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Silence as communication in psychodynamic psychotherapy

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Abstract

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

Keywords: Patient's silence; Therapist's silence; Silence as intervention; Silence as resistance; Silence as transference; Nonverbal communication

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

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1. Introduction

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

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

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

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

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