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Silence as communication in psychodynamic psychotherapy

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Abstract

Moments of silence in the therapy hour, on the part of the client or therapist, can communicate important psychodynamic information, as well as deeply facilitate the therapeutic encounter. The client may be communicating emotional and relational messages of need and meaning. The therapist can use silence to communicate safety, understanding and containment. However, if this intervention is not skillfully and sensitively employed by the practitioner, the client may feel the therapist's quietness as distance, disinterest, and disengagement, leading to breaches in the trust and safety of the therapeutic alliance.

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I have suggested that silence is unconsciously related to the void, to nothingness, to fear of death and annihilation and is ultimately connected with deep-rooted anxiety; and yet I have also said that it is full of over-determined, rich significance and that it can express any feelings including joy, excitement and gratitude. I have said that silence is a bridge and I have said it is a container; that it is a shield and that it is an intrinsic element of all verbal exchanges; I have said that, being related to a preverbal form of communication, it characterizes regression but I have also implied that not saying what cannot be talked about is at times the most mature thing to do. (Andrea Sabbadini, 1991, p. 414)

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1. Introduction

In traditional psychoanalysis, Freud (1912, p. 102) viewed silence somewhat negatively, as “the most powerful resistance” to transference thoughts regarding the analyst, to remembering in general and, specifically, as a resistance against anal erotic wishes. Ferenczi (1911, 1916, pp. 250–252), elaborating upon Freud’s position, viewed verbalization as a form of discharge of instinctual impulses and silence as holding back or hoarding. Abraham (1919) suggested that, if one of the functions of speech was the discharge of affect, then silence represented a defense, displaced from the original erotogenic zones to the organs and functions of speech, for the purpose of repression.

Reik (1926, p. 181) was among the first to point out that “the emotional effect of silence had been completely overlooked.” Since then, other psychodynamic writers have discussed the meaning and purpose of silence in psychotherapy, in both the patient and therapist. Most agree that it can greatly contribute to the understanding of the therapeutic relationship and of the patient’s conflicts, defenses, and interpersonal style. For example, Fliess (1949) classified silences in terms of the libidinal stages, perceiving silence as a defense against the bodily sensations, thoughts, and emotions associated with a particular phase. Thus, a phallic silence may be a defense against castration or primal scene anxiety.

Shafii (1973, p. 434) observed that the earlier contributions generally emphasized a need for the therapist to help the patient “overcome his silent posture so that he could *verbalize* his thoughts and fantasies.” Silence was conceptualized as a “form of inhibition, withholding, transference resistance, and severe ego regression” (p. 431).

However, beginning in the 1960s, emphasis in the literature shifted to the role of silence as a form of *communication* within the therapeutic alliance. The complexities of silence began to be seen as an elaborate means of defense and communication (Arlow, 1961; Blos, 1972; Bollas, 1996; Brockbank, 1970; Greenson, 1961; Khan, 1963; Langs, 1976; Liegner, 1971; Loomie, 1961; Shafii, 1973; Zelig, 1961). Calogeras (1967) viewed silence as an over-determined psychic state that serves a variety of ego processes. In particular, silence was conceptualized as expressing or acting out unconscious transference fantasies, that is, reenacting or living out fragments of experience with objects of the past. Such moments of silence represent a meaningful communication of these transference fantasies, memories, and introjects. This view modified the early analytic focus on verbalization as the primary means of communication of the transference. For example, Streaun (1969, p. 235) pointed out that, although most therapeutic interventions require the use of spoken language, some patients are “not sustained by verbal reassurance,” while others have fixations “in the nonverbal phase of development and consequently need nonverbal forms of intervention.” These patients may include those who were abandoned before speech or “before they could put thoughts and feelings into words” (p. 236).

This paper will focus on the specific function of silence as a form of nonverbal communication in therapy. The authors will demonstrate that silence invariably *communicates* valuable information concerning the patient’s intrapsychic conflicts, transference reactions, and adaptive functioning. While it may act as resistance, silence necessarily communicates messages important to a complete understanding of the patient and the therapy.

Silence, likewise, affords a means of communication from the therapist to the patient, when words seem inadequate or interfering.

2. Patient's silence

The patient's silence has been historically interpreted as communicating a wide variety of meanings related to intrapsychic conflicts and transference reactions, while more recently it has been seen as an indication of adaptive functioning. After first reviewing the psychoanalytic literature on the various meanings of patient silence, this paper will then address how silence can be employed in psychotherapy, informed by recent empirical research demonstrating the importance of maintaining the quality of the therapeutic alliance.

2.1. Silence and conflict

Silence may convey anger, fear, depression, disinterest, withdrawal or absence of emotion in the patient (Liegner, 1971). For Sabbadini (1991), silence is meaningful insofar as it originates from unconscious fantasies and is the result of a psychic conflict. It is not just “an absence (of words) but an active presence” (p. 408). A patient's silence may serve to transform unconscious anxiety connected with a conflict into more manageable, conscious anxiety related to the analytic relationship. In the midst of this anxiety, silence can become “a sort of self-censorship for one to reassure oneself not to say anything wrong,” which may include words that would expose aggressive, retaliatory or sexual emotions (p. 412). Coltart (1991) writes that, when a patient is greedy, demanding or sadistic, silence may result from a fear that such qualities will be exposed and lead to alienation. Similarly, Kurtz (1984) opines that silence may be protecting

a precious core of authentic existence from destruction... silence... is an attempt *first* to counter the reappearance of a once dangerous instinctual demand and *second* to counter forces that would disrupt the now stable system that developed in reaction to it. (p. 232)

Another cause of speechlessness, according to Coltart, is an overactive unconscious that is “stuffed with unassimilated, unprocessed material” (p. 443). For example, a patient may be unconsciously burdened by prodigious amounts of unprocessed sorrow stemming from an idealized father's death.

Thus, in silence, the patient may be communicating fear and anxiety, or the desire to regress to a safer space, which in fantasy may be symbolized by the womb, the cot or sleep. More consciously, a patient's silence may suggest a reluctance to talk about a particular subject or difficulty translating previously unexplored thoughts and feelings into words (Storr, 1990). Benjamin (1981) writes that a patient's quiet may imply confusion and a need to organize thoughts and feelings. It may also provide the means for both patient and therapist to absorb something “heartwarming, tragic, shocking or frightening” (p. 24).

To illustrate, Khan (1963, p. 300) chronicled his treatment of an adolescent patient who relied on silence, which served the discharge function of “seeking a magical symbiotic fusion

with the analyst.” Khan demonstrated how silence in the transference communicated unconscious memories and fantasies related to a disturbed childhood relationship with the patient’s mother, one that fostered identity diffusion. The author, through his counter-transference, perceived the primitive object relationships as expressed by the boy’s silence, and understood his silence as recollecting, integrating, and working through the troubled relationship with his mother.

In another example, [Busch \(1978\)](#) presents a poignant case in which the patient’s silence served to communicate a conflict around separation/individuation. The young female patient’s childhood was “filled with loneliness and incapacitating obsessions” (p. 492). Her mother was a cold and distant woman who was unavailable to the patient, while her father was also unresponsive and avoidant of problems. The patient fantasized that therapy would be terminated before she was ready, analogous to her feeling that she was cut off emotionally from her parents. She was sensitive to changes she perceived in the therapist, and she searched for evidence that the therapist was becoming more distant from her. Fantasies expressing the patient’s fear of separation, and her perception of its permanence, emerged in the therapy, as did her wish to remain in an infantile relationship.

This patient regularly remained silent for periods of up to half an hour, periods that powerfully symbolized, through lack of individually articulated words, her desire to persist in a symbiotic, undifferentiated relationship with her mother. In therapy, the patient was re-experiencing her unresolved conflict involving an insufficient separation from the mother by insisting on being silent and expressing anger when the therapist interrupted her silences. She hoped that he would understand her feelings without the use of speech, as would the empathic mother prior to the development of the young child’s language abilities. The patient was avoiding differentiation of her self from the therapist’s “other.”

2.2. *Silence and transference*

As in the above examples, the patient’s silence sometimes serves as an important manifestation of the transference. In an example detailing silence as transference, [Morgens-tern \(1980, p. 251\)](#) eloquently describes a case in which a young female patient, a pediatrics resident, was “comfortably silent” throughout much of the first 25 sessions, periods that constituted a reliving of a deep bond the patient had shared with her now deceased father. These silences were also eventually understood as duplications of her father’s serene detachment at the close of his life. Shortly before his death, the patient realized that her father had reached a state of silent remoteness, as if he was now prepared to accept his demise in peace. With ambivalent feelings, the patient respected her father’s final wish and sat bedside in silence. Rather than a defense, silence in therapy with this depressed patient was viewed as a method of discharge, as well as a way of forming an object relationship.

[Leira \(1995\)](#) argues that the classical concept of transference is inapplicable here because of its relation to the transference neurosis, which requires verbalization. This author instead conceptualizes her silent patients’ cases using [Modell’s \(1990\)](#) “dependent/containing transference,” which parallels the mother–child relationship and affords the actualization of developmental conflicts. Rather than rely on verbalized material, Leira used her own

countertransference feelings, mood, and experiences to help understand what was occurring in the relationship with her silent patients. According to the author, the quiet, containing atmosphere and the therapist's attitude of total attentiveness fostered greater autonomy for these patients, as they were able to work through early attachment conflicts, such as fusion and individuation; both patient and therapist recapitulated early developmental phases in the context of the transference. Leira concludes that:

The psychoanalytic setting makes concessions to the patient on a pre-linguistic level, analogous to the early mother–child relationship, where the seeds to rhythm and continuity, meaning and connection are sown. . . . The very setting of analysis encourages nonverbal dialogue and growth, a curative process, which develops at its own pace and along its own path, as long as it is not impeded, for instance, by verbal intervention. (p. 63)

2.3. Adaptive silence

In contrast to the notion that a lack of speech is in some way counter-therapeutic or representative of a patient's problem, silence may also signify adaptation and psychological health. Balint (1958) explains that:

The pedestrian analytic attitude is to consider the silence [of the patient] merely as a symptom of resistance to some unconscious material stemming either from the patient's past or from the actual transference situation. One must add that this interpretation is nearly always correct; the patient is *running away* from something, but it is equally correct that he is *running towards* something, i.e., a state in which he feels relatively safe and can do something about the problem bothering or tormenting him. (p. 338)

Among the many positive meanings and functions of the patient's silence, Liegner (1971) identifies feelings of pleasure, harmony, acceptance, approval, and understanding. She notes that some patients feel gratified and free when they are allowed to remain silent, sometimes leading to a resolution of resistance.

In one of the earliest descriptions of silence serving a creative purpose, Nacht (1964) viewed silence as an "integrative factor." He stressed the deep contact between patient and analyst, involving nonverbal and preobject stages of development and gratifications related to the preobject phase of seeking fusion with the object. Nacht suggested that the fantasy of fusion is disrupted by the development of language and that the patient's moments of silence were the equivalent of a perfect union between self and object, patient and analyst. Such a fulfillment promotes integration. At such times, the analyst must be a good object and the analysis free of hostile fantasy. The analyst's implied desire to help and total acceptance of the situation are reparative and eventually lead to integration and the development of the self (Nacht, 1964). In this way, the verbal relationship depends on a strong nonverbal relationship.

Shafii (1973) has emphasized the "adaptive aspects of silence," how it can be a positive, creative, and meditative experience. As in meditation, silence can be conducive to the development of internal peace and harmony (p. 431). To this author, control of body movement and the ability to sit silently can play a role in the control of affects and reality-oriented problem-solving and lead to growth, health, and self-integration. For

example, the author proposes that silence is adaptive and healthy if speech has been routinely and unwittingly abused. Speech in the context of a repetition compulsion may be confining, whereas silent meditation affords the person a chance to “tolerate physical pain, master body tension and develop patience” (p. 437). Silence, he adds, is less destructive and requires less psychic energy. Through the active use of silence, particularly meditation, an individual may regress to a preverbal level, rekindling the mother–child relationship and the phase of “basic trust.” In sum, “compulsive, repetitive, and driven behaviors and fantasies give way to the feeling of peace, freedom, and enlightenment” (p. 442).

Other beneficial purposes of the patient’s silence have been described (Editorial, 1993). These include sharing interpersonal experience, facilitating self-revelation, and allowing self-reflection. When a level of trust is present in a relationship, including the therapeutic one, silence may be a way to share one’s emotions. Martyres (1995, pp. 122–123) writes that words can be detrimental in therapy when they take away from the communication of emotional messages: “Attaching a word to an emotion gave a boundary to it, particularly when the patient accomplished it himself.” During periods of silence or silent reflection in therapy, profound insights may be realized and memories of others may be rekindled:

When silence is used in this way it is almost as if the therapist penetrates the patient’s thoughts and feels the patient’s emotions. This kind of rapt attention—a silence dedicated entirely to the patient—enables the therapist to understand the patient’s dilemma and to render interpretations that are accurate. (p. 169)

Bollas (1996, p. 13) describes this type of patient silence as affording “dense internal experiencing.”

2.4. *Therapist’s reactions to silence*

While some therapists, such as Morgenstern (1980), mention briefly their emotional reactions to a patient’s silence, a few have focused more intently on this subject. Brown (1987) described his experience with a patient who reported a history of extreme parental abuse and victimization, as well as instability in relationships. During a session in the fifth month of treatment, the therapist suggested after a brief period of quiet that silence was a perfectly acceptable way for her to use her time. Soon thereafter, the patient maintained an unwavering silence for the entire length of a session that proved severely uncomfortable and anxiety-provoking for the therapist. He details his emotional associations in one session in which the patient was speechless:

. . . if only she would speak! Why is she doing this to me? Why is she angry at me? Is this a transference problem or does she hate my tie? . . . Is it possible that only twenty-four minutes have elapsed since we entered into this excruciatingly loud silence? . . . Who’s in the hot seat, anyway? . . . I find myself wishing for a fire drill, or maybe just a fire. Even a small earthquake would be helpful. How can she torture me like this? (pp. 126–127)

The therapist’s inner voice concludes with another question: “Sigmund, where were you in my darkest hour?” (p. 127). Nevertheless, the author persisted in keeping quiet himself, ending the session by pronouncing in carefully chosen language that, “We need to stop now”

(p. 127). The patient later acknowledged that her extended silence was a way of testing whether the therapist would adhere to his word. Following this groundbreaking session, the patient made significant progress (becoming more honest and expressing a broader range of affect), this seemed to confirm that the working alliance had been strengthened.

Gilhooley (1995) writes about therapy with a perceptive, but reclusive and unemotional schizophrenic patient and the feelings that the silence aroused in the therapist. The latter noted that the room “was often charged with incredible tension, and at times I had a nearly irresistible desire to flee” (p. 266). He felt “dead” while being with the patient during his speechless periods. He felt trapped, tortured, and enraged, culminating in a desire to murder his patient. The therapist experienced emotions of emptiness, as if he was an “infant without an object. . . hopeless and indelibly flawed” (p. 267). The patient’s silence elicited such a powerful emotional reaction in Gilhooley that he seriously considered ending his involvement in the profession of psychoanalysis. These feelings subsided, however, as the therapist gained understanding into the nature of the patient’s and his own murderous feelings.

2.5. *Techniques for handling silence*

Just as there are many potential meanings and functions of a patient’s silence in therapy, there are a variety of ways for the therapist to deal with it. Coltart (1991) writes that the fundamental question is whether to intervene with or without silence. She suggests making terse observations, such as “You seem stuck today.” She urges that the therapist approach silence with benevolence and patience, not out of feeling persecuted by the client; if the therapist is frustrated or provoked by the silence, the patient will sense this. Coltart further argues that the development of an attitude of being *with* the patient, and a faith in one’s training and abilities are useful when dealing with the silent patient.

Other practical techniques have been recommended. Storr (1990) suggests repeating in an interrogatory tone the last part of a patient’s utterance if silence has followed it. Szasz (1965, p. 161) claims that under no circumstances should a patient’s silence in the initial sessions be treated with silence on the part of the therapist because the former is unaware of “the sort of game he is expected to play.” Szasz notes that he, as therapist, responds to such early silence by explaining to the patient that he can provide therapy/analysis only if information about the patient is provided, that anything considered important may be related, that not everything must be disclosed, and that the relationship is entirely confidential. If this type of clarification fails, the patient may be asked why it is difficult to express himself, but Szasz warns of the danger of complying with the patient’s request to be asked questions. In sum, the therapist must “at the earliest possible moment, indicate that he expects the patient to assume responsibility for communicating or not communicating with the therapist” (p. 162).

Hadda (1991, p. 117) suggests that, because silence is a communication, its relevance for the patient may be explored “whenever it occurs, through systematic inquiry into its subjective significance.” In contrast, Sabbadini (1991, p. 407) implies that the analyst should allow and even at times encourage a “silent space” within the patient, the analyst, and the therapeutic relationship. Thus, her recommendation in certain instances is not to interfere with the patient’s silence. She states that silence in the session should be treated like a dream’s

manifest content by listening to it and understanding it in terms of the latent wishes, fantasies, and ideas from which it came. Similarly, Wilmer (1995, p. 728) encourages analysts to listen to the patient's silence: "It might just be that true dialogue and empathy occurs not when we are listening to our patients' narratives and dreams, but only when we have become skilled at listening into silence."

Liegner (1971) suggests that silence be approached by the therapist with mirroring, joining or reacting emotionally. This therapist describes her "constructive use of negative counter-transference" (p. 240) in her treatment of a retired, female schoolteacher. The woman considered herself to be timid and conforming and showed great difficulty in offering spontaneous speech during therapy. After several unsuccessful approaches to her, silence was tried by the therapist, including casual, friendly conversation (about books and movies) and encouraging her to describe trivial details of daily events, a highly provocative and seemingly unwarranted, though utterly creative, technique was attempted. Fueled by authentic feelings of rage, the therapist threatened to play Russian roulette with the patient, using a gun the former claimed to have in the office, if the patient did not talk. Consequently, the woman understood that she was an important person to the therapist and began to proffer emotionally invested material. (She apparently knew that her therapist was not intending to cause her harm.)

3. Therapist's silence

Perhaps the most prolific writer and analyst who values the importance of the therapist's silence is Robert Langs (1973, 1976, 1982, 1988). He describes silence in two ways: when it is used appropriately, that is, holding and containing the patient and maintaining "a sound therapeutic symbiosis," and when it is misused, representing a "failure to intervene" (1982, p. 642).

3.1. *Silence as intervention*

For Langs (1973), silence is used appropriately as an intervention in listening and communicating any of a wide range of meanings to the patient. According to this author, it can convey acceptance and tolerance of aspects of the patient that others have found objectionable, enabling the therapist to avoid making moral judgments or criticisms, with the patient then more apt to explore these unappealing qualities in the process of gaining insight. It can convey approval of a nonneurotic adaptive response and demonstrate that it is the patient's responsibility to make behavioral adaptations (Langs, 1973). It can permit the transference to grow in intensity and clarity, and associations to develop without interference, as well as strengthen the patient's ego, by reinforcing autonomy and advancing the ability to maintain mature object relationships. To further these goals, Langs suggests responding to patient's queries with silence, which enhances his or her tolerance for frustration. These benign applications of silence, Langs warns, must be "accompanied by inherent warmth and natural sincerity" (p. 376).

However, if the therapist is silent, will this warmth and sincerity be detected by the patient? The use of silence can pose risks. [Aull and Streat \(1967\)](#) reviewed the literature on the analyst's silence and experimentally demonstrated the phenomenon by employing a "therapeutic technique of silence" with six patients ranging from a few sessions to 18 months in therapy. The authors concluded that "prolonged silence of the analyst serves as a form of 'intervention' and, as such, can have both positive and negative therapeutic effects" (p. 78). On the positive side, it may offer a form of gratification, acceptance, and understanding, as well as protection against unacceptable impulses, wishes, fears, and fantasies. Moreover, it shows respect for the patient's defenses and activates the patient's dependency needs and the expression of core problems. On the negative side, the analyst's silence may feel like deprivation, neglect, and result in withdrawal and the intensification of fears of desertion and abandonment.

Recent empirical research has alerted us to the dangers of not focusing on elements that contribute to the quality of the therapeutic alliance. This alliance has been defined as the collaborative, positive relationship between the therapist and patient ([Price & Jones, 1998](#)). This definition is traceable to [Freud's \(1912\)](#) original description of transference in which one aspect of it induces cooperation. According to Freud (p. 105), these "friendly and affectionate feelings" are "admissible to consciousness and unobjectionable, persists and is the vehicle of success in psychoanalysis." [Bordin \(1980\)](#) also delineated the differences between the transference and the positive joining of the therapist and client in an alliance against the client's pain and suffering.

Studies in psychotherapy process have demonstrated the critical importance of the therapeutic alliance. [Horvath & Symonds \(1991\)](#) conducted a meta-analysis of 24 studies, many of which had used a variety of alliance measures and types of treatment, and found that the therapeutic alliance is a strong predictor of psychotherapy outcome. In another study, [Krupnick et al. \(1996\)](#) analyzed data from the National Institute of Mental Health (NIMH) Treatment of Depression Research Program and found that alliance accounted for more of the variance in outcome than did treatment modality. In turn, the nature of the therapeutic alliance has been shown to be influenced by the quality of patient–therapist interaction, in a study correlating and factor analyzing outcome data from a sample of 30 brief psychodynamic psychotherapy sessions ([Price & Jones, 1998](#)). This quality, in turn, was shown to depend upon successful communication, that is, whether the patient feels understood by the therapist and understands the therapist's comments and interventions. These conclusions suggest that the use of silence can be problematic, in that patients may or may not understand what is being conveyed by silence or the therapist's attitude in silence.

Unless prudently and tactfully used, silence can create an impression of distance. In an investigation of the relationship between initial interview and client return for another session, [Tryon \(1990\)](#) found that client return was positively related to longer and deeper interviews, as rated by client and counselor. "Depth" was defined as increasing clients' understanding of themselves, through interpretation. The author construed these findings as indicating the importance of "engagement," which occurs when the interaction has depth and value for the participants. Similarly, a number of studies have identified the variable of therapist's interest and positive emotional involvement as contributing to the alliance

(Bachelor, 1991; Coady & Marziali, 1994). In a study that correlated clients' affective experience during session with client-rated session quality, Saunders (1999) found that client's rated session quality higher when they perceived the therapist to be confidently involved and not distracted. Moreover, seeing the therapist as interested and alert was associated with better treatment outcome. In this study, clients reported feeling more determined and hopeful when they felt intimate with the therapist. These findings are important because they caution us to the perils of being silent with our patients. Use of silence runs the risk of being perceived as disengaged, uninterested, distracted, and uninvolved emotionally, any of which can compromise the all-important therapeutic alliance.

A patient experiencing the therapist's silence, especially a fragile patient, may begin to feel unsafe. Rhodes, Hill, Thompson, and Elliott (1994) have shown that feeling safe and supported in the therapeutic relationship permitted clients to assert themselves, in a qualitative study investigating how clients felt about and resolved misunderstandings with their therapists. In contrast, Saunders (1999) has shown that when clients feel unassertive and withdrawn, treatment outcome is negatively affected.

All of these studies focus on client's perceptions of therapist feelings, highlighting the necessity for therapists to focus on how they and their interventions are being experienced by clients. In view of Bachelor's (1991, p. 547) finding that client's perceptions of the alliance were better predictors of outcome than therapists', it seems advisable that practitioners attend to how well their patients are experiencing therapist "helpfulness, emotional involvement, and efforts to explore relevant material." Bachelor found that clients perceive the therapist's efforts to explore and understand clients' problems as indicative of a supportive and involved stance. Such exploration cannot proceed in silence.

3.2. *Specific silent interventions*

Rather than using silence as an approach to *understanding* the transference, Ogden (1994) relies on a form of silence, "interpretive action," to *convey to the patient* an understanding of the transference and countertransference. He describes interpretive action as the therapist's communication of an understanding of a component of the transference–countertransference to the patient without using words or speech. With some patients, as in the cases Ogden presents, interpretive action is not only useful, but necessary for therapy to progress. For instance, he writes about a middle-aged, well-educated female patient who initially complained of extreme anxiety about her fear of losing her job. She believed that her career was a fraud and, similarly, that she could not possibly be of interest to the therapist. The daughter of an idealized and passive father and a scornful, unaffectionate mother, she felt incapable of creativity and refused to reflect on the material that she so straightforwardly reported. In sum, her speech had only one purpose: to elicit the therapist's words, which constituted her way of feeling alive. When this became apparent to the therapist he began to feel sadness and despair, rather than anger, and elected to employ a nonverbal interpretation. The speechless intervention followed each of the patient's questions and created an emotionally charged therapeutic environment. It compelled the patient to realize her anger at being excluded from her idealized conception of the therapist's internal world. If he would have answered her

questions, she would have felt to be in possession of him, which would have hindered the development of insight. Silence was intended to communicate to the patient that she could interpret the transference herself. Ultimately, the patient articulated her own thoughts and experienced them as her own. She developed a voice for herself independent of the problematic transference–countertransference. However, this type of intervention should only be attempted with a patient whom the therapist deems able to tolerate such withholding.

In another instance involving the deliberate use of silence by the therapist to effect healthy change, Blumenson (1993) managed to penetrate in a creative fashion the preverbal world of a schizophrenic patient. She employed not silence per se, but a speechless intervention that consisted of “silent mirroring” of the patient’s bodily movements. The patient was a 75-year-old female residing in a nursing home, who suffered from symptoms of paranoid schizophrenia, depression, dementia, and agitation. She was scarcely verbal, speaking only when her name was called and occasionally disrupting the residence with outbursts of screaming. In choosing to use a nontraditional approach, one that had previously been applied successfully with autistic and cognitively impaired children, Blumenson reasoned that she would assume the role of the patient’s “twin image” so as to join her resistance and support her defense. The analyst imitated the patient’s hand-to-face gestures, leg crossings, and her tendency to look at and then suddenly away from an object, in an effort to make an emotional connection. After several sessions, the patient started to become more alert, comfortable, and aware, occasionally looking at the analyst. The author described how the mirroring technique functioned as a way for this regressed patient to feel validated and resume a degree of control over her environment. Evidence of therapeutic gains appeared in the final session, in which she remained silent, displayed minimal agitation, and made eye contact as the analyst said goodbye. Blumenson concluded that, for this patient, silence constituted a defense against a hostile world: “She rejected the world as it undoubtedly had rejected her” (p. 187). However, silence was a salient ingredient of an intervention that allowed the analyst access and acceptance into a patient’s chaotic, preverbal milieu. An emotional connection was forged.

3.3. *Silence as countertransference*

Brockbank (1970) noted that the analyst’s silence is frequently a result of countertransference, which may be rationalized as analytic neutrality. This silence in turn may contribute to the patient’s quietude, which may never fully be understood until the countertransference is understood. He concluded that for the therapist to comprehend sufficiently the meaning of a patient’s silence, both the patient’s and the therapist’s intrapsychic conflicts and transference fantasies, and the “dynamic interplay” between these, must be investigated (p. 464). Due to identification with an analyst who is silent, patients may introduce only material that conforms to the orientation and expectations of a silent therapist.

The four discussants who responded to Aull and Streat (1967)—J.A. Infante, B. Joseph, A. L. Koch, and M.A. Zeligs—considered the therapist’s silence to be detrimental on the whole, an expression of countertransference retaliation and hate that takes the form of oral deprivation. They argued that the application of long periods of silence on the analyst’s part as a technique is antithetical to the structure of psychoanalysis. The technique was believed to

represent an acting out rather than a sensitivity to the transference on the part of the analyst. The analyst, rather than analyze, withheld from the patient.

More specifically, misapplied silence on the therapist's part may reflect an expression of anger, with a desire to punish or to withdraw, perhaps as a sanction against a maladaptive response, or a defense against the therapist's "sexual or aggressive intrapsychic conflicts and fantasies about the patient" (Langs, 1973, p. 386). Silence may suggest a defense against feelings of rage provoked by the patient, or alternatively, the wish to gratify the patient's need for closeness, which in turn can be interpreted as seductive. For Langs, such countertransference manifesting in excessive and repetitive silence is an unnecessary and inappropriate deprivation for the patient. Such use of silence indicates a lack of sensitivity to the patient's needs and represents a failure in the therapist to help the patient to effect healthy change. When this occurs, patients may act out, regress or develop symptoms.

Use of silence is considered to be particularly hazardous and contraindicated with patients who react by falling silent themselves, resulting in their distrust, terror, and rage. Therapists can detect whether they are using silence appropriately, or reacting in countertransference, or just feeling lost or unsure how to proceed by paying attention to their own internal thoughts and feelings. Detecting unpleasant feelings of anger, hurt or fear in oneself may point to countertransference reactions provoked by interaction with the patient. This type of self-awareness can also allow the therapist to honestly acknowledge to him or herself the absence of understanding and technique.

4. Conclusions and summary

Silences of both the patient and therapist may have numerous meanings and purposes. Silence can be a powerful instrument, but, like all other therapeutic tools, it should be mastered and understood by its user. Silence can be very important for the therapist's understanding of the therapeutic relationship and of the patient's conflicts and defenses, resistances, adaptive functioning, and interpersonal style. Periods of silence are a means of communication, whether initiated by patient or therapist. They always possess meaning, often stemming from anxiety concerning the concealment and possible disclosure of an unconscious fantasy. By listening to both the patient's words and silences, we learn about his or her inner life. Similar to a manifest dream, metaphor or symptom formation, silence is a compromise formation that must be studied in order to understand its latent content and the unconscious meaning that it conceals. The patient's silence can also afford the communication of important emotional messages, allow a healthy regression to the preverbal mother-child relationship and reflect other adaptive reactions of the patient. However, for patients in need of emotional connection and support, the therapist's silence can be potentially disruptive. Use of such an intervention requires that the practitioner be aware of how silence may affect the quality of the therapeutic relationship. In sum, silence in the patient is communication to be understood. Silence in the therapist is also communication, but it must be a skillful one that continues to convey involvement and engagement.

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