

Contemplating Silence:

A review of understandings and clinical handling of patient silence in psychoanalytic  
psychotherapy

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## Attestation of authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person, no material which to a substantial extent has been submitted for the award of another degree or diploma of a university or other institution of higher learning.

Signed \_\_\_\_\_ Date \_\_\_\_\_.

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## Abstract

Patient silence may cause the therapist serious anxiety. It is an enigmatic, over determined phenomena that has been variously defined and clinically addressed in psychoanalytic literature. This dissertation is a systematic literature review (with clinical illustrations) of psychoanalytic literature on patient silence. The findings have been classified into three broad categories: first, silence as resistance; second, silence as communication; and third, silence as creativity. Patient silence is illuminated as one of the greatest barriers to, and one of the deepest moments in an analysis.

## Introduction

We recall that the first patient called psychoanalysis a 'talking cure'. As significant as this expression may be, it is nevertheless not correct to attribute the effect of analysis entirely to the word. I believe it would be more correct to say that psychoanalysis shows the power of the word and the power of silence. (Reik, 1968, p. 173)

By and large, psychotherapists listen to the words of their patients in order to attempt to understand their struggles and eventually relay this understanding through words. What patients have to say has historically been the focus of psychoanalytic literature. Therapist and patient, however, do more than simply talk. Together they create a world of sounds, words and silences.

In my third year of psychotherapy training I encountered Sabbadini's (1992) article *Listening to silence*. Although most of us recognise that the difference between words and their absence is not arbitrary, I identified with his recognition of the anxiety that patient silence can rouse in the therapist. The therapist may feel impotent, disarmed, frustrated and helpless when faced with patient silence. He may wish to give up in the face of what feels like an assault on his therapeutic effectiveness, fill the silence with meaningless speech or deem the patient unsuitable for therapy. In other words, it is an important topic for therapists to consider.

The patient's silence tests the therapist more so than words, perhaps due to its inherent ambiguity.

It may evidence agreement, disagreement, pleasure, displeasure, fear, anger or tranquillity. The silence could be a sign of contentment, mutual understanding, and compassion. Or it might indicate emptiness and complete lack of affect. Human silence can radiate warmth or cast a chill. At one moment it may be laudatory and accepting; in the next it can be cutting and contemptuous. Silence may express poise, smugness, snobbishness, taciturnity, or humility. Silence may mean yes or no. Silence may be giving or receiving, object directed or narcissistic. Silence may be the sign of defeat or the mark of mastery. (Zeligs, 1961, p. 8)



With so many possible meanings, the aim of this dissertation is to offer a frame for trying to understand and think about patient silence. The two research questions are:

1. *How has patient silence been described and understood in psychoanalytic literature?*
2. *How can therapists use this understanding for the clinical handling of patient silence?*

The reader is advised that there is very little coherency in the psychoanalytic literature on patient silence. For the purposes of illumination I have separated patient silence into three broad areas yet there is significant overlap between them. The first chapter reviews silence as resistance and the second, silence as communication. The third chapter reviews silence as creativity and also includes further understandings of silence that do not fit into the aforementioned categories.

Although the focus of this dissertation is patient silence it is also essential for the therapist to consider the significance of their own silence. Therapist silence is noted as being the best way of facilitating the patient's free associations, manifesting their unconscious thrusts and expressing their neurosis (Langs, 1978). Therapist silence may inhibit or elicit responses from the patient, be felt as an empathic, encouraging intervention, or a threatening, abandoning withdrawal. Whilst therapist silence is included where important to the findings of this dissertation, the reader may find a systematic review on this topic in Warin (2007).

## Methods

The method of this dissertation is a modified systematic literature review. First this section looks at the components of such a review followed by the place of the review within the socio-cultural matrix of the health professions. Second it looks at the rationale for using this method and lastly an outline of the process and modifications used within this review.

The appropriateness of any research methodology and the evidence that it consequently acquires is dependant on an understanding of the discipline and the aim of the research (Milton, 2002). Within the profession of psychotherapy there has been spirited debate about the suitability of research methods particularly as psychotherapy attempts to define its place as a health care profession for an ever more discerning and distrustful consuming public (Bruhn, 2001; Feltham, 2005). There is no single hegemonic psychotherapy knowledge base (Totton, 1999), and within the scientific research outcomes, neither technique nor training conclusively affect the benefits reported (House, cited in Totton). This is concerning news when this scientific evidence is the yardstick of the socially powerful profession of medicine. Consideration is therefore due regarding this uneasy relationship between psychotherapy and the current dominant knowledge paradigm of Evidence-based practice if we as practitioners strive to enrich and enhance our work and our relationships with the public and other professions.

Evidence-based practice often fits within the larger positivist epistemological paradigm. This approach to knowing emphasises the importance of objectivity, systematic observation, testing hypotheses through experimentation and verification (Grant & Giddings, 2002). Most psychotherapy writing comes under the interpretive paradigm which, rather than seeking the 'truth' of an experience, looks to understand what it is to be human and what meaning people attach to the events in their lives (Bernstein, 1983). "The language of psychotherapy is rooted in human experience, not in scientific formulation... constantly enriching itself, finding accuracy in accumulated events, not in precise definition" (Weisman, 1955, p. 242).

As well as there being differences in the assumptions and values regarding positivist and interpretive paradigms there is also a difference in the relationship between the researcher and researched. In the positivist tradition the researcher is 'expert' and maintains an objective stance towards the subjects of the research (Grant & Giddings, 2002). Conversely, the empirical basis of psychoanalysis is the clinical situation (Fonagy, cited in Milton, 2002) and the relationship between the researcher and researched is highly subjective and complex. The attempt with this dissertation is to combine the objective canons of Evidence-based practice with elements of practice-based evidence; in effect to present a piece of research that is both rigorous and relevant to psychotherapy (Barkham & Mellor Clark, 2003).

Systematic literature reviews are considered the 'gold standard' for assessing the effectiveness of a treatment or intervention within the Evidence-based practice paradigm (NHS centre for Reviews and Dissemination cited in Hamer & Collinson, 1999).

The key components to a systematic literature review are:

1. defining a research question
2. methods for identifying research studies
3. selection of studies for inclusion
4. quality appraisal of studies
5. extraction and synthesis of the data

(Hamer & Collinson, 1999).

The aim of the systematic literature review is to collate and assess all of the available research, increase power and precision for estimating effects and risks, and limit bias and improve the reliability and accuracy of recommendations (Mulrow, 1994).

Systematic reviews most often use quantitative, usually randomised control trials' data from experimental research as the primary source of evidence (Hamer & Collinson, 1999). Randomised control trials are considered the most scientifically rigorous research method due to their internal validity (DeAngelis, 2005). However there is very little of this sort of research within the psychoanalytic literature and therefore the first modification to this review is the use of qualitative research rather than quantitative. Qualitative research is extremely valuable as it draws from a

number of epistemic foundations on which it bases clinical judgement and intervention. These include the knowledge of:

1. valid logical forms of argument and inference
  2. the application of such logical forms to empirical phenomena
  3. findings from direct, firsthand empirical observation of patients
  4. findings derived from the creation and testing of empirical hypotheses regarding the patients' specific problems
  5. empirical truisms
  6. probabilistic scientific findings and their application
  7. ideas based on intuition and anecdotal evidence
  8. cultural institutions, social practices, and behavioural norms
  9. a system of relevant constructs or concepts
  10. ideas derived from clinical practice of others and oneself
- (Bergner, 2000).

The second modification to this review is the inclusion of my own clinical vignettes for illustration purposes.

I began this study with the broad question of how psychotherapists can make sense of patient silence to enhance the outcomes of the work. I decided to limit my search to Psychoanalytic Electronic Publishing (PEP) because I was looking at silence from a psychoanalytic viewpoint and this database contains full text articles from seventeen major psychoanalytic journals between the years 1920 - 2000. Beyond 2000 I obtained articles from the Auckland University of Technology library, through inter-loans or from my supervisor's journal collection.

The table below represents the keyword searches I performed.

| Search term                     | Number of articles | Relevant articles with exclusion criteria |
|---------------------------------|--------------------|---|
| Silence (title)                 | 52                 | 21  |
| Silent (title)                  | 26                 | 6   |
| “Silent patient”<br>(paragraph) | 87                 | 26  |

|  |     |                                 |
|--|-----|---------------------------------|
| Communication silence (paragraph)      | 167 | 38                              |
| Resistance silence (paragraph)         | 218 | 45                              |
| Resistance (title) Silence (paragraph) | 35  | 4                               |
| Non-verbal (title)                     | 6   | 2                               |
| Nonverbal (title)                      | 30  | 9                               |
| Non-communication (paragraph)          | 45  | 3                               |
| Quiet (title)                          | 3   | 0                               |
| “no words” (paragraph)                 | 4   | 0                               |
| Wordless (title)                       | 1   | 0                               |
| Wordlessness (title)                   | 1   | 1                               |
|  | 675 | 154<br>93 (double ups excluded) |

The exclusion criteria are any studies about children, adolescents, family or groups. I also excluded all studies that were not in English and studies that were not relevant to my question. After this I searched the reference lists of the articles I found, searched the Auckland University of Technology’s library catalogue for books and have also been referred literature from colleagues and my supervisor.

Notes:

- The words *analyst* and *therapist* will be used interchangeably in this review as used by psychoanalytic authors.
- The word *he* will be used to refer to the patient throughout the dissertation.

## Chapter One

### Silence as Resistance

In psychoanalysis, when the patient breaks the fundamental rule of free association with a period of silence, it is mostly interpreted as an indicator of gross behavioural resistance, a defence or as opposition, as a result of restriction on the drive of the id, a threat to the defenses of the ego and an incursion of the demands of the superego. (Gale & Sanchez, 2005, p. 209)

The purpose of this chapter is to review the meanings psychoanalysts ascribe to their description of silence as resistance and how these assist us to think about and deal with patient silence. The chapter begins with a description of early thoughts on silence as resistance and following on from this, psychosexual explanations. Next the influence of ego psychology is expounded followed by recommendations of clinical handling of silence as resistance and lastly a summary and critique of silence as resistance.

#### *Early Thoughts on Silence as Resistance*

The technique of psychoanalysis in the early years was that the ego's resistances and defences should be made inoperative so that the id could be revealed (Brockbank, 1970). The 'talking cure', within which the analyst would interpret the contents of the unconscious in order to undo repression, took place through verbalisation and insight. This would allow for the unrelenting energy of the instinctual drives to be released in small portions rather than through actions or symptoms that remained unconscious and problematic for the patient. So long as the patient talked and the analyst interpreted, the unconscious would be emptied, repression lessened and symptoms eased (Zeligs, 1961). Patient's silence therefore, was considered resistance to the process of analysis, in opposition to the authority of the analyst and a disobedience of the basic rule (Arlow, 1961; Levine, 1996). In psychoanalysis, resistance refers to any opposition, whether it is in the words or actions of the patient, to the process of bringing their unconscious processes into consciousness (Laplanche & Pontalis, 1980).

Early on Freud (cited in Dewald, 1980) saw resistance as located in the preconscious or conscious, directed against recall and verbalisation. Resistance was seen as an expression of negative transference and Freud's technical advice was that if silence ensued:

The stoppage can invariably be removed by an assurance that he is being dominated at the moment by an association which is concerned with the doctor himself or with something connected to him. As soon as this explanation is given, the stoppage is removed, or the situation changes from one in which associations fail into one in which they are being kept back. (Freud, 1912, p. 101)

Freud's advice where the silence had become conscious was for the analyst to give logical arguments against it and promise the patient ego rewards and advantages if it gives up its resistance.

However, Freud (1926) then went on to propose his structural hypothesis and discovered through observation that verbalisation did not necessarily prevent resistance and that resistance itself could be unconscious. The definition of resistance was no longer simply a by-product of dammed up libido but also unconscious ego anxiety against danger. Resistance could now provide the analyst with important information regarding the ego and its compromise formations (Arlow, 1961; Inderbitzin, 1988).

Freud's first theory necessitated working with silence as resistance in order to undo repressed drives while the second requires exploration of the perceived dangerous affects which set off the resistance (Busch, 1992). Here we have the beginnings of a more dynamic rather than energetic view of resistance, yet Freud offered no additional technical recommendations for the handling of silence.

#### *Psychosexual Formulations of Silence as Resistance*

Prior to 1958 patient silence was commonly considered a conflicted unconscious defense against the discharge of instincts. Masochistic forms of libidinal and aggressive drive expression and anal levels of psychosexual development were most often mentioned (Waldhorn, 1959). The two theorists most loquacious about silence

in relation to psychosexual levels of development were Bergler (1938) and Fliess (1949).

Bergler (1938) describes silence primarily as resistance linked with the dominant libidinal level for both positive and negative transference positions. Fliess (1949) theorizes that from each pre-genital zone there is a distinctive type of speech and a corresponding quality of silence. He posits that the act of speech helps to overcome repression through the release of regressive affect and that silence is the equivalent of sphincter closure displaced from the original erotogenic zones to the organs and functions of speech. The function of silence being: to maintain repression of pre-genital impulses. Psychoanalysts have written about silence as resistance linked with oral, anal and phallic-erotic wishes and along with Bergler and Fliess are expanded on next.

*Silence as resistance against oral-erotic wishes.*

Psychoanalysts have described oral-erotic silence as having several meanings: for Ferenczi (1911) silence was a fear of uttering obscene words and later a neurotic symptom associated with a repressed urge for the sexual use of the mouth (Ferenczi, 1919). For Reich (1928), silence as defense against the basic fellatio wish.

Bergler (1938) wrote that patients with oral mechanisms want either to receive or to revenge themselves for the alleged refusal of their oral needs. When in contrast the analytic situation asks of them to 'give' in the form of words they often resist. He describes oral patients as often pretending to be stupid by saying they do not understand and then becoming silent, others displaying oral obstinacy and aggression without this former trait.

Fliess (1949) describes his category of patient oral-erotic silence as resembling mutism. The patient may also convey that he has physically made himself absent and express no sense of struggle. Fliess believes this is the most regressive of the silences and an intrusion of a primal transference into the analytic situation that is narcissistic in nature. The patient demands mutual incorporation of subject and object and discharges these strivings by temporarily becoming an 'infant'.



With orally regressed patients prolonged silences may be experienced as a gratifying pre-verbal state. Conversely, the silence may be felt as deeply depriving dependant on the analysts response. When regression can be maintained in the therapeutic relationship original frustrations can be re-experienced and attenuated in the transference and the ego consequently strengthened (Zelig, 1961).

*Silence as resistance against anal-erotic wishes.*

The anally fixated patient is noted for unconsciously equating silence with strength; connecting the hoarding of words with that of faeces (Coriat, 1933; Ferenczi cited in Calogeras, 1967). The retention of words is linked with an unconscious wish to retain the original libidinal bind with the mother, the patient not wishing to loose their infantile helplessness and the early nursing object (Coriat).

In patients with anal mechanisms ambivalence is noted as a prominent feature (Bergler, 1938; Sabbadini, 1992). Anal-erotic silence may be the acted out expression of anal obstinacy and aggression where all the patient's unconscious hatred and ambivalence is preserved (Bergler). This may be so strong that the patient cannot decide which thoughts to express and therefore remains silent. Paranoid patients with anal mechanisms are noted for their omnipotence of thought, assuming there is no need to speak as the analyst already knows what they are thinking (Bergler).

Evidence of compulsion neuroses in patients with anal-erotic mechanisms may not always be an absence of words but in their use of the defense mechanism of isolation where they may speak in minute detail about their symptoms yet cannot observe the fundamental rule. These patients may alternate between this old pattern of speech and a sort of helpless silence (Bergler, 1938).

Anal-erotic silence has been observed as appearing at odd times in the grammatical structure and paired with an exhibition of bodily tenseness and struggle. The silence appears involuntary and is likely followed by a thought fragment rather than a thought. It is often accompanied by a rage response on the resumption of speech; feelings of hostility, and accompanying guilt (Fliess, 1949).

The anally fixated patient's silence may be unconsciously motivated by either, the fear of losing something, or, the pleasure of retaining something (Reik, 1924). The fear of, or need for punishment was also noted as strong in people suffering from an anal fixation (Reich, 1928).

*Silence as resistance against phallic-erotic wishes.*

Phallic-erotic silence may be a defense of isolation or repression against oedipal impulses (Bergler, 1938; Fenichel, 1928). With the reincarnation of oedipal fantasies in the transference these patients may say they "cannot think of anything to say" (Bergler, p. 178). The anxiety associated with the dangers of sexuality, aggression and retaliation, characteristic of the oedipus complex, may be relieved by the patient's unconscious equation of silence with phallic impotence (Sabbadini, 1991).

Masochistic acting out is noted in phallic silence (Bergler, 1938). In this situation the patient may have the conscious feeling of "having to do something" (p. 179) and of the analyst forcing them to talk. Silence for these patients derives from pleasure associated with an unconscious fantasised assault. Underlying this silence may be unconscious ambivalence or castration fear (Fliess, 1949; Levy, 1958; Reik; 1968; Zelig, 1961). The transference situation for these patients revives feelings towards the father (analyst), both hostile and affectionate (Bergler).

Bergler (1938) distinguishes between male and female variations of phallic-erotic silence. In male patients Bergler describes the silence representing an unconscious homosexual wooing. Bergler warns that if the analyst simply interprets the resistance without acknowledging the patient's sacrifice, "you have already castrated me, now be good to me" (p. 179) the patient may feel rejected by the analyst. This may lead to an aggressive stage and termination due to a lack of therapeutic cooperation. With female patients he notes that acting out in silence usually occurs after an unsuccessful attempt at seduction or when conflicts around these wishes become overwhelming in the face of the unmoved analyst. The patient in this case may consciously feel the analyst not to like her and unconsciously Bergler suggests this means "he does not want me because I have no penis" (p.179). The hatred

towards the father (castrator) is enacted as: “You refuse to love me, I refuse you words” (p. 180).

Lastly Bergler (1938) notes that some phallically organised patients are silent consciously because “you are silent too” (p.182). The patient here is saying “See how I do not want to be treated” (p. 182). Bergler notes that this type of silence parallels Anna Freud’s description of the defense mechanism of identification with the aggressor. This defense creates the opportunity for situations previously experienced passively to be repeated actively. Bergler warns that if not interpreted patients will experience this situation as free from guilt as it is experienced to be the analyst’s aggression.

#### *Introduction to the Influence of Ego-Psychology on Silence as Resistance*

The aim of therapy was reformulated in Freud’s *The Ego and the Id* to help repair the faulty processes in the ego structure and to aid the patient to abandon costly defense mechanisms for less costly ones (Balint, 1950). Freud (1926) came to see that resistances could be explained as deriving from: the id (as the source of repetition compulsion), the superego (in terms of negative therapeutic reaction, guilt and demand for retribution), and third, the ego (as manifestations of defense mechanisms). Following from this theory, an understanding of patient silence was hypothesised based on which structural part of the personality is at any particular time predominantly active (Calogeras, 1967; Levy, 1958; Zelig 1961).

The psychoanalytic situation induces processes of regression whereby the patient is expected to become aware of the derivatives of the id and at the same time to maintain a level of mastery over the ego function of verbalisation. However, this function most often becomes embroiled in the neurotic conflict. As the ego wards off anxiety associated with the conscious or unconscious dangers stemming from the superego or id demands the patient may become silent (Arlow, 1961). From an ego-psychology perspective the intention of the particular intervention to silence is to alter the relationship between the discharge tendencies of the id or superego and the defense function of the ego (Arlow, 1961; Levy, 1958; Pressman, 1961; Zelig, 1961).

*The relationship between the ego and the id in silence as resistance.*

As previously mentioned, one of the functions of patient silence is defense. Here the silence represents a counter-cathexis against the demands of the id (Arlow, 1961). If the derivatives of the id are not entirely repressed there may be an intrasystemic conflict where the derivatives have entered consciousness but are repudiated by the ego. Silence may denote conflict between the structural levels, simultaneously expressing an ego defense and a satisfaction of id tendencies (Levy, 1958).

Unconscious ego process of repression may prevent or bind internal verbalisation by the conscious ego via the process of suppression on an expressive, auditory level (Zelig, 1961). Loewenstein (1956) believes that resistance to verbalization is due to two types of motivation. First, a fear of being carried away by expression of intense emotions that may affect the analyst and second, that putting their emotional states into words disrupts their silent gratification. Other motivations may be the fear of loss of love or esteem from the analyst and fear of punishment (Loewenstein; Reik, 1968).

Several analysts have noted that silence may be an ego defensive reaction to the interpretations or observations of the analyst (Arlow, 1961; Greenson, 1961; Levy, 1958; Zelig, 1961). Greenson notes that patient silence often follows from an incorrect interpretation, whether it is caused by the patient's disappointment at not being understood or that the timing of dosage of a potentially correct interpretation is faulty.

On disturbed and severely regressed levels a patient's silence may be a sign of autistic withdrawal or splitting of the ego (Zelig, 1961). In this case the analyst must reintroduce himself as a real object as this type of silence is no longer in the service of the ego. Patients who are sick or regressed have been noted as especially sensitive to the analyst's silence (Greenson 1961; Zelig, 1961). Analyst silence in response to patient silence is contraindicated with certain borderline and psychotic patients where there is an intrinsic impairment in communication. These patients require a more supportive and relational approach due to the weakness of the ego in

relation to anxiety tolerance and integrative capacity and the danger of regressing too much and too quickly (Aarons, 1962; Pressman, 1961).

*The role of the superego in silence as resistance.*

Freud's (1926) structural theory adds to our understanding aspects of the super-ego in relation to the ego and the process of repression that may lead to patient silence.

The ego represses on account of its dread of punishment and subsequently directs its sadism against itself. Through the binding of the aggressive tendencies in the masochistic, doubly impelled to this: in the higher strata, which are nearer to consciousness, by its social sense of guilt (anxiety of conscious) and in the deeper strata by its fear of punishment (at heart, fear of castration). (Reich, 1928, p. 231)

The understanding of the concept of transference resistance, and later the resistance attributed to repetition compulsion, recognised the significance of the secondary gains in creating and maintaining resistances to treatment (Kohut, 1957). Early problems related to fixations at different psychosexual stages are often compounded by later influences, particularly that of the superego (Coltart, 1991). For example a greedy and demanding patient (oral features) who fears his insatiability and its alienating effects is impelled into silence.

The conscious wish of the patient's ego may be obstructed by the superego and lead to silence if, for example, parental prohibition on talking is re-cathected (Fresco, 1984; Levy, 1958). An angry silence in this situation may derive from identification with the aggressor (Kurtz, 1984). Where the superego is implicated in the formation of the ego-ideal due to a narcissistic battle between the ego-ideal and the reality shame may be a common cause of silence (Aarons, 1962; Coltart, 1991; Loomie, 1961; Reik, 1968; Thomson, 1991).

Patients with compulsion neurosis may equate words and thoughts with deeds (Bergler, 1938), show a prominent use of fantasy and denial and use silence as a tool in their ongoing isolation (Loomie, 1961). In this situation the infusion of words with 'magical' significance causes the appearance of the super-ego defense as aggressive thoughts towards the analyst or others. These may cause feelings of guilt

and responsibility that lead to the superego's installation of a prohibition on speaking (Levy, 1958). Where speech is aggressivised or sexualised the superego may demand punishment for these impulses (Pressman, 1961).

The patient's silence may both punish the therapist for their silence and also invite punishment for their own silence (Arlow, 1961; Levy, 1958; Levy, 1982; Loomie, 1961; Weisman, 1955; Zelig, 1961). Glover (1955) notes the importance of superego processes in silence with patients where projections mask the guilt situation and at the same time, involve punishment systems directed by the patient towards external objects but ultimately harmful to themselves. For example:

*Vignette.*

*Ms S frequently struggled to continue to talk without me asking her questions. She displayed signs of an overly critical superego in her silencing of her associations whenever she was getting in touch with her vulnerability. She would become silent then, after a period of overt tenseness decry angrily that she may as well be talking to the wall for there was no difference between this and being with me. Ms S was seemingly inviting me into the position of having to force something out of her, something which (she had earlier told me) she felt resentment for in her family. By reflecting my dilemma and asking her if we could wonder whether the feelings she was now experiencing towards me reminded her of similar feelings she has had in the past, she was able to let me know how meaningless talking about her feelings had been in her family. She revealed her family had dealt with difficult feelings especially sadness and anger either by denial or, in public, by putting up a façade then saying the opposite when in private.*

*Clinical Recommendations for Handling Silence as Resistance*

Ferenczi (1919) recommended that after educational measures to encourage free association are exhausted, the analyst should oppose the patient's silence with his own. This technique was later criticised as potentially aiding the patient's defenses (Glover, 1955). If for example the patient has a severely critical superego his sense that the therapist is critical of him may become a conviction (Pressman, 1961).

Glover suggests an elastic attitude depending on the particular patient's diagnosis. Loomie (1961) suggests that the analyst offer himself as a less rigid superego and more flexible ego "the patient can only renounce his anxiety defenses when he feels himself safe in the externalised superego, represented by his analyst" (Levy, 1958, p. 57).

Bergler (1938) suggests that once the silence is understood according to the dominant libidinal level of development the following technical methods are applicable:

1. For orally fixated patients there should be interpretation and a technique of 'giving' words until a positive transference is effected therefore establishing a basis for analytic work.
2. For phallic and anally oriented obstinate patients there should be interpretation and the opposition of the analysts own silence to that of the patient.
3. For phobic and masochistic clients there should be interpretation and encouragement to give up the silence, never oppose the silence.

Levy (1958) suggests that the problem of reducing the anxiety is the first factor to deal with in regard to the patient's silence. The analyst must signify to the patient an expectant but not impatient silence.

If the analyst does not tyrannise the patient verbally and maintains an empathic, listening attitude, the patient's primitive ego seems ultimately to be strengthened...he then knows like the wise parent, when and how much frustration can be instituted in the service of maturation. (Zeligs, 1961 p. 410)

Pressman (1961) agrees and notes the importance of the judicious use of analyst silence in weighing the patient's levels of anxiety. Rushing in to break the patient's silence, prodding or questioning them risks becoming directive and may interfere with their spontaneous attempts to overcome their resistance which can be a corrective experience for the patient, particularly for those who are passive-submissive (Aarons, 1962).

Arlow (1961) warns that an interpretation that is directed towards exposing an emergent id or superego wish timed badly, may have the effect of intensifying the patient's defensive effort and a prolongation of the silence. In such situations the patient may not be prepared for the exposure of warded off wishes. Here the analyst may direct their interventions towards the defensive endeavours of the ego in order to allow the patient to continue to talk (Arlow; Blanck, 1966; Levy, 1958; Zelig, 1961). "Silence, on this view, 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" (Kurtz, 1984, p. 232).

The analyst's silence may be introjected by the patient (Zelig, 1961). An empathic, benevolent and attentive attitude on behalf of the analyst is noted as necessary for providing the patient with satisfaction of his unconscious needs (Arlow, 1961; Greenson, 1961). If the patient's words and thoughts are used as nutrients to serve the analyst's narcissistic aspirations the patient may be sensitive to their empathic withdrawal in the silence. "During this preparatory non-verbal period, self assurance and self-realisation develop if the patient senses that the analyst's silence grants him the right to be silent if he is unable to speak" (Zelig, 1961, p. 408).

One of the most significant effects of resistance is that the analyst often feels at these times that the patient is working against them (Busch, 1992). This can bring up issues of narcissistic injury and anger in the analyst and affect their capacity to be empathic. It is at these times however, that the analyst needs to be most empathic with the patient's earliest anxieties and fears of being overwhelmed. The analyst may utilise his own defense of intellectualisation in interpreting before the resistance and affect has been explored to defend against the patient's and his own primitive anxieties and hostility brought about in the silence (Busch). Bypassing the ego resistances to get to the unconscious libidinal component of the resistances "reflects a regressive view of patients whereby an enfeebled ego is there primarily to protect and guard the infantile wishes" (Busch, 1992, p. 1108) and the threat to the ego remains unacknowledged (Dewald, 1980). The analysts desire to make resistant attitudes and behaviour stop or disappear is understandable yet is an unhelpful analytic attitude which will actually intensify the behaviour or motivation that is wished to resolve. "Emphasising the adaptive functions of resistant behaviours and



attitudes is crucial. It mitigates the person's dread of being helplessly exposed to overwhelming danger" (Adler & Bachant, 1998, p. 460).

For a full exploration with the patient around his silence the analyst may like to consider Dewald's (1980) suggestions for interpretation of the resistance as including:

1. the fact and nature of their existence
2. the conflict elements being resisted
3. the current version of that conflict as experienced in the transference relationship
4. the genetically determined version of that resistance, including the genetic source of the specific behaviour being used

(p. 65).

### *Summary and Critique*

This chapter has looked at the ways that psychoanalysts have thought about patient silence as resistance beginning with early thoughts and psychosexual formulations followed by the influence of ego-psychology. What is apparent is that there are numerous different ways in which patient silence can be understood as resistance and there is no clear consensus between analysts as to what the resistant silence may mean. The therapist may however be able to wonder what stage of psychosexual development is manifest and having an understanding of the conflicts and needs of patients in relation to these stages may aid the understanding of, and ability to, interpret the silence. This is based on an assumption that the silence needs to be interpreted. Far from the early technique of simply attempting to get the patient to speak, we can see that analysts have increasingly become concerned with attempting to make meaningful for the patient the unconscious reasons for his inability to speak.

Early descriptions of patient silence as resistance did not recognise that the patient may be protecting the defective self for growth in the future in the best way he knows how (Malin, 1993). However, ego psychology has added to our understanding of silence as resistance through consideration that in the particular developmental context, the ego employs defenses to counter the feelings of anxiety

associated with the emergence of an instinctual impulse. By analysing the resistance to the emergence of id or superego wishes from the perspective of ego defensive purpose of protection, the analyst may help this to be integrated into the ego without undermining the patient's defenses.

Descriptions of silence as associated with the gratification of drives from different levels of psychosexual development have been critiqued as having too narrow a focus on unconscious fantasies related to spoken words and their relationship to food, faeces, the phallus or urination (Arlow, 1961; Benedek, 1949; Blos, 1972; Calogeras, 1967; Waldhorn, 1959). In this chapter it can be seen that descriptions of silence as resistance are largely concerned with the patient's intrapsychic processes and rarely are interpersonal aspects of patient silence taken into account. Although resistances are located in, and expressed by the patient, they are not totally intrapsychic. They are often based on inputs from the analyst and his interventions (Balint, 1950, Langs, 1980).

Kanzer (1961) notes the importance of the real relationship in considering silence as resistance. He reminds us that not all resistances that interfere with free association derive from the patient's past and the analyst must also be aware of their current empathy with the patient as a lack of feeling of understanding may be the decisive factor in a patient's silence. If therapists consider patient silence simply as resistance, without taking into account what is potentially being communicated in the silence, the risk of becoming authoritative and apathetic is high (Martyres, 1995; Reik, 1968). Currents of a derogatory tone can be noted in some descriptions of patient silence as resistance: "It can be noted that their self-punitive life behaviour is paralleled by an analytical propensity for negative therapeutic reaction and the continuation of spiral patterns of provocativeness and atonement" (Loomie, 1961, p. 72). It may be easy to feel the patient is working against us in his silence. However, it is the analyst's task to find a way of understanding this in the relational context and will be discussed more fully in Chapter Two.

Considering the definition of resistance as words or actions that block unconscious processes from becoming conscious, what has been described in this chapter are the ways in which analysts have, with increasing sophistication begun to try to

understand what may be being communicated in the patient's silence. The patient's silence may be a form of resistance, yet recognition of the importance of understanding this as part of the entire communication matrix which occurs in the therapeutic relationship including the transference and countertransference may offer the analyst a more holistic perspective. The next chapter therefore looks at ways in which analysts have described silence as communication.

## Chapter Two

### Silence as Communication

There is room for the idea that significant relating and communicating is silent. (Winnicott, 1965, p. 184)

This chapter reviews those authors who describe silence as communication. First it outlines the theoretical contributions of Winnicott to understandings of silence as communication, followed by silence as pre-verbal communication and silence as communication of loss and fear of abandonment. Next this chapter looks at silence as communication of separation-individuation processes. In the last section this chapter looks at recommendations for clinical handling of silence as communication divided into: attention to nonverbal, analyst's use of countertransference and finally to interpret or not to interpret. This chapter concludes with a summary and critique of silence as communication.

#### *D.W. Winnicott*

Several analysts refer to the work of Winnicott in their understanding of silence as communication (Gabbard, 1989; Hadda, 1991; Leira, 1995). As a proponent of object relations theory which places emphasis on pre-oedipal stages of human development in the context of the mother-infant relationship Winnicott (1958) hypothesised that the capacity to be alone is one of the most important signs of maturity in emotional development. This capacity is a paradox in that it is the experience of being alone in the presence of another. The mother who is able to provide an experience of ego-relatedness with the infant allows the infant the opportunity to discover his own personal life as opposed to a false self based on reactions to external stimuli. This requires a presence without demand from the mother. In this state, (similar to that of the adult relaxing) id impulses and sensations arrive spontaneously and allow the infant to feel real, introject the ego-support from the mother and let go of the need for omnipotence. Conversely, an infant deprived of this environmental provision, the result of either neglect or impingement, may become developmentally arrested, displaying severe anxiety based on fears of abandonment and annihilation.

Winnicott (1965) also proposed the concept of the transitional or potential space. This is a space between fantasy and reality, symbol and symbolised, where the infant (or person) creates out of themselves rather than being simply reactive (Ogden, 1986). Winnicott emphasised the need for this space to not be disrupted and replaced by reality too soon. This includes not being ahead of the patient in terms of the analyst's knowing as whilst they may be correct in their assessment of the struggle the patient is grappling with they may be incorrect regarding the patient's readiness to hear or absorb this knowledge (Weiss, 1997). The ability to tolerate the ambiguity and uncertainty of such a situation is fundamental in the analyst's attitude as this allows the patient to take the initiative and produce something from within himself. Following from Winnicott's theory, analysts have described the importance of allowing patients to spontaneously overcome their silence without intervention.

Hadda (1991) describes a case where her patient was silent for a whole year. She chose not to interpret the silence as resistance surmising that her patient may have perceived her interventions as an indication that her autonomous strivings were unacceptable. This may have led to her feeling compelled to be a 'good' analysand, potentially also keeping her mirroring fantasies hidden away. It is worth noting here a question I have over allowing silence to endure like this.

The silent analyst may allow the legitimisation of the patient's private, non-communicating self (Gabbard, 1989). Menaker (1981) in choosing not to interpret his patient's request to lie in silence in the session was received by the patient as a demonstration of his willingness to affirm her needs and faith in her capacity to grow. The patient may feel gratified and free when allowed to remain silent leading to a dissolving of the resistance (Liegner, 1971). Calogeras (1967) describes a largely silent patient with whom interpretation would only appear to increase her feelings of loss of autonomy and hence further silence. It was not until Calogeras recognised the need for these long periods of silence and allowed his patient to withhold her associations that the patient was able to become more trusting and feel understood. The gains henceforth in terms of the patient's sense of ego-integrity and autonomy led to a reduction in periods of silence and freedom of speech.

In healthy development a most important experience for the infant is the refusal of the good or potentially satisfying object. This may manifest clinically as silent periods or sessions (Winnicott, 1963). Silence may assist in achieving position and integrity in relationships with powerful people (Greenson, 1961; Kurtz, 1984). Levy (1982) described his patient's silence as "asserting her right to hold back associations in order to free herself from her oppressive infantile environment" (p. 363). Patient silence may serve as a protection of the true self or expansive (grandiose) self; a means of guarding a cherished but vulnerable core from the intrusion of others (Kurtz, 1984). Patients who can bear the silence in therapy may be demonstrating a developmental step having now integrated the ego-support from the mother (analyst) and established their own internal environment (Winnicott, 1958). The silence itself may be the content that the patient is trying to convey or an unconscious re-enactment of an historical event where silence was significant (Arlow, 1961; Greenson, 1961; Zelig, 1961).

#### *Silence as Preverbal Communication*

The silent qualities of the psychoanalytic frame such as the constancy of the environment and the analyst's ability for empathy, neutrality and containment have been noted as allowing patient regression in such a way that transference-countertransference patterns of communication emerge as adult derivatives of the early mother-child relationship (Leira, 1995; Zelig, 1961). The silent patient may be communicating the desire to regress to a safer place which may be represented in fantasy by the womb, cot or sleep (Sabbadini, 1991; Wilmer, 1995). The patient may be actively reconstructing or reliving the early stages of nonverbal development simultaneously yet divergently from verbal interactions (Leira, 1995). If attuned to this the therapist may notice how the resumption of arrested growth at nonverbal levels interacts with silence on an ongoing basis (Hadda, 1991).

Patient silence has been hypothesised as an attempt at finding the original unity with the mother (Arlow, 1961; Greene, 1982; Khan, 1963; Nacht, 1964; Serani, 2000; Shafii, 1973; Van der Heide, 1961; Youngerman, 1979). This silence may be a desperate retention of communion and holding on to infantile omnipotence where the patient's use of silence expresses his longing for union where words are not

necessary as they are intrusive and emphasize separateness (Blos, 1972; Youngerman, 1973). In some regressed patients speech may be experienced as an intrusion, annihilating invasion or takeover by the analyst, “silence enables them to feel less acutely the basic aloneness imposed upon them by their very existence and identity” (Caruth, 1987, p. 61). There is an expectation from the patient that he can be understood omnipotently (without the need to communicate). The patient’s silence in this case is analogous to wishing to be alone in the presence of another person. Premature impingement in this case may take away from the patient the time and opportunity needed to come to their own perceptions without interference or intrusion (Meissner, 2000).

#### *Silence as Communication of Loss of Object / Fear of Abandonment*

Language is situated between the cry and the silence. Silence often makes heard the cry of psychic pain and behind the cry the call of silence is like comfort. (Green 1977, p. 148)

Silence has been noted as expressing the loss of an object or the fear of abandonment related to the fear of separation from mother during the first few years of life (Arlow, 1961; Caruth, 1987; Greene, 1982; Khan, 1963; Sabbadini, 1991; Shafii, 1973; Weinberger, 1964; Zelig, 1961). This silence may be an attempt to maintain control over feelings, to re-establish a sense of self-esteem or to recathect the lost object. The need to recapture the state of union experienced in the first few months of life may be present in the silent moments of analysis where the patient can reach the object more directly through the silence rather than speech which serves as a reminder of the object’s separateness. The patient’s silence in this case is an ego regression that serves both the purpose of gratification and a defense against conflicts of separation-individuation (Busch, 1978). Alternatively silence may be expressing the love without words of the preverbal stage of development (Altman, 1977).

Patients who have experienced a loss (not necessarily total) in relationship with their mothers between 18 months and three years of age have been noted as displaying a triad of silence, masochism and depression (Weinberger, 1964). At this age, infants do not have the emotional resources for communication adequate to express the sense of loss or injury to their self-esteem. Where there is no substitute for the

unique relationship with the mother a pattern of suffering and withdrawal from emotional contact with others and depression ensues. These symptoms prevent further feelings of injured self-esteem by passively and unconsciously trying to restore the lost relationship, punish the mother in fantasy and frustrate and control her or her surrogates in everyday life. "...The triad of silence expressing both the defence against being hurt and the fear of success in treatment as preliminary to being hurt and rejected" (Weinberger, p. 308). In relationships these patients express the trauma of narcissistic injury and loss through silence experienced as a repetition of earlier experiences of actual or psychological abandonment from a time when they lacked the emotional resources and methods of communication developed later in life (Caruth, 1987; Greene, 1982).

#### *Silence as Communication of Separation-Individuation Processes*

‘I think, therefore I am’, one might add ‘I speak, therefore I am and he is’: solace for the solitude of separation, communication to replace communion, secondary narcissism and object relations to replace symbiosis. (Caruth, p. 41)

The silent patient may be symbolically reworking problems from the practicing sub-phase or rapprochement phase of separation-individuation (Blos, 1972; Busch, 1978; Kurtz, 1984; Leira, 1995; Munschauer, 1987). Busch and colleagues observed that toddlers with normal development used words with enthusiasm and pleasure and contrasts this with Mahler et al’s (cited in Busch) observations where toddlers with difficulties in the separation-individuation phase had corresponding speech difficulties. Language development aids the process of individuation and assists the child to deal with the loss or separation. The early words of the child may function as transitional objects which aid in internalising the soothing functions of the mother whilst helping the child to separate (Winnicott, 1963). Early difficulties in the relationship with the mother may hamper speech development and instead of having a soothing function connected with pleasure may instead be linked with ambivalently cathected maternal representations and painful processes. Instead of words serving the function of transitional object the patient may even use silence as a self-created transitional phenomena to secure his omnipotence in the face of a frightening non-maternal world (Youngerman, 1979).



Busch (1978) describes how separation-individuation themes interacted with the silences of his patient. Early in treatment in the patient's silences (lasting 20-30 minutes) he felt a pleasant atmosphere as his patient sat calmly, seeming content with closed eyes and a slight smile. He likened these silences as reflecting the holding environment. Separation themes soon began to emerge in the form of extreme anxiety about vacations and cancelled appointments; expression of concern that the therapy would be terminated before the patient was ready, and concern that attachment to the therapist would mean being separated from her parents. Concordantly, the patient began to show signs of struggle and tension in the silences. The patient expressed feelings of not being understood and that in talking or being asked questions by the analyst she felt like she was giving something up and being pushed out of therapy. The patient's fear at this time was that if she talked then she would be expected to be grown up and find herself out alone without any help or support. Busch reflects on the individuation themes inherent in these fears as speech takes the infant out of the union with the omniscient mother whom the infant relies on for the empathic anticipation of their needs.

Munschauer (1987) similarly sees the therapy of a young borderline adult patient characterised by "stony silences, oppositionalism, and persistent rage reactions on the part of the patient" (p. 99) as acting out in the service of development and a repetitive reliving of merger and separation. In trying to find a therapeutic stance that would relieve the negative reaction of the patient he drew on Kohut and Kernberg's approaches and came to see them as representing the two poles of Mahler's rapprochement conflict; Kohut's approach representing the merger pole with the immersion of the self with the self-object and Kernberg's, representing the differentiation pole via an active focus on self and other differentiation. The result of either technique however was largely negative and met with rage.

When I tried to absorb and immerse myself in her subjective, experiential state (Kohut), she repelled and pushed me off; when I tried to interpret or comment on her dynamics from a more distant and more objective perspective (Kernberg), she felt angered, injured, and abandoned because I was not seeing things from her point of view. (Munschauer, 1987, p.110)

Munschauer (1987) recommends trying to find a way to maintain an “optimal level of pursuit of the patient, which allows for both separation and detachment as well as for union and empathy” (p. 113) and approaching the patient from both the inside (Kohut) and the outside (Kernberg) even in the event that both approaches are rebuffed. This way the need for the patient to feel in control of the proximity of the dyad rather than passively dependent on the others giving and withholding can be realised. “The use of negation can be understood as an attempt to maintain an identity and an effort to effect self-differentiation” (p. 115).

Similarly, Ferber (2004) discusses from an attachment theory perspective how patient silence may serve to achieve proximity and distance to the therapist. Dewald (1980) gives the example of a patient who had experienced an excessively prolonged and intense symbiotic relationship with his mother in which she demanded he tell her everything, prolonged silence during the middle phase of his analysis represented an “early step toward separation-individuation and self-regulation in the resolution of the maternal transference” (p. 62).

### *Clinical Suggestions for Handling Silence as Communication*

#### *Attention to nonverbal.*

He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his fingertips; betrayal oozes out of him at every pore. (Freud, 1905, pp. 77-78)

The significance of body language, posture movements, facial expressions, intonations and muscular tension have long been noted as paths to understanding the patient. Both verbalisation and silence are accompanied by repetitive forms of kinetic and akinetic body movement and patterns. Attention to these may reveal symbolised, somatised and erotised features of the transference neurosis and give the analyst clues to the formation of body image and symptoms, defensive processes and character traits (Greenson, 1961; Grinberg, 1995; Jordan, 1997; Kiersky & Beebe, 1994; Knoblauch, 2001; Leira, 1995; Suslick, 1969; Weisman, 1955; Zeligs, 1961). The unconscious, symbolic or affective meanings of nonverbal interactions have

been advanced by research in neuroscience and studies of early infant behaviour that point to the significant role of nonverbal indicators for self-regulation and attachment (Jacobs, 1994; Pally, 2001).

It is outside of the limits of this dissertation to describe all of the possible meanings of nonverbal communication in silence, however, Greenson (1961) notes that observations of his silent patient's eyes led to the discovery that they can tell us important clues about the underlying feelings in the resistance. His clinical experience indicated that open eyed silences most often denote hatred and rejection whilst closed eyed silences signify love and acceptance. Patient eyes that are clamped shut may indicate the patient is preparing for an attack from which they are helpless or that they are attempting to protect the analyst from some terrible feeling.

Research into whether or not the analyst should comment directly on the information they may note in the nonverbal behaviour of the silent patient has heralded mixed opinion. Coltart (1991) suggests extreme caution when considering using comments on body language with silent patients as a way of breaking through the barrier because for the self-conscious patient this will be counterproductive. Similarly, Winnicott (1965) warns against interpreting nonverbal details suggesting to instead leave them undisturbed till the patient is ready to verbalise them. Anthi (1981) concludes that whilst nonverbal communication may be an avenue to facilitate reconstruction of early psychic development and has proved useful with patients who have strong egos and neurotic character structure, it has also been seen to provoke disintegration of defense in ego-weak patients within the borderline group and those with severe narcissistic disturbance and is therefore contraindicated.

*Therapist's use of countertransference.*

*Vignette.*

*Ms A would often become silent at times when she was getting in touch with her sense of loss and grief. My countertransference in the silence was strong. I felt a desire to be aggressive and demanding with her and at the same time felt impotent and worthless. It was not until I had internally processed the significance of these*

*feelings for Ms A; her self experiences of feeling worthlessness and impotence in the face of her critical and physically abusive alcoholic mother, and her identification with her mother as aggressor that I could relay this to her and we came to understand the silences. I was experiencing what Ms A had felt at a time when the person she depended on had grossly disappointed her. Being able to recognise and understand what was being communicated in the silence led to Ms A having a sense of being understood as well as ownership for her anger.*

When the patient is silent one of the most important tools for attempting to understand this is the analyst's countertransference (Coltart, 1991; Boyer, 1986; Brockbank, 1970; Grinberg, 1995; Khan, 1963; Leif, 1962; Leira, 1995; Liegner, 1971; Zeligs, 1960: 1961). In addition to the function of silence as defense, Arlow (1961) recognises that silence can also be used in the service of discharge, "by virtue of its ambiguity, silence may be used to induce in the analyst a re-instinctualisation of the process of empathy. Silence is perhaps the most effective tool at the disposal of the patient to stimulate countertransference" (p. 51).

Countertransference may be used as the instrument for deciphering affect, archaic object-relationships, and understanding aspects of repressed material during patient silence (Blos, 1972; Gabbard, 1989; Kernberg, 1979; Khan, 1963). Although the analyst may not be speaking, being receptive to and sorting inner images, thoughts and the emotional experience with the silent patient constitutes the analyst's work (Khan; Leira, 1995).

In a detailed case study Khan (1963) describes his use of countertransference with a patient who was silent over six sessions. He concluded that his patient was communicating through the transference a very disturbed early relationship with his mother and was using him an auxiliary ego in making him experience what he himself had experienced in the original childhood experience.

In the 'bleak deadness' of the silence Khan deduced his patient was presenting him with another person who suffered acute depression. "It re-enacted and expressed the mood and manner of a person, a person who was not Peter, but on whom the child-Peter had been intensely dependent" (p. 305).

Khan (1963) provided concentrated, alert attention to his patient, focussing on “every nuance of his body-behaviour and mood atmosphere” (p. 303) during the silence. The verbal technique he used was to make regular but economical comments about observed shifts in mood and feelings from observing his patient’s nonverbal behaviour. Khan hypothesised his verbalisations proved to the patient that he was not going to retaliate with his own silence and also indicated that he had been watching and participating, therefore establishing his separateness, and providing links from session to silent session. “...It meant that another person...could empathise with his state of mind and feelings, without his either becoming overwhelmed by them or subsumed by them” (p. 307). After the sixth silent session Khan interpreted what he had gathered through his impressions and observations. His patient thereafter was able to discover the value of shared sadness and mourning and re-discover his spontaneity and initiative. “What he was seeking was a setting and relationship in which both dependency-needs and aggression could be integrated” (p. 309).

Although the analyst may appear to be ‘doing nothing’ in silent response to the silent patient they may be able to build a picture of the patients internal object relations through an examination of the here-and-now transference-countertransference situation (Gabbard, 1989). Gabbard surmised that his patient had retreated into a passive state of silence in response to the unacceptable feelings of rage and resentment towards the analyst as he felt forced to submit to him. By drawing on Bion’s theory in working with primitively organised patients where the analyst’s function is to serve as a container for the self-and object-representations that are projected into the analyst he was able to hold and process these elements silently. Gabbard was able to disentangle his identifications in the countertransference with his silent borderline patient. He identified a concordant identification of intense anger and desire to make his patient speak and a complementary identification of his patient’s self-experience of helplessness and hopelessness. By discovering these elements he was henceforth able to act differently from his patient’s internal object relations. He could also disengage from both the process of projective identification from the patient as well as his own expectations of the need to change his patient. Consequently the patient was able to eventually own his anger and begin to speak.

Grinberg (1995) is another analyst who draws on Bion's theory when working with borderline silent patients. He attempts to wait with floating attention to the silence and without memory or desire of material from previous session or theories until he can feel within himself some countertransference idea or feeling that can be confidently connected to what is happening between himself and his patient in the session.

From these examples we can see that there may be great clinical value in analysts' countertransference receptivity with silent patients. However, some authors warn of the analyst's use of countertransference responses with silent patients. The analyst's countertransference feelings may be unrelated to the patient and the analyst's private associations may burden the patient or not accurately reflect what is going on for the patient (Brockbank, 1970; Meissner, 2000). The countertransference of the analyst may on occasion produce a battle in which silence is used as a weapon by both participants (Leif, 1962).

A countertransference response may lead to an extension of the silence, due to either an inappropriate interpretation or simply through the patient picking up the countertransference of the analyst. The analyst must be aware that the process of projecting unwanted elements of oneself onto the other is not uni-directional. The patient can become a container for the projections of the analyst, particularly with silent patients (Langs cited in Gabbard 1989). Meissner (2000) suggests that making an effort to attune to the patient's meaning as the primary focus of attention without contaminating this with one's own conscious thought processes is the recommended way of listening. The primary focus being on the patient whilst the secondary on the analyst's own inner processes or reverie. If the analyst focuses too much on listening to themselves then they run the risk of promoting and imposing their subjectivity over the patients.

The nature of the analyst's countertransference is influenced by the analyst's theoretical orientation to psychoanalysis (Thomson, 1991). There are potential problems that may arise whether the analyst has a more classical or romantic approach (Akhtar, 2000). In the classical approach the analyst may become judgemental and a superior authority of reality where the main risk of the romantic

approach is that the therapist may become overindulgent and identified with the child-self representations of the patient. However, both approaches may be suitable for one patient at different times during treatment, the classical working better when the patient is more organised and aligned with the therapist and the romantic when engaging a patient during times of turmoil, self-absorption and regression. The choice of perspective is dependent on the therapist's evaluation of the patient's capacity to hear and assimilate the information (Akhtar).

Thomson's (1991) exploration of his patient's silence led him to formulate that cause was inhibition arising from shame reactions caused by ineffectual parental responsiveness. Despite Thomson's efforts to be encouraging and responsive his patient experienced him as the opposite. Thomson's countertransference was to feel angry and guilty that his patient did not see his compassion. Supervision and self-analysis led him to understand that his perception of the patient's silence as resistance (a result of his classical training) led him to push the patient to speak or counter the silence with his own. The patient then re-experienced the trauma of his non-responsive parents. It was not until he acknowledged his own contribution to the patient's experience that patient could express his anger towards him and the therapy moved forward.

It is not unambiguous as to who is unresponsive to whom in cases of silent patients (Josephs, 1995). Josephs notes that intersubjectively oriented therapists may treat their countertransference feelings as primarily their own responsibility and therefore solely taking the blame for the patient's silence. For example the analyst may assume in frustrated response to a silent patient that this frustration is only a product of the analyst's defensive need to be considered kind. It may also however be the patient's need to make the analyst feel rejected. After empathically attuning to the patient's experience it is important to then analyse the possibility of identification with the aggressor and unconscious role reversal.

*To interpret or not to interpret.*

Differences abound between analysts' thoughts as to whether interpretation is always necessary or whether in fact simply holding and containing the patient in the silence is curative in itself. Hadda (1991) suggests whenever silence occurs its relevance for the patient must be explored through systematic inquiry, whereas Sabbadini (1992) says that analysts should allow for and at times encourage a silent space within the therapeutic relationship.

Greene (1982) recommends that even in the face of an enduring patient silence and patient experience of object loss in the silence, the analyst should remain adhered to the basic rules of the analytic framework. The most important function in the work being interpretation along with conveying appropriate concern for the pain the patient may be experiencing in the actualising of object loss in the transference. Whilst Greene cites other analysts who believe that with patients who have experienced loss before the time when they have the capacity to mourn there is a necessity to introduce parameters such as frequent use of 'mmhms' and supportive comments in order to make ones presence felt and reduce the regressive anxieties that the patient cannot bear, Greene disagrees. He believes that the analyst should simply listen and wait until there is enough material for a meaningful interpretation and it becomes possible for the patient to use the analyst as a symbol for the earlier loss without maintaining the patient's fantasy that the analyst is an actual parental substitute.

Calogeras (1967) recommends that the analyst allow the silent patient to remain silent under certain parameters. He describes a silent patient who did not have the ego capacity to 'split' therapeutically into a perceiving and experiencing portion. Affects of anger, humiliation and disappointment that were mobilised in the transference were of such an overwhelming nature that they would literally flood the patient and obstruct her from control over her regression and ego functions.

One may decide whether or not to interpret based on their assessment of whether the silence is a communication of intrapsychic conflict or development arrest. Analysts are warned that "the consequences that result from misinterpreting the manifestation



of an arrested development phase as a resistance appear to us far graver than the error of misconstruing a resistance as a developmental step” (Stolorow & Lachmann, 1978, p. 97).

Developmental arrest as distinguished from structural conflict applies to failure in ego development, principally concerned with aspects of self-object differentiation and integration. Absence or impairment in the patient’s sense of identity, ability to reality test, anxiety tolerance and impulse control are indications of borderline or psychotic levels of ego development (Trimboli & Far, 2000). The recognition of developmental arrest may be through the diagnosis of the patient’s use of primary defense mechanisms, for example projective identification and splitting rather than repression or else a lack of secondary defense mechanisms (McWilliams, 1994). Assisting one’s judgement as to whether the patient’s silence is conflict or developmentally based may be in the garnering of a full history in the preliminary interview. In Coltart’s (1991) thirty year experience, the potential for the patient to become silent cannot be predicted.

*Other considerations.*

Even when the patient’s thoughts are suppressed or repressed in the silence there may be visual imagery or sensory experience that they are aware of in the silence (Boyer, 1986). After asking the patient to recall the omitted thought in the silence he suggests wondering with the patient about these sensory or visual experiences which may provide analysable symbology.

Coltart (1991) suggests making interpretations as simple and economic as possible with silent patients and avoiding theorizing or intellectualizing. Extending an invitation to the patient in order to search for what is being communicated in the silence may be the only way the patient can feel unchallenged or attacked (Blos, 1972).

Clues to the significance of the silence can often be found in the patient’s last expressed ideas. These may have led to some disturbing recollection or association. Likewise, what the patient has to say immediately after the silence may be relevant

although often it is difficult to recognise (Weisman, 1955). Indeed attention to these factors has been of great therapeutic benefit in my experience.

### *Summary and Critique*

Psychoanalytic authors who have written about silence as communication believe that silence is an analysable phenomenon that can be understood in light of the object related transference and here and now relationship. Understanding the silence in the interpersonal field is emphasised in this chapter. Patient regression, often stimulated by the analytic situation, may induce the re-creation of early and even preverbal relationships and is seen as a chance to resolve these and resume growth.

Although there are similarities in the way in which silence as communication and silence as resistance are described as according to the developmental struggles the patient is grappling with, object relations theory has added to the understanding that whilst the analyst may be able to decipher what is going on for the patient during their silence, this is not necessarily amenable to interpretation. Allowing the patient to overcome their silence by themselves may provide them with the necessary conditions for growth. This is most important with patients with severe developmental deficits.

The authors who describe silence as communication recognise the importance of both an attitude of analytic openness to, and an understanding of concordant and complimentary aspects of countertransference as tools to assist the analyst to tolerate the silence. Countertransference responses are largely seen as indispensable with the silent patient to assist in building a picture of the patient's internal object relations. However, judicious use of these responses is important so not to impose the analyst's subjectivity over the patients. In the case of non-neurotic patients, analysts may silently form ideas about the patient's struggles and internal object relations but not necessarily interpret or push these understandings back onto the patient. In these situations it is important to keep these countertransferences in the feeling state, disengage from the patient's projective identifications and act differently.

Whether or not the analyst should interpret the silence or simply leave the patient to overcome the silence themselves is an area of disagreement for analysts. The consensus is that if the silence is because of a developmental arrest then the analyst should tolerate the silence without intervention, simply being with the patient and allowing them to spontaneously overcome the silence. There are however additional questions that have not been addressed such as how long the therapist should endure the silence without intervention and the possible ethical and professional responsibilities of the therapist in these cases.

In a similar fashion to those who describe silence as resistance, authors in this chapter overemphasise the interpersonal aspects of silence with little consideration for the aspects of unconscious intrapsychic resistance. The reality that silence may contain aspects of both of these has seemingly been polarised. This may be due to the political nature of theoretical allegiances in psychoanalytic circles. It should not be a case of to hold vs to interpret but rather, recognition that both are necessary for a full understanding. Like Kernberg (1979) I believe that balancing an empathic attitude and genuine concern, with persistent efforts to cognitively understand is most important with silent patients.

## Chapter Three

### Silence as Creativity

The space between symbol and symbolized, mediated by an interpreting self, is the space in which creativity becomes possible and is the space in which we are alive as human beings, as opposed to being simply reflective reactive beings. (Ogden, 1986, p. 213)

This chapter includes understandings of patient silence as creativity. First it looks at patient silence as reverie and space for symbolic expression. Second this chapter describes silence as developing inner peace, and third, silence as connection. Fourth, this chapter looks at silence as thinking, remembering and reflecting. Fifth, this chapter looks at two additional understandings of silence, as non-communication followed by silence as socio-cultural. The last section of this chapter is a summary and critique.

#### *Silence as Reverie and Space for Symbolic Expression*

Patient silence may be a creative space for reverie (Goldberg, 1989, Leira, 1995, Ogden, 1997, Slochower, 1999). “The analytic use of reverie is the process by which unconscious experience is made into verbally symbolic metaphors that re-present unconscious aspects of ourselves to ourselves” (Ogden, 2003, p. 727). Bion (1962) hypothesised that reverie (preconscious dreamlike thinking) in concert with unconscious dreaming and conscious reflections are the ‘container’ processes. The enhancement of these functions, in particular the capacity for dreaming one’s experience whilst both awake and asleep in dynamic interaction with thoughts and feelings derived from lived experience (the contained), is what he viewed as the aim of psychoanalysis. It is seen as the analyst’s task to create the conditions necessary for this growth.

Leira (1995) draws from Bion’s concept of reverie in her work with silent patients and attempts to maintain a state of calm receptiveness. This allows her to take in the patients’ feelings, give them meaning and make sense of the underlying fears. Just like the mother and infant, the analyst does the unconscious psychological work of dreaming the infants’ (patient) unbearable experience and makes it available to him

in a form he may utilize for dreaming his own experience. Eventually then, the infant (patient) introjects this capacity for reflection of his own states of mind.

Balint (1958) relates silence to primary psychic creativity and creation as they emerge in early ego development. He described the 'creation level' of the mind where there is no external object and his main concern is to "produce something out of himself" (p. 337). It is from this area of the mind that creative processes, insight and understanding develop. The silent analytic space may present the necessary conditions for the patient to develop an experience of self as subjective subject and object, where they experience a sense of self as "alive, vital and resilient" (Slochower, 1999, p. 840). "In silence, discarding space-filling clichés and verbal automatisms, there is the possibility of a gap within which symbolic expression becomes possible" (Greene, 1982, p. 186).

Patient silence may function as a protection of an inner space and promote inner transformation and connection between experiences, affect and verbal language that enables changes in relationships (May, 1999, Ronningstam, 2006). A silent space in therapy may offer the psychotic patient a chance to "rebuild walls that have been ruptured catastrophically" (Kurtz, 1984, p. 241) and a place where the person can individually define themselves and reach out to others.

### *Silence as Thinking, Reflecting and Remembering*

In silence the patient may be seriously thinking about an experience. It may be a time where the patient is engaged in quiet self-reflection (Lane, Koetting & Bishop, 2002; Martyres, 1995; May, 1999; Olinick, 1982) or "a period of germination that potentially contributes to the genesis of useful clinical material and self-generated insight" (Meissner, 2000, p. 347). Silent moments may represent the "direct facilitating prelude to conscious ideation and verbalisation" (Wallerstein & Lilleskov, 1977, p. 694).

The silent patient may be examining, absorbing and internalising an interpretation (Fonagy & Target, 2000, Gale & Sanchez, 2005, Greenson, 1961). Greenson notes that a correct interpretation could be followed by a silence where the patient is

breathless with surprise or one where he is taking time to digest a new insight. These types of silences are followed by confirmatory material. Patient silence may imply confusion and a need to reorganise thoughts and feelings (Lane, Koetting & Bishop, 2002). The patient may be attempting to re-establish a sense of self esteem after a recollection or an interpretation by the analyst that has wounded the patient's narcissism (Arlow, 1961). Whether the patient is quietly connecting with or struggling to regain or maintain control over their feelings, the therapist may need to simply respect these silences. The types of patient silences noted in this section are abundant in the therapeutic relationship and perhaps it is this obviousness that has led to little psychoanalytic commentary on them.

### *Silence as Developing Inner Peace*

Deep in the unconscious of man is a longing for silence and quiescence. (Shafii, 1973, p. 432)

Silence may be important for the development in the patient of internal peace and strength (Nacht, 1964, Shafii, 1973). Silence between the patient and analyst may be a "tranquil, quiet experience of harmony" (Balint, 1955, p.239), or a soothing place of solace (Olinick, 1982). Here "the analyst must limit himself to a certain way of being present, with an underlying, deep-felt attitude compounded of acceptance, availability, and the sincere desire to help the patient" (Nacht, 1964, p. 301). The analyst must "be, without qualification, the good object who will allow the patient, through an internal process leading to a resolution, to experience the integration of the object so satisfying that he will definitively abandon the regressive phenomenon of transference corresponding to an archaic incorporation, both oral and aggressive, of the analyst" (Nacht, 1964, p. 301).

When this process has been achieved the patient may be able to hear and integrate the words of the analyst from a peaceful inner silence rather than the agitated and tumultuous currents of thought that abound when there is fear associated with their silence. "All opposition and all ambivalence will lose their sense and their *raison d'être*. It is precisely this which allows the patient to accept willingly the integration of the analyst as object" (Nacht, 1964, p. 301). Inner strength may be garnered from

such times of union and at the same time Nacht warns against the patient settling into or clinging to this state and the analyst only allowing it at crucial moments.

### *Silence as Connection*

#### *With the therapist.*

Well individuated people can share times of deep appreciation - a sentiment I associate with the ability to love without blurring one's boundaries. Sometimes they are birth-moments of incorporation- the patient takes the analyst in as a new object and an indestructible resource. Or there can be a joyful mingling of feelings that is not threatening but revitalising. These are healing passages in a relationship. (Kurtz, 1984, p. 239)

The silent space may provide a means for affective connection where the patient and the therapist are joined in absorbing something significant, whether they are experiencing something frightening, shocking, heart-warming or otherwise (Bolgar, 2002; Lane et al. 2002; Loewenstein, 1961; Olinick, 1982). In these wordless instances Stern (2002) suggests that the analyst resist the temptation to speak and simply be satisfied with the feeling of resonance. Connecting with the nuances and shades of feeling associated with such moments is not a verbally articulated experience. When the patient can be silent this may represent a profound trust in the analyst (Kurtz, 1984).

#### *Vignette.*

*Towards the end of the hour Ms D (diagnosed with schizoaffective disorder, a patient of mine from the beginning of my training with knowledge of my upcoming graduation) asked whether I was finished my studies. Replying that I would be finished in a few months she said how great that would be and told me that over the time she had known me I had changed a lot. I replied that she also had changed. Ms D then said 'maybe we have changed each other' and I replied that I believed we had. Ms D and I became silent with a feeling of recognition that something very significant had come between us. The silence was filled with a sense of connection*

*and contentment that was both unexpected and vitalizing, where there was no need for words.*

*With oneself.*

Drawing from eastern philosophy and meditation practices some authors emphasise the adaptive and liberating experience of silence (May, 1999; Shafii, 1973). In silent meditation the individual directly confronts his own being, breaking the chain of cause and effect potentially allowing freedom from the compulsive use of body movement, language and thought. As the patient allows himself to let go of previously held automatic defenses he renews the opportunity for new processes of inner reorganisation (Fiumara, 1977; Nacht, 1963; Olinick; Serani, 2000). May (1999) defines personal freedom as “the capacity to pause in the midst of stimuli from all directions” (p. 163).

*With a higher power.*

Silence has played a central function in the human search for insight into universal principles and has held special importance for religious and philosophical groups in attempts to establish direct communion with a higher power or with nature (Gale & Sanchez, 2005; May, 1999). “Through all of history, silence has been associated with feelings of awe and reverence by which man moved closer to ineffable and inexorable forces” (Weisman, 1955, p. 244).

One of Freud’s close friends proposed to him that the source of religion was “...a sensation of ‘eternity’, a feeling as of something limitless, unbounded- as it were, ‘oceanic...it is a feeling of an indissoluble bond, of being one with the external world as a whole” (1930, pp. 64-65). Freud acknowledges the existence of the oceanic feeling in people but does not believe it to be the source of religious needs. He argues that for a feeling to be a source of energy it is the expression of a strong need. Freud traces the infant need for the father as protector to infant helplessness and the oceanic feeling to the restoration of limitless narcissism, “a shrunken residue of a much more inclusive- indeed, an all embracing bond between the ego and the



world about it” (p. 68). Beyond this, psychoanalytic theory is not adequate to understand mystical or spiritual experiences.

### *Two Additional Understandings of Patient Silence*

#### *Silence as non-communication.*

There are some patients whose silence is representative of their inability to utilise the verbal-symbolic code necessary for both intrapsychic and interpersonal communication (Goldberg, 1989). These (non-neurotic) patients are unable to join the analyst in the “exchanging or sharing of experiences within a consensual framework of meaning” (p. 454). Silence for these patients may correspond to a fundamental alienation from the analyst’s frame of reference born of an original failure of the environmental provision of “the hold” (p. 459). The failure to internalise the holding environment leads to a dialectical incapacity between the experiences of reality and fantasy for the patient. In this situation substituting interpreted meaning for experientially symbolised meaning will have little useful effect for the patient (Bollas, 1987, Bromberg, 1994).

In this situation the first task for the analyst is to actively search internally for a holding or containing position that is acceptable to the particular patient. The difficulty in this situation being that the patient is not only alienated from the analyst’s verbal-symbolic frame but they will also attack this frame as it represents the destruction of their own frame which may include narcissistic, hallucinatory or somatic forms of self-containment and meaning-creation (Goldberg, 1989).

With some patients silence may indicate a return to “the pretend mode” of the very young infant (Fonagy & Target, 2000). In this state they are incapable of maintaining contact with ordinary reality as they have entered a separate psychic reality. In this state the patient is not amenable to interpretation and in fact may not even hear the analyst’s words perhaps responding only as if they had been awakened from a state of reverie. This dissociation may be an attempt to escape from the intensity of feelings that the analytic situation produces (Dince, 1977; Fonagy & Target, 2000).

Gabbard (1989) also writes that with the management of borderline and psychotic patients it is of optimal importance that the analyst maintains openness to the patient's projections yet keeps these in the realm of a feeling state rather than acting out of the counter-transference. He notes that after the analyst has recognised the projective identification he may wish to return these to the patient in the form of interpretation, however this will only heighten the resistance. Adopting a non-intrusive attitude until the analyst becomes a transitional object and the analytic space a potential place of play is cited as the useful technical choice with silent non-neurotic patients (Green, 1975). Leira (1995) describes her attitude as corresponding to Winnicott's (1956) description of 'primary maternal preoccupation' with silent patients described as having an infantile character.

*Silence as socio-cultural.*

In a rare psychoanalytic paper that deals specifically with silence and culture Ronningstam (2006) looks at the ways in which cultural experience of silence influences the formation of the therapeutic alliance and the outcome of the therapeutic process. She notes that silence may be perceived as polite by some cultures and in others it may be an expression of hostility, exclusion or ostracism. In some cultures silence is highly valued yet in others silence is considered an indisposition or handicap. Some cultures value silence because it is better to remain silent than to lose control and risk separation or estrangement. The use of silence in everyday speech is not a culturally universal phenomenon and analysts need to be aware of the cultural differences as possibly influencing the patient's use of and relationship to silence. White (cited in Blos, 1972) suggests that the clinician takes time to understand these socio-cultural aspects and other cultural phenomena such as physical proximity, eye contact and facial movements.

Other factors that may influence patient silence may be related to socio-economic factors as White (cited in Blos, 1972) noted in psychiatric interviews with lower class patients which indicated conscious suppression of verbalisation because of the unfamiliarity of the situation and socio-cultural expectations. Different cultures have different perceptions of the psychoanalytic relationship, for example a seemingly

passive and largely silent patient may not be simply compliant but may be expressing their respect for the authority of analyst related to their cultural background.

### *Summary and Critique*

This chapter describes the creative and integrative aspects of patient silence. In silent reverie the patient may be enhancing their capacity to connect with unconscious aspects of his self. If the analyst is receptive to their own reveries created in the therapeutic dyad they may enable the patient to introject the capacity to do the unconscious psychological work of dreaming that enhances the relationship between container and contained processes that leads to growth.

Alone in silence, the patient may find the space within himself for the creation of symbolic expression which increases their sense of vitality and aliveness. Here, connections, insights and inner transformation may take place. Similarly the patient may be thinking, reflecting or remembering in their silence. The analyst may be able to assist the patient to develop a sense of internal peace in silence if he limits himself to a way of being that contains without qualification a deep-felt attitude of acceptance and devoted availability.

Patient silence may represent occasions of deep affective connection in the relationship between themselves and the analyst where words are unnecessary. It also may represent the patient's connection with himself in a way that frees him from previous automatic defenses and compulsive patterns of being. Patient silence may produce a feeling that can be described as mystical and limitless that gives him a sense of strength and connection with something greater than himself.

In the light of the abovementioned creative silences, the conditions for these may be dependent on the analyst's ability to find a therapeutic stance that allows for meaning to be created within a consensual framework. Some patients may be alienated from the analyst's verbal-symbolic frame of reference. Here, an active and creative effort to search internally for a holding or containing position that is acceptable to the patient is the analyst's initial task. Socio-cultural variations may also influence a

lack of understanding in patient silence. This is an area that lacks thorough investigation.

This chapter is significantly smaller than the first two perhaps because the psychoanalytic literature emphasises patient silence as resistance and communication. These creative silences however, may represent some of the most significant moments for the patient and for the depth of relationship between patient and analyst.

## Conclusion

The ideal to be strived for is the acceptance of complexity, of paradox, of multiple determinations, and, by implication, of a fluid though informed and thoughtful technique. (Akhtar, 2000, pp. 276-277)

### *Summary of Findings*

This dissertation considers three broad types of patient silence to provide the therapist with a frame for understanding and clinical decision making. This division is a simplification of the many possible determinants of patient silence. Patient silence at any moment may be an interaction between resistance, communication and the creativity of the patient and analyst.

The findings of chapter one understand patient silence as resistance. Silence in this view is seen as unconscious intrapsychic conflict that can be viewed through the lens of psychosexual stages. Knowledge of structural processes between the id, ego and superego help to inform interpretations aimed at getting the patient to resume talking. If the analyst is sensitive to the patient's level of anxiety and directs the interpretation at first assisting the patient to understand the dynamic and genetic determinants of his silence as an ego defensive reaction, the patient may be able to integrate these without being overwhelmed by an interpretation aimed directly at the unconscious wish.

The findings of chapter two emphasise the communicative and interpersonal aspects of patient silence. Internal object relations and the transference manifestation of these may be understood through processing of the therapist's countertransference responses to the silence. Pre-oedipal developmental needs or deficits may be communicated in silence and re-worked in the therapeutic dyad through the analysts' holding and containing functions. In this situation adult language may not always suffice. This brings into question the necessity of interpretation and verbalisation as the only means to the resumption of growth. With patients who have severe developmental deficits, holding and containing the silence is seen to assist the development of ego-strength. Patients who display less regressive features in the

silence may also respond well to the therapist accepting their silence without interpretation yet efforts to cognitively understand as well as empathically ‘be with’ the silence are necessary aspects of a full analysis.

The findings of the chapter three enlighten therapists to the creative and integrative aspects of silence. Within these silences, the patient may be connecting with their conscious and unconscious in new ways that create symbolic expression, inner transformation and insight. The patient and therapist may be affectively connecting with each other in profound, wordless moments. Silence as non-communication and silence as socio-cultural are two additional types of silence included in this chapter, highlighting areas of consideration where patient and therapist may hold differing frames of reference that may impede the therapeutic process.

The purpose of dividing patient silence into these three broad categories is to shed light on the differing perspectives in which patient silence can be understood and used in the service of the patient. However, these categories are not exclusive. There are resistant silences that may communicate something to the analyst and communicative silences that may involve processes of resistance. Creative processes may be at work within either of these silences. By holding this frame in mind however, the therapist may feel more capable of tolerating and making use of patient silence for therapeutic gains.

#### *Limitations of Study / Further Research*

Inevitably, there is a level of subjectivity in the inclusion and exclusion of studies and material presented in this dissertation. However, attempts to limit this bias have been made through the advice of my supervisor. As this dissertation is exclusively qualitative research from expert opinion and case studies, judging the rigor and validity of these is not defined as in the case of quantitative research methods.

This review includes only psychoanalytic literature on patient silence and in doing so leaves out understandings offered by other psychotherapeutic modalities. This includes some quantitative research and further expert opinion which may provide insights into patient silence. Quantitative psychoanalytic research on patient silence

would add a level of validity to these findings and as such would be useful further research.

The area of socio-cultural aspects of patient silence is greatly overlooked by psychoanalytic authors and research in this area may provide insights for therapists. In New Zealand it would be useful to have knowledge of socio-cultural aspects of patient silence from our own context, including cross-cultural investigations.

It is beyond the limitations of this dissertation to review all of the literature on non-verbal communication yet the addition of these studies would complement this review enormously.

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