Silence in the Conversation

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Abstract

This paper explores the difficulties of working with clients who struggle to use words in the therapeutic context. How do we work with these difficult clients? I focus particularly on those clients whose organizing principles predispose them to using silence as a means of holding themselves together or who persist in using silence in dissociated ways, often when traumatic memory gets triggered. I present a clinical example, a "silent" client, as a way of developing the sense and feeling of silence in therapy and I explore how we can understand such "silent" clients. Concepts such as dissociation (our clients' and our own), intersubjective and interpersonal listening, and poetic and nonlinear conversation will be considered. Drawing particularly on Bromberg's and Meares' work I will then look at what the therapeutic task is with these clients.

> What is the source of our first suffering?
> It lies in the fact that we hesitated to speak.
> It was born when we accumulated silent things in us.
> Gaston Bachelar

This quotation captures something of the essence to which we, as therapists, orientate ourselves in the therapeutic conversation, particularly with those clients who struggle to speak in the sessions. Understanding why some clients are unable to speak, how we listen to 'silence', use it, orientate ourselves towards it, what it means, and how we might have a conversation with 'silence' are the questions I will explore.

I will focus on those clients who struggle to use words in the therapeutic context, particularly those clients whose organizing principles predispose them to using silence as a means of holding themselves together or who persist in using silence in dissociated ways, often when traumatic memory gets triggered. Such clients can be in considerable psychic distress and pose special challenges to the therapeutic endeavour.

Difficulties that arose with one such client of mine have inspired me to explore this topic. I have formulated specific questions around my 'silent' client in the hope of expanding my knowledge of how better to enter into a conversation with her and thus with clients of this nature in general.

For many of our clients there is bewilderment and significant distress at their inability to speak. It does not seem reasonable. What they don't understand is that due to the way our brain is designed, emotional life defeats reason. We are not usually speaking to the logical reasoned part of the brain but rather to its emotional life; therefore some creative way needs to be found in order to speak to this 'silence'.

Robert Hobson says: "The skill of a psychotherapist lies in his ability to learn the language of his patient and to help in creating a mutual language – a personal conversation" (1985:46). What does this language of silence mean? With no words to help us, how do we learn and understand this silent language? He also notes: "A therapist in action needs to draw upon a large repertoire of different ways of 'speaking' verbally and non-verbally" (1985:47). What repertoire do we need for the non-verbal encounters? How can we help our clients elaborate and transform their conversation?

When our clients are mostly silent, how can we establish what Meares believes to be the first aim of therapy, which is to "establish a form of relatedness in which the experience of self emerges"? (2004:7). Korner puts it this way: "The sense of self is only possible through processes of mutual recognition through a system of self and others" (2003:18). What is it that our clients are expressing and needing us to recognize in their silence? Although at times we may be able to identify intrusion of traumatic memory, it is more difficult to achieve what Meares believes to be the second aim of therapy, which is to "integrate them into the ordinary ongoing dualistic consciousness" (2004:1). We need to find a way of helping our clients 'know' and express their thoughts so that they enter into the world proper.

Helen: a clinical example

Helen is an extremely thin, married, fifty-four year old mother of two adult children, who was referred for psychotherapy by her General Practitioner. At the time of writing, she had been seeing me twice weekly for almost four years. Helen suffered from a serious disorder of the self. Her history was one of agitation, depression, anorexia, somatisation and self harm. She had several long admissions to hospital. On presentation she told me rather angrily that her doctor had

instructed her to come but she was there under sufferance and although I sensed she was in considerable distress, both mentally and physically (she suffered severe headaches), it was difficult for her to tell me what was wrong.

It was in those early sessions that I found that one way I could help her to say a little was by asking some direct questions about her history. I rather naively inquired as to whether there had been other times in her life when she had found it impossible to speak - a question I thought might have been asked by others when she was treated in hospital. But she reported people working with her becoming angry with her silence, demanding that she speak and accusing her of not helping herself.

My timing must have been right for she was able to let me know that at the age of twelve she had been raped by her uncle. She felt deeply shamed and blamed herself, for she believed that if she had not frozen but had instead told him to leave her alone she might have been able to stop him. Much later in the therapy, after months of sessions where she spoke very few words, she was also able to tell me of being raped again, this time as a married woman, by a family "friend". Again she was deeply distressed at having been frozen, without words to ward him off. Unable to speak, she once more blamed herself. I wondered if, in part, her response to this trauma was dissociated. Bromberg states that to "freeze" is "one of the hallmarks of a dissociated response to trauma" (2003:690).

This inability to speak was re-enacted many times in the course of our therapy as was the way she came to think about it. Helen's inability to "act" and her sense of lack of agency influenced the way in which she viewed traumatic events in her life and in therapy. This further diminished her sense of value and worthiness. "Why couldn't I speak?" "Why can't I speak?" were constant sources of distress for Helen.

Helen lived with the trauma of growing up in an emotionally unresponsive environment. Her developmental history was one of neglect in which she lacked an attuned caretaker who could provide appropriate responsiveness to her own subjectivity. The second oldest of a large family, Helen's early memories were of having to keep everything to herself. Her early life experience meant that she had a self-organising and self-regulating system that predisposed her to being silent. Symington (1985) suggests that if a baby has the experience of a mother who is absent, or present but emotionally unable to contain the baby's distress, then the baby has to resort to ways of holding herself together. Perhaps silence was a system that held Helen together and helped her manage her anxieties. Her inner life was undeveloped and as a result she was stimulus entrapped.

At twelve, after the rape by her uncle, she began to exercise obsessively - this became a lifelong habit as did staying silent about her distressing feelings.

This information was hard won. In most of our sessions, Helen experienced herself as being hopelessly silent. I too could feel hopeless as week after week, month after month, year after year, a significant part of each session was taken up with us grappling with Helen's difficulty in giving voice to the distress she was feeling inside. To make matters worse, not only did traumatic memories return in the silence, but our silence in the sessions resembled the original traumatic experience and so further triggered her traumatic memory system. My own silence was not experienced as a sanctuary by Helen, rather it brought a constant tension. If the silence continued for too long Helen would cry out "Leave me alone", as if I was her silent abuser. There were times when I too feared I might be an abuser as we sat in this unbearable silence. When her defences did break down and she was able to speak she was left feeling exposed, confused, depressed, anxious and at risk of fragmentation.

The trauma memories, when described, were "script-like", stunted, without the progressive, sequencing quality of a true narrative. Her traumatic memory system was organized around negative self attributes. It was repetitive and invariant. It was a difficult place for her (and often me) to be. She was ashamed of her difficulty in speaking. Before she came to the session she would tell herself that she would speak this time, but when she was there the overwhelming feeling tended to be that it was better to say nothing or worse still, she simply had no words to describe what was happening inside. It was terrifying for she feared "losing control". In those moments it was as if her reflective capacity was wiped out. She suffered terribly. When she was able to speak she told of her desperate feelings of agitation, shame and acute physical pain. She also spoke of her suicidal thoughts.

There were times when I felt at a loss as to how to convey my understanding of her and yet other times where we became out of reach of each other and I could not even guess at what was in her mind. I could only use my own countertransference feelings and imagine how out of touch, isolated and ineffectual Helen might feel. At these times I would feel responsible for not grasping what was going on and worried that I was cruel to put her through this therapy.

Discussion

In order to have a conversation with Helen's silence and to understand what her silence actually meant I had to confront several problematical issues. Clients such

as Helen seem to have evolved the powerful organizing principle that it is not safe to speak. This traps them in their silence. We often (initially at least) have to guess at the reasons why this has occurred. They do not have an adequate self-structure or 'psychic headquarters' with which to symbolise experiences. To complicate matters further the silence often occurs when these clients are dissociated. Hersch asserts "that dissociation is a very specific alteration in consciousness – one that involves at its core a loss of experience of self" (2202:94). How then do we create a sense of relatedness with such clients? How do we have a conversation with experience that is not yet symbolized? When our conversation is with silence, how can a self structure begin to develop and organizing principles be modified? If we understand that Helen's silence was often an enacted dissociated experience then what is it that she was enacting and how might we best have conversations with clients such as Helen whilst in these dissociated states?

Dissociation

It is important and useful to have a clear understanding of what dissociation means in this context. Freud made a considerable contribution to our understanding of dissociation with his "conviction that we have mental content outside of conscious awareness, which paradoxically affects our experience of ourselves, others and the world" (1998:17). Pulman (1992) has described the mechanism of dissociation which helps us cope with trauma as "the escape when there is no escape" (1998:104). Bromberg says:

> When ordinary adaptional adjustment to the task at hand is not possible, dissociation comes into play. The experience that is causing the incompatible perception and the emotion is "unhooked" from the cognitive processing system and remains raw data that is cognitively unsymbolised within the particular self-other representation, except as survival reaction." (1998:269).

Meares explains how this "unhooking" happens. He sees "dissociation, at its first appearance, as the manifestation of a subtle disorganisation of cerebral function brought about by the overpowering effect of the emotions associated with the traumatic event" (2000:44). Explained in this way, dissociation is not seen as a defence. The explanation that the prior experience of trauma creates a vulnerability which may lead to its recurrence gives insight into Helen's silence. It also involves changes in attention which Janet describes as a "contraction of the field of consciousness" (2000:45). We might understand Helen's retreat into a wordless 'self' as a process that Jackson calls "dissolution" (2000:48), whereby when environmental circumstances are unfavorable the self becomes stunted

and there is a retreat down the developmental and evolutionary pathway of the brain-mind system, leaving only the earliest, most primitive, preverbal memory systems functional. Meares (2000) describes this perceptual representational memory system as pre-reflective, highly accurate and specific, but automised and inflexible as was the case with Helen.

In order to stay empathically immersed so as to establish some form of relatedness with these clients we need to at least have some idea of the complexity of what is going on. This is a difficult task without the usual assistance of speech. Equally challenging is Helen's struggle to integrate her traumatic intrusions into her stream of consciousness without the aid of words.

Bromberg is helpful here. He reminds us that Helen's dissociated state, in particular her silence, is not fragmentation. Rather, in speaking, she feared fragmenting. Her silence was what held her together. Helen's dissociated traumatic system seemed so firmly established that there were times when it felt that change was impossible. This makes more sense when we understand that clients such as Helen have a personality organised more around a dissociative mental structure rather than around conflict which, according to Bromberg, means that there is a greater resistance to losing their depressive reality.

Intersubjective and interpersonal listening

All that we have to go with when these clients are silent is the feeling that arises between us - what Anthony Korner (2003) calls the language of "primary intersubjectivity". Meares says that "privilege must be given to feeling-tone and how it arises in particular forms of relatedness" (2000:75). Bromberg (1994) suggests that what we need is "an interpersonal and intersubjective listening stance". Laub and Auerhahn (1989) stress the need for us to be receptive and authentic.

When I listened to Helen she certainly conveyed something. Her facial expressions, her breathing and her body posture gave me some clues. Her deep despair and distress were palpable. Sometimes there were no words. At other times I sensed she was remembering the trauma and at yet other times I felt as though I was doing something cruel to her. There were periods when it felt as though Helen was controlling me and forcing me to speak. Bromberg (1994) describes eloquently what was happening during such times.

He says:

> In the interplay of silence and words, a patient can, at least potentially, force the analyst to give up his attempts to 'understand' his patient and allow himself to 'know' his patient – to know him in the only way possible – through the ongoing intersubjective field they are sharing at that moment (1998:523).

Often in these moments my sense of her despair and my genuine compassion for her distress was communicated without words but 'felt' between us.

For Helen there were often times when her attempts to convey in words how she was feeling felt futile. It was not till some time into the therapy that I realised it was also futile for me to try to put words to what I supposed were her experiences. My anxiety to translate recognition of this state into understanding and to give her my own words was not always helpful. It was as if I was trying to catch not a fact but a feeling, but this feeling had no words. I was to come to understand that this was not an empathic stance.

Laub's and Auerhahn's article "Failed Empathy" (1989) speaks to this. They explain that when memories of the traumatic past break through they can be neither absorbed nor organized. Discussing the past can feel like reliving it again. They emphasise, like others, the importance of our client's ability to sense some form of relatedness with a 'good other' who can hold things together. No wonder it takes time to work with clients such as Helen, for the capacity to trust has to be rebuilt in the therapeutic relationship.

Laub and Auerhahn also describe how survivors of trauma "remember their experiences through a prism of fragmentation and usually recount them only in fragments" (1989:386). It makes perfect sense that these clients who have suffered severe trauma have a diminished sense of self given that, as Meares explains, "memory, at least a certain kind of memory, unifies the multitudinous atoms of experienced data, past and present, that make up the flow of inner life" (2000:32). Little wonder that, with a depleted inner life, there are times when there is nothing to say. As Helen put it, "there is nothing there".

Symington believes that babies can develop primitive survival mechanisms that hold them together. These mechanisms develop in the absence of a reliable good object and so a belief (or organizing principle) "in having to do it [hold oneself together] oneself becomes so ingrained that it is difficult for anyone to get through to the fragility underneath" (1985:133). Helen, when silent, was frequently overcome with a feeling that it was better to keep things to herself and that I could not help her for she "needed to do it on her own".

Being able to turn such fragments of memory into a cohesive story or narrative is one of the aims of therapy. It requires the capacity to be alone so that clients can become attuned to what is happening inside but for clients such as Helen, and Helen states this, being alone is terrifying. The therapeutic relationship is perhaps the first time Helen has had the experience of a reliable "good object", or selfobject, to enable her to tolerate being alone with her experience. Winnicott states "that the capacity to be alone is based on the experience of being alone in the presence of someone and that without a sufficiency of this experience the capacity to be alone cannot develop" (1985:33). Meares (1992) notes that this is a prerequisite for exploration and play. To have a sufficiency of such experience will take time, which perhaps explains why therapy with these clients progresses slowly.

As Helen became able to feel held by silence rather than feel isolated, these silent pauses in our sessions would be of a quite different quality. They would be more like pregnant pauses before the birth of something new, the awakenings of an inner life and growing sense of self. Knowing this helped me hold on to myself when progress seemed so slow. It gave me some understanding about what it was we were aiming for as well as hope that if I could stay with her for long enough we would get somewhere.

Despite this knowledge there continued to be moments when I felt that I failed Helen dismally by being unable to stay with her. The intersubjective space was at times unbearable for me and Helen's great fear that I would not be able to tolerate her silences became real. What she needed to know was that even in this silence I hadn't given up trying. It was when I could stay with her that something important seemed to be happening. Bromberg remarks that "through the forced involvement with what the patient needs to call attention to without communicative speech, the dissociated self can start to exist" (1998:526). Meares' concept of helping our clients integrate the traumatic memory systems into "self as the stream of consciousness" (2000:4) has its beginnings in these moments.

Where there are no words

Psychic structure, in part, is organised by trauma. Meares explains that the more severe traumata will be represented in the perceptual representation and procedural systems of memory where no words exist. It is not then surprising that some trauma can be wordless. When our clients move into these silent dissociated spaces they often return to the "trauma zone" (Meares) where the intensity of their anxiety wipes out all sense of their inner life and they experience

what both Meares and Bromberg describe as "not-me" states of mind. Bromberg says these states of mind, in order "to be taken as objects of self-reflection ... must first become 'thinkable' while becoming linguistically communicable through enactment in the analytic relationship" (1985:539). Until this happens, this traumatic dissociated state continues to be repeated. Freud first noticed this when he spoke of repetition compulsion. Chu (1991) states that trauma that is dissociated gets repeated.

Silent enactment is a state of consciousness that has its own relational context. It brings with it particular difficulties when in a dissociated form because without the language, thought or spoken, it is not possible to move into the "play-space", for neither client nor therapist can know what this enactment symbolises. All Helen and I had to work with was what was going on between us in the silence and sometimes the only thing I had to go on was what it felt like was being done to me. There were often times when this was gruelling as I sat and experienced the excruciating depth of her psychic pain and despair. How were we to move to something that was known and that could be symbolized so that we could work with it together in the play-space?

Although Helen continued to be constrained by the powerful organizing principle that it was dangerous for her to speak she was eventually able to spend the first few minutes of each session talking of quite ordinary things. It could be about the traffic on the way to the session. She was delighted to discover that we both took the same route. At other times it could be the weather. As her sense of connectedness to me strengthened these conversations lengthened, were more affect laden and contained some personal details – for example she might tell of a problem she had with her demanding mother or what she had done with her beloved granddaughter, though she appeared secretive about such things.

Eventually, whether it was two minutes or ten minutes into the session Helen would plummet into silence and the Helen who had been with me just a second before would effectively disappear. It was as if this affective shift signaled the presence of a self state that was not only disjunctive with the one preceding it, but also relatively inaccessible to it. Because of the discontinuous realities that trauma and dissociation breed they are not amenable to interpretation.

At times Helen was able to say that whilst in these states she was often unable to think - there were no words. She might begin a session with something she wished to speak about, even longed to give voice to, but when the time came the words could disappear or there could be an over-riding thought, "don't tell anyone" – a warning both perpetrators had given her. At other times she would

be overcome with the thought that it would make no difference to her distress if she spoke, even though in other moments when not dissociated she knew it to be helpful. There were yet other times when she felt I would not be interested or that she was a burden and I would find her "too much" or that she could harm me. All this made sense in the context of Helen's early traumatic, unattuned environment. I understood this also in the context of Helen's personality which was organized by dissociative protection against trauma so that she was prone to these shifts in states of consciousness.

Occasionally an unattuned response from me might cause this shift but mostly it was her internal narrative that was the trigger. What was difficult was that while in this state Helen's ability to reflect – what Meares (2002) calls doubleness – was wiped out. There were many things that Helen felt shamed by and she feared fragmenting if she spoke them out loud – the sexual abuse, the hatred towards her mother, her inability to cope, her suicidal thoughts, her agitation, her resentments to name but a few. There were times when Helen was able to articulate a thought, feeling or memory but the fear of being shamed could trigger these dissociated states.

Poetic, nonlinear conversation

How was I to speak to such states? Apart from attempting to stay empathically attuned I recognised that using metaphor, elaborating and noticing the multi-layered meanings and feeling tone within words seemed important. Lewis, Armini, Lannon suggest that poetry, with its nonlinear, associational form, is one of the few languages that 'speaks' to the emotional mind. "Poetry transpires at the juncture between feeling and understanding – and so does the bulk of emotional life" (2000:4). Bromberg suggests that one of the goals as an analyst is "to enable our patients to experience a spontaneous overflow of powerful feelings [Wordsworth's definition of poetry] as safe rather than shame ridden" (2003:708). He adds that to help our clients "transmute traumatic affect into a potential for poetry" is one of the aims of therapy.

My listening stance, too, needed to be nonlinear so that I could recognize and then begin tentatively to explore these shifts within a relational context using Helen's transference and my own countertransference responses. I looked for subtle shifts in bodily movements and facial expressions. It was not always easy as several dissociated states seem to occur almost simultaneously and I needed to remain mindful of them all. But when I was able to notice and give voice to what was happening in the immediacy of the moment the therapy came alive.

It has been a slow process, but there are now moments when we are able to work together like this. In this relational context my willingness to explore, value and understand her feelings has been a new experience for Helen. Unlike the traumatic process, with what Meares describes as "shifting, oscillating and discontinuous forms of relatedness" (2000:92) what Helen needs to experience is a stable form of relatedness to me. It allows us to put some tentative language around what is happening out of which a new kind of story, a 'narrative', can evolve. Moments when Helen gets a glimpse of a cognitive insight are precious, as they are when she understands and experiences herself in a new way and experiences a new form of relatedness with me. At these times a small step forward enables Helen to move from a dissociated state to a more integrated one.

In Bromberg's words, "Dissociated domains of self can achieve symbolization only through enactment in a relational context because experience becomes symbolized not by words themselves but by the new relational context that the words come to represent" (1998:534). I would add that this process needs to happen time and time again. Bromberg also notes that the process of moving from dissociation to conflict and integration requires "the use of language in the act of constructing cognitive meaning from experience" (1998:535).

Laub and Auerhahn (1989) explain the difficulty of putting words to the recurring traumatic memories. When clients enter this zone it is as though they are in a "black hole" causing an effective blackout of the present. It is desolate and lonely. The sense of self is wiped out with little possibility for connectedness or creativity. Meares believes that in those who have suffered severe trauma "the state of self is diminished or almost lost" (2000:92).

Therapeutic task

What then is the therapeutic task with such clients? Laub and Auerhahn believe that "the therapist must take the integrative step and lead the reconstructive process more actively than he or she would normally" (1989:389). This helped me articulate my own questions. For example, when Helen called out in the silence "leave me alone", could I have helped her integrate this into something more coherent by putting into words what was happening and tentatively verbalizing my thoughts that as she relived the trauma she was trying to tell me that she wished she could have told her attackers to leave her alone? Or could I have suggested that she was saying to me what she wished she had been able to say to her abusers? Rather than waiting for her to come to this herself as I ordinarily would with other clients it seemed that at the right moment it might

be useful to speak these things with Helen. It does not seem to contradict an empathic stance but rather to strengthen it by giving Helen a way of putting words to what might be happening when she was not yet able to symbolize through language. Feeling deeply understood by me would simultaneously strengthen our relatedness.

Wolf (1993) states that it is not whether a verbal statement reaches the client's unconscious that is most important but rather the experience evoked by the statement. It appeared helpful and soothing for Helen when she moved out of her dissociated state at the end of the session to occasionally provide her with an explanation particularly around her guilty feelings – for example, my explaining that being raped at twelve would make her especially vulnerable to freezing again as an adult. As Nolan eloquently says, this facilitated "a disentanglement from a traumatic system as well as a reconnection to others [me], self and life" (2002:9). As Helen was unable to reflect or think about this it was as if I undertook to do this task for her, modeling how to 'double 'so that, little by little, this would be taken in and assimilated by her. In addition it would leave her with the experience that I did not judge her. There is general agreement in the literature that it is the relationship with our clients which is all important. Laub and Auerhahn write of these clients' need to know we are involved with them and of how harmful analytic neutrality can be. They go on to say that "The task of the therapist working with a traumatized individual is to re-establish relations which would result in the reinstatement of symbolization and wishing" (1989:391).

How we do this with our silent clients is more complex, although the Conversational Model gives us some clues as to our analytic stance. Meares suggests that the client's experience of resonance when we converse in a style rather like the "proto-conversation" can have a transformational effect. If we are to think of the early conversation with our babies there may be no words, only the expression of face and eyes, the movement of our body, the tone of our voice, abbreviated or incomplete sentences. We are somehow 'right in there'. Using our imagination and flow of feelings, our conversation and listening stance is not unlike poetry. We are involved with our child's experience in an ongoing way. Not only what we do but how we 'are' is perhaps the process that Bromberg describes as "the 'knowing' one's patient through direct relatedness ...so that those aspects of self that can not 'speak' will find a voice" (1998:536). In this way we can be the selfobject our clients need.

Remaining involved in our client's world can be an exhausting and demanding task. There were times when I would feel frustrated and impatient with Helen's

silence. It could feel as though I was trying to force feed a baby who was stubbornly shutting her mouth. What Helen required was an authentic and receptive response to her distress. It was my understanding that it was more about not knowing how to open her mouth or trust that she could swallow something life-giving that helped me to take a more empathic stance. This matched more accurately and helped create "a feeling of fit" that would ultimately give value to Helen's experience and out of which meaning would emerge. Meares writes that "the feeling that gives value also gives meaning" (2000:68). Without meaning there can be no words. My own words, inadequate as they may have been, were necessary, for as with the child, these first words needed to be provided by another.

Before these first words can be spoken, even by the therapist, the client needs to feel as if the dissociated self-state holding the experience of the trauma is 'known' by them both. It is with the felt experience of being in the silence with our clients that we get to live through their inevitable enactment of the original trauma. This provides the best chance of having this unprocessed experience become a real memory. There were times when I was so immersed in Helen's world that my breathing or body posture replicated hers. We were in this preverbal state together. There were yet other moments when I consciously thought of this and was reminded of Meares' stance, which is that to mirror our clients' affective state, we need to attend to the minute particulars of their 'conversation'.

Bromberg explains why these clients experience often unbearable psychic distress. Because the mind experiences and retains these dissociated states of consciousness as a dread of what can happen or is happening, rather than as memories of what has happened, their world then becomes (through continual enactment of this experiential memory) a miniature version of the original trauma. For Helen this meant that she was in a constant state of tension and experienced a nameless dread (Bion:1967). There was no respite; she slept badly, remaining tense and vigilant, even in her sleep, on the outlook for attackers. She would hear noises that would paralyze her with fear, imagine men in her room and dream of being attacked by groups of men.

In the first few years of therapy she suffered from an unbearable sense of internal pressure, as if she could explode, trying to push the memories to the back of her mind. She did not always have words to describe what it was she was avoiding or if she did they could disappear once she entered into the memories. Whilst in such states contemplating speaking to me was terrifying as she feared the memories would become even more real or that she would fragment. There

could be weeks of silent sessions where she held something in her mind before she would be able to give voice to it. Each time it was as if I was forced into becoming involved in her excruciating psychic reality so that I could 'know' it. I would search for words to describe what I was feeling but could find none and so became speechless myself. We would share this intersubjective space together. It seemed that what Helen needed of me was my willingness to stay with this process so that she could have the experience of a "good enough" other creating a safe and consistent environment that she could rely on. It was the way we approached these dissociated traumatic memories rather than what was actually said that enabled change to slowly take place.

Bromberg further challenges us when he suggests that we need to think not only about our client's dissociative states but our own. He writes "therapeutic action depends on the freedom of the analyst to make optimal use of dissociation as an interpersonal process (the analyst's dissociative experience as well as the patient's) and, in so doing to maximize a patient's capacity to self-regulate affect in these areas where trauma has left its mark" (2003:707).

This stretched my thinking around Helen. My own supervisor often pointed out that there was something angry and resistant in Helen's silence but I seemed unable to 'know' this. Could I not bear to know about her anger? What of my own anger and frustration? Is this a dissociated aspect of myself? There had been an occasion when out of frustration I had said rather crossly to Helen that I wasn't a mind reader. On reflection, that was a time when Helen was able to respond with some words. Perhaps more of this co-constructed interaction of our various shifting self states, both mine and Helen's, was needed? Bromberg believes that in order for traumatic experience to be cognitively symbolized what is needed is "a 'safe-enough' interpersonal environment – one that has room for both analyst's affective authenticity and an enacted replaying and symbolization of the early traumatic experience that does not blindly reproduce the original outcome" (2003:708).

Change can occur, says Bromberg, when:

> an enactment is serving its proper function and the patient's dissociated experience that the analyst has been holding as part of himself is sufficiently processed between them for the patient to begin to take back into his own self-experience little by little (1988:544).

A way forward

As this process slowly moved forward there were significant changes for Helen as she moved from a place of dissociation to one of conflict. In this new place she has had to deal with her own difficult feelings. Her experiences in the therapeutic relationship with me in which neither of us fell apart when she spoke, gave her the opportunity to modify her old organizing principle. Her repertoire of affects and ability to communicate them has expanded. There have been moments when Helen has been able to truly speak to me about herself. Bromberg states that such moments "mark a point of true structural growth in personality. . . signaling steps in the organization of mental structure from dissociation to internal conflict" (1998:22). In a recent session Helen was able, with some embarrassment and difficulty, to express her yearnings for connection by saying, "I keep feeling this wish that someone would hold me and tell me everything will be alright". There have been the beginnings of mourning for what has been lost; resentment for what wasn't provided. In our current sessions she suffers less from flashbacks and has some relief from her debilitating feelings of tension and pressure. Our conversation is transforming. Helen is able to make some links between her past and present. It is still tentative but there are precious moments of warmth and intimacy between us. Most recently, at the end of the session, Helen showed me a photo of her granddaughter. There was shared pleasure in our interaction that was communicated both in silence and with words.

When our clients are able to 'know' their pain and their pleasure our conversation with 'silence' will feel and be quite different. This silence will be one of nourishment and safety as well as a signal that our clients are in touch with their inner world. A new kind of language will emerge which is full of silence and words, a fine balance of intrapsychic and intersubjective experiencing. This new language, instead of being a substitute for experience, will allow something new to emerge and enable a new self narrative to be created so that, as Meares puts it, "the therapeutic aim [which] is to reverse this hierarchical descent and to foster the emergence of a larger dualistic form of consciousness and a growing sense of spontaneity, or freedom of movement in psychic life" (2002:223) will be achieved.

> If you do not bring forth what is within you what is within you will destroy you.
>
> If you do bring forth what is within you what you bring forth will save you.
>
> Gnostic Gospel

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