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THERAPIST, PATIENT AND SILENCE. THE PHENOMENON OF SILENCE FROM A PSYCHOANALYTIC PERSPECTIVE

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Silence is in a sense the very foundation of all reality.
It comes from it and comes back to it.
Richard Rohr, *Silent Intercourse. Finding God in contemplation.*
[1, p.10]

Summary

The phenomenon of silence during a therapy session is commonly observed by psychotherapists. The reasons for silence may have various sources springs. The psychoanalytic theory tries to describe and explain them. Different psychoanalytic currents propose diverse concepts of the appearance of silence during psychotherapy sessions. The article presents views of such schools as classical Freudian psychoanalysis, ego psychology, Klein school, self-psychology, and Bionian school. Especially the views derived from the Bionian school, according to the author, allow clearly and legibly read the message included in the patient's silence in the session. The author demonstrates the topic by means of the clinical case presentation of a work with a female patient who is silent on the therapy session.

1. Introduction

In one of his first films - Silence - Kazimierz Kutz tells the moving story of a teenage boy named Staszek. The boy lives in a provincial town that returns to a normal life after the war's turmoil. The boy is an orphan - he lost his entire family during the war. It is commonly condemned by the inhabitants of the town because of its "otherness". One day news is spreading that Staszek took the life of a local priest. Despite the lack of evidence, the small-town community has no doubt that Staszek is guilty and gives him a sentence. Soon after, during reckless play with a dud, the boy suffers a serious accident and loses his sight. Instead of compassion, he hears only voices about the well-deserved divine punishment. He cannot count on spiritual help, although he knows that the boy is wrongly accused by his surroundings. The priest chooses silence [2]. In one of the moving scenes, the blind Staszek goes through the town square, using a white cane, surrounded by silent inhabitants of the town, who silently watch the blind Staszek, struggling to find his way.

The film accurately reflects the relational character of silence. It would seem that it is a kind of state of static separation and isolation, but in the market scene we can see that "something" connects Staszek with the inhabitants, when in silence he comes out of the town escorted by the hateful glances of the inhabitants. This "something" is a state of silence, containing many meanings, which the

director decided to leave to the viewer to read and interpret. I believe that a similar process may take place during "silent therapeutic sessions", when the therapist becomes both a witness to the patient's history and the recipient of the silent meanings transmitted by him. In this article, I would like to discuss the phenomenon of silence during therapeutic sessions, reading it from various theoretical perspectives, and especially the perspective of the Bionist theory that is close to me.

2. Silence - different perspectives

There are different ways for therapists to cope with the problem of patient's silence. Understanding the periods of "psychotherapeutic silence" and dealing with it may result from the psychotherapeutic training profile of the therapist and the model of mind chosen by him. Among the several directions of the psychoanalytic theory dealing with the phenomenon of silence, one can distinguish, among others, the perspective of classical Freudian theory of drives, a look from the point of view of psychology of self, the perspective of the Klein trend and the perspective of the Bionian theory.

Freudian theory and ego psychology

In the drive model, Freud focused on the analysis of sexual and aggressive sex drives and the analysis of resistance that formed during the development of individuals, opposing the full expression of the drive. The followers of this classic model, representatives of the ego theory of ego focused in a special way on the ego's defence mechanisms, noticing that the ego of an ardent struggle for the expression of the life of the drive is taking place in the ego. Both mentioned related trends of the psychoanalytic theory noticed the presence of the phenomenon of silence during the psychotherapeutic session.

According to the model derived from the classic Freudian theory, patient silence during a therapeutic session is an obvious form of resistance, which is often encountered in psychoanalytic practice. "In the treatment of psychoanalytic resistance is called everything that is contained in the words and actions of the person being analysed, and what hinders her to gain access to the unconscious. In a broader sense, Sigmund Freud spoke about resistance to psychoanalysis, defining the term as an unfavourable attitude towards its discoveries, because they revealed the unconscious desires of man and gave him a psychological blow [3, p. 196]. Generally, silence means that the patient knowingly or unknowingly does not want to communicate his thoughts or feelings to the analyst [4]. It is assumed that the patient may find it very difficult to express thoughts and fantasies of an aggressive and sexual nature in relation to the therapist. "Therefore silence at the session may concern these feelings. One can assume the hypothesis that in a prolonged silence the patient has thoughts and feelings related to the therapist who are difficult to talk about "[4, p. 98]. The phenomenon of silence may also have other meanings from the perspective of Freudian theory. It may be a repetition of an important event of the past in which silence played a significant role [4]. The

patient's silence may be a reflection of his surprise, fear, horror as a reaction to the primary stage, that is, "the stage of sexual intercourse between parents, which the child observes, which he can guess based on certain signs or imagines. In general, it is interpreted by the child as an act of rape on the part of the father "[3, p. 299].

In the work “Inhibition, symptom, anxiety” Sigmund Freud distinguished five forms of resistance [5]. "Three of them are related to the ego: repression, transfer as a resistance and secondary profit from illness, which is based on the inclusion of the ego symptom [3, p. 229]. It is also necessary to add to the resistance of the unconsciousness, that is, the resistance of the id and resistance of the superego [3]. Continuing these findings, his daughter and successor Anna Freud claims that the patient's silence may be a reaction to the intensification of the conflict between the id and ego structures. The symptom of silence is, according to her, rooted in the defence mechanism of repression located in the ego [6]. Manifested in this way resistance is identical to defence. It consists of unconscious parts of the ego - defensive mechanisms - holding impulses that cause fear [7]. Described by Anna Freud "hysterical patients remove from their consciousness imaginary representations of sexual impulses [...]. When associations activate the defence of the ego, they are removed from consciousness. The patient only feels emptiness, he is silent "[8, p. 29]. The therapist who works in the classic Freudian theory paradigm at the moment when the patient is silent may ask himself what character and content have unacceptable impulses that the patient does not approve of in his consciousness? A therapist who uses the theory of ego psychology in his work may also ask why the patient has worked out the defence mechanism of repression in the form of silence at this point in the session?

Psychology of self

Heinz Kohut, a psychoanalyst working in the United States, in his practice tried to integrate the classical Freudian psychoanalytic theory with the theory of relationship with the object (Margaret Mahler). The core of his theory was the concept of developing the self-structure of self (I) and an attempt to explain the formation of deficits in it, which later affect the clinical picture of narcissistic patients. "Self, in accordance with the proposal of the theory of relationship with the object, is distinguished from the internal, mental representation of the person with whom the child is strongly emotionally connected (self-object, or self-supporting object). Kohut assumed that the early relationship between the child and the parent or guardian determines the course of self-development processes leading to the creation of a comprehensive and integrated self (Self) or the occurrence of narcissistic disorders "[9, p. 67]. This indigenous self of a child crystallizes around two important narcissistic needs: the first, revealing its size and omnipotence, which is undeniably confirmed by parents and their reactions, and the second, the child acquires an idealized image of parents through admiration for them [9]. Both narcissistic self-images and parents (self-objects) are the final stage in

the healthy development of a child's personality. Admiration towards parents gives rise to his ideals, values and goals. The sense of the size of the child, confirmed by parents, gives rise to his ambitions and aspirations for success. "Between the ambitions (I can) and the ideals (it is worth) arises> the arc of tension <which is the motor of psychic activity controlled by the self (self) system [9, p. 68]. The self-shaped self is bipolar and is responsible for having a clear concept of self and a well-established sense of identity. Therefore, disturbances of the relationship with the object, focusing on the feeling of lack of empathetic reference from the guardians (self-objects), cause a deficit in the self-structure. Inadequate response (reflection) of parents or too drastic frustration of the child's size need to create a false self-structure, adapted to the unfavourable environment of the child. In contrast, the real self is split off and becomes the target of internal aggression. The key moment for this development dilemma of dealing with ambivalent feelings of love and hatred, with its own greatness, is the sub-phase of a second rapprochement in the phase of separation-individuation (15-24 months) in the child's development cycle according to Margaret Mahler [10].

In the process of psychotherapy of a narcissistic patient, we can encounter three forms of expression of his self. Usually the most accessible, superficial one is the expression of false self, which is characterized by: perfectionism, dependence on achievements, size, omnipotence, pride, claimability, concentration on oneself, manipulation and objectification of other people. It fulfils a compensating role. The second form of self-expression is called self - symptomatic, which is associated with the activation of defence mechanisms that protect the patient from the breakdown of personality structure and contact with the real self. Symptoms of self-symptomatic are: sensitivity to shame and humiliation, hypochondria, psychosomatic symptoms, sense of worthlessness, auto-depreciation, as well as isolation states (manifested by patient's silence), states of loneliness, depression, inertia, inhibition at work. The third form of self - expression, the most difficult to find, is a true self, which is characterized by: a feeling of emptiness, vacuum, panic states with weakness and self - fragmentation, archaic demands of rapprochement, a feeling of rage and pain in the face of lack of empathy towards archaic demands of intimacy [10].

As mentioned earlier, when the patient begins to free himself from the long-term domination of a false self and recovering a real self, he encounters massive difficulties in his development, in the form of the so-called the crisis of "annihilation-abandonment". Stephen M. Johnson points out that the patient at this crucial moment of the mental breakthrough experiences "fear of his own deep, but forbidden feelings, including anger, sexuality, lust for power, joy or fear as such" [10, p. 130] . Johnson notes that in these important moments of the psychotherapy process, the therapist must remain present, silent, accompanying, reflecting the emotional state of the patient when he experiences feelings related to the "narcissistic wound". "Often during the most severe emotional crises that the client must live to regain his origins and himself, the most difficult thing is simply to

do nothing but to be with him [...]. True presence is everything you need. If we cannot be present and direct, we stick to the therapeutic technique, position or theory, and thus block the overwork "[10, p. 131], concludes Johnson. A therapist who uses the idea of self-psychology may ask during the session which part of the patient is in contact with him when he is silent? What kind of self-object in experiencing the patient is the therapist in the moment of mutual silence during the session?

The trend of Klein's theory

Introduced by Melanie Klein, the distinction between the two basic groups of anxiety and defence, i.e. between the paranoid-schizoid and depressive positions, is one of her most valuable achievements in the field of psychoanalytic theory and the understanding of the human psyche [11]. Its concept assumes that the mental life of each person at the deepest levels is based on oscillation between the two positions, never staying in one of them permanently. The paranoid-schizoid position is a kind of relationship with the object that is established in the first four months of a child's life. Later, it can be found in an adult, especially in paranoid and schizophrenic states [3]. "The characteristics of the paranoid-schizoid position are as follows: Aggressive drives co-exist with libidinal tendencies and are particularly strong; the object is partial (above all it is the mother's breast) and split into two objects, a "good" object and "bad"; the dominant processes are introjection and projection; Anxiety, which is very intense, has a persecutory character "[3, p. 238] and concerns fear of destruction from the wrong object. The depressive position follows the paranoid-schizoid position and is reached between the 4th and the 6th month of life and is gradually overcome during the first year of life. It can come back during a later childhood, when the child faces new losses and developmental challenges. In adults, it may also reactivate, especially during mourning and depression. "The characteristics of the depressive position are as follows: the child is henceforth capable of perceiving the mother as a holistic object; the cleavage between the "good" and "bad" objects decreases, and the libidinal and hostile drives now begin to refer to the same object; anxiety, called depression, refers to the danger created in the fantasy of destruction and loss of a mother as a result of her own sadism; this fear is fought by various types of defence (manic defence or more adequate defence, such as reparation or suppression of aggression) and overcome when a loved object is introjected in a permanent and safe manner [3, p. 237]. More recent findings have shown that movement between depressive and paranoid-schizoid positions also takes place at short intervals, e.g. at a therapeutic session [11]. It can also be observed that some patients are closer to the world of experiences, fears and fantasies from the paranoid-schizoid position. These patients have difficulty in reaching a depressive position, because depressive anxiety and the associated state of experiencing guilt (realizing their sadism) is too painful for them.

The problem of difficulty in achieving a depressive position was dealt with, among others Donald Meltzer at work titled Threshold of the depressive position [12]. He notes that the patient,

crossing the threshold between the paranoid-schizoid position and the depressive position (threshold of the depressive position) in his experience and unconscious fantasy, begins to have contact with the destructive parts of his own self and internal bad objects, which is important in the process of psychotherapy. The central problem of this moment of analysis is establishing trust in good objects, especially the mother's breast, recognition of its reparative and protective function along with repelling attacks from the previously dismissed elements: the destructive part of self and internal bad objects. During this period of psychotherapy, the depressive position is penetrated deeper and deeper by the analytical process. We note that the patient begins to painfully confront the ability to accept forgiveness of the earlier moments of violation of his "good faith". During this time, as Meltzer notes [12], the attitude of the patient towards the analyst changes - the earlier attitude of indifference, blocking, turns into interest and listening in silence to his words. After the analyst speaks, the patient can stay silent for a long time. His attention and awareness are directed at the therapist [12].

Another important Kleinist author, Herbert Rosenfeld, who works with deeply disturbed patients suffering from psychotic and borderline states, noted that the silence of his patients is related to their reaction to struggling with contradictory, unclear and confusing feelings and thoughts [13]. According to Rosenfeld, these patients suffered "because of very early and very distorting experiences that are associated with concepts of primitive projective identification and osmosis communication. Such patients need [...] non-verbal communication for many months, they often remain silent or speak in a very confused, monotonous or symbolic way "[13, p. 189].

Rosenfeld's patients had considerable difficulty entering the depressive position. The states of confusion experienced by them, manifesting themselves in silence, intensified as a result of interpreting persecutory anxieties derived from the paranoid-schizoidposition. The inability to enter a depressive position was intensifying on the so-called threshold of a depressive position. A therapist who uses concepts derived from the Klein theory in his work may try to answer some important questions: What is the current state of mind of the patient at the session? Is this a state related to persecutory fear (paranoid-schizoid)? Does anxiety have a character of separation (depressive) anxiety? Do the interpretations given above cause silence, in other words, do they intensify the confusion of the patient?

3. Bion and the phenomenon of silence

A special concept that can be helpful in understanding the phenomenon of patient silence, seems to be the concept of containerization, i.e. a room, coined by W.R. Biona [14]. According to him, child development requires an object that proto-emotions and proto-thoughts of the child. This object becomes the mother. By specifying this term, we can refer to the ability to take the infant's initial, partial, fragmented emotional experiences, which are then modified and returned by the mother to the child in the form of her conscious and unconscious thinking about what the infant wants

to convey to her in this primitive way. Thanks to such non-verbal / verbal communication, based on containerizing emotional states by the mother, the child is able to create emotional connections in his fragmented internal world and to develop his mental apparatus (alpha function), and thus at the next stage of development think with his thoughts about his experience [15]. "Unsuccessful thoughts and harsh sensuous feelings of the baby (beta elements) emerging from his encounters with the world are transformed into thought-free thinking (alpha elements) thanks to the mother who completes the infant's immature psyche with her own ability to be accommodated (alpha function)" [15, p. 127]. Seen from the perspective of containerization, the patient's silence can be understood as an expression of the desire to pass on to him primitive emotional states and an expression of the expectation that they will be received and returned to him in the form of words after prior development in the therapist's inner world.

An interesting fragment of the description of such a study of silence can be found in one of the group "Brazilian supervision" by W. R. Bion indicating how to deal with the patient's silence and how to understand it [16]. A 29-year-old woman volunteered for analysis with great speaking difficulties; he is silent for long periods of the session, showing only with his hands that he is experiencing anxiety. The analyst-supervisee reports that she has great difficulty describing her condition related to the patient's silence. Bion, addressing the supervisory group, suggests an explanation: "There are two people in the room, but the patient knows something that we do not know - there is also silence in the room. Silence is not just anything; if she is afraid of silence, then it is not that she is afraid of the ?nothing?. Silence in a sense must be a place where there is a person or thing. I could put it this way: there are three people, three things - analyst, patient and silence. And it seems that silence is what awakens at that moment "[16, p. 127]. At some point during the session, the analyst feels that an Egyptian mummy is lying on the couch, and he begins to have the conviction that in this way the patient's resistance to therapy is revealed. At the same time, the patient notices that talking and thinking makes her very difficult, she feels like she is dead. Bion once again comments on this moment of the session - "a dead mummy is very dangerous: if a dead mummy does not speak, it is very dangerous to be alive and speak" [16, p. 127].

She adds, referring to the supervisee: "If you will listen to silence like the words you say, then it will be easier to understand your silence messages" [16, p. 128]. he then notes that he can hardly bear the patient's silence and cannot listen to him without tension. After a while, he begins to feel more at ease and begins to pay attention to what happens to her during the joint silence of her and the patient. She notices that her thoughts go to other matters than analysis. At the same time, the patient states that she is afraid she will not be able to withstand the analysis. Bion again interprets the existing analytic situation: "I think you must also draw her attention to the fact that she discovered that you cannot speak if she does not know anything, if you are not informed on a regular basis. So her silence

keeps you silent; one of these people in the office cannot be an analyst and the other cannot be a patient - none of them is satisfied. This object is very hostile; if she does not get permission to speak, we will not be able to conduct the analysis. You may try to draw her attention to the fact that if she speaks, she is afraid that something will start; he is afraid of the opposite of silence, he is afraid that he will say so much that you will not hear your thoughts "[16, p. 128].

4. Judith L. Mitrani - open mindfulness

The described fragment of the process of transforming the emotional experiences of the patient presented in the supervision by Bion in the "thoughts available thinking" by the mother / analyst is called the motherly reverie or reverie, which Judith Mitrani calls "open mindfulness" [17]. According to this Californian psychoanalyst, silence is a state in which there is intense communication between the unconscious and the conscious [18]. Therefore, it is very important in determining the situation of silence that the psychotherapist puts two basic questions: how does the patient's silence affect the therapist and how does the therapist's silence affect the patient? [17]. Answers to these two questions allow the therapist to orientate himself in the context of the transference-countertransference therapy relationship, and find the right words that the patient lacks to describe what is happening to him in a state of silence. The interpretation formulated in this way acquires the features of interpretations that contain difficult-to-express emotional proto-messages conveyed in states of silence. An interesting suggestion here seems to be the suggestion of Leslie Kane's "hints" describing states of silence as a kind of "language of the states of silence" [19]. Kane mentions several types / states of silence, including: silence as apathetic silence, silence as a fertile consciousness, silence as a state of surprising confusion, silence as stifled indignation, silence as sober seriousness, silence as a state of active perception, unpleasant impasse, hard silence of waiting , silence, which is a manifestation of distrust, silent silence of approval, silence as a state of abusive accusation, state of eloquent silence full of respect, alarming silence of silence, peaceful silence of communion, irrevocable state of silence of death [19]. As you can see, the above suggestions for emotional experiences during silent sessions proposed by L. Kane are specific mixtures of silence related to the emotional aspect of the patient's internal object that the therapist currently has contact with and which is placed in the therapist in a wordless process projection.

5. Clinical presentation - a part of the session with Ms. A.

I would now like to present a short fragment of my own struggle with the phenomenon of silence during a session with a patient named Ms. A. She applied for therapy four years earlier, complaining about the difficulties in determining what to do in life, for temporary states of depressed mood and troubles in establishing stable, satisfying relationships with people. She associated them with the difficulties prevailing in her family home. At the time of starting the therapy, the patient was about 26 years old, unmarried and childless. She worked as a specialist in a small but dynamically

developing company in the ICT industry. The first year attended therapy in setting one session for a week; from the second year of therapy, there has been a change to two sessions a week. This setting was maintained for the subsequent years of psychotherapy. The session presented below took place in the fourth year of psychotherapy.

Mrs. A. entered the session uncertainly, looking at me with embarrassment. I got the impression that I was looking at it; maybe I have changed somehow since our last session (two days earlier). When she sat in the chair, I could feel signs of fatigue in her behaviour. There was a silence between us waiting for something that could happen next. More minutes passed and the silence continued; I sensed the slowly growing tension. After a long moment, Mrs. A. uttered the first few words, stating in a quiet voice that she did not want to come to the session today. I had the impression that the tone of her voice was unpleasant, but I could not clearly identify what it might have been about. I wondered what would happen to Mrs. A., which meant that she did not want to come to the meeting. I tried to remember the course of our last session. At that time, when I considered her reasons for reluctance to come, the silence that was growing between us returned more and more. Seeking an answer to this initially reluctant message directed towards me, I realized that what I say could become another burden for Mrs. A. Also, I was beginning to understand more and more clearly that I am the burden for her. I had a feeling that whatever I said, if I did, it would be perceived as threatening and then attacked and rejected. After a moment of hesitation, I decided to give a more open commentary that would somehow touch this state of rejecting my person, while not intensifying the persecutor's feelings of the patient. I said that maybe something had changed in her since our last session, when she seemed cheerful and full of energy - today she looks tired. Mrs. A. agreed with me, adding that she was happy two days ago, but later something "came to her". She added that it may be a wave of sadness. Mrs. A. associated her appearance with her work, in which she gave a lot of herself, she was committed and devoted to sacrifice. She added after a moment that what happened later was the worst for her. At the end of the work, she thought she had enough and did not want to talk to anyone anymore. Mrs. A.'s words assured me that I had done the right thing without giving too much haste to her words. Probably in Mrs A. our joint work aroused similar feelings of dislike as her professional work. The patient did not feel understood either here or there. It seems that the patient's transference message to me without his clear, clear clarification on my part enabled her to explore more deeply the emotional meaning of the state of aversion towards me (also to the undiscovered aspects of her own self). After this brief exchange, there was again silence between us, tedious minutes passed, during which I felt helpless in the face of Mrs. A.'s reluctance and unease against me. We were still silent and I returned to reflect on what Ms. A. wanted to communicate to me in her reluctant transfer, which could mean that he gives a lot. After all, Mrs. A. almost said nothing, she remained silent. It occurred to me that Ms. A. is not in contact with the fact that she exerts a hatred on herself and that

it is easier for her to see her aversion for my emphasis on her than to acknowledge that this pressure comes from her alone. At that moment, when these reflections came to me, Mrs. A. leaned her head on the chair and closed her eyes. I had the feeling that he was beginning to fall asleep. After a few minutes, Mrs. A. unexpectedly opened her eyes, raised her head and began to say that she had the impression that I would immediately throw her out of the session because she was sleeping on her. I felt that after a wave of unspeakable dislike towards me came the moment when the patient gave me momentarily access to myself in a positive emotional sense. At the moment I told her that maybe this is the place where she feels safe enough to fall asleep and rest. The patient replied that here there is such silence that he hears two clocks (a big one hangs on the wall, a small one stands on a table next to the therapist's chair) they beat synchronously. It seemed strange to her, because at earlier sessions she had the impression that they were not going asynchronously. After these words of Mrs. A. a feeling of warmth and fleeting satisfaction appeared. The thought came to me: "so that's it, for word ?synchronously". Mrs. A. enlivened herself more and more, like "waking up", she realized that she realized how tense she was inside, adding that she still had many things to do after the session. She must go to the masseuse yet, and the massage and the session are something pleasant for her, give her a rest. I interpreted this statement by Mrs. A. saying that she seems to expect active care from me and from the masseuse. This care is to rely on the fact that the patient in my office and in the masseuse's office may remain passive, but she is afraid to say it clearly, and instead she prefers to be tense because it seems that I could not agree to it. or throw it away, for not working at the session. Mrs. A. was silent for a moment, then said that it was true that she needed this care, but she did not know how to ask for it. She does not understand it because it seemed to her that she just wanted to come to the session, sit quietly and rest.

6. Summary

The therapist, meeting with the patient's silence during the session, has several perspectives to listen to, understand and interpret the relationship with the patient. In the article, I tried to show that different theoretical perspectives of listening do not have to be mutually exclusive. On the contrary, they can constitute wealth, available to a psychotherapist. What is important here is the ability to flexibly listen, which can be described as the skill of "open mindfulness". It seems that special attention should be paid to "mindfulness" because it concerns not only what the patient says or experiences, but also what the therapist receives in his own interior (reception of communication projective identifications). From the perspective of the Bionian theory, it is often deposited and recorded raw beta elements, non-cultured proto-emotions, proto-thoughts of the patient. They are placed inside the therapist using communicative projective identification by the patient [11] with the hope that he will be proficient in the art of translating these unclear parts of himself to the patient. In the quoted fragments of the supervision of W. R. Bion, he emphasizes that for him silence becomes

an analytical object, which in the example cited the patient introduces into the intersubjective analytical field. The task of the analyst-supervisee becomes at this moment dealing with this object, through the gradual process of finding your thoughts about the analytic object in yourself.

In the clinical case presented by me, for a long time Mrs. A. has used contact with me in projective identification, trying to convey my insistent desire to get care from me, at the same time rejecting and attacking myself for it - which was also placed in me. Contact with the rejecting inner object along with the emotions of craving for care was the essence of the content removed from her consciousness. Overcoming the recovery of split parts of the self was associated with the patient experiencing severe mental pain from which she wanted to escape. During this session, during this session I tried to find in myself the feelings and thoughts related to the communicational projection identities placed in me, fragments of the patient's emotional and mental experience. In other words, one can say that in the process of overworking the therapist using the skills of: receiving, containering, thinking about the transferred material (translation) and its interpretation, allows the patient to attempt to exceed the "threshold of the depressive position". The whole process of overworking conflict material on the part of the patient is manifested by the occurrence of the phenomenon of silence in the therapy session.

It seems that art, and especially the film, has much to offer in terms of receiving hidden meanings, silent feelings, or moments of understatement, with which we often meet in our offices, listening to patients. The key role here is played by the ability to collect patient's projective identification. Thomas Ogden notes that W. R. Bion noticed "projection identification as a separate, the most important form of interaction between a therapist and a patient, both in individual and group therapy (self-explanatory)" [20, p. 370]. It is important to notice that Bion is of the opinion that "the addition to projective identification, which is a fantasy, is the manipulation of one person by another, i.e. interpersonal relation, interaction" [20, p. 372]. Bion's work also helps to unravel some complexities and puzzles determining the experience of being used as a container (ie a recipient) of projective identification. He compares this experience to the idea of "thought without thinking". In this sense, being "the recipient of projective identification is like thinking thoughts that are not mine" (personal translation) [20, p. 372].

I would like to quote in the end an interesting saying of the American poet Jack Spicer, who comes from the poetic art of the artisans. These words were directed by him to his students at the academic courses of writing poetry in the 1950s at one of the universities. He was to say that "the poets often think they should be players [baseball] who throw the ball while they should rather be the ones who catch the ball" [21]. I think that these apt words may also apply to the work of psychotherapists, because it seems that the psychotherapist should first pay attention to how he receives the patient's message, especially the one unaware of the patient, before giving the patient

interpretations. Unfortunately, we often make a mistake of giving an interpretation already prepared before the patient's deep message is received. This makes it impossible to establish deep communication and leads to interpretation from an intellectual level that may make it difficult to truly understand the patient's silence.

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