Clinical Article

The Sound of Silence: Engaging the Quiet Adolescent

Alexander H. Sheppe, M.D.

Abstract

Engaging the silent adolescent is a major psychotherapeutic challenge. This article presents a comprehensive approach to this problem, illustrated with clinical material. This approach emphasizes a careful diagnostic assessment, including an assessment of the patient's level of personality organization and capacities to participate in psychodynamic psychotherapy. Three approaches to the silent teenager are explored in depth: a mostly supportive approach focused on containment of maladaptive behaviors; a psychodynamic approach with supportive elements focused on demonstrating safety through humor, play, normalization, and self-disclosure while exploring the patient's automatic relationship patterns; and a psychodynamic approach using transference-focused psychotherapy for adolescents (TFP-A), aimed at effecting long-lasting changes in the patient's views of self and others and their characteristic ways of managing conflict and stress, with gradual movement from a tendency for controlling, protective silence to vulnerable, cooperative sharing.

Keywords: personality disorders, transference focused psychotherapy, psychoanalytic psychotherapy, psychodynamic psychotherapy

Engaging the silent adolescent represents a unique challenge in psychotherapy. Teenagers use silence with great frequency—silence is encountered here perhaps more than at any other developmental stage. Clinicians need ways of conceptualizing and effectively addressing this important, difficult, and ubiquitous issue.

Surprisingly little has been written about how to handle this challenge in psychotherapy with teenagers. A search of the psychodynamic psychotherapy and psychoanalytic literature yields few examples of this problem, and fewer still detailing techniques to address it. There are several discussions of silence in adults (Arlow, 1961; Blos, 1972; Cooper, 2012; Fliess, 1949; Freud et al., 2001; Fuller & Crowther, 1998; Greenson, 1961; Levy, 1958; O'Toole, 2015; Sabbadini, 1991; Zeligs, 1961), but these

Corresponding author: Alexander H. Sheppe, 122 East 42nd Street, Suite 3200, New York, NY 10168. Email: ahs2156@cumc.columbia.edu.

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do not consider the unique challenges and developmental differences in adolescents. Acheson et al. (2020) gave an excellent overview of the limited history of theory about adolescent silence, and they developed a novel research method of examining silences in psychodynamic therapy sessions with adolescents, but they did not discuss specific techniques of engagement. Several writers detailed case examples of their experiences with silent teenagers in attempts to approach this issue.

Masud Khan (1963) was one of the first to describe silence in adults and young people as not only a resistance to engagement but also a communication of an internalized relationship pattern. He illustrated this in psychotherapy with an 18-year-old traumatized young man, who communicated through silence a relationship in which the patient was acting as the controlling aggressor, and the therapist felt the experience of the helpless victim (a reversal of the roles in the patient's traumatic childhood experience). The therapist's technique was to tactfully verbalize this relationship, which resulted in a reflective discussion.

Billow (2004) described a case of a 15-year-old who was often silent and said she had "no need of therapy" despite multiple difficulties. His technique included efforts to "contain" the "projective identifications" of "retaliatory silences" and "with humor, sarcasm, nonverbal as well as verbal acknowledgment, [attempt] to bring to the fore . . . the reality of her negative feelings . . . about [the therapist]" while avoiding what he saw as unhelpfully "unduly confronting her defensive inconsistencies, denials, and rationalizations."

Anagnostaki (2013) illustrated a 3-year period of silence with a preadolescent patient who alternated between angrily raging against the therapist and silently hiding under a couch. The therapist attempted to "contain" the patient's "acting out" by balancing between her own "holding" silence ("not a 'talking cure' but a 'silent cure'") and putting into words the patient's nonverbal emotional communications ("I'm trying to understand why you are so angry with me . . . maybe you think I am also angry with you," and, "You sound so sad").

Gensler (2015) used three clinical examples to show movement from adolescent silence to engagement because of "relational" interventions, particularly his use of containment ("staying interested and not giving up"), humor ("mock complaint"), and countertransference examination and disclosure ("I told him that at times I felt inadequate").

These writers skillfully illustrate in individual case examples many of the challenges the silent teen poses. They also demonstrate several helpful techniques that appear in nearly all discussions of this issue. These include careful use of humor and irreverence, "containment" (tolerating the uncomfortable situation and trying at first to understand it without trying to change or escape it), examining countertransference

for clues about the patient's internal world, and tactfully putting into words for the patient hypotheses about what is happening in the relationship and why. These techniques attempt to engage the patient and promote talking and reflecting over the action of silence. The eventual goal is to use this knowledge of automatic patterns of relating to better understand the patient's presenting difficulties, and to consider different and flexible ways of managing life's challenges. These case examples are quite useful, but all lack a comprehensive and systematic approach to the matter of adolescent silence.

I advocate for such a comprehensive and systematic approach grounded first in a careful diagnostic assessment and a psychodynamic formulation of the patient's difficulties and likely reasons for silence, followed by deployment of psychotherapeutic techniques specifically tailored to those diagnostic impressions and the formulation of the meaning of their symptoms. These techniques include entirely supportive measures, psychodynamic measures blended with supportive techniques, and a psychodynamic approach using techniques of transference-focused psychotherapy for adolescents (TFP-A; Normandin, Ensink, et al., 2021).

Diagnostic Assessment

Any discussion of the management of silence needs to be grounded in a diagnostic assessment of the patient's difficulties. Before speculating about the psychological meaning of silence, it needs to be considered whether silence follows from a medical or psychiatric condition. If the patient has autism spectrum disorder or a psychotic disorder, silence should not be managed primarily with psychodynamic psychotherapy; instead, wraparound services, family and behavioral interventions, and medication may be indicated. If the patient is silent due to major depressive disorder or a major anxiety disorder, these should be treated—while psychodynamic approaches can in some cases be helpful, alternative approaches should be considered, including medication, cognitive-behavioral therapy (CBT), interpersonal therapy, and others. If a patient is silent and has posttraumatic stress disorder, approaches such as trauma-focused CBT and prolonged exposure therapy should be considered.

Once medical and psychiatric diagnoses have been considered, it is important to assess the adolescent's level of personality organization and to consider the diagnosis of a personality disorder. Personality disorders in adolescents often manifest symptomatically with silence during sessions, and these diagnoses, particularly borderline and

narcissistic personality disorders, are demonstrably and specifically treatable with evidence-based psychodynamic psychotherapeutic techniques (Caligor et al., 2007, 2018; Clarkin et al., 2007; Diamond et al., 2022; Normandin, Ensink, et al., 2021; Yeomans et al., 2015). A standardized measure of assessing personality organization and pathology in adolescents is the Structured Interview for Personality Organization in Adolescents (STIPO-A), adapted from the adult version (Clarkin et al., 2016) and expanded to include scales representing domains of personality functioning and development in adolescence (Biberdzic et al., 2018; Normandin, Weiner, et al., 2021).

The adolescent's level of personality organization will generally correspond with the nature and degree of silences presented in psychotherapy. Teens with typical (or "normal") personality organization demonstrate developmentally appropriate integrated and flexible views of themselves and others, use of mature defenses, intact reality testing, low levels of aggression, and integrated moral functioning (Biberdzic et al., 2018). They tend to readily engage in psychotherapeutic encounters and can logically verbalize why they are seeking help or why psychotherapy is not necessary for them. Silences in these patients, rather than pathologic, are likely to be effective uses of contemplation and reflection, and demonstrations of a healthy "capacity to be alone" (Winnicott, 1958).

Adolescents with a neurotic level of personality organization display integrated views of themselves and others, but with one circumscribed area of conflict. These patients function well overall in life but have symptoms of rigidity, inhibition, and anxiety, often when faced with conflictual issues around aggression, assertiveness, and sexuality. Patients with neurotic personality organization include those with obsessive-compulsive, depressive, and hysterical characters, and those with comorbid anxiety disorders, most commonly social anxiety. A clinical example is Olivia,* a 16-year-old patient who is high-achieving in school and has a group of five close friends, but who struggles with recurring thoughts that her friends find her to be "mean" when she sets reasonable limits, feels mild but not greatly limiting social anxiety, and has dated two or three boys but feels notably anxious when a boy initiates sexual touch; she also struggles with occasional intrusive, unpleasant obsessive thoughts about harming her friends or having sex with a family member. These patients are most often silent in therapy due to anxiety about a thought, feeling, or impulse they feel is unacceptable (often of an aggressive or sexual nature). They believe the thought, feeling, or impulse is unacceptable both within themselves and (via

* All patient names have been changed and identifying information has been disguised.

projection) unacceptable to the therapist, so they stay quiet to protect themselves from judgment and embarrassment. These silences stimulate countertransference fantasies or urges in the therapist to rescue and help the patient, or (often in frustration) to prod the adolescent to be more appropriately aggressive, assertive, or sexual. These patients can often be helped with psychodynamic psychotherapy, psychoanalysis, medication management, CBT, or a combination of these modalities.

Adolescents whose personalities are organized at a borderline level present the greatest challenges with silences that can be effectively addressed by psychodynamic psychotherapy. Teenagers with borderline personality demonstrate developmentally inappropriate identity diffusion (a problematically distorted and inconsistent view of self and others), predominant use of primitive defenses (denial, projective identification, omnipotent control), intact reality testing that can waver under stress, dangerous use of aggression (against self, others, or property), and compromised moral functioning (repeated lying, cheating, and/or stealing). These patients often present as emotionally and behaviorally chaotic, at times using dangerous aggression, and they exhibit compromised capacities to perform in school and to form stable friendships and romantic relationships. While identity consolidation is a major task of adolescence, and all typical adolescents struggle with forming a sense of identity, those with borderline personality exhibit an exaggerated inability to keep in mind objectives and commitments and lack stable representations of others. At least one validated instrument has been developed to distinguish typical identity from the disturbed identity seen in adolescents with personality disorders (Biberdzic et al., 2018; Feenstra et al., 2014; Goth et al., 2012).

In addition to other psychiatric diagnoses noted above, the differential diagnosis here also includes attention-deficit/hyperactivity disorder (ADHD), disruptive mood dysregulation disorder (DMDD), oppositional defiant disorder (ODD), and conduct disorder (CD); all of these may be better treated by medication and/or behavioral therapies (including DBT for DMDD) if a comorbid personality disorder is not present. For DMDD, ODD, and CD, a careful diagnostic assessment will often yield a comorbid personality disorder amenable to a structured psychodynamic psychotherapy.

Silences in teenagers with borderline personality have a different quality than those presented by typical or neurotic personality patients. Rather than pensive (typical) or anxious (neurotic), these silences often have aggressive, controlling, and sadomasochistic qualities. These qualities are communicated nonverbally, whether through facial expressions (furrowed eyebrows, frowns, bored expression), body language (tensed muscles, clenched fists/jaw), glaring or persistently avoidant

eye contact, and brief verbal expressions ("no," "fine," "whatever") that are dismissive of the therapist's earnest curiosity and friendly attempts to engage them. These kinds of reactions to the therapist, often present from the first encounter, demonstrate an internalized object relation (I often use the more accessible term "automatic relationship pattern") the patient is bringing into the room via transference. Transference refers to the "patient's conscious and unconscious experience of the analyst in the psychoanalytic situation as it is shaped by the patient's internalized early life experiences" (Auchincloss & Samberg, 2012). This distorts the reality of the therapeutic relationship, in which a curious and compassionate but imperfect therapist is attempting to help a patient who can trust, depend upon, and be grateful for (but also disappointed by) the therapist's imperfect but valuable help. Silence in the consulting room is often the end product of negative transference, a preconceived experience of the therapist as unhelpful, humiliating, controlling, uninterested, abusive, and so on. Patients may protect themselves against this image of the therapist unconsciously by role-reversal (a more accessible term for projective identification)—exerting power, control, and dominance over a perceived hostile situation by remaining silent (unconsciously enacting the hostility perceived in the therapist). In most cases, silence can be seen as the defense of omnipotent control exercised over a negative transference relationship born of a hostile automatic relationship pattern. Why engage with a powerful monster? It is safer to be a silent and powerful monster yourself.

In addition to diagnosis of potential pathology underlying silence, an assessment of the patient's psychological capacities is critical to treatment selection. Patients amenable to psychodynamic treatment, including those with personality disorders, also require capacities to engage in those treatments, however minimally and haltingly at first. Capacities with a particularly good prognosis include high verbal intelligence, psychological mindedness (curiosity and capacity for reflection), and earnest motivation (seeing a problem and wanting to work on it). Silent patients who demonstrate these capacities can be effectively treated with psychodynamic psychotherapy. Patients limited in these capacities may benefit more from behavioral treatment, including motivational interviewing, CBT, DBT, supportive approaches, or psychodynamic approaches with supportive elements. Adolescent patients at or beyond the limits of psychodynamic treatability include those with malignant narcissism, antisocial personality disorder, severely dangerous behavior that cannot be contained, and total unyielding silence and therapeutic disengagement. These patients often merit supportive treatments.

The assessment of all adolescents, particularly those with personality pathology, must include an assessment of active parental contributions to the teen's presentation and difficulties. This is a complex matter that deserves increased attention in future contributions to the psychotherapeutic literature. In optimal circumstances, parents provide a "good enough" environment for the child to mature along typical developmental lines (Winnicott, 1953). For most teenagers, parents are active external influences in their lives, not internalized ghosts from the past. Parental abuse, neglect, and psychopathology can have profound negative implications for ongoing adolescent personality development and the prospect of successful treatment for personality pathology. Teens with personality pathology characterized by predominant silences may have very good reasons to think, feel, and behave as they do in an actively hostile parental environment, and therapeutic attempts to alter the teenager's automatic relationship patterns may fail unless parental contributions to the problem are assessed, contained, and altered to whatever extent possible. This might involve recommending or requiring family therapy, treatment for one or both parents, or involving child protective services. The types and dynamics of problematic parental contributions to the teen's presentation are too various and complex to adequately address here, but I will mention two common examples. Some teenagers are brought to treatment because parents with psychopathology want to locate the source of the problem in the adolescent rather than in themselves, or because parents want to offload parenting functions onto a therapist. A teen's silence in such cases may represent their best attempt to appropriately push back. The teen may have minimal to no psychopathology and individual treatment for them may not be the best or only solution; family therapy, parent management training, or individual therapy for the parent(s) may be indicated in addition or instead. As another example, sometimes parental conflicts around adolescent separation/individuation result in attempts to keep the teenager from developing into an increasingly independent person. Parents may consciously or unconsciously encourage the teenager to silently withdraw from the therapist in order to keep the teenager under their sole influence indefinitely, which actively undermines both the teenager's development and the treatment process. In short, active parental contributions to the adolescent's presentation and psychopathology should be assessed, contained, and altered to whatever extent possible as part of the successful assessment and treatment of the quiet adolescent.

In the following sections I discuss three treatment approaches and specific techniques within those approaches, with a particular focus on

a psychodynamic object-relations approach using TFP-A, which I have found especially effective for engaging silent teens.

Supportive Approach

Steadfastly silent adolescent patients can succeed in avoiding treatment, but they cannot avoid reality forever. If a steadfastly silent teenager is not markedly impaired or engaging in dangerous behavior, they will likely not be treated, and continue a suboptimal developmental trajectory with consequences later in life. If such a silent teenager is markedly impaired, as is often the case with teens with borderline personality, caregivers will seek to contain damage and deterioration, even if the adolescent is completely disengaged from treatment. While this lack of engagement is unfortunate, as we treaters want desperately to engage and foster positive change in our patients, we cannot and should not force them into exploratory treatment. In these cases, a supportive approach is indicated. Family therapy and parental guidance may also be helpful.

In the case examples discussed by writers in the introduction (Anagnostaki, 2013; Billow, 2004; Gensler, 2015), a frequent theme is that of "containing" or "holding," referencing Winnicott (1960). While these terms are most often used to describe a function of the psychodynamic therapist, in these cases where such therapy is not possible, external holding environments are necessary for containing (Gershy, 2018). These include higher levels of care, such as a residential treatment facility, therapeutic boarding school, wilderness therapy, hospital emergency department, inpatient psychiatric unit, partial hospitalization program, or intensive outpatient program. In cases where the adolescent is willing to engage somewhat with nonpsychodynamic outpatient treatment, psychodynamically oriented supportive psychotherapy can focus on consolidating strengths (Rockland, 1989); DBT can address problematic behaviors through learning and applying skills (Linehan, 1993); and motivational interviewing can enhance the patient's motivation to address the problem more effectively (Miller & Rollnick, 2013).

Emma demonstrates the effective use and limitations of a supportive approach. She is a 15-year-old bisexual girl who presented to me after three inpatient psychiatric hospitalizations for impulsive suicide attempts and significant self-harm via cutting. She had been variously diagnosed with depression, bipolar disorder, and schizoaffective disorder and treated unsuccessfully with several medications before the

latest hospitalization, when clinicians began to suspect she had borderline personality disorder. She presented as not actively depressed, hypomanic/manic, or psychotic. She struggled with an eating disorder and ongoing self-harm and suicidal ideation prompted by interpersonal rejection. She had no friends and was failing school due to refusal to attend. Her parents described her as "a rollercoaster, switching between glee and rage throughout the day, depending on what was happening around her" and they felt "constantly scared of what she might do—we're walking on eggshells."

During the evaluation Emma related to me in a silent, angry, contemptuous, and dismissive manner. I was able to engage her somewhat by containing her stance toward me and verbalizing silent indicators of emotion with an attitude and tone of curiosity, with careful use of humor and irreverence: "You look absolutely deathly angry with me" (curious/surprised tone); "Hold on, don't be *too* eager to get started!" (playful tone); "Who should start the argument off here, you or me?" (playful tone); "You're experiencing me now as eager to control you, and you're protecting yourself by being quiet—but also keeping me from being of much help." These techniques are discussed further below. She would soften when her angry and fearful stance was contained, verbalized, and interpreted, and after playful comments she would smirk and reluctantly engage with me in a play-combat dialogue. I discussed my diagnosis of borderline personality with the patient and her parents. They all felt a sense of relief and agreed this diagnosis made the most sense.

While Emma did participate marginally in the evaluation, it was evident she was lacking in psychological mindedness and motivation for psychodynamic treatment, and she lacked basic control over her dangerous eating disorder and self-harm behaviors. I referred her to a DBT-focused residential treatment program followed by a residential eating disorder program, both of which she completed successfully with increased control over these behaviors. Her parents then enrolled her in a therapeutic school. She continues to demonstrate polarized views of self and others with a suspicious and contemptuous stance, rapid oscillations in mood related to interpersonal interactions, and maintains no friendships. Emma still engages with me for medication management for anxiety and motivational interviewing around pursuing a more in-depth treatment. My hope is as she continues treatment, with more maturity, she may be able to work with psychodynamic techniques. These might help Emma verbalize her feelings, entertain curiosity about the meanings of her behaviors, and identify her predominant automatic relationship patterns.

A Psychodynamic Approach Using TFP-A

My preferred approach for the often-silent adolescent with borderline personality organization who is willing and able to engage in a fully psychodynamic treatment is TFP-A. Transference-focused psychotherapy (TFP) is an evidence-based contemporary model of individual psychodynamic psychotherapy derived from psychoanalysis and based in object-relations theory, designed for patients suffering from personality disorders (Yeomans et al., 2015). TFP begins with a careful diagnostic assessment and a discussion of the results of that assessment with the patient/family as part of informed consent. It also involves an explicit and detailed discussion about treatment goals. Prior to starting treatment, the therapist engages the patient in mutually establishing a treatment contract/frame that is necessary for effective treatment and for optimally addressing the patient's stated goals. TFP-A is modified from TFP for adults to address the unique circumstances and challenges of working with adolescents, including considerations for development and the involvement of parents (Normandin, Ensink, et al., 2021).

I use the case of Rachel to discuss the process and techniques of TFP-A. Rachel is a 14-year-old girl, living with both parents, in ninth-grade regular education. She was referred to me by her DBT therapist who felt she had a basic grasp on skills use and would benefit from a psychodynamic approach. Rachel's difficulties began in fifth grade when she reported being bullied at school. While some bullying was indeed observed, this was also clarified to mean that peers were accusing Rachel of being bossy, dismissive, and rude, qualities that her parents independently reported they often observed in Rachel. In the wake of perceived rejection from peers, Rachel began self-harming by cutting her legs with a pair of scissors every other day for several months and hid this from her parents (an early indicator of the use of silence). Several months before seeking treatment with me, she was psychiatrically hospitalized after attempting suicide by cutting her wrist with a box cutter in the wake of an upsetting interpersonal encounter. In the hospital she was diagnosed with unspecified depression and anxiety, prescribed an antidepressant, and referred to an intensive outpatient program with a DBT treatment focus. She engaged well and completed the program, and self-harm stopped with the effective use of DBT skills. Lingering issues at that time included a continuing bossy, dismissive, and rude approach to family and peers, school refusal involving missing several days each quarter resulting in much lower grades than her abilities suggested (her IQ had been measured at 138), and isolation from peers. She had no friends and spent all her free time playing video games alone.

During Rachel's evaluation with me, she and her parents endorsed several symptoms consistent with borderline personality disorder, including unstable interpersonal relationships (friendships were brief and ended in angry rupture), an unstable and fluctuating sense of self ("better than everyone" and "totally worthless") and others ("she's the best . . . actually, she's sort of the worst"), a history of impulsive suicidal and self-injurious behavior, feelings of emptiness, reactive mood and intense anger including screaming at home and dismissiveness towards others at school, and stress-related paranoia related to interpersonal interactions ("everyone hates me"). They denied medical problems, denied a predominantly depressed or irritable mood and active neurovegetative symptoms of depression, and denied significant anxiety and panic.

In additional to probable previous but currently inactive diagnoses of major depressive disorder and generalized anxiety disorder, I discussed the diagnosis of borderline personality with Rachel and her parents. The reaction was one of great relief at having a diagnostic framework that they all felt accurately accounted for her difficulties. I then explored Rachel's treatment goals with her. Rachel stated several goals, including attending school more regularly so that her grades would improve (she wants to be a lawyer), addressing her fluctuating self-esteem, figuring out why she was being bullied and why so many people referred to her as bossy and rude, trying to make more friends, and improving her low weight. She demonstrated high verbal intelligence, psychological mindedness, and earnest motivation for a psychodynamic treatment. Rachel said she felt she knew enough about skills and liked the idea of TFP because she preferred a one-on-one treatment that would focus on understanding herself, her relationships with other people, and her actions. We discussed starting TFP, beginning with mutual agreements necessary for the treatment to be successful.

The contract, which I refer to as "agreements" as a more accessible term with adolescents and parents, functions to set up a shared reality prior to treatment that can always be referred to when difficulties in the treatment process inevitably emerge. It is critical that teenagers genuinely and earnestly agree to a contract. "Lip-service" or non-earnest agreement needs to be carefully monitored for; this is usually expressed nonverbally (eye-rolling, downcast gaze, angry body language, and so on). If this is suspected, it needs to be addressed directly with the teenager: "I get the sense you may be saying yes but you may not mean it—if you actually don't agree, I really want you to tell me so we can discuss it together, otherwise we're going to run into big issues later on, which won't really help you achieve your goals." If the patient does not earnestly agree to basic measures of the contract,

TFP-A is not feasible, and either supportive approaches (see above) or psychodynamic approaches with supportive elements (see below) are indicated.

Rachel earnestly agreed to attend sessions twice a week, on time, and talk about whatever it was that came to her mind about her presenting difficulties. She agreed if she felt suicidal or had an impulse to harm herself, and felt unable to contain those urges, she would tell an adult or call emergency services. She agreed to attend school daily and on time. She agreed to see her pediatrician to discuss ways she might increase her weight. Rachel's parents agreed to respect confidentiality, and not unduly interfere with treatment progressing primarily between Rachel and me. They agreed to meet with me every one to two months to discuss updates and progress, and to make timely payments. They agreed to inform me of any changes in Rachel's life or observations that concerned them. I agreed with all of them that I would attend sessions on time, attend to scheduling, listen carefully, and comment when I felt I could deepen Rachel's understanding of herself. With these agreements in place, we were able to begin TFP-A treatment.

While Rachel engaged well in the assessment and contracting phases, silences began to emerge almost immediately in treatment. In one early session, she arrived 10 minutes late, and was silent. In TFP-A, identifying the dominant affect in a session is of primary importance. I observed Rachel's nonverbal communications from a standpoint of technical neutrality and curiosity, internally reflecting on what was happening without immediately acting. I saw that she appeared angry and dismissive in her facial expression and posture. I also paid close attention to my countertransference. Countertransference refers to the therapist's feelings and attitudes toward the patient in the therapeutic situation, which are influenced by the internal worlds of both the therapist and the patient (Auchincloss & Samberg, 2012). The object-relations approach informing TFP observes that patients with personality pathology make more frequent use of projective defensive mechanisms, which can induce powerful countertransferences in the therapist. In TFP, the therapist examines countertransference as one of the possible "channels of communication" used by the patient and considers countertransference an invaluable source of information about the patient's emotional states and object relations (Yeomans et al., 2015). In observing my countertransference, I noticed feeling angry Rachel was not talking, a feeling of being controlled by her, a sense of incompetence, and an impulse to retaliate, make her speak, or withdraw from her into prolonged silence. I remembered that the subject of recent sessions was school attendance, which had begun to slip—she had arrived to school 30 minutes late on

three occasions. I hypothesized that the dominant affect in the session was anger, expressed by Rachel nonverbally and experienced by me in the countertransference.

The first technique I employed here was "containment" or "holding." In this example containment serves at least three functions for Rachel: It provides a reflective function that the patient does not have herself in the moment (she is acting out something nonverbally rather than reflecting and verbalizing, which I am attempting to do for her), it models for the patient a new example that can be internalized (she may see me reflecting and consider doing that herself), and it provides a new model of interpersonal interaction (a new object relation)—I am not immediately responding as she might expect by impulsively acting against her or withdrawing from her, but rather am attempting to understand her. I was not silent myself in angry retaliation for her silence and did not attempt to cajole or seduce her into talking—I reoriented myself emotionally into a position of genuinely curious reflectiveness and was silent only as long as necessary to think.

Now that I had provisionally identified the dominant affect, I attempted to consider the automatic relationship pattern that had emerged between Rachel and me. This is where the contract is invaluable. There had been a notable shift in the representation of Rachel's object relations in the therapeutic dyad. During contracting, she had experienced herself as someone with difficulties who was willing to make changes and to seek help from a doctor who has limitations but is warmly interested and able to help her achieve her goals. She had expressed an earnest agreement to attend school on time, and to say what came into her mind during sessions. Now, she was arriving to school late, and was silent with me. I needed to make sense, with her, of this confusing contradiction.

I began by simply pointing out to Rachel that she was silent. Her face seemed to harden into greater anger. Note the contrast here with healthy or neurotic patients, who instead of maintaining silence would likely begin to express why they are silent. I moved on to a different technique, which is to verbalize the nonverbal for Rachel—I said to her that she seemed very angry with me. Rachel continued her silence, but seemed to soften in her posture, likely a nonverbal reflective response to my holding: I had acknowledged something she was experiencing and put it into words for her; she was considering that anger may not be so justified against me if I was clearly attempting to understand and help her. I then advanced a hypothesis to Rachel, and acknowledged it was just a tentative idea, not a proclamation from on high: "I don't really know, but it could be that you're angry with me because you

feel I've been forcing you to go to school." This approach to silence—contain, address silence, address affect, advance a hypothesis about the object relation, repeat—is common in TFP.

Rachel finally responded to this, saying, "Yes, I'm furious that you're forcing me to go to school on time. Sometimes I just want to sleep in. You don't care about me at all, you're just rigid and controlling. So I'm not talking with you." As noted above, it is often the case that adolescent silence is the defense of omnipotent control exercised over a negative transference relationship born of a hostile automatic relationship pattern. I elaborated this object relation to her in a calm and curious tone: "You feel I'm uncaring and controlling, and I'm forcing you to do what I want, and you're really mad about that. You're silent to protect yourself from me." This was a clarification, one of the core techniques of TFP-A, derived from classical psychoanalytic technique. This therapist-centered clarification of an object relation serves a containing function. When patients experience a therapist as hostile and controlling, and the therapist voices this calmly out loud, the picture of the therapist as hostile and controlling gets hazy; if the therapist truly were hostile and controlling, the therapist probably wouldn't acknowledge they're being seen that way. The therapist has demonstrated capacities the patient doubted—the capacity to listen carefully and to attempt understand them—which promotes a softening of the automatic object relation, and reflection. This was the case with Rachel—she looked hesitant, internally questioning if she could be wrong about my hostility and desire to control her.

I went a step further and used the tool of the contract to make a bid for reflection (the core technique of confrontation). In patients with borderline personality, containment is necessary but rarely sufficient—reality-distorting defenses are symptoms for which the patient is seeking help, and they need to be tactfully addressed via bids for reflection. I said, "There's something that's confusing to me—you're saying it's my desire that you go to school and I'm forcing you to do that. But I'm only saying you should go to school because *you* said you wanted to do that, to achieve your goals of making friends and bringing your grades up." Here is the payoff of the contract: It gives us a secure base from which we can observe dissociative defenses in borderline patients. Rachel had used the unconscious dissociative defense of splitting, accompanied by a role-reversal (projective identification, a mixture of projection and omnipotent control). She had "forgotten" the part of her that wants to attend school (splitting), attributed that part to me via projection ("you're forcing me to go to school"), and attempted to control the projection in me through silence, a role-reversal (she experienced me as controlling but she was the controlling one).

After my comment, Rachel's demeanor changed from angry to reflective, and she began speaking. "I guess I did say that. Maybe you aren't really controlling me. I know that you want me to go to school because it would help me. It's just really hard sometimes. I don't like the people there and it's hard to deal with them, especially on days when I don't feel great about myself. It's hard to trust them. I guess I'd rather fight with you than fight with myself about going to school." Here, silence has disappeared because the negative transference has, with curiosity, been addressed and confronted by referring to the contract. This prompted reflection in Rachel, an acknowledgement of her reality-distorting defenses ("I'd rather fight with you than fight with myself"), and a shift into acknowledging a more accurate object relationship in which I want to help and she wants to help herself, but it's difficult (a shift from the paranoid-schizoid to the depressive position).

The final core technique of TFP-A is interpretation, derived from classic psychoanalytic technique, which is a hypothesis about the underlying unconscious motivator for a defense. A complete interpretation would outline the object-relation dyads of the defense, the anxiety motivating the defense, and the underlying conflictual impulse. After further exploration of Rachel's underlying anxieties about interacting with peers, I said to her, "You often see me, and others, as mean and controlling towards you, and to cope with that, you turn the tables. You try to control them—you're dismissive towards peers, and with me, you're silent. That protects you, but this thinking can also turn people into something they aren't and get in the way of their helping you. We've seen that with me. As you said, you'd rather fight others than deal with anxieties in you. I think you're really worried no one really likes you, that you can't ever depend on people, even though you really want affection and to show others affection. That sounds really tough." This starts to get at an underlying conflictual dyad around love and dependence. Rachel wants to love and be loved by a caring, responsive other, but fears this is impossible, so she enacts a defensive object-relations dyad in which someone is controlling, and the other is controlled. This protects her but also ensures no one will show her the love she desperately wants.

After about a year of TFP-A, Rachel is attending school regularly and on time, has improved her grades and fostered some friendships, and has courageously begun to allow herself to seek out and anticipate love, rather than remain stuck in a world where the only options are to control or be controlled. The techniques of careful diagnostic assessment, discussing the diagnosis and goals, contracting, containment, verbalizing the nonverbal, clarification, confrontation, and interpretation have aided her in overcoming the tendency toward silence.

Psychodynamic Approaches with Supportive Elements

Some adolescent patients with personality pathology characterized by silence are able and willing to engage in unstructured psychodynamic psychotherapy. These patients benefit from more than purely supportive approaches but are not able or willing to commit to TFP-A. TFP-A is an intensive and ambitious treatment with the goal of lasting personality change, and patients who are able to engage in it can reap those benefits with effort, but it is not for everyone. A psychodynamic approach with supportive elements can still provide significant benefit to these patients, but the pace of personality change is slower, and the depth and stability of change less than with TFP-A.

Common reasons patients are able to engage in psychodynamic treatment but are unable to participate in TFP-A include access, cost, time, and an unwillingness or lack of motivation in the patients, parents, or both to agree to universal elements of the contract. In cases of the latter, one should carefully explore the objections to elements of the contract (being careful not to slip into starting the treatment prematurely), because it is sometimes the case that upon reflection, patients are willing to tentatively engage. Sometimes parents are not able or willing to agree to parental measures of the contract, often due to parental psychopathology. As discussed above, some parents have difficulties with trust, dependency, and control, and are not willing to "hand over" their child to the therapist or allow the teenager to develop a normative sense of independence. They may insist on violating confidentiality ("What did my child say in the session?") or otherwise interfere with the progression of treatment via frequent and intrusive contact, unreasonable demands for availability, asking the therapist to treat them directly or indirectly, not making timely payments, not adhering to safety planning, and so on. While it is painful to decline offering TFP-A to a willing adolescent with problematic parents, treatment cannot proceed successfully without parental contracting.

There are several modifications to TFP-A, which I refer to as a psychodynamic approach with supportive elements. Of course, psychodynamic psychotherapy can be conducted less frequently than twice weekly (most commonly once weekly) and without the presence of a contract. Without the frame of the contract to fall back on as a secure base for bids for reflection, the therapist must rely more on supplying certain things to the patient in an attempt to effect change. Humor, play, normalization, and self-disclosure are effective examples of supportive techniques within a psychodynamic framework, which I illustrate with the case of Liam.

Liam is a 16-year-old boy, living with parents, in 11th-grade regular education. He presented with a chief complaint of procrastination, resulting in conflict at home and school performance below his abilities. Careful assessment yielded no medical or psychiatric diagnosis (ADHD, depression, anxiety, and so on), but Liam demonstrated evidence of personality pathology including rapid oscillations and inconsistencies in his view of himself ("I'm better than anyone at school, I just don't try," "No one would want to be my friend if I was just myself") and others ("Everyone cheats and lies, but you probably never do"), a paranoid orientation ("No one really likes me, they just say they do to get things from me"), and a complete aversion to dependency and asking for help ("Why would I voluntarily make myself look weak?"). He lacked spontaneous and genuine interests and said his only motivation to succeed was "to dominate others so they can't make fun of" him. Reality testing was preserved but wavered under stress. He felt some anxiety in social interactions and when contemplating doing work. He saw work and success as the only way to guarantee no one could make fun of him, but the enormity of the success required to totally protect him combined with his total lack of spontaneous interest in work resulted in procrastination. His paranoid anxieties about others led to frequent silent withdrawal. I discussed with the patient and his family the diagnosis of a personality disorder with paranoid and narcissistic features, with which they agreed, and we explored the possibility of TFP-A.

Liam identified clear goals, including improving procrastination, developing a clearer sense of his interests and career goals, reducing his anxious experience of others as contemptuous of him, and improving his ability to ask for help. However, he did not want to meet twice weekly, and was hesitant to agree to say whatever came to his mind during the session. He wanted to pursue psychodynamic therapy, but the nature of his difficulties (paranoia and narcissistic avoidance of dependency) rendered him unable to agree to these elements of the contract, despite my attempts to explore this refusal and to underline it as a symptom of his difficulties that he would benefit from actively exploring with me. We decided to proceed with once weekly meetings, with the understanding that the rate of progress and depth of change would be limited compared to TFP-A, which the patient accepted.

Some authors in the introduction above discussed humor as a useful tool for engaging silent teens (Billow, 2004; Gensler, 2015). It was helpful with Liam, and I strongly advocate for a careful use of humor with nearly all adolescent patients, to varying degrees. Teenagers are above all allergic to stuffy intellectual condescension, and humor serves to dispel this. As a technique, from an object-relations perspective,

humor is a type of containment in which the therapist attempts to effect change in the patient by acknowledging the patient's sense of danger and demonstrating themselves to be a safe object. Humor and laughter likely evolved as safety signals between people ("The world is dangerous, and some people are dangerous, but you and I are on the same team and we're safe together"), so it is not surprising it is used this way in psychotherapy (Gervais & Wilson, 2005). It is an attempt to effect change in the patient through demonstration and convincing the patient of external reality (the therapist is good and safe), rather than through direct clarification, confrontation, and interpretation of the patient's distortions (the therapist is bad and not safe). This is useful but limited—demonstration and convincing often work temporarily, but rarely change underlying assumptions in the patient. When Liam was distrustful and silent, I would use humor to engage him and demonstrate I was on his side, with additional hopes of increasing his sense of safety enough to motivate him to engage in a deeper treatment: "Wait, you're telling me I'm the only person on Earth who doesn't lie? Can you get me nominated for the Nobel Peace Prize?" and "You're pretty quiet today—maybe you're procrastinating again. I mean, I'm not very fun homework." Liam would usually respond with a smile and a joke of his own and would often start talking more freely. The risk of humor is the patients feeling that the therapist is laughing at them, not with them, and if a joke ever lands this way (if the patient tells the therapist, verbally or nonverbally), the therapist should apologize, explain the joke as an attempt to connect, and inquire about how the misstep was experienced by the patient.

Play therapy is a standard psychodynamic approach when treating young children (Meersand & Gilmore, 2018). With silent adolescents, play can be used as a supportive measure, like humor, to demonstrate safety and facilitate engagement. Shortly after starting treatment, Liam was silent during a session, saw I had a chess set assembled in my office, and asked if we could play. We spent three sessions playing quietly together, after which he was able to speak more about his concerns about competitiveness with peers at school (reflecting a competitiveness with me while playing).

Self-disclosure and normalizing are two other useful supportive techniques. If a silent adolescent is caught up in a negative automatic relationship pattern, this is perpetuated if the therapist is a blank slate: They fill in the gaps with their preconceived notions and remain silent. Especially when evaluating new patients who are mostly silent, I will often share an innocuous fact or two about myself and my interests. This is like humor in that it attempts to demonstrate to the patient I am a human and safe to talk to but does not directly examine the distorted

belief ("the therapist is an untrustworthy robot"). In a similar vein, normalizing is a technique that serves to lower silent patients' anxiety by assuring them they are not alone in their experience. This does not examine the patients' distorted belief that they are alone, but tries to convince with reassurance, which can be helpful. Liam expressed a recurring belief that he was unique in his inability to get work done, that no one procrastinated as badly as him. In a mixture of normalizing, self-disclosure, and humor, I said, "Look, procrastination like this is one of the most common reasons people come to me for help. I sometimes feel bad treating it because I've been putting off writing a paper for weeks."

There are many other such techniques, but these are several common supportive interventions within a primarily psychodynamic approach for quiet teens. In addition to the goals of containment and demonstration of safety, patients will often see some loosening in their fixed automatic negative relationship patterns in the transference to allow for a reexamination of TFP-A. If an earnest interest in deepening the treatment is expressed, contracting should be explored. This was the case with Liam, who is now engaging well in TFP-A.

Conclusion

Engaging the silent adolescent is a major psychotherapeutic challenge. Clinicians need ways of conceptualizing and effectively addressing this issue. I have presented a comprehensive approach to this problem, illustrated with clinical material. I have emphasized a careful diagnostic assessment, including an assessment of the patient's level of personality organization and capacities to participate in psychodynamic psychotherapy. Finally, I have presented three approaches to the silent teenager grounded in diagnostic assessment: a supportive approach focused on containment of maladaptive behaviors; a psychodynamic approach with supportive elements focused on demonstrating safety through humor, play, normalization, and self-disclosure while exploring the patient's automatic relationship patterns; and a psychodynamic TFP-A approach, aimed at effecting long-lasting changes in the patient's views of self and others and their characteristic ways of managing conflict and stress, with gradual movement from a tendency for controlling, protective silence to vulnerable, cooperative sharing.

Alexander H. Sheppe, M.D., Assistant Clinical Professor of Psychiatry, Columbia University Vagelos College of Physicians and Surgeons

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