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WHAT WE DO IN THE SILENCE: AN EXPLORATION OF THE CHALLENGES AND OPPORTUNITIES PRESENTED BY SILENCES IN THERAPY

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ABSTRACT

The silence of patients in therapy provides many challenges to the therapist. It is vague, undefinable and is difficult to challenge. It can signify resistance and negative transferences but can also be a space for the patient to communicate something that cannot be expressed in words. As a result of its ambiguous nature it can challenge the therapist's confidence in their own abilities and create anxiety or tension in the therapeutic relationship. This paper aims to explore some of the developments in the understanding of patients' silences in therapy, as well as some of the ways an therapist can work with silent patients. It is hoped that the paper will help therapists to understand more about what a patient's silence can mean and also provide guidance on how best to work with silence in therapy.

CHAPTER ONE: INTRODUCTION

The realm of psychotherapy is one of speech. The patient presents themselves primarily in their words. The phrase “talking cure” is so deeply embedded in the idea of psychotherapy that the importance of silences can be overlooked. When silence does occur it can cause discomfort, unease, tension, and fear. Ultimately the only resolution to silence is to break the silence, to end it with speech. Silence does not resolve silence as speech may resolve speech.

Silence has long been thought and written about in areas such as philosophy, the arts and theology, with writers as diverse as Adolus Huxley, Martin Heidegger and Mother Teresa contributing to the subject (Valle, 2019). However, what the definition of silence is can be hard to pin down. Outside the world of psychotherapy many attempts have been made to categorise the different types of silence that exist. Bruneau and Ishii (1988) proposed three categories of silence-related phenomena: silence (solitary or mystical), silences (conscious silence and turn-taking silences) and silencing (where one is silenced by fear or a power imbalance), whereas van Elferen and Raeymaekers (2015) suggested another Five Forms of Silence: metaphorical, silence by negation, actual silence, virtual silence and absolute/metaphysical silence. In therapy silences can occur that last a few seconds (Hill, Thompson, & Ladany, 2003), right up to cases where silences have lasted across several sessions (O'Toole, 2015).

In early psychoanalytic thinking Sigmund Freud (1912) saw silence as a resistance to the process of analysis, stating that transference issues relating to the therapist and sexual conflicts caused the patient to be unable to free associate. In writing about the patient’s use of silence Freud spoke of silences as a function of defence (1912) before developing a theory which saw silence as a resistance which in itself could communicate something about the patient’s unconscious processes and their ego (1926) .

In the field of psychotherapy, research attempts to categorise and define the types of silences that occur in therapy include Tindall & Robinson (1947) who examined counsellor initiated versus

counselee initiated silences, and the Pausing Inventory Categorization System (Levitt, 1998) which sought to differentiate between Productive and Obstructive silences.

Studies have suggested that silences between therapist and patient can be caused by interpersonal problems such as attachment insecurity (Daniel, Folke, Lunn, Gondan, & Poulsen, 2018) . According to attachment theory silence can be perceived by patients as hostile or punishing depending on how silences were used in the patient's childhood as has been seen in a number of case studies (Khan, 1974) (Lief, 1962) (O'Toole, 2015).

A strong therapeutic relationship is key to the effective use of silence and caution has been suggested around using too much silence with patients who have been diagnosed with a personality disorder (Flora, 2018). A therapist must be conscious that using silence can be seen as a judgement, and that for different patients it can be seen as an expression of "agreement or disagreement, pleasure or displeasure, anger or love" (Lief, 1962)

The importance of silence in the therapeutic relationship should not be underestimated and this paper will look to highlight some of the key theories around silence and how it can be worked with for the benefit of the patient. Winnicott stated that "there is room for the idea that significant relating and communicating is silent" (1965, p. 184). Silences have been seen to make up an average of 5% of a therapy session (Sharpley & Harris, 1995) and in other cases to make up many weeks of sessions (Khan, 1974). As such silences should be seen as an important part of the work that takes place between therapist and patient.

However, in widely used college textbooks (Culley & Bond, 2011) (Mearns, Thorne, & McLeod, 2013) there is little time given to the significance of silence and how best to work within it. Guidance is given on how to break silences but not on how it might be useful, what to look out for in a silence, or where silence should be avoided. This paper will look to bring together theories of silence from psychoanalysis and object relations to provide the trainee therapist with a greater appreciation of the depth and potential of silence in therapy.

This paper does not discriminate between silences of a few seconds or minutes, and those that last a number of sessions. At the core of a silence of any length there is one common factor: a space between therapist and patient of great potential. A potential that rivals that of speech in its ability to stimulate growth, promote self-awareness and strengthen the bond between therapist and patient.

Chapter Two will look at psychoanalytic theories around silence in therapy, particularly how Freud's early view of silence as a form of conscious resistance by the patient developed into a view of silence as a symptom in itself which could be worked with in analysis. This development can be seen as a softening of the approach of psychoanalysts from a rigid and prescriptive position where silence was not tolerated, to a position where understanding and empathy are given greater importance. It will then look at silence through the lens of the Object Relations school. It will focus on the works of D.W. Winnicott and John Bowlby as they explored the significance behind silences and what it can communicate about early childhood experiences and how the patient relates to their environment.

Chapter Three will explore some of the ways in which psychoanalysts can work with patients who are silent and how the approach has become more tolerant and curious about the roots of the silence. Attention will be paid also to the growing appreciation of the role of countertransference when working with silent patients. The importance of a therapist's self-awareness and ability to tolerate and sit in the silence is shown to be a critical skill.

CHAPTER TWO: PSYCHOANALYTIC THEORIES ON SILENCE IN THERAPY

Anna O can be said to have done a great disservice to how psychoanalysis views the phenomenon of silence when she named the treatment she undertook with Breuer as the "talking cure" (Freud, 1893). This moniker has followed psychotherapy over the last century and from his earliest writings it is clear that Freud agreed with Anna O, in that speech was the most essential part of therapy. About the treatment Anna O received Freud (1926) wrote that "nothing takes place between them except that they talk to each other". This chapter will look at how psychoanalysis initially viewed silence as a form of resistance to treatment, and the development of the theory that silence can also serve as communication when words fail. Attention will also be paid to Attachment Theory and the work of D.W. Winnicott and John Bowlby.

Freud and Psychoanalysis – from defence to communication

From his observations on the case of Anna O (1893) Freud developed the belief that any attempt to avoid speaking or supress speech was against the very spirit of the psychoanalytic treatment. For Freud silence was a form of resistance which the patient was consciously using to avoid revealing thoughts which they found too painful to reveal (Arlow, 1961). In speaking and verbalising their thoughts, the energy of the patient's instinctual drives would be released slowly and in a controlled manner, as opposed to through their actions or symptoms; speaking was the only way to release the unconscious and to ease the patient's symptoms (Zeligs, 1961). By refraining from speaking the patient was seen to be breaking the basic rule of treatment.

Freud's solution was to explain to the patient that their silence was a resistance to treatment and that their silence would not be permitted:

> "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)

He believed that by simply reassuring the patient that speaking was the path to their cure then they would drop their resistance and the treatment could continue. This would suggest a level of control over the resistance, that the silence is a conscious choice and that the therapist's role is to reassure the patient and alleviate the obstruction through simple instruction (Zeligs, 1961). For an early therapist this would have been a reassurance, a very simple solution without any need to feel a responsibility to examine the silence more closely.

It was not until many years later when Freud (1926) introduced his structural hypothesis of the id, ego, and superego that this view would change. In this theory the motivation behind the repression, such as silence, is usually outside the patient's awareness (Inderbitzin, 1988) . According to Arlow (1961) silence is the result of this conflict between the discharge tendencies of the Id and the Superego which the Ego tries to mediate as safely as possible. The Ego fears that it may lose control if it allows free expression of the Id, as well as a fear of the therapist's negative reactions and their own shame (Davies, 2007). As a form of defence there is an "unconscious ego process of repression" which supresses the patient's speech to satisfy this conflict between the Ego and the Id (Zeligs, 1961).

Freud (1926) described how the Super-Ego uses silence as a defence when speech may reveal identifications that are too dangerous to be communicated. This can be the case when the super-ego is trying to protect the patient from forces in the therapy that would alter its personality (Kutz, 1984). The function of the Super-Ego can also be to use silence to punish the therapist while simultaneously inviting punishment on the patient themselves (Davies, 2007).

This theory adds much more significance to the patient's silence and the impact of the therapist's response is therefore to be of much greater importance. Whereas previously silence was seen as a conscious objection or protest against the treatment, it was now recognised as a symptom in itself and something that had to be worked with, rather than as an obstruction to the greater work at hand (Arlow, 1961). The analysis of silence as a form of resistance could now be seen to yield important information about "the ego and its contributions to normal and pathological compromise formations"

(Inderbitzin, 1988). Sabbadini (1991) likens silence to Freud's parapraxes (1908). Similar to how we do not forget appointments, but rather decide not to remember them, silence is an active process, a repression that requires mental expenditure (Sabbadini, 1991).

As psychoanalytic theory had developed the perspective that silence is a function of discharge (O'Toole, 2015) or communication (Davies, 2007) has become more widely investigated and accepted within psychoanalysis. The gradual acceptance that silence can also operate as communication, especially of infant or childhood traumas, was greatly supported by the work of theorists in the field of object relations.

Winnicott and object relations

Coming from an object-relations background Winnicott was primarily concerned with the pre-oedipal stages of human development and the relationship between mother and infant (Winnicott, 1958). He believed that the capacity to be alone in the presence of another is one of the most important signs of maturity in the emotional development of the infant. The infant is able to discover their own personal life when they are provided with an experience of ego-relatedness by their mother. They become able to allow id impulses and sensations to arrive and be experienced spontaneously without the need for omnipotence (Davies, 2007). Without this ability the infant can display feelings of anxiety as a result of fears of being abandoned. This can be caused by neglect by the mother and deprivation in the environment provided to the infant (Winnicott, 1971).

Winnicott (1965) also proposed the concept of the transitional or potential space. This is a space between fantasy and reality, where the infant (or patient) creates out of themselves rather than being reactive (Ogden, 1986). Winnicott emphasised the need for this space to not be disrupted and replaced by reality too soon. This includes the therapist being ahead of the patient in terms of their interpretations, 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). In this situation silence can take hold and the therapist's ability to tolerate

the ambiguity and uncertainty of such a situation is fundamental in allowing the patient to take the initiative and produce something from within himself (Winnicott, 1971).

Winnicott's theory of play (1971) is also relevant in the theory of silence as communication. In this space the patient can create rather than react. The therapist's presence plays the role of the mother and in the silence the patient experiences the interplay of "personal psychic reality and the experience of control of actual objects" (Winnicott, 1971, p. 71). In this space the patient can use silence to communicate with the therapist, enacting experiences from their earlier life or express something about how they relate to the therapist. Silence has been seen as a way to express fear of the therapist (Calogeras, 1967), a way to guard one's self from exposure of vulnerability (Kutz, 1984), and asserting authority in the face of what can be seen as the more powerful figure of the therapist (Greenson, 1961)

By allowing the patient's silence to exist the therapist is following Winnicott's rule to resist the urge to reintroduce reality too soon (Winnicott, Playing and Reality, 1971). This allows the patient to lead and create something independent of the therapist (Winnicott, 1971). Therefore space and time should be given to allow the patient to spontaneously overcome the silence without intervention from the therapist (Davies, 2007). For Winnicott silence is analogous to play and his solution to the problem of how to work with a silent patient places the responsibility on the therapist to create the conditions that will allow the patient to play in the silence between them:

> "psychotherapy is done in the overlap of two play areas, that of the patient and that of the therapist. If the therapist cannot play, then he is not suitable for the work. If the patient cannot play, then something needs to be done to enable the patient to become able to play, after which psychotherapy may begin" (Winnicott, 1971, p. 72)

As Sabbadini (1991) puts it, the task of the therapist is not to make the patient talk, but rather to discover "why he cannot speak to me".

Coming similarly from the Object-relations school of thought Ronald Fairbairn developed the Endo-psychic structure in which the inner world is a reaction or response to how the patient is treated and

how they experience their object relations. According to Fairbairn (1952) the infant ego splits the object when their object relations fail to show that he is loved. From this splitting of the object comes the splitting of the ego. The schizoid person then turns in on himself to deal with the cruelty of this object relations. As the patient represses the pain and distress of their caregivers failure to meet their basic needs it can be repressed to such an extent that it presents as silence in the therapeutic process (O'Toole, 2015). In this way the silence that occurs is not just a result of the patient's internal psychic structure, but must be understood relationally, as an interpersonal attachment dynamic.

Bowlby and Attachment theory

Building on John Bowlby's attachment theory (Bowlby, 1988) the theory of silence as defensive strategy is explained by O'Toole (2015). He suggests that silence comes to be used as a technique to regulate the patient's arousal of their fear system when there is an absence of effective caregivers. This is an unconscious process and the patient will generally be unaware they are using silence as self-defence.

Bowlby suggests that there are two instinctive systems: careseeking and caregiving (O'Toole, 2015). These two systems are dynamic with one being unable to exist without the other:

> "A careseeker cannot achieve the goal of careseeking without the co-operation of a caregiver. Likewise, the caregiver cannot achieve the goal of caregiving without the co-operation of a careseeker" (Heard, 1997).

Heard suggests that Winnicottean "play" is interrupted when careseeking is aroused. Play cannot resume until the caregiver is able to "hold" the infant in a way that the goal of careseeking is achieved. Following the satisfactory resolution of the attachment dynamic the infant can return to play (O'Toole, 2015). In patient's where this dynamic was not satisfied at a young age there can develop an inability to seek care when they have repeatedly been disappointed previously (Bowlby, 1988). This can manifest in silence in therapy as the patient fears they will be disappointed by the therapist's response similar to how they were let down in childhood (O'Toole, 2015). Recognising that silence may be the only way the patient has learned to communicate this aspect of their trauma is very important in these

situations as a negative or unhelpful reaction can serve to confirm the patient's fears and deepen the silence further.

As the theory of silence as purely a form of resistance to treatment has been replaced with a greater appreciation of the communicative value of silence the approach of therapists to working in the silence has also changed. In the following chapter we will look at some of the ways the therapist can work with and support the silent patient by applying the theories outlined in this chapter.

CHAPTER THREE – WORKING IN THE SILENCE

Where the first chapter looked at some of the psychoanalytic theories that try to explain why a patient may present silently in a session, this chapter aims to explore some of the ways in which an therapist can work in that silence. It will also look at the value of countertransference and self-awareness when working with a silent patient. As we have seen defining what a silence can mean, or its roots for the patient, is a difficult task. However, it should be recognised as an area where significant work can occur:

> "…silence during analysis, whether it be a pause or a prolonged interval, serves either to *promote* or to *impede* the analytic process. Which of these occurs depends on how the patient uses silence in the transference, and, likewise, on how silence is dealt with by the analyst" (Zeligs, 1961, p. 17)

Psychoanalysis and Silence

Davies (2007) draws together a number of key learnings on how silence as resistance can be worked with. Initially the early recommendations were that the therapists should meet the patient's silence with their own (Ferenczi, 1919). However, this was seen as a potential contributory factor to the patient's defence if they interpreted their therapist's silence as an implicit criticism (Glover, 1955). Similarly, Borderline and Psychotic patients are believed to be more sensitive to silences, and they may require more support due to weakness in the ego (Greenson, 1961).

A more compassionate approach is espoused by Levy (1958) to help reduce the patient's anxiety around their silence. The therapist must not badger and hound the patient with questions and statements, but rather present an "expectant but not impatient silence" (Davies, 2007). The therapist must retain their sense of empathy and not attempt to too quickly interpret the patient's silence; if we are too quick to try to relieve the patient's discomfort and not hold the tension and friction that silence creates then the therapist can miss the chance to work in that space (Somerville, 2016). A curious and open attitude must be maintained to allow the therapist to reflect on the sources and aims of the silence the patient is presenting. Silence should be recognised as a two-way street by the

therapist, where the patient is studying the therapist's silence with as much attention as the therapist is studying the patient's (Coltart, 2000).

The therapist is also warned against taking offence or becoming frustrated at a patient's silence, as this can be sensed by the patient (Greenson, 1961). The therapist can be left to feel useless if the patient does not speak and may feel that the patient is working against them by withholding material (Busch, 1992).

Where silence is manifesting as a resistance to the process in stubbornly silent patients care must be taken. Sabbadini illustrates the difficulty faced by the therapist when deciding whether or not to confront or draw attention to a patient's consistent silence:

> "I knew that she was likely to experience my letting her stay quiet as evidence of my lack of understanding and caring; at the same time I also knew that she would have experienced my breaking of the silence as a painful and persecutory intrusion into her space" (Sabbadini, 1991, p. 234)

Although Sabbadini may be overestimating her ability to predict her patient's reactions accurately, this vignette does illustrate the ambiguity of silence and the challenge for the therapist in knowing how best to respond.

Coming from the object relations viewpoint the therapist must be aware that the patient's silent withdrawal has been learned in the dynamics of attachment with their primary attachment figure and "only by re-entering a relationship where their fear can be regulated by an effective response from the caregiver… can the full restorative process become active and a sense of well-being restored" (O'Toole, 2015, p. 352). The importance of being able to sit with a patient's silence and notice one's own feelings is critical in relating to the patient and attempting to hear in the silence what they cannot express verbally. This view is supported by Leira (1995) who states that if the therapist can remain aware of his nonverbal participation in the transference that forms between the therapist and patient then a "shared creativity of insight occurs in the intersubjective space" between them.

Non-verbal ques like facial expression, body language, and where muscular tension is held in the body can also provide clues to understanding patients who are silent (Davies, 2007). Even when the patient is silent there is communication occurring as described by Freud:

> "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, p. 77)

Greenson (1961) agrees that even the silent patient will betray their desire to communicate. The therapist can focus on their patient's "posture, his movements, or his facial expressions" and observe their embarrassment, anger, or other repressed energy. While silence can suggest that there is a resistance to communication the body can reveal some of their feelings in how they hold themselves. He gives the example that eyes lightly closed can reveal love or safety, while eyes clamped tightly can suggest fear and helplessness (Greenson, 1961). While this can be a useful starting point he warns that pointing out such expressions to a patient can leave them feeling exposed or vulnerable.

Countertransference

The importance of countertransference is emphasised by Khan (1974) and O'Toole (2015) and is now recognised as of great importance when working with patients who are silent (Fuller & Crowther, 1998) (Elson, 2001). Countertransference can be a useful phenomenon if "the therapist successfully understands his or her reactions and uses them to help understand the patient" (Hayes, Gelso, Goldberg, & Kivlighan, 2018). When faced with silence there is a need to examine and be aware of one's own reactions as a window into what the patient is communicating. Coltart (2000) states that "the best work with a silent patient is done within the transference, by means of the finely tuned instrument of the countertransference", while Blos (1972) wrote that the therapists own reactions to the quality of silence in analysis will help them to understand the material that the patient is repressing.

According to Fuller & Crowther (1998) "silence is the patient's best method of stimulating countertransference in the analyst" (p. 527). They explore how in sessions with patients who were

silent over a long period of time they could see that the patients were suffering but unable to express it. Other countertransference reactions which were noted were shame at not being enough use; a feeling of hatred towards the patient; a feeling that they were being used as objects by narcissistic patients; and that silence may represent the patient's self-sufficiency. This final point could be very dangerous for a therapist. By allowing themselves to believe that the patient is silent because they don't need help, they could allow themselves off the hook and become complicit in allowing a patient to maintain a long-term silence unchallenged or unexamined (Sabbadini, 1991).

Similar to Bowlby's theory of caregiving/careseeking outlined previously, they note how one patient was torn "between the need for help in unlocking her impasse and her resentment at needing such help" (Fuller & Crowther, 1998, p. 528). In the therapeutic setting, a patient who is unable to seek care from the therapist will fall silent. As outlined previously this is usually the impact of experiences where caregivers did not respond satisfactorily to the patient in their infancy and childhood (O'Toole, 2015). When the caregiver is inactive and not responsive the careseeker stops trying to provoke the reaction they desire for fear of continued rejection. O'Toole gives a number of examples of patients who learned in their early years that to look for care or attention was futile and destined to disappoint and as a result, they presented in therapy with "a learned defence of silence" (O'Toole, 2015, p. 352). The therapist needs to be able to sit in this discomfort and feel in the countertransference what the patient is trying to communicate with their silence (Zeligs, 1961).

A case study published by Masud Khan is used to illustrate how an eighteen-year-old patient name Peter remained silent over six sessions and drew the therapist into the experience that he had lived through in his own childhood. Khan (1974) examines how the patient, through their prolonged silence, was forcing him as the therapist to experience the silence that had dominated their own childhood. Through this countertransference he came to recognise how difficult the patient's childhood had been, as well as the futility and impotence the patient was reduced to:

> "I could sense in my role as child-Peter, that he must have felt reduced to impotence, futility, and exhaustion, through the mood and behaviour of this other person, just as I was experiencing these now through him" (Khan, 1974, p. 172).

For Peter silence was the most effective way to communicate the pain and loss he felt.

Through his own case studies O'Toole (2015) suggests that through close observation of his own reactions to the patient's silence this lapsed careseeking instinct can be recognised by the therapist. As he recognised his own boredom and apathy when working with his patient, he became conscious of how the patient required the therapist to reawaken their interest in the world and in communication. He says he "had to tune into how I was feeling being with him, my countertransference, and begin to help him think about things and describe them" (O'Toole, 2015, p. 354) . O'Toole realised that he had to be different to the patient's previous caregivers and actively engage the patient to reawaken their enthusiasm and stimulate careseeking behaviour. In this case to have responded with extended silences would have only strengthened the patient's belief that to look for attention was hopeless, and that staying silent was their best defence from further disappointment. The interplay here between knowledge of object relations theory, as well as countertransference issues, contributed to his ability to work effectively with the patient's silences.

CHAPTER FOUR: CONCLUSION

While silence has captured the imaginations of artists and philosophers for many years placing any single meaning on it has proven an impossible task. Similarly, the role of silence in the therapeutic relationship between therapist and patient has inspired much research and thought but precious little in the way of conclusions or concrete theories.

Since the early work of Sigmund Freud there has been a softening of attitudes towards patient's silence. As the theory of Ego Psychology developed there is a greater appreciation of the unconscious repression of energy by the ego to avoid loss of control, judgement and shame. Where it was once seen as a resistance it is now recognised as an important part of the work between therapist and patient, a phenomenon that must be treated with as much attention and care as what the patient presents in their speech.

The work of Bowlby and Winnicott of the Object-Relations school has shone a light on how silence can communicate experiences and emotions from a pre-verbal stage in the patient's life. When words fail silence should be recognised as an expression in itself, one that can provide rich material for analysis. While it may appear on the surface that very little of value is occurring, the transference between patient and therapist can be very powerful and come to reflect early childhood traumas where silence became a learned system of defence.

Working with patients who are silent is a challenge for an therapist. The ability to sit with a silent patient patiently and without rushing to judgement is key. Therapists must not submit to feelings of frustration or annoyance with a patient who they feel is being uncooperative. An open-minded approach as well as a confidence that there is something being communicated by their silence is necessary to work effectively and to not abandon the patient.

Countertransference has also come to be seen as one of the best tools available to help the therapist hear what cannot be put into words. By sitting with the patient, accepting their silence, and paying

attention to one's own reactions and emotions, the therapist can hopefully bring to light for the patient something they might never have been able to express in their words. When the therapist can sit warmly and in an accepting manner with their patient in the silence, they can reduce the chances of the patient feeling abandoned or ignored by a lack of a verbal response. However, working with silence requires commitment and ability on the part of the therapist. The ability to recognise one's own reactions and emotions has been shown to be key to this work.

For the inexperienced practitioner, the importance of one's own personal therapy is emphasised by the case studies on silence. To sit with a silent patient is a situation that requires patience, understanding, courage and self-control. Vanity can be the therapist's greatest obstacle to effective work, when a desire to show one's usefulness and provide an interpretation can interrupt the opportunity to do valuable work with the patient.

Due to the difficulty in categorising and defining silence there is limited quantitative data that can guide those working with silent patients. At present case studies currently provide the greatest support and guidance in this area. Research that look into the levels of discomfort, anxiety and feelings of being useful to silent patients, and whether these reactions vary with theoretical background would be useful in exploring what training could be helpful for inexperienced and trainee practitioners.

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