also a scale variable taking values between 1 and 5.

Summaries of the regression models and regression coefficients for each Countertransference factor are presented in sections below.

3.3.1. Predicting Inadequate / Disengaged Countertransference with the Silent Client

In the single model presented in Table 13, the Silence component Anxiety / Urge to End explained 38.2% of the variance in Countertransference factor Inadequate / Disengaged, $F(1,98) = 62.097$, $p < 0.001$. None of the other independent variables were included in the significant model in stepwise regression analysis.

Table 13 The Model Summary of Stepwise Regression Analysis for Countertransference Factor Inadequate / Disengaged

Model	R	R^2	Adjusted R^2	SE of the Estimate	R^2Change	FChange	df1	df2
1	.623[a]	.388	.382	.58090	.388	62.097	1	98

a. Predictors: (Constant), Silent Component Anxiety / Urge to End

The regression coefficients and standardized beta values are listed in Table 14.

Table 14 Stepwise Regression Analysis for Variables Predicting Countertransference Factor Inadequate / Disengaged

	B	B SE	Beta	t	Sig.
(Constant)	.250	.203		1.234	.220
Anxiety / Urge to End	.659	.084	.623	7.880	.000

The inspection of the model suggested that Countertransference factor Inadequate / Disengaged increased .659 units for each Silence component Anxiety / Urge to End unit of measure.

3.3.2. Predicting Overengaged / Protective Countertransference with the Silent Client

In the third model presented in Table 15, the Silence component Appreciation, Having Insight-oriented / Expressive Theoretical Orientation (Binary) and Silence component Discomfort / Negativity explained 25.6% of the variance in Countertransference Factor Overengaged / Protective, $F(3,96) = 12.346$, $p < 0.001$. None of the other independent variables were included in the significant model in stepwise regression analysis.

Table 15 The Model Summary of Stepwise Regression Analysis for Countertransference Factor Overengaged / Protective

Model	R	R^2	Adjusted R^2	SE of the Estimate	R^2Change	FChange	df1	df2
1	.413[a]	.171	.162	.70905	.171	20.188	1	98
2	.486[b]	.237	.221	.68381	.066	8.369	1	97
3	.528[c]	.278	.256	.66831	.042	5.553	1	96

a. Predictors: (Constant), Silence Component Appreciation

b. Predictors: (Constant), Silence Component Appreciation, Having Insight-oriented / Expressive Theoretical Orientation (Binary)

c. Predictors: (Constant), Silence Component Appreciation, Having Insight-oriented / Expressive Theoretical Orientation (Binary), Silence Component Discomfort / Negativity

The regression coefficients and standardized beta values are listed in Table 16.

Table 16 Stepwise Regression Analysis for Variables Predicting Countertransference Factor Overengaged / Protective

	B	B SE	Beta	t	Sig.
(Constant)	.569	.356		1.595	.114
Appreciation	.494	.109	.398	4.516	.000
Having Insight-oriented / Expressive Theoretical Orientation (Binary)	.339	.138	.220	2.464	.016
Discomfort / Negativity	.312	.132	.209	2.356	.020

The inspection of the model suggested that the strongest predictor for Countertransference factor Overengaged / Protective was the Silence component Appreciation with a Beta value of .398. CTQ factor Overengaged / Protective

increased .494 units for each Silence component Appreciation unit of measure, .339 units by Having Insight-oriented / Expressive Theoretical Orientation, and .312 units for each Silence component Discomfort / Negativity unit of measure.

3.3.3. Predicting Overwhelmed Countertransference with the SilentClient

In the third model presented in Table 17, Silence component Discomfort / Negativity, Total Number of Difficulties and Having Just Child-Adolescent Clients (Binary) explained 25.4% of the variance in Countertransference factor Overwhelmed, $F(3,96) = 12.210$, $p < 0.001$. None of the other independent variables were included in the significant model in stepwise regression analysis.

Table 17 The Model Summary of Stepwise Regression Analysis for Countertransference Factor Overwhelmed

Model	R	R^2	Adjusted R^2	SE of the Estimate	R^2Change	FChange	df1	df2
1	.393[a]	.154	.146	.63025	.154	17.884	1	98
2	.465[b]	.216	.200	.60992	.062	7.641	1	97
3	.526[c]	.276	.254	.58912	.060	7.970	1	96

a. Predictors: (Constant), Silence Component Discomfort / Negativity

b. Predictors: (Constant), Silence Component Discomfort / Negativity, Total Number of Difficulties

c. Predictors: (Constant), Silence Component Discomfort / Negativity, Total Number of Difficulties, Having Just Child-Adolescent Clients (Binary)

The regression coefficients and standardized beta values are listed in Table 18.

Table 18 Stepwise Regression Analysis for Variables Predicting Countertransference Factor Overwhelmed

	B	B SE	Beta	t	Sig.
(Constant)	.716	.204		3.509	.001
Discomfort / Negativity	.366	.121	.278	3.038	.003
Total Number of Difficulties	.150	.049	.276	3.050	.003
Having Just Child-Adolescent Clients (Binary)	.461	.163	.249	2.823	.006

The inspection of the model suggested that the strongest predictor for Countertransference factor Overwhelmed was the Silence component Discomfort / Negativity with Beta value of .278. Countertransference factor Overwhelmed increased .366 units for each Silence component Discomfort / Negativity unit of measure, .150 units for each Total number of Difficulties unit of measure, and .461 units for Having Just Child-Adolescent Clients.

3.3.4. Predicting Anxious / Fearful Countertransference with the Silent Client

In the third model presented in Table 19, the Silence component Anxiety / Urge to End, Level of Experience and the Silence component Self-Reference explained 34.9% of the variance in Countertransference factor Anxious / Fearful, $F(3,96) = 18.700$, $p < 0.001$. None of the other independent variables were included in the significant model in stepwise regression analysis.

Table 19 The Model Summary of Stepwise Regression Analysis for Countertransference Factor Anxious / Fearful

Model	R	R^2	Adjusted R^2	SE of the Estimate	R^2Change	FChange	df1	df2
1	.519[a]	.270	.262	.71346	.270	36.223	1	98
2	.565[b]	.319	.305	.69243	.049	7.045	1	97
3	.607[c]	.369	.349	.67022	.050	7.534	1	96

a. Predictors: (Constant), Silence Component Anxiety / Urge to End

b. Predictors: (Constant), Silence Component Anxiety / Urge to End, Level of Experience (1-5)

c. Predictors: (Constant), Silence Component Anxiety / Urge to End, Level of Experience (1-5), Silence Component Self-Reference

The regression coefficients and standardized beta values are listed in Table 20.

Table 20 Stepwise Regression Analysis for Variables Predicting Countertransference Factor Anxious / Fearful

	B	B SE	Beta	t	Sig.
(Constant)	.837	.376		2.226	.028
Anxiety / Urge to End	.408	.111	.343	3.675	.000
Level of Experience	-.186	.065	-.244	-2.868	.005
Self-Reference	.396	.144	.245	2.745	.007

The inspection of the model suggested that the strongest predictor for Countertransference factor Anxious/Fearful was the Silence component Anxiety / Urge to End with Beta value of .343Countertransference factor Anxious / Fearful increased .408 units for each Silence component Anxiety / Urge to End unit of measure, .396 units for each Silence Component Self-Reference unit of measure and decreased .186 units for each Level of Experience unit of measure.

CHAPTER 4
DISCUSSION

The present study aimed to explore the perception of silence during psychotherapy sessions and to identify its personal and professional correlates for psychotherapists who practice in Turkey. Within the framework of this aim, the relationship between therapists' perception of silence and certain demographic and professional characteristics (e.g. age, theoretical orientation, level of experience) and their counter-transferential experiences were investigated.

The summary of results and related discussion will be presented in three parts: 1. Scale Development and Adaptation, 2. Correlates of Therapists' Silence Perception, and 3. Factors that Predict the Counter-transferential Reaction to a Silent Client.

4.1. SCALE DEVELOPMENTAND ADAPTATION

4.1.1. Silence Perception Questionnaire for Therapists (SPQ-T)

4.1.1.1. Summary of Results

A Silence Perception Questionnaire for Therapists (SPQ-T) was designed and used to assess therapists' perception of silence inside and outside the psychotherapy setting. An exploratory factor analysis was conducted, and reliability of SPQ-T was assessed with a sample of 129 participants, who were Turkish psychotherapists. The results suggested that SPQ-T was a reliable tool for the assessment of silence perception for therapists.

Four silence components were identified: Discomfort / Negativity and Anxiety / Urge to End, Appreciation, Self-Reference.The first component Discomfort / Negativity indicated negative feelings towards and/or discomfort with silence in the session. The second component Anxiety / Urge to End referred to heightened anxiety during and/or an urge to end the silence. The third component

Appreciation reflected a sense of positive regard for silence as well as an appreciation of it as a therapeutically productive. The fourth component Self-Reference included items in which the reason for silences was attributed to the therapist.

Internal consistency for each of the four components was examined. Discomfort / Negativity, Anxiety / Urge to End and Appreciation had high internal consistency as indicated by Cronbach's alphas of .76 and .89. Only the fourth component, Self-Reference, had a minimally acceptable internal consistency with the alpha of .67.

The silence components Discomfort / Negativity and Self-Reference had quite low means and ranges for the sample of this study, whereas Anxiety / Urge to End and Appreciation demonstrated a rather dispersed distribution with moderate means.

While designing the SPQ-T, how a therapist reacted to silence in general was also expected to be related to his or her silence perception in sessions. With the aim to capture and assess this attribute, certain items were designed and added to the SPQ-T. However, the Daily Silence Preference Sub-scale, which included those items, did not turn out to be a measure that is sensitive to individual differences, as indicated by a high mean and low reliability.

4.1.1.2. Discussion on Silence Perception Questionnaire for Therapists (SPQ-T)

The components derived from the SPQ-T were in line with the literature. The client's silence has been attributed to many meanings and feelings both negative and positive (Basch, 1980; Blos, 1972; Gill, 1984; Greenson, 1966; Ladany et al., 2004; Moursund, 1993; Reik, 1968) however, negative attributes were more frequently emphasized. As such, the data collected for this research also confirmed this tendency.

Two of the four components of SPQ-T, Discomfort / Negativity and Anxiety / Urge to End, accounting for 19 items of the 29 item scale, were related to more

negative aspects of silence, either feeling disappointment or discomfort with silence, expressed in the SPQ-T component Discomfort / Negativity or more specifically feelings of anxiety and tendency to escape silence and disengage, expressed in the SPQ-T component of Anxiety / Urge to End. Several authors have emphasized similar perceptions of silence in therapy. Fuller & Crowther (1998) presents clinical cases where the silent clients were perceived to convey inhibition, shame and fear and how that induced despair and frustration, helplessness and failure on the therapists' side and eventually caused a rejecting attitude towards their clients, dreading their arrival. Other clinical case presentations included; a silent client whose silence communicated early childhood conflicts around separation from mother with feelings of loneliness and fear of being abandoned (Busch, 1978; Fuller & Crowther, 1998); a silent client who was unemotional at first, went later into silence, communicating feelings of hopelessness and being flawed and leaving the therapist with tension and a desire to flee the room as well as with feelings of deadness and perceiving silence as trapping and torturing (Gilhooley, 1995; Lane et al., 2002), just to mention a few. As can also be observed in the examples cited above, this component included items that reflected a feeling of acting out on the part of the therapist with items such as "When a client becomes silent, I feel like immediately breaking it by saying something" and might also involve aversive attitudes on the part of the therapist by getting involved with his or her own thoughts and personal preoccupations and as such lose touch with the client (Blos, 1972).

The SPQ-T component Appreciation included items that reflected a sense of positive regard for silence (e.g. Silences during sessions make me happy) as well as an appreciation of it as a therapeutically productive moment (e.g. When a client becomes silent, I think he/she is absorbing what we've talked about). A qualitative study done by Ladany et al. (2004) which included several interviews conducted with therapists in the USA regarding their perception of using silence in therapy, also presented perceptions of silence, commonly agreed upon among participant therapists, as conveying empathy and facilitating reflection as well as supporting a sound therapeutic alliance. However, despite similar expectations in the current

study, the correlations showed that SPQ-T component Appreciation was negatively correlated with the therapist's level of experience and positively correlated with countertransference feelings of Overengaged / Protective, both of which suggested that this component might be reflecting an overly welcome attitude or attributing too many meanings to silence and in that way might be showing a tendency of feeling ambiguity towards silence rather than seeing it a positive event (Reik, 1968; Serani, 2000; Shafii, 1973; Zeligs, 1961) or even some sort of anxiety-related acting out on the part of the therapist as being overly engaged and protective (Fuller & Crowther, 1998).

The other SPQ-T component Self-Reference included items that reflected silence being attributed to the therapist, such as the therapist being the cause of the client's silence. In that way, this SPQ-T component also reflected an over involvement with silence. This component was found to be correlated with the total number of difficulties encountered during the therapy process and may be a sign of anxiety and/or burnout on the side of the therapist. This may also be related to the personality characteristics of the therapist, a sign of a narcissistic state or presence of depressive guilt, however this claim was not in the scope of this study to confirm.

When comparing the means of these four SPQ-T components, it was observed that Discomfort / Negativity and Self-Reference had quite low means and ranges for the sample of this study, whereas Anxiety / Urge to End and Appreciation demonstrated a rather dispersed distribution with higher means. This may show that, psychotherapists of Turkey perceived their clients' silence as a negative phenomenon and had heightened anxiety, thus an urge to end it and/or as a rather ambivalent situation with a seemingly appreciative, yet overly involved attitude. This might be due to a cultural idealization of silence in Turkey. However, further cross-cultural comparisons are needed to confirm this.

Contrary to expectations, the Daily Silence Preference Sub-scale, which included items to assess the general tendency of therapists toward silence did not turn out to be a measure that is sensitive to individual differences, as indicated by a high mean and low reliability. This may be due to the fact that the number and content coverage of the items were not enough to be able to selectively and correctly

measure this attribute. However, it can also be a cultural effect as silence is a commonly accepted phenomenon in Turkish culture and the participants were biased to respond with a positive regard toward silence in general. Knowing when to be silent is a sign of competence and a required attribute in the Turkish culture (Zeyrek, 2001).

4.1.2. The Adaptation and Psychometric Properties of Countertransference Questionnaire (CTQ)

4.1.2.1. Summary of Results

The study further aimed to investigate the therapists' counter-transferential reactions toward a silent client. For this aim, The Countertransference Questionnaire (CTQ), which is a 79-item self-report questionnaire, designed to assess countertransference patterns in psychotherapy by Betan et al. (2005) was used. The CTQ was first translated to Turkish and then an exploratory factor analysis was conducted to assess the factor structure and the reliability of Turkish version of the CTQ with a sample of 100 participants, who completed that part of the survey. The results suggested that the Turkish version of CTQ was a reliable tool for the assessment of countertransference reactions. Seven countertransference factors were identified using the same extraction and rotation methods as in the original study: Inadequate / Disengaged, Overengaged / Protective, Hostile / Mistreated, Erotic / Sexualized, Overwhelmed, Anxious / Fearful and Special.The first factor Inadequate / Disengaged indicated feelings of inadequacy or incompetence with a silent client and/or detachment during silence in session. The second factor Overengaged / Protective described wishes to protect and nurture and/or feelings of being overly engaged with the client during silences. The third factor Hostile / Mistreated reflected a sense of being devalued or unappreciated by the client during silence in sessions. The fourth factor Erotic / Sexualized described sexual feelings or a sexual tension during silence. The fifth factor Overwhelmed indicated feelings of dread and being overwhelmed. The sixth factor Anxious /

Fearful indicated feelings of anxiety as well as and fear. The seventh factor Special described a sense of seeing the client as special.

Internal consistency for each of the seven factors was examined. All seven factors, had high internal consistency as indicated by Cronbach's alphas that range between .715 and .954.

In terms of the descriptives of the CTQ factors; Inadequate / Disengaged, Overengaged / Protective, Overwhelmed and Anxious / Fearful all yielded a reasonable mean and variance for further analyses, with Overengaged / Protective having the highest mean. On the other hand, Hostile / Mistreated and Special countertransference reactions towards a silent client were reported as quite low for the majority of the sample. Erotic / Sexualized Countertransference scores did not even provide a distribution. Thus, these 3 factors were excluded from further analyses.

4.1.2.2. Discussion on theAdaptation and Psychometric Properties of Countertransference Questionnaire (CTQ)

The factor structure presented in this study for CTQ- TR was slightly different than the original published factors, but the changes were minimal and therefore they can be considered as clinically and theoretically coherent as in the case of the original study (Betan et al., 2005). The reason behind the emergence of a slightly different factor structure might be due the fact that the participants were instructed to respond to the CTQ, thinking of a client whose silence as noteworthy, instead of client from a specific diagnostic group or a client who evokes any strong countertransference reaction.

In the original study, Disengaged was a separate factor and Anxious / Fearful did not exist. In the current study, Disengaged was combined with the items of the CTQ factor Inadequate / Helpless; and thus, renamed as Inadequate / Disengaged. In addition, the CTQ factor Anxious / Fearful was extracted from original CTQ factors Overwhelmed/ Disorganized, Hostile / Mistreated, and

Helpless / Inadequate and represented a distinct factor when countertransference toward silent client was considered.

The items that constituted two separate CTQ factors, Positive / Satisfying and Parental / Protective were grouped under one factor in this study that was labeled as Overengaged / Protective. This might be attributed to two factors. First, therapists of this culture might be overly nurturing, i.e. overengaged and protective compared to therapists in Western cultures. The Turkish culture and family is represented with high degree of proximity, reflecting a high density and emotional reactivity within relationships (Fisek, 1991; 1995), in which context the self is familial and connected (Fisek, 1995), where the individual finds selfhood in relation to family, in contrast to individual self with autonomous existence and contractual equal relationships (Roland, 1988). This has implications for therapy as having control and nurturance as goals to attain on the part of the client (Roland, 1988). Further, in the psychotherapy setting, the therapist is subject to biases of his/her own cultural context, which influence his approach to selfhood and relationships. As such, it may be no surprise that Turkish therapists might be overly nurturing compared to their Western colleagues. This nurturing attitude reflecting familial proximity can manifest in an increased wish for mirroring (Kohut, 1977; Roland, 1988), for being understood when in silence, and for being accepted (Fisek & Kagitcibasi, 1999). Furthermore, the label of the CTQ factor in the original study as Positive was kind of misleading since many items represented a “special” and/or “exaggerated” quality.

Among the CTQ factors, Anxious / Fearful and Overwhelmed have similarities to characteristic countertransference responses to Cluster B clients, with disorganized or avoidant attachment in young children and unresolved ones in adults (Betan et al. 2005; Cassidy & Mohr, 2001; Main et al., 1985). The CTQ factors Sexualized, Overengaged / Protective and Special are associated with intimacy as well as entrapment in the therapeutic setting; a complexity which can be clinically observed (Betan el al., 2005). The original factor Positive / Satisfying did not appear separately in the current study, but contributed to the factor Overengaged / Protective, which included items that reflected an overly nurturing

attitude. This might support the earlier argument that the participants tended to report negative aspects of their perception of silence, which contributed to rather negative countertransference reactions. Whether this was solely due to their perceiving silence as negative or also to the fact that the SPQ-T did not have enough items to capture this attribute is debatable.

When the means of the CTQ factors were examined, CTQ factor Overengaged / Protective stood distinctively higher than the other factors' means. This may be due to the fact that Turkish therapists may be culturally more nurturing and as such more overengaged and protective with their clients in general, an argument presented above in terms of the collective and high proximity attributes of Turkish culture and within the more familial self of Turkish individuals as compared to more individual self in their Western counterparts (Fisek, 1991; 1995). CTQ factors Hostile / Mistreated, Special and Erotic / Sexualized towards a silent client were excluded from further analyses due to the first two having low means and the latter not even providing a distribution. The reason behind this could be a lower tendency to experience these counter-transferential feelings specifically with silent clients. Another reason could be that these feelings are experienced with silent clients, but therapists might have a tendency to deny these feelings or choose not to report them. Further studies that compare countertransference towards silent vs. non-silent clients are needed to shed light on this.

4.2. CORRELATES OF SILENCE PERCEPTION AND COUNTERTRANSFERENCE

4.2.1. Silence Perception, Countertransference toward a Silent Client and Demographic and Professional Characteristics of the Therapists

4.2.1.1. Summary of Results

The second part of the study investigated the professional and demographic correlates of therapists' silence perception and their countertransference reactions

toward silent clients. The investigated correlates were Age, Education, Theoretical Orientation, Work Setting, Client Population, Number of Clients, Level of Experience, and the overall areas of Difficulties.

With the components of SPQ-T, the correlations indicated a decrease in all aspects of perception of silence in sessions, except Self-Reference, as the age and experience increased. Self-Reference was only significantly correlated with the total number of difficulties. With regard to correlations of the components of SPQ-T with Education, Theoretical Orientation, Work Setting, and Client Population, it was observed that BA graduates all had higher means in all components of SPQ-T. A similar pattern was observed with therapists who worked with Just Child-Adolescents. Specifically, therapists who worked with Just Child - Adolescents perceived clients' silence as anxiety provoking and had an urge to end it, when compared with the therapists working with Just Adult or Mixed client populations

With the factors of CTQ, the correlations also indicated a decrease in all counter-transferential reactions as the age and experience increased. The therapists who were BA graduates, the therapists who worked with Insight-oriented / Expressive theoretical orientation and the ones who worked only with Child - Adolescent clients all had higher means for all four CTQ factors similar to the results obtained for SPQ-T components. Specifically, therapists who worked only with Children and Adolescents reported feeling significantly more overwhelmed and more anxious / fearful with their silent clients as compared to therapists working with just adults or mixed populations. The results also showed that the PhD graduates had a significantly lower Anxious / Fearful countertransference towards a silent client as compared to BA graduates when level of experience is controlled. Further, the therapists with Insight-oriented / Expressive theoretical orientation felt significantly more Overengaged / Protective in their countertransference reactions towards their silent clients when compared to therapists working with other theoretical orientations.

4.2.2.2. Discussion on Silence Perception, Countertransference toward a Silent Client and Demographic and Professional Characteristics of the Therapists

With the components of SPQ-T, the correlations indicated a decrease in all aspects of perception of silence in sessions, except Self-Reference, as the age and experience increased. This was expected with correlates of age and level of experience as it has been similarly reported in the literature that with experience, therapists typically thought they had become more flexible, comfortable and confident about using silence **(**Ladany et al., 2004). Self-Reference was not significantly correlated with any of the variables except with total number of difficulties. This meant that the therapists who had higher levels of difficulty had a higher tendency to interpret the client‘s silence as related to themselves. Both of these tendencies might be related to the therapists own personality dynamics as also mentioned above. However, this is beyond the scope of this study to comment as therapists' personality dynamics were not included as a variable in this study.

With regard to correlations of the components of SPQ-T with Education, Theoretical Orientation, Work Setting, and Client Population, it was observed that BA graduates all had higher means in all components of SPQ-T. This might suggest that silence perception was heightened in general with BA graduate therapists and may be explained with their low level of experience. Further, therapists who worked with Just Child - Adolescents perceived clients' silence as anxiety provoking and had an urge to end it, when compared with the therapists working with Just Adult or Mixed client populations. The reason behind this result may be related to what has been reported in the literature, that children are often more "silent" than adults and silence is more prevalent and at times more enduring while working with children (Wheeler Vega, 2013). As the silence prevails and becomes more enduring, it may create anxiety on the part of the therapist. The reasons that might be behind this finding are further explored below when countertransference reactions of therapists working with Child - Adolescent are discussed.

Similar to SPQ-T components, when CTQ factors' correlations with demographic and professional variables were considered, the results also indicated

a decrease in all counter-transferential reactions as the age and experience increased. Similar findings were reported in a study done by Brody & Farber (1996) that when compared to experienced clinicians, students and interns were more likely to feel that their countertransference emotions were too strong, too frequent, and needed to be defended against.

Findings of this study also showed that therapists who were BA graduates, the therapists that worked with Insight-oriented / Expressive theoretical orientation and the ones who worked only with Child - Adolescent clients all had higher means for all four CTQ factors.

The therapists who worked only with Children and Adolescents reported feeling significantly more overwhelmed and more anxious / fearful with their silent clients as compared to therapists working with just adults or mixed populations. Several authors in the field of child therapy highlighted the intensity of the therapist's countertransference reactions to child clients, which could create extra strain on the therapist (Bick, 1962; Bonovitz, 2009; Bornstein, 1948; Katz, 2000) and leave them vulnerable to heightened countertransference reactions in general, and to anxiety and guilt in particular, which makes them more susceptible to acting out with their child clients (Bonovitz, 2009).

Looking at the child therapy literature, several factors were identified that could explain the high intensity of the countertransference for therapists that work with child and adolescents.

First, in child therapy, communication is only partly verbal. Rather than verbal language, the child uses other means of expression, a symbolic level in play or bodily expression, which can more appropriately display their emotional experiences, rooting from earliest period of life and which might be conflictual and frightening (Piene et al., 1983). As such, the therapist is continuously involved, with little time for reflection. This has direct consequences on the degree of the therapist's exposure to countertransference feelings (Piene et al., 1983). Similarly, child clients communicate non-verbally through projective identification, as in the interaction of the parent-infant penetrating each other through projective and introjective identifications (Altman, 2002; Bonovitz, 2009; Pantone, 2000; Stern,

1995), which also result in intense countertransference reactions (Alvarez, 1983; Bonovitz, 2009; Ferro, 1999).

Second, the countertransference feelings in the therapists working with child clients are more complex than that of adult clients as they share the transference field not only with the child client, but also with the child's parents and other family members (Bonovitz, 2009), which could complicate and intensify countertransference reactions.

Third, although a child therapist may experience a similar range of emotions as with therapists with their adult clients, the intensity may be quite different due to heightened parental responsibility, protectiveness, and concerns about doing harm or damage towards a child client. These heightened concerns have the potential to interfere with the therapist's countertransference feelings (Bonovitz, 2009).

Fourth, therapeutic work with children and adolescents might re-surface the therapist's anxieties and feelings related to his or her own childhood, and as such can have a twofold influence of the child client's anxiety and relations with child client's inner objects (McCarthy, 1989).

Overall, the therapeutic work of the therapist with child clients can be more straining than with adult clients as there are greater demands on the therapist's contact with his own feelings and the therapist is more conducive to countertransference and the acting outofcountertransferencethan in adult analysis (Piene et al., 1983).

The results also showed that the PhD graduates had a significantly lower Anxious / Fearful countertransference towards a silent client as compared to BA graduates when level of experience is controlled. It could be argued that the doctorate education and/or the PhD title might provide the therapist with an increased level of confidence and decreased level of anxiety.

The results further showed that the therapists with Insight-oriented / Expressive theoretical orientation felt significantly more Overengaged / Protective in their countertransference reactions towards their silent clients when compared to therapists working with other theoretical orientations. This finding might come

unexpected at first, as psychodynamic analytic frame specifically prevents overengagement. However, the very same fact that the analytic frame prevents overengagement also encourages the therapist to become more aware of such feelings rather than deny them and limit any overengaged behavior. As such, the psychodynamic analytic frame provides a safe space for the therapist to experience these feelings.

4.2.2. The Association between Silence Perception and Countertransference with a Silent Client

4.2.2.1. Summary of Results

With regard to associations between components of therapists' perception of silence and their countertransference reactions toward silent clients, two points were observed. First, negative components of SPQ-T, Discomfort / Negativity and Anxiety / Urge to End as well as Self-Reference were all significantly and positively correlated with negative countertransference feelings of Inadequate / Disengaged, Hostile / Mistreated, Anxious / Fearful as well as countertransference reaction of Special. Second, the SPQ-T component Appreciation which included a positive regard for silence as well as an overly welcome or attributing too many meanings to silence was only associated with countertransference feelings of Overengaged / Protective, which suggested that for this population, this attribute related more to the latter.

4.2.2.2. Discussion on the Association between Silence Perception and Countertransference with a Silent Client

The observation of significant and positive correlations between the negative components of SPQ-T, Discomfort / Negativity and Anxiety / Urge to End as well as Self-Reference and the negative CTQ factors, Inadequate / Disengaged,

Hostile / Mistreated, Anxious / Fearful as well as countertransference reaction of Special was expected. This further supported the validity of the SPQ-TR.

Further, the SPQ-T component Appreciation which included a positive regard for silence as well as an overly welcome or attributing too many meanings to silence was only associated with countertransference feelings of Overengaged / Protective, which suggested that for this population, this attribute related more to the latter. However, as also mentioned above, CTQ factor Overengaged / Protective also included reactions that were labeled as Positive / Satisfying in the original study done by Betan et al. (2005) and in this respect a positive correlation with the SPQ-T component Appreciation would also be expected.

4.3. FACTORS THAT PREDICT COUNTER-TRANSFERENTIAL REACTION TOWARD A SILENT CLIENT

4.3.1.Summary of Results

The significant correlations between CTQ factors and certain professional factors as well as components of SPQ-T suggested that the therapist's perception of silence and professional characteristics such as level of experience, theoretical orientation and client population might predict their counter-transferential reactions. To assess this predictability, and their comparative strengths, four regression analyses were performed, which provided strong results.

The regression analyses showed that SPQ-T component Anxiety / Urge to End was a strong predictor of both of the CTQ factors Inadequate / Disengaged and Anxious / Fearful, accounting for 38% and 26% of the total variance in each factor respectively. Similarly, SPQ-T component Discomfort / Negativity was a predictor of both of the CTQ factors Overwhelmed and Overengaged / Protective, accounting for 15% and 4% of the total variance in each factor respectively. Having Insight-oriented / Expressive Theoretical orientation was a predictor only for CTQ factor Overengaged / Protective. Therapist's level of experience and SPQ-T component Self-Reference were both predictors only for CTQ factor Anxious / Fearful but for

no other factors. Similarly, Total Number of Difficulties and Working with Just Child-Adolescent Clients were predictors only for the CTQ factor Overwhelmed, but not for any other CTQ factors. SPQ-T component Appreciation was also a predictor only for Overengaged / Protective CTQ factor. Daily Silence Preference was not a predictor for any of the CTQ factors.

4.3.2. Discussion on Factors That Predict Counter-transferential Reaction Toward a Silent Client

In relation to the findings reported above for SPQ-T component Anxiety / Urge to End predicting both of the CTQ factors Inadequate / Disengaged and Anxious / Fearful, and, the SPQ-T component Discomfort / Negativity predicting both the CTQ factors Overwhelmed and Overengaged / Protective, it is reported in the literature that therapists who have countertransference feelings of helplessness and inadequacy also have a tendency to reject and disengage from their clients and often feel dread and anxiety about their arrival (Fuller & Crowther, 1998). It could be argued that this relationship would hold for all clients regardless of their being silent or not. In a study done by Rossberg et al. (2007), the results showed that the clients with Cluster A and B personality disorders were reported to evoke more negative and less positive countertransference reactions than those with Cluster C. Among clients with Cluster A and B personality disorders, borderline clients are specifically known to evoke a high degree of countertransference feelings of anger and irritation and the least degree of liking, empathy, and nurturance (Brody & Farber, 1996; McIntyre & Schwartz, 1988). The therapist may feel bored, angry, panicky or overwhelmed with borderline clients (McWilliams, 2011). Furthermore, borderline clients are known to communicate affect through nonverbal communication, which has similar characteristics of communication between mother and infant (McWilliams, 2011; Schore, 2003). Sherwood (1994) also describes quiet borderline clients who are compliant, insecure and have as-if personalities. These reports and findings from the literature can support the results found in this study that borderline clients who communicate characteristically

nonverbally, and whose silences might be noteworthy can evoke strong countertransference reactions of feeling inadequate, disengaged, anxious, fearful and overwhelmed.

It is also reported in the literature that silent clients project the need for containment, rather than projecting feelings in the unconscious hope of finding containment as in other clients, leaving the therapist carrying the need, and feeling helpless, puzzled and undermined in their therapeutic identity (Fuller & Crowther, 1998).

Alternatively, returning to the argument that the relationships described above would hold for all clients regardless of their being silent or not, an explanation could be made through silence having additional heightening effect on counter-transferential reactions (Fuller & Crowther, 1998; Lorenz, 1955; Zeligs, 1961). There are empirical studies done with not necessarily silent clients, which produced similar results to this study, examining which diagnoses and symptoms evoke specific countertransference reactions among therapists (Rossberg et al., 2010; Schwartz & Wendling, 2003). The study done by Rossberg et al. (2010) revealed that there were significant correlations between client symptoms of anxiety and countertransference reactions of being on guard, which could also be taken as disengaged, feeling inadequate as well as anxious and fearful. The study also showed significant correlations between symptoms of anger and hostility and countertransference reaction of being overwhelmed. However, the study did not include any regression analyses to compare comparative strengths.

The regression results showed that the therapists' tendency to interpret silence with Self-Reference could explain some of the variance in countertransference reaction of feeling Anxious / Fearful. As the therapists attribute a client's silences to themselves, it would be expected that they would feel anxious, however, no other empirical clinical study could be found to further support this finding.

The results further showed that the therapist's level of experience could also explain some of the variance in the CTQ factor Anxious / Fearful. The effect of

therapist's level of experience on feeling more confident and less anxious was already discussed before.

The finding that the therapists' perception of silence as Appreciation could explain some of the variance in countertransference reaction of feeling Overengaged / Protective supports the previous argument that the therapists' perception of silence as Appreciation had some ambivalent meaning. This component included items that reflected a positive regard for silence but also and maybe more so, included items that attributed an overly welcome or too many meanings to the client's silence. As such, it would be expected that having an overly welcome attitude or attributing too many meanings to silence would have associations to countertransference feelings of Overengaged / Protective.

Having Insight-oriented / Expressive theoretical orientation could also explain some of the variance in the countertransference factor Overengaged / Protective. The possible explanation for this relationship was discussed previously above.

Whether the therapist worked only with a Child / Adolescent clientele could predict a countertransference reaction of feeling Overwhelmed. Possible explanations to this finding were explored previously when the results of the correlation studies were discussed above.

Total number of difficulties further explained some of the variance in the CTQ factor Overwhelmed. In the study done by Rossberg et al. (2010), it was found that higher levels of client's symptoms, which might be closely related to their number of difficulties as perceived by the therapist, were related to lower levels of positive countertransference feelings and higher levels of negative countertransference feelings. In the same study it was argued from a symptom perspective that higher level of symptoms staying prevalent during the therapeutic process would weaken the therapeutic alliance as the relationship would be found disappointing, the therapist would feel less important and confident, more bored, overwhelmed and inadequate. Their finding of a strong relation between therapeutic change and countertransference supported this argument (Rossberg et al., 2010).

Similar argument could be made in this study in terms of total number of difficulties and countertransference factor Overwhelmed.

4.4. CLINICAL IMPLICATIONS

Silence is an inevitable part of the therapeutic process (Wheeler Vega, 2013) and has significance in the development of therapeutic alliance (Nacht, 1964; Shafii, 1973) as well as in the transference process (Arlow, 1961).

As reported in literature, different kinds, meanings and functions of silence may affect the therapeutic process differently. It is important to be able to assess whether it hinders or helps the process and how the therapist's interventions need to be in response (Coltart, 1991; Lane et al, 2002). If its purpose is to communicate, its relevance for the client may be explored through systematic inquiry (Hadda, 1991; Lane et al, 2002). Conversely, if it is more like a dream, to understand its content, it should be allowed and even encouraged (Sabbadini, 1991) and as such by listening to silence a true dialogue might emerge (Wilmer, 1995; Lane et al, 2002).

To be able to answer this technical question inspired by silence, whether the client is in need of the therapist's mutual participation in the silence or, alternatively, a facilitating comment upon it, the therapist needs to understand the silence occurring in that specific moment in the first place. The SPQ-T designed in this study is hoped to provide a preliminary tool to close this gap and help to ease tension mentioned in literature between allowing silence or attempting to foster speech (Fuller & Crowther, 1998; Bravesmith, 2012).

The second part of the study investigated the counter-transferential reactions to silence and how these correlated with the perception of silence. It is therapeutically significant to understand countertransference processes to capture interpersonal relational patterns in sessions, information about the client and the treatment process (Betan et. al., 2005). This study provides evidence of silence perception predicting countertransference reactions and as such can offer value in understanding countertransference with silent clients.

Findings implicate that as SPQ-T component Self-Reference was not common and also was correlated with total number of difficulties. In cases where therapists notice themselves perceiving their client's silence as attributing to themselves, they should investigate further. It might be a sign of burnout.

4.5. LIMITATIONS AND SUGGESTIONS FOR FURTHER RESEARCH

Although this study aimed to investigate therapists' perception of silence, not all attributes related to therapists were involved in the study. It is important to note that therapists' personality characteristics and family-of-origin experiences with silence may affect their perception of silence and moderate their understanding and subsequent use of silence effectively **(**Ladany et al., 2004). A similar study that takes into account the therapists' personality characteristics as well would be a valuable addition to understand their perception of silence. Specifically, as silence is reported to re-enact object relations within the transference-countertransference relationship between the therapist and the client (Arlow 1961; Kris, 1952; Lane et al., 2002; Wheeler Vega, 2013; Zeligs, 1961), a measure of therapists' object relational world could be a valuable addition to understand their perception of silence.

The study did not differentiate between silent clients apart from the fact that the participating therapists were asked about their client population. There was no direct question of what kind of a client (in terms of age, personality, presenting problem, socio economic status etc.) the participants had in mind when they answered the questions. Silence may have different meanings for different clients in accordance with their own dynamics and may provoke reactions related to the client (Gale & Sanchez, 2005). Therefore, investigating the client side might have been a valuable addition to this study.

Silence has been reported to have a heightening effect (Fuller & Crowther, 1998; Lorenz, 1955; Zeligs, 1961), an intensification of what is already there (Arlow, 1961). In that respect, a comparative study that involves silent and not so silent clients would be a valuable contribution to understand this effect.

It might also be helpful to distinguish between pauses and silences as they might relate to different meanings and therefore require a different technical stance. Some examples such as a theatrical pause, a pause following conjunctions, pauses after a comma, may all signal different things; narcissistic need (Brewer, 1894; Zeligs, 1961), defense (Wheeler Vega, 2013) to name a few. This study did not distinguish between these and looked at the silence phenomenon more in general and left it to the participant therapists' take on the meaning of a silent client. A more detailed study where silence was more operationally defined could provide valuable additions to current study.

A separate silence perception study with therapists working only with Just Child and Adolescents may also provide more insight as to why silences were found to be more overwhelming and anxiety provoking when working with this population. It is reported in the literature that children are often more silent than adults (Wheeler Vega, 2013) and they may be a different kind of population in terms of silence, requiring a more focused study to understand more about their silence. Child analysis and the play technique were developed while working with children clients, who were more silent than the usual adult (Wheeler & Vega, 2013). Similarly, a study more focused on child clients and their silence might provide more information in understanding silence in their context.

Time perception of the therapist might have correlations with how they perceive silence and investigating this possible association would be an interesting addition to this study.

Finally, a cross-cultural study investigating therapists' silence perception and its professional and counter-transferential correlates would provide valuable comparisons among therapists from different cultures.

CHAPTER 5
CONCLUSION

Silence is part of the therapeutic process like speech and may relate to different and at times opposing meanings for each client-therapist dyad as well as

at different times of the therapeutic process within the same dyad. Therefore understanding silence may enhance understanding the client and the therapeutic relationship and help the therapeutic process.

This study looked at the perception of client's silence from the perspective of the therapist. To investigate this perception, a Silence Perception Questionnaire for Therapists was developed. The results showed that SPQ-T was a valid and reliable measure of therapists' silence perception with clinically coherent factor structure.

Further, significant correlations were found between therapists' perception of silence, their professional and demographic characteristic as well as their corresponding countertransference reactions. On the basis of these significant correlations, a series of regression analyses were performed. The results showed that therapists' silence perception had significant predictive power in their countertransference reactions. Whether this predictive power was due to silence alone or silence acted as a heightening factor is left to be investigated in further studies.

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APPENDICES

APPENDIX A: Informed Consent Form

Sayın Katılımcı,

Bu araştırma İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı bünyesinde Yrd. Doç. Dr. Alev Çavdar Sideris danışmanlığında, Elif Emel Kurtuluş tarafından yürütülmektedir. Çalışmanın amacı terapistlerin terapi seanslarındaki sessizlik algısını etkileyen faktörleri araştırmaya yöneliktir. Bu amaç doğrultusunda katılımcılara, hem gündelik yaşamlarındaki hem de terapi seanslarındakisessizliklerdeki duygu, düşünce, tutum ve davranışları ile ilgili sorular sorulmaktadır. Çalışmanın amacına ulaşması için sizden beklenen, rahat hissettiğiniz sürece, bütün sorulara eksiksiz ve içtenlikle cevap vermenizdir.

Bu araştırmanın hiçbir aşamasında kimlik bilgileriniz sorulmayacaktır. Yanıtlar toplu halde ve sayısal olarak analiz edilecek ve sadece bilimsel araştırma ve yayın amacıyla kullanılacaktır.

Araştırmada demografik bilgi formu ve benzer konularda sorular içeren3 ölçek bulunmaktadır. Tüm soruları yanıtlamak yaklaşık 30dakika kadar sürmektedir. Soruların doğru veya yanlış cevabı yoktur.

Bu araştırmaya katılım tamamen gönüllülük esasına dayalıdır. Bu araştırmaya katılmayı tercih etmeyebilirsiniz. Araştırmanın herhangi bir aşamasında herhangi bir neden göstermeksizin araştırmaya katılmaktan vazgeçebilirsiniz. Bu durumda verileriniz kaydedilmeyecek ve/veya kapsam

dışında bırakılacaktır.Araştırmanın amacı, süreci veya sonuçları ile ilgili sorularınız için elifemel@hotmail.com email adresinden araştırmacıya ulaşabilirsiniz.

Değerli katkılarınız için teşekkürler.

Bu araştırmaya katılmayı kabul ediyor musunuz?

Evet

Hayır

APPENDIX B: Demographic Form

1. Yaşınız?

2. Cinsiyetiniz?

    Kadın

    Erkek

    Diğer

    Belirtmek istemiyorum

3. Eğitim durumunuz?

    Üniversite mezunu

    Yüksek lisans öğrencisi

    Yüksek lisans mezunu

    Doktora öğrencisi

    Doktora mezunu

    Diğer

4. Medeni durumunuz?

    Evli

    Bekar

    Boşanmış

    Diğer

5. Çocuk sahibi misiniz?

    Evet

    Hayır

6. Hangi ülkede yaşamaktasınız?

7. Mesleki ünvanınızı tanımlayan seçenekleri işaretleyin. Birden fazla seçenek işaretleyebilirsiniz.

   Psikoterapist

   Psikanalist

   Psikiyatrist

   Psikolojik danışman

   Klinik psikolog

8. Teorik yöneliminiz nedir? Birden fazla seçenek işaretleyebilirsiniz.

   Psikodinamik / Psikanalitik

   Sistemik

   Hümanistik / Varoluşçu

   Bilişsel-Davranışçı

   Çözüm odaklı

   Diğer (lütfen belirtin)

9. Nerede çalışmaktasınız? Birden fazla seçenek işaretleyebilirsiniz.

   Hastane / klinik

   Psikoterapi / danışmanlık merkezi

   Sivil Toplum Kuruluşu

   İlköğretim okulu / Lise

   Üniversite

   Belediye

   RAM

   Özel ofis

Diğer (lütfen belirtin)

10.Çoğunlukla çalıştığınız danışan popülasyonu kimler? Birden fazla seçenek işaretleyebilirsiniz.

Yetişkin

Ergen

Çocuk

Çift ve aileler

11. Haftada kaç danışan/hasta görmektesiniz?

12. Kaç yıldır danışan / hasta görmektesiniz?

13. Mesleki deneyim düzeyinizi en iyi tanımlayan seçeneği işaretleyin:

Çok deneyimsiz				Oldukça deneyimli
1	2	3	4	5

14. Gündelik yaşamınızı ciddi düzeyde etkileyen bir fiziksel sorununuz var mı?

Evet

Hayır

Evet ise lütfen belirtin_____

15. Gündelik yaşamınızı ciddi düzeyde etkileyen bir psikolojik sorununuz var mı?

Evet

Hayır

Evet ise lütfen belirtin_____

16. Sizi mesleki hayatınızda danışanlarla çalışırken en çok zorlayan konular hangileridir?

İntihar riski/ Kendisine ya da başkasına zarar verme

Erotik aktarım

Narsisist kırılmalar,

Güven-bağlanma meseleleri

Ayrışma/bireyselleşme meseleleri

Dürtüsellik

Öfke

Kayıp/yas

Kaygı

Depresif ruh hali

Sembiyotik ilişkilenme

Karşı cins ile ilişkiler

Güvensiz bağlanma

Sınırlarla ilgili meseleler

APPENDIX C: Silence Perception Questionnaire for Therapists (SPQ-TR)

Ölçek 1: Terapistlerin Sessizlik Algısı Ölçeği

Bu ölçek seans içinde sessizliklerde hissedilebileceğiniz duygu, düşünce ve tutumlara dair ifadeler içermektedir. Lütfen her ifadeyi okuyun ve yürüttüğünüz psikoterapi süreçlerinde ve günlük yaşamınızda bu ifadenin sizi ne kadar tanımladığını belirten seçeneği işaretleyin.
Aşağıdaki ölçeği kullanın:

Hiç tanımlamıyor	Az tanımlıyor	Orta derecede tanımlıyor	Çok tanımlıyor	Tam olarak tanımlıyor

1. Gündelik hayatımda, etrafımdaki insanlar sustuğunda konuşma başlatmam gerektiğini hissederim.
2. Bir danışanım sustuğunda benden utandığını düşündüğüm olur.
3. Bir danışanım sustuğunda kendine ait bir alana ihtiyaç duyduğunu düşünürüm.
4. Kaygılı bir danışanın susması, diğer danışanlara kıyasla, daha kolay gelir.
5. Seanslarda sessizlik olduğunda zihnimde görsel imgeler belirir.
6. Seanslarda sessizlik olduğunda fiziksel bir rahatsızlık hissederim (kas gerginliği, baş ağrısı, vb.)
7. Bir danışanım sustuğunda benden korktuğunu düşündüğüm olur.
8. Bir danışanım sustuğunda genellikle bir şeylerin ters gittiğini düşünürüm.
9. Bir danışanım sustuğunda genellikle konuştuğumuz şeyleri sindiriyor olduğunu düşünürüm.
10. Bir danışanım sustuğunda genellikle benimle sembiyotik bir ilişkiye girdiğini düşünürüm.

11. Seansta bir sessizlik olduğunda, terapist olarak başarısız ve/veya beceriksiz hissederim.
12. Seansta bir sessizlik olduğunda, aklıma başka danışanlarım gelir.
13.Sessizlik çoğunlukla olumsuz bir şeye gebedir.
14. Bir danışanım sessiz kaldığında müdahale edilmemesi gerektiğini düşünürüm.
15. Sessizlik hemen hemen her seansımda olur.
16. Gündelik hayatımda, sessizliği severim.
17. Beni zorlayan seanslarda danışanım sustuğunda rahatlama hissederim.
18. Depresif bir danışanım sessiz kaldığında, diğer danışanlara kıyasla, daha çok rahatsız olurum.
19. Danışanların sessizliği, sözleri kadar önemlidir.
20. Seanslardaki sessizlikler beni öfkelendirir.
21. Seanslardaki sessizlikler bana çaresiz hissettirir.
22. Sessizlik beni karşı cinsten danışanlarla iken daha çok rahatsız eder.
23. Seanslardaki sessizlikler beni korkutur.
24. Seanslardaki sessizlikler bana hayal kırıklığı hissettirir.
25. Bir danışanım sustuğunda benden bir cevap / tepki beklediğini düşünürüm.
27. Seanslardaki sessizlikler beni endişelendirir.
28. Seansta bir sessizlik olduğunda, danışanımın aklından neler geçtiğini tahmin etmeye çalışırım.
29. Seanslardaki sessizliklerde boşlukta gibi hissederim.
30. Sessizlik anlarında danışanımla göz göze gelmekten kaçınırım.
31. Seansta bir sessizlik olduğunda, ben bu sessizliğin nedenini düşünüyor olurum.
32. Gündelik hayatımda, sessizliğin iyileştirici olduğunu düşünürüm.
33. Seanslardaki sessizliklerin beni danışanımdan uzaklaştırdığını düşünürüm.
34. Seansta bir sessizlik olduğunda bir an önce bir şey söyleyerek sessizliği bozmak isterim.
35. Bir danışanım sustuğunda çoğunlukla önemli bir şey anlatmaya hazırlanıyor olduğunu düşünürüm.

36. Bir sessizlik olduğunda danışanımı konuşmaya başlaması için cesaretlendiririm.
37. Seanslardaki sessizlikler beni şaşırtır.
38. Danışanımla iyi bir ilişkim varsa sessiz kalmak daha kolay gelir.
39. Seansta sessizlik olduğunda konuşması gerekenin ben olduğumu düşünürüm.
40. Gündelik hayatımda, yanımda başkası varken sessizlik olması beni rahatsız eder.
41. Sessiz bir evde büyüdüm.
42. Seanslardaki sessizlikler beni utandırır.
43. Seansta sessizlik olduğunda konuşması gerekenin danışanım olduğunu düşünürüm.
44. Seanslardaki sessizlikler uzamaya başladığında endişe duyarım.
45. Bir danışanım sessizlikten rahatsız olmadıkça ben de olmam.
46. Seanslardaki sessizlikler beni mutlu eder.
47. Sessiz bir çocuk değildim.
48. Seanslarda kısa sessizlikler olduğunda rahatsız olurum.
49. Bir danışanım sustuğunda seanstan sıkıldığını düşündüğüm olur.
50. Bir danışanım sustuğunda bana kızdığını düşündüğüm olur.
51. Kendine zarar veren bir danışanımın susması, diğer danışanlara kıyasla, daha az endişe verir.
52. Bir danışanım sustuğunda zihninin benim söylediğim/yaptığım bir şeyle meşgul olduğunu düşünürüm.
53. Bir danışanım sustuğunda benden bir şey gizlediğini düşünürüm.
54. Seanslarda sessizlik olduğunda duygularımın ve dürtülerimin yoğunlaştığını hissederim.
55. Benden yaşça küçük bir danışanım sessiz kaldığında hiç rahatsız olmam.
56. Seans içinde sessizliklere ihtiyaç duyarım.
57. Travma geçmişi olan bir danışanım sessiz kaldığında, diğer danışanlara kıyasla, daha çok endişelenirim.

58. Seansta bir sessizlik olduğunda, seans/danışanla ilgisi olmayan şeyler düşünürüm.
59. Seanslardaki sessizliklerde engelleniyormuş gibi hissederim.
60. Terapi süreçleri ilerledikçe sessizlikte daha rahat hissetmeye başlarım.
61. Seanslarda uzun sessizlikler olması beni hiç rahatsız etmez.
62. Gündelik hayatımda sessizlik bana dünyadan kopmuş olduğumu hissettirir.
63. Sessizlikler esnasında karşımdakinin iç dünyasını daha iyi anlayabileceğimi düşünürüm.
64. Genelde bir toplulukta en sessiz ben olurum.
65. Seanslardaki sessizlikler sıklaştığında endişe duyarım.
66. Seanslardaki sessizlikler bana suçlu hissettirir.
67. Gündelik hayatımda, rahatlamak için müzik, TV gibi sesli aktiviteleri tercih ederim.
68. Bir danışanım sustuğunda bana küstüğünü düşündüğüm olur.
69. Gündelik hayatımda, bir ortam tamamen sessiz olduğunda rahatsız olurum.
70. Gündelik hayatımda, sessiz ortamlarda vakit geçirmeyi tercih ederim.

APPENDIX D: Countertransference Questionnaire – Turkish (CTQ-TR)

Ölçek 2: Karşı Aktarım Ölçeği

Bu ölçek seans içinde **sessizlikleri belirgin olan bir danışanınıza karşı** hissedilebileceğiniz duygu, düşünce ve tutumlara dair ifadeler içermektedir. Lütfen her ifadeyi okuyun ve yukarıda bir anınızı paylaşmış veya paylaşmamış olsanız da, yürüttüğünüz terapi sürecini ve sizi en iyi tanımlayan seçeneği işaretleyin.

Aşağıdaki ölçeği kullanın:

Hiç tanımlamıyor	Az tanımlıyor	Orta derecede tanımlıyor	Çok tanımlıyor	Tam olarak tanımlıyor

1. Tedaviden edindiği veya edinmesini beklediğim kazanımlarla ilgili çok umutluyum.
2. Bazı zamanlar ondan hoşlanmıyorum.
3. Onunla çalışmayı heyecan verici buluyorum.
4. Ona karşı merhamet hissediyorum.
5. Keşke onu hiç hasta olarak almamış olsaydım.
6. Kale alınmamış ya da değersizleştirilmiş hissediyorum.
7. Eğer danışanım olmasaydı, onunla arkadaş olabileceğimi düşünebilirim.
8. Onunla olduğum seanslarda sinir olmuş hissediyorum.
9. Onun seanslarında tam olarak angaje olmuş hissetmiyorum.
10. Onunla olan seanslarda kafası karışmış hissediyorum.

11. Bana söylediklerine güvenmiyorum.
12. Onun tarafından eleştirildiğimi hissediyorum.
13. Onunla seansları korkuyla bekliyorum.
14. Onun hayatındaki kişilere öfke duyuyorum.
15. Ona karşı öfke hissediyorum.
16. Onunla olan seanslarda sıkılmış hissediyorum.
17. Ona cinsel bir çekim hissediyorum.
18. Onunla seanslarda depresif hissediyorum.
19. Onunla olan seansları sabırsızlıkla bekliyorum.
20. Ona haset duyuyorum, ya da onunla rekabete giriyorum.
21. Keşke ona başkalarının asla verememiş olduklarını verebilseydim.
22. Onunla seanslarda hüsrana uğramış hissediyorum.
23. Bana kendimle ilgili iyi hissettiriyor.
24. Ona karşı hissettiklerim nedeniyle suçlu hissediyorum.
25. Aklım sıklıkla onun anlattıklarından başka şeylere kayıyor.
26. Onun güçlü duyguları karşısında boğuluyorum.
27. Ona karşı çileden çıkıyorum.
28. Sıkıntıda olduğunda veya durumu kötüye gittiğinde, sanki bir şekilde sorumlusu benmişim gibi, kendimi suçlu hissediyorum.
29. Bende güçlü duygular canlandırıyor.
30. Onunla çalışırken kaygılı hissediyorum.
31. Ona yardım etmeyi beceremediğimi hissediyorum veya ona yardım edemeyeceğime dair endişeleniyorum.

32. Bana duyduğu cinsel hisler beni endişeli ya da rahatsız yapıyor.
33. Onun tarafından kullanılmış veya manipüle edilmiş hissediyorum.
34. Onunlayken yanlış bir şey söylersem patlayacak, dağılacak ya da çekip gidecek korkusuyla parmak ucunda yürür gibi hissediyorum.
35. Beni korkutuyor.
36. Onunla çalışırken kendimi eksik ve yetersiz hissediyorum.
37. Onula kendimi kontrolcü olurken buluyorum.
38. Kendimi değiş tokuş edilebilir hissediyorum, onun için herhangi birisiymişim gibi.
39. Agresif ya da eleştirel bir şey söylememek ya da yapmamak için kendimi durdurmam gerekiyor.
40. Onu anladığımı hissediyorum.
41. Ona kızgın olduğumu söylüyorum.
42. Onu korumak istediğimi hissediyorum.
43. Ona söylemiş olduğum şeylerden pişmanlık duyuyorum.
44. Ona karşı insafsız ya da acımasız olduğumu hissediyorum.
45. İfade ettiği duygularla ilişki kurmakta güçlük çekiyorum.
46. Onun tarafından kötü davranılmış veya taciz edilmiş gibi hissediyorum.
47. Kendimi ona karşı besleyici hissediyorum.
48. Onunlayken sinirime hakim olamıyorum.
49. Onunla seanslarda üzgün hissediyorum.
50. Onu sevdiğimi ona söylüyorum.
51. Onun ihtiyaçları karşısında boğuluyorum.

52. Onunla çalışırken kendimi ümitsiz hissediyorum.

53. Onunla olan seanslardan sonra kendimi hoşnut ve tatmin olmuş hissediyorum.

54. Başka bir terapistle veya başka tarz bir terapiyle onun daha iyi olacağını düşünüyorum.

55. Ona karşı çok sıkı sınırlar koymaya itildiğimi hissediyorum.

56.Kendimi onunla flört eder buluyorum.

57. Onunla çalışıyorken kendimi içerlemiş hissediyorum.

58. Terapiyi bitirmeyi düşünüyor ya da hayal ediyorum.

59. Elim kolum bağlanmış gibi ya da çözülmesi imkansız biçimde bağlanmışım gibi hissediyorum.

60. Telefon mesajlarıma bakarken ondan bir mesaj gelmiş olma ihtimaline karşı endişe ya da dehşet hissediyorum.

61. Odada cinsel bir gerilim hissediyorum.

62. Onun itici olduğunu hissediyorum.

63. Onun tarafından takdir edilmemiş hissediyorum.

64. Ona karşı sıcak, nerdeyse ebeveyn gibi, hislerim var.

65. Onu çok seviyorum.

66. Seanslardan sonra onunla ilgili diğer hastalarımla olduğundan daha fazla endişeleniyorum.

67. Onun seanslarını, diğer hastalarımla yaptığımdan daha fazla, süreyi aştıktan sonra bitiriyorum.

68. Diğer hastalarıma kıyasla ona yardım etmekte daha az başarılı hissediyorum.

69. Başka hastalarla yapmayacağım şekilde onun için bir şeyler yapıyorum ya da fazladan çaba gösteriyorum.
70. Onun aramalarına diğer hastalarımınkilere döndüğüm kadar çabuk dönmüyorum.
71. Onunla olduğumda kendi hislerimi diğer hastalarla olduğundan daha fazla açığa vuruyorum.
72. Terapi seansları arasında onu diğer hastalarıma kıyasla daha çok arıyorum.
73. Süpervizör ve meslektaşlarımla onu diğer hastalardan daha sık tartıştığımı fark ediyorum.
74. Benim en sevdiğim hastalarımdan biridir.
75. Diğer hastalarıma kıyasla onunlayken daha fazla gözüm saatte oluyor.
76. Diğer hastalara kıyasla ona özel hayatımla ilgili daha çok şey söylüyorum.
77. Bir çok hastayla olduğundan daha sık, kendimi seans bittikten sonrasına kadar farkına varamadığım şeylerin içine çekilmiş hissediyorum.
78. Onunla seanslara, diğer hastalara kıyasla, daha fazla geç başlıyorum.
79. Eşim ya da partnerimle onun hakkında diğer hastalardan daha fazla konuşuyorum.

APPENDIX E: Countertransference Questionnaire – English (CTQ-TR)

1. I am very hopeful about the gains s/he is making or will likely make in treatment.

2. At times I dislike him/her.

3. I find it exciting working with him/her.

4. I feel compassion for him/her.

5. I wish I had never taken him/her on as a patient.

6. I feel dismissed or devalued.

7. If s/he were not my patient, I could imagine being friends with him/her.

8. I feel annoyed in sessions with him/her.

9. I don't feel fully engaged in sessions with him/her.

10. I feel confused in sessions with him/her.

11. I don't trust what s/he's telling me.

12. I feel criticized by him/her.

13. I dread sessions with him/her.

14. I feel angry at people in his/her life.

15. I feel angry at him/her.

16. I feel bored in sessions with him/her.

17. I feel sexually attracted to him/her.

18. I feel depressed in sessions with him/her.

19. I look forward to sessions with him/her.

20. I feel envious of, or competitive with him/her.

21. I wish I could give him/her what others never could.

22. I feel frustrated in sessions with him/her.

23. S/he makes me feel good about myself.

24. I feel guilty about my feelings toward him/her.

25. My mind often wanders to things other than what s/he is talking about.

26. I feel overwhelmed by his/her strong emotions.

27. I get enraged at him/her.

28. I feel guilty when s/he is distressed or deteriorates, as if I must be somehow responsible.

29. S/he tends to stir up strong feelings in me.

30. I feel anxious working with him/her.

31. I feel I am failing to help him/her or I worry that I won't be able to help him/her.

32. His/her sexual feelings toward me make me anxious or uncomfortable.

33. I feel used or manipulated by him/her.

34. I feel I am "walking on eggshells" around him/her, afraid that if I say the wrong thing s/he will explode, fall apart, or walk out.

35. S/he frightens me.

36. I feel incompetent or inadequate working with him/her.

37. I find myself being controlling with him/her.

38. I feel interchangeable—that I could be anyone to him/her.

39. I have to stop myself from saying or doing something aggressive or critical.

40. I feel like I understand him/her.

41. I tell him/her I'm angry at him/her.

42. I feel like I want to protect him/her.

43. I regret things I have said to him/her.

44. I feel like I'm being mean or cruel to him/her.

45. I have trouble relating to the feelings s/he expresses.

46. I feel mistreated or abused by him/her.

47. I feel nurturant toward him/her.

48. I lose my temper with him/her.

49. I feel sad in sessions with him/her.

50. I tell him/her I love him/her.

51. I feel overwhelmed by his/her needs.

52. I feel hopeless working with him/her.

53. I feel pleased or satisfied after sessions with him/her.

54. I think s/he might do better with another therapist or in a different kind of therapy.

55. I feel pushed to set very firm limits with him/her.

56. I find myself being flirtatious with him/her.

57. I feel resentful working with him/her.

58. I think or fantasize about ending the treatment.

59. I feel like my hands have been tied or that I have been put in an impossible bind.

60. When checking my phone messages, I feel anxiety or dread that there will be one from him/her.

61. I feel sexual tension in the room.

62. I feel repulsed by him/her.

63. I feel unappreciated by him/her.

64. I have warm, almost parental feelings toward him/her.

65. I like him/her very much.

66. I worry about him/her after sessions more than other patients.

67. I end sessions overtime with him/her more than with my other patients.

68. I feel less successful helping him/her than other patients.

69. I do things for him/her, or go the extra mile for him/her, in ways that I don't do for other patients.

70. I return his/her phone calls less promptly than I do with my other patients.

71. I disclose my feelings with him/her more than with other patients.

72. I call him/her between sessions more than my other patients.

73. I find myself discussing him/her more with colleagues or supervisors than my other patients.

74. S/he is one of my favorite patients.

75. I watch the clock with him/her more than with my other patients.

76. I self-disclose more about my personal life with him/her than with my other patients.

77. More than with most patients, I feel like I've been pulled into things that I didn't realize until after the session was over.

78. I begin sessions late with him/her more than with my other patients.

79. I talk about him/her with my spouse or significant other more than my other patients.

ETİK KURUL DEĞERLENDİRME SONUCU/RESULT OF EVALUATION BY THE ETHICS COMMITTEE

(Bu bölüm İstanbul Bilgi Üniversitesi İnsan Araştırmaları Etik Kurul tarafından doldurulacaktır /This section to be completed by the Committee on Ethics in research on Humans)

Başvuru Sahibi / Applicant: Elif Emel Kurtuluş

Proje Başlığı / Project Title: Therapists' Perception of Silence in Psychotherapy Sessions

Proje No. / Project Number: 2017-20024-96

1.	Herhangi bir değişikliğe gerek yoktur / There is no need for revision	XX
2.	Red/ Application Rejected Reddin gerekçesi / Reason for Rejection	

Değerlendirme Tarihi / Date of Evaluation: 21 Kasım 2017

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