Intervention in psychotherapy is usually thought of as an active process in which the analyst says or does something. That the therapist’s silence may be a stimulus eliciting or inhibiting responses from the patient may be overlooked. The silent patient has from time to time evoked discussion in the literature, but comparatively little has been written about the therapist’s silence. In a sense, this is somewhat strange, since every beginner in psychotherapy or in psychoanalysis is immediately confronted with the question, “When do I speak? When do I keep quiet?” It was put well by Ferenczi 2 years ago when he said a perpetual problem to decide is “when one should keep silent and await further associations and at what point the further maintenance of silence would result only in causing the patient useless suffering.” The quotation implies that silence may be beneficial or harmful. This paper will discuss some of the situations in which silence is salutary or damaging, and the various technical problems confronting the psychotherapist who has to deal with these situations.

PSYCHOLOGY OF SILENCE

The general meaning of silence has been discussed at length by Zeligs and by Enelow. Briefly, silence may be protective, provocative, or envelop a shared experience, either pleasurable or painful. Silence may express and even enhance empathy, or may express and even enhance misunderstanding or angry disruptive feelings between people. A person may signify his defensive, resistant attitude by his silence. On the other hand, silence may be profoundly expressive and deeply communicative.

Silence may indicate agreement or disagreement, pleasure or displeasure, anger or love. It may be expressive of a sense of fulfillment or of emptiness, of compassion or an absence of feelings. Silence may warm or chill, may be laudatory and accepting or cutting and contemptuous, may say yes or no, or may be giving or receiving.

Silence may reflect many varying moods and feeling states. Its ambiguity in interpersonal relations may be seen by a perusal of the listings under silence in the Oxford Dictionary of Quotations. A partial list of descriptive words and phrases includes eternal, expressive, icy, sad, gracious, restful, desolating, deep as death, deep as eternity, heavenly, golden, noble, the virtue of fools.

Although the ambiguity of silence...
makes for ease in misunderstanding, it also provides a medium *par excellence* for communication of affect. Feelings come through undistorted by words which may also conceal as well as reveal.

If silence is not necessarily empty space-time, but is often full of meaning, when and under what conditions does the therapist's silence become meaningful and thus become an intervention? Obviously, much of the time when the patient is free-associating the silence of the therapist is not an intervention, but the passive complement of the patient's activity. In this situation, the silence of the therapist is not felt by the patient as a stimulus. When the analyst's silence becomes a stimulus, whether this is perceived consciously or unconsciously, it is an intervention. This is true whether the analyst's silence is deliberate or not.

Since silence on the part of the therapist can be an intervention, and since silence can often convey affect better than words, it stands to reason that it has to be used with a great deal of tact. As Zeligs puts it, "The misuse of the analyst's prerogative of silence, either by gross omission or by failure to make a subtle or timely intervention (maybe just a grunt or an 'ah!'), may have strikingly untoward effects." The patient almost always regards the therapist's silence as deliberate and calculated.

Actually, there are many reasons why the analyst remains silent. Most deliberate is his remaining silent when the patient wants or expects the therapist to talk. A somewhat less deliberate silence occurs when the doctor is in conflict about what to say or how to say it and decides the safest course is to remain quiet. On occasion, the therapist remains silent because he is afraid that speaking will betray his feelings. During most of the time the therapist is silent he is attempting to facilitate the patient's communication through his own silence.

When the silent patient feels the two-person silence as an emptiness, as a void, quite frequently he fills it by resuming his associations. Not infrequently the silence is felt as a threat to his control. He feels diminished by his inability to perform. As one patient put it, he feels guilt by lack of association. In this case, the therapist's silence is a definite intervention.

Much more frequently the patient feels the therapist's silence as an active encouraging force and reacts positively to it. In this case silence, while an intervention, is empathic and non-threatening. On occasion, however, the doctor's countertransference produces a battle in which silence on both sides is used as a weapon for control. In this type of transaction silence may be a much more potent intervention than talk.

The battle for control may produce a passive rather than an active silence on the part of the therapist. He may play the complementary passive and silent partner to a very active and loquacious patient who controls the session through a long-sustained filibuster. The patient who constantly interrupts the therapist before he can get started with an interpretation taxes the ingenuity and patience of the therapist, who may for a time, at least, take the easy way out through remaining silent. This type of patient usually does not feel the therapist's silence as an intervention unless the silence is greatly exaggerated. I have seen an analyst in this situation fail for several weeks to say anything at all, even hello or goodbye, to such a patient until it became apparent to the patient that something was wrong. Countertransference feelings may make the therapist use silence unwise in an oppositional or com-