Maren Scheurer (Frankfurt a.M.)

"What Speech Conceals and What Silence Reveals": Therapeutic Silence in Theater and Psychoanalysis

Theater has often been drawn to the "talking cure", although – or perhaps because – it is riddled with silences. This article seeks to trace this fascination through a comparative reading of psychoanalytic theories on speechlessness and two theatrical takes on therapeutic silence: Tom Kempinski's *Duet for One* (1980) and Sarah Kane's *4.48 Psychosis* (2000). Both plays are focused on therapeutic encounters in which the characters fight with each other as much as they fight fatal illness and suicidal depression. In the written texts, speechlessness must be indicated, through stage directions or through empty spaces on the page; in the theatrical production, these indicators are inevitably transformed into different forms of silence. A discussion of these texts thus allows for a reflection on the various functions of silence in therapy and their transposition into the literary realm as well as for an exploration of the transmedial representation, performance, and reception of silence.

1. Theater and the Talking Cure

Psychoanalysis is known as the "talking cure": therapist and patient meet in order to speak to each other and to resolve the patient's difficulties through language. Even in its laconic simplicity, Sigmund Freud's description of the therapeutic process in *The Question of Lay Analysis* (1926) reflects this focus on speech: "The analyst agrees upon a fixed regular hour with the patient, gets him to talk, listens to him, talks to him in his turn and gets him to listen." (Freud 2001d: 187) However, Freud imagines that an impartial person who has just been introduced to psychoanalysis might be astonished and ask: "Nothing more than that? Words, words, words, as Prince Hamlet says." (ibid.) While Freud's belief in the power of words shall not be disputed here, I will indeed argue that psychoanalysis does not proceed by "words" only. Freud's notion of a therapeutic encounter that depends on alternate talking and listening carries with it the implication that silence may be as much a part of the analytic process as words, and upon close inspection, therapeutic conversations are almost always riddled with troubling moments of speechlessness. Theodor Reik warns his psychoanalytic colleagues that they will always have to contend with "what speech conceals and what silence reveals" (Reik 1948: 126).

In Reik's following brief case study, a pervasive silence thus comes to represent much more than a tranquil listening mode:

> One certain analytic session passed in the following way: [the patient] was silent for about six minutes, then said he had gotten a letter from his mother. Renewed silence. Then: the mother wrote that his father's […] heart attack was interpreted by the doctors to indicate that the end was near. Another long silence. Then came the word which I

> introduced in the beginning: analysis was an "impossible situation" […]. He obviously expected a reaction on my part. Naturally it was not forthcoming. He asked, "Does it often happen that your patients can't say anything at all?" No answer. After a few minutes he said a few sentences about the problem of freedom of will, in which he did not believe. His hands are fists, he shifts his head to the other side of the pillow. […] Suddenly he throws himself about so that I cannot see his face and breaks into uncontrollable sobbing. Toward the end of the session he says, surprised, "I don't know what the hell I cried about" […]. A comment from me was neither necessary nor desirable […]. The session netted only a few sentences, and yet signified a turning point in this analysis. (Reik 1968: 180)

At first, silence seems to be a problem on the patient's side: Something is obviously troubling him so much that he cannot put his pain into words. However, less than half-way through Reik's vignette, other questions become pertinent: Why does the analyst not intervene? Why does he not ask anything or comfort his patient, who is faced with the imminent death of a parent? Even when the patient starts questioning his therapist, Reik chooses to remain stubbornly silent. Almost comically, the situation seems to confirm the stereotype of the mute or absent therapist, which has inspired as much ridicule as awe in popular culture. And yet, this silence, though totally devoid of comfort, is more than a joke; Reik even believes it contributed to turning the entire therapy around. His case study, brief though it is, provides readers with a sense of the ambivalent power of silence: On the one hand, they witness the patient's speechlessness in the face of traumatic experiences and inexpressible emotions. On the other hand, silence is obviously a tool employed by the therapist both to contain and to incite intersubjective frictions within the therapeutic dyad.

However, even as the tension heightens within the patient, he does not necessarily turn to more words to express his discomfort. Reik notes how he clenches his fists, how he moves his head, turns away from the therapist, and starts to cry. The "impossible situation" therapist and patient are faced with clearly cannot be resolved by linguistic means alone, but involves a much more far-reaching performance of words, silences, para- and nonverbal communication. For this very reason, the therapeutic disciplines have long felt a kinship with theater, and numerous psychoanalysts have used theatrical metaphors to come to grips with the communicative complications that arise during a psychoanalytic session.[1] This discursive relationship between psychoanalysis and theater has been reinforced by a fascination with the therapeutic process among playwrights such as T.S. Eliot, Peter Shaffer, Joe Penhall, and Conor McPherson. Among the great number of plays depicting therapy sessions, Tom Kempinski's *Duet for One* (1980) and Sarah Kane's *4.48*

1 See, for instance, Arndt (2004: 380).

Psychosis (2000) pay particular attention to the silences that permeate therapeutic relationships. By exposing a variety of forms of therapeutic speechlessness for analysis on the theater stage, these plays point to interdisciplinary entanglements that shall also be the guiding questions of this article: What are the functions of silence in therapy and in theater? Is there an affinity between therapeutic and theatrical silences, and can they be employed in similar ways? The discursive interconnectedness between the two fields suggests that therapeutic principles may serve as a basis for exploring theatrical principles, and vice versa. Therefore, in what follows, I will first look at psychoanalytic conceptualizations of silence before drawing a comparison between the functions of speechlessness in a therapeutic and a theatrical context. Finally, I will discuss these functions in my readings of Kempinski's and Kane's dramatic renditions of therapeutic silence. In therapy and theater, silence may be used as a device to organize action, facilitate response, and complicate representation. Thus, whether it serves as a resistive barrier, as a protective container, or an overdetermined carrier of meaning, silence also expedites metatherapeutic and metadramatic reflection.

2. Silence in Theater and in Psychotherapy

In psychotherapy, the interplay of two types of silence, the silence of the patient and the silence of the therapist, shape the rhythm of analysis. Whereas the therapist is already acquainted with the dynamics of psychotherapy and, as Reik's case study has demonstrated, may use silence in strategic ways, oftentimes the patient's silence is a consequence of his or her insecurity. Even garrulous patients may never have talked about their "most intimate affairs" or the most private parts of their selves with another person before entering therapy. (Reik 1968: 175) However, as a principle, the "talking cure" does not tolerate the patient's silence forever. The fundamental rule of psychoanalysis requires the patient to say whatever comes to mind, and Freud cautions against any form of concealment:

> You will be tempted to say to yourself that this or that is irrelevant here, or is quite unimportant, or nonsensical, so that there is no need to say it. You must never give in to these criticisms, but must say it in spite of them. (Freud 2001b: 135)

Following these cues from Freud, the silence of the patient has mostly been interpreted as a form of resistance, a "barrier" or a "shield", which is used by the patient as defense against the intrusion of the analyst (Sabbadini 2004: 232). This behavior may be experienced as an almost aggressive form of resistance, but silence can also

"function as a protection of an inner space and promote an inner transformation and connection between experiences, affect and verbal language" (Ronningstam 2006: 1278). By delineating the defensive and protective functions of a refusal to speak, analysts emphasize the self-enclosed, non-communicative dimension of silence.

However, silence, as Andrea Sabbadini argues, is not exclusively a blockade and not the opposite of communication but "a complement to words, in constant dialectical interaction with them" (Sabbadini 2004: 231). Just as language can hinder understanding, silence may be employed to convey what speech cannot capture. Symbolically, it may be related to death and nothingness, but it could also express joy, excitement, or significance; silence may be empty or overdetermined, and it can harbor "verbal impotence" as much as "verbal pregnancy" (ibid.: 239). Therefore, the patient's silence could be conceived of as "a *container of words*", which, according to Sabbadini, should be interpreted like a dream (ibid.: 232–233). Rather than forcing the patient to talk, it is more important to explore why he or she cannot speak and find meaning in his or her speechlessness.

Conversely, the analyst's silence is also continually interpreted by the patient. In the early stages of analysis, it is taken to be a "sign of sympathy", a protective sheath that allows the patient to speak (Reik 1968: 175). This is encapsulated in Freud's second analytic rule, which addresses the analyst's evenly suspended attention:

> [H]e must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone. (Freud 2001c: 115–116)

Listening in silence allows the analyst to perceive the slightest changes in the patient's communicative behavior. However, throughout the analysis, the therapist's speechlessness takes on a more sinister quality. In everyday conversations, speakers are not used to long silences; on the contrary, it is customary that dialogue partners share the burden of speech and acknowledge each other's requests for a response. Prolonged silence, in turn, is associated with "a threatened or already present loss of love" (Reik 1968: 179). The analytic situation deliberately breaks with the convention of reciprocal, reassuring speech acts; there is no such thing as comforting small talk from the analyst. This uncustomary reticence is perceived as unbearably threatening and irritating, and may thus be used to force the patient to open up, assuming that he or she would rather speak than confront the analyst's "disturbing" silence (ibid.: 177–178). In this way, silence becomes an "active force", with both reflective and activating functions, "which drives the patient forward, which pushes

him into a realm deeper than he had originally intended" (ibid.: 177). The ambiguity of silence thus emerges at both ends of the therapeutic process: patients and therapists may both use it as a sign of "disapproval" or of "approval", with "positive and negative symptoms"; and on both sides it may be "icy, weighty, oppressive or calming, haughty or humble, […] condemning or pardoning" (ibid.: 182). Conceived of in this way, silence is not only meaningful, an "active presence" (Sabbadini 2004: 232), but seems to contain an endless potential of meaning.

In this spirit, Sabbadini calls for a new mode of listening to patients: "learning about their inner worlds involves listening to their silences, not just to their words" (ibid.: 230). But how is listening to silence even possible? Psychoanalysts argue that silence communicates through the relationship between therapist and patient. Patients tend to transfer the experiences they have made in previous relationships to the therapeutic relationship and treat the therapist, unconsciously and often non-verbally, just like they would treat their significant others. To this so-called "transference", analysts respond with their own countertransference, which includes emotions that have been triggered by their patients' behavior. In becoming attuned to their countertransference, analysts thus gain access to an important part of the patients' unconscious communication, which may be transmitted even through their silences. Thus, Elsa Ronningstam reports that while with some patients, silence would make her feel "empty, constricted, numb, or dreadfully bored", with others, she continues "to feel present, curious and creative" (Ronningstam 2006: 1286). It is thus important to recognize that each silence is unique to each analytic pairing and finds its meaning only within the context of a singular relationship (cf. Vega 2013: 1213f.).

When Leslie Kane notes in her book *The Language of Silence* (1984) that silence is "ambiguous and suggestive, implicit and connotative" (Kane 1984: 19), one might assume that she talks about silence in therapy. However, her object is silence in theater, which, in her analysis, emerges as similarly diverse, polysemous, and uniquely context-bound. Phenomenologically, dramatic silences may range from explicit "ellipses, pauses, and wordless responses" to forms of "indirect dramatic expression such as innuendo, intimation, hesitation, reticence, and bivalent speech that implicitly conveys more than it states" (ibid.: 15). Clearly, silence's theatrical manifestations also blur the demarcations between speech and speechlessness, and they open the dramatic text to ideas that cannot otherwise be performed:

> Silence […] is infinite. A nonverbal, nonanthropomorphic mode of communication, neither bound to nor fragmented by time, silence is a perfect medium for the multiplicity of human responses antithetic to place, time, and clarity. (ibid.: 179)

Therefore, these strategic employments of silence in theater may stand for the limits of language, for everything that is unspeakable or beyond linguistic expression. Besides indicating a particular kind of skepticism or a negation of language, however, silence may also emphasize the musical quality of language itself, its rhythms and sounds dependent on intermittent and underlying silences (cf. Elzenheimer 2008 19–20). Thus, theatrical silence, to return to Sabbadini's comment on therapeutic silence, can be used to convey joy and significance.

And yet, simply celebrating silence in theater for its boundless ability to encompass (in)significance would be a critical shortcut. Just as much as words, silence can be violent and repressive. For psychoanalysis, Reik and Sabbadini have emphasized the threatening, destabilizing, and irritating forces of silence. During a theatrical performance, silence can indeed have a haunting effect for the audience, who are also, as Rudi Laermans points out, asked to remain silent:

> For this massive silence is not only a performative "death point" but also articulates an unsaid, impossible intimacy between performers and public. Precisely this intimacy, which is full of unspoken dreams and unheard wishes, makes a dramaturgical silence nearly intolerable […]. Indeed, a stretched silence confronts the spectator with her or his own intimacy, with the strange *Schaulust* (Freud) or voyeurism which is constitutive of every performance. (Laermans 1999: 4)

In a manner similar to the activating silence in therapy, theatrical silence can thus become confrontational, allow spectators to review their own relationship to the represented action on stage, and expose the desires and anxieties triggered by the performance. Looked at in this way, theater may even fulfill a quasi-therapeutic function by triggering self-reflection in the audience.

However, complete silence in theater, even for a short while, is impossible. "During a performance", Laermans argues, "the pure word – or the pure movement – is at once made impure by the body that acts as the medium of what intends to be a medium in itself" (ibid.: 5). Again, a comparison with the therapeutic situation helps to illuminate this comment. Both psychotherapy and theater rely on verbal and nonverbal means of communication; because of the patient's transference, his propensity to re-enact rather than reflect on his history, Freud believed that the patient "produces before us with plastic clarity an important part of his life-story" (2001a: 176). Within the therapeutic relationship, the patients become, so to speak, the actors and producers of their own biographies. This is particularly relevant for silent

communication: In theater as in therapy – and as opposed to the written text – silence is usually filled with nonverbal expressions of meaning.

Apart from these compelling similarities, though, therapy is a private form of communication restricted to two individuals, whereas theater is a public representation of communication between fictional creations, scripted beforehand and frequently distributed via writing in addition to its theatrical performance. Therefore, an analysis of theatrical representations of silence in therapy cannot only pay attention to its functions in the play, but must also look at different means of medial transformation.

3. Communicative Silence: *Duet for One*

Tom Kempinski's play *Duet for One,* first performed in 1980, features only two characters: psychotherapist Alfred Feldmann and patient Stephanie Abrahams, a celebrated violinist who has recently been diagnosed with multiple sclerosis – a condition that makes it impossible for her to play her instrument, let alone pursue her career. Stephanie enters therapy to come to terms with this devastating news, and in six one-on-one sessions, Feldmann unearths her anger and her despair, which she has carefully shielded under a mask of optimism. In contrast to many other plays focusing on psychotherapy, *Duet for One* privileges the "internal struggle" of the patient rather than external conflicts between therapist and patient (Jones 1985: 138). This focus on Stephanie's inner world also makes room for the silences this inward-movement entails. Indeed, Kempinski's play is particularly rich in detailed stage directions that indicate and explain significant moments of speechlessness.

Pauses occur frequently throughout the play. Stephanie falls silent "*as she once again determinedly overlooks her inner feelings*" (Kempinski 2009: 20) or when she "*feels as though she has been taken mentally to the cleaners*" (ibid.: 42). Silences such as these often follow long speeches, which the characters have to mull over, and thus also serve as a pause for the audience to reflect on what they have just heard. However, reflective moments may also manifest as short breaks in conversation:

> **Stephanie** […] You're lying; it's as plain as plain chocolate, mate… (*She stops in mid-sentence, and stares into herself*)
> *Feldmann waits a moment for something else. When nothing comes, he probes*
> **Feldmann** (*quietly*) What is it, Miss Abrahams?
> **Stephanie** That's what I used to say to my father, when he invented some nonsense to try and get back into favour with me. That's what I used to say…
> *Slight pause. Stephanie's sarcastic defence is breached.* (ibid.: 25)

Her silence is a moment of interiority, which follows a short statement that the audience – like Feldmann – cannot process in the same way as Stephanie. They have to wait for her to explain her silence after the apparently innocent figure of speech "as plain as plain chocolate". Her pause is thus a complicated form of communication, which tells her audience that something is happening inside. But until she reveals the story with her father, they can only speculate about the meaning of her hesitation.

These communicative forms of silence demonstrate that it can serve as a container for emotions. Stephanie's anger "*shows in her face and grim-faced silence*" (ibid.: 12) just as much as she may be able to use a pause to "*fill […] like a balloon with joy*" (ibid.: 28). It is presumably the actor's task to make these emotions visible for spectators who are unaware of the stage directions. Interestingly, silent anger is also among Feldmann's palette of reactions: "*Pause. When Feldmann asks his question, it really seems that he is suppressing anger. Surely not; is the objective Doctor actually annoyed? It is not clear at first*." (ibid.: 40) The stage directions are curious: Whoever supplies this annotation seems to be unsure about Feldmann's state of mind, and comments ironically on the implicit assumption that Feldmann, as therapist, must stay neutral at all times. None of this is visible to a theater audience: They have to interpret Feldmann's silence without these clues. If silence serves as emotional container, it does so as an ambiguous device: The hesitant stage directions reflect an uncertainty about its meaning. The clear distinction between readership and theater audience is blurred for a moment, as both have to wait for further action before they can interpret the emotional content.

Silence, however, may also be an action in itself. Feldmann describes Stephanie's evasiveness as "defensive behaviour" (ibid.: 24). To illustrate his point, he recounts the story of another patient "who would also not speak. The poor man wasted an enormous amount of money for nothing" (ibid.: 24f.). When pauses invade her speeches, when the stage directions call repeatedly for "*A long silence*" (ibid.: 30) or "*Silence. Silence. Silence*" (ibid.: 37), Stephanie refuses to speak, in order to protect herself from further therapeutic intrusion and progress. In addition, her resistance incites anger and frustration in the therapist. For a theater audience, these silences are similarly difficult to tolerate. Whereas a reader may skip over them quickly, theatergoers are at the mercy of the production and its interpretation of the

actual length of "a long silence". The pauses thus create moments of irritation for Stephanie's listeners.

Due to this irritating quality, silence may also be an instigator of progress, as the stage directions indicate:

> *She waits for his next question. When after quite a long pause it does not come she realizes he is not going to ask another, and looks down at her legs. The pause goes on. And on. And on. To break the embarrassment she asks a question*
> Is that the end of the interview?
> **Feldmann** No. We have quite a lot more time left.
> *There is another long pause, during which Stephanie experiences for the first time the painful feeling of being left to dangle by a psychiatrist as a means of forcing out one's own thoughts and feelings.*
> **Stephanie** (*eventually*) To be honest, I wasn't all that sure about coming to see you, actually. (ibid.: 6)

Clearly, Feldmann is using silence to exert pressure through embarrassment. Therapists consciously use this technique to give their patients room to develop, reflect on, and express their feelings. In a similar manner, the pause in theater serves to heighten the tension and the curiosity of the audience, who may become impatient as they anticipate Feldmann's or Stephanie's next move. Again, due to medial constraints, the theatergoer is less knowledgeable than the reader of the play, less supported and thus "dangling" just as Stephanie is. In consequence, the silences created by the play are more irritating and, therefore, more activating, asking spectators to fill them with their own thoughts and emotions.

Due to Feldmann's and Stephanie's comparatively high standard of communication and self-expression, the "dangling" of the audience is resolved rather quickly by revealing the result of the reflective processes of patient and therapist. In *4.48 Psychosis*, in contrast, the pressure exerted on both readers and theatergoers is more straining.

4. Disturbing Silence: *4.48 Psychosis*

Sarah Kane's *4.48 Psychosis* has neither plot nor clearly delineated characters; it is a composition of lists, poetic interjections, and notes, of disjointed monologues and dialogues. A few pages into the play, however, readers sense that the main topics of the apparently incoherent collection of texts are grief, depression, and suicide, and that they may be witness to the inner life of a psychotic mind (cf. Greig 2001: xvi). And while a secure allocation of character positions remains impossible, certain passages suggest an interchange between a patient suffering from suicidal de-

pression and a doctor attempting to treat her.[2] This interpretation is usually supported by biographical evidence: The play was written while Sarah Kane suffered from depression and was finished only days before she took her own life. Biographical readings of the play abound (cf. Saunders 2006: 110), even more so because the text itself is hermetic and remains silent on such important matters as character and setting. To skip the difficulties of the play by placing it within the interpretative frame of Kane's personal tragedy, however, would not do justice to the irritation these and other ellipses create. Thus, I will not read the play's silences as symptoms of the author's depression but look for their significance within the construction of *4.48 Psychosis*.

The relevance of silence for the structure of the text becomes immediately apparent upon glancing at the first sentences of the play:

> (*A very long silence*.)
> – But you have friends.
> (*A long silence*.)
> You have a lot of friends.
> What do you offer your friends to make them so supportive?
> (*A long silence*.)
> What do you offer your friends to make them so supportive?
> (*A long silence*.)
> What do you offer?
> (*Silence*.) (Kane 2001: 205)

One interpretation of this encounter may be that a therapist is trying to elicit a response from a patient who remains locked in resistant silence.[3] The longer she remains unresponsive, the less likely it is that she needs these pauses to reflect on the questions of her interlocutor and the more aggressive her silence appears. However, even this remains a conjecture, or possibly an intuitive reaction to the silence to which the play exposes the audience. Readers and spectators cannot actually assess the patient's motives, as they receive no further information on the meaning of her speechlessness, neither from the patient nor from the play. The contrast to *Duet for One* is twofold: First, Stephanie is a much more outspoken patient, who, despite her silences, is able to communicate most of her emotions freely; secondly, unlike Kane, Kempinski provides readers with lucid stage directions to guide their interpretation.

2 Alicia Tycer, for example, reads these passages as "transcripts from psychiatric sessions" (Tycer 2008: 33).

3 Other interpretations remain possible, such as an exchange between lovers. However, the neutral and efficient language, as well as the reference to a "professional relationship" in a similar conversation (cf. Kane 2001: 237) suggest a confrontation between a doctor and a patient.

One way to approach this different type of silence is by discussing it within a pathological framework. Clinically, there is a clearly established link between depression and silence. Depressed patients speak less, more hesitantly, and more monotonously than other individuals (cf. Segrin / Abramson 1994: 657). They turn away from their environment and concentrate on themselves, as their pain "tends to draw attention inward and overwhelm all else" (Bucci / Freedman 1981: 353). Sometimes, this psychic pain is not verbalized but remains vague and somatized, surfacing in physical symptoms like headaches (cf. ibid.: 335f.). Crucially, however, the unique structure of silence in *4.48 Psychosis* suggests that we should use these clinical findings as heuristic tools to assess the form of the play rather than to diagnose the characters or the author.

The play exposes language itself as disjointed and depressive, but at the same time, readers may begin to apprehend a form of textual somatization beyond its linguistic features. As the play progresses, line breaks and conspicuous word arrangements leave ever more white space on the page. Eventually, empty, blank spaces dominate the reading experience. Thus, the layout captures as much or perhaps even more than the words themselves; Alyson Campbell observes that it "gives them a sort of tangible, corporeal life of their own" (Campbell 2005: 88). The body of the text becomes the body onto which silence is inscribed. *4.48 Psychosis* is thus a challenge for a theater performance, considering that this communication of silence via blanks is not available to the theatergoer. The impossibility of directly transferring silence to the theater emphasizes its medial specificity and, more generally, the difficulty of meaningfully expressing ambiguous, non-verbalized emotions (cf. Hauthal 2007: 112–118).

Productions of the play usually transfer the silence of the text-body to the body of the performer. In a production by Claude Régys, Isabelle Huppert's performance as the patient was described as almost immobile:

> Every few minutes she extends a finger or two; at two moments of wild, angry emotion she splays both palms. Otherwise, Huppert keeps to a state of near paralysis for the whole performance. (Turk 2007: 159)

The play thus challenges performers to develop analogous, yet different modes of medial visualization of what is not or no longer available to verbalization. The written drama and the theater employ different means to draw the audience into a confrontation with the irritating, unyielding silence of the patient.

The disturbing potential of the patient's silence – which creates a curious tension with Reik's notion of the therapist's disturbing silence – is most clearly encapsulated in another one-sided conversation between putative patient and therapist:

> We have a professional relationship. I think we have a good relationship. But it's professional.
> (*Silence*.)
> I feel your pain but I cannot hold your life in my hands.
> (*Silence*.)
> You'll be all right. You're strong. […] And I know you'll be ok.
> (*Silence*.)
> Most of my clients want to kill me. When I walk out of here at the end of the day I need to go home to my lover and relax. […] I need my friends to be really together.
> (*Silence*.)
> I fucking hate this job and I need my friends to be sane.
> (*Silence*.)
> I'm sorry. (Kane 2001: 237)

Clearly, the patient's silence proves to be utterly frustrating for the therapist, reversing the logic of activating silence discussed by Reik. The patient is, for all her restraint, in a position of power because she is not willing to give the therapist the reaction he needs in order to proceed with his work (Watson 2008: 190). By not yielding to his interventions, she draws him into her despair. Similarly, the audience is drawn into the depression of the patient by the silences of the text: resistance and emptiness frustrate and disorientate them. Alicia Tycer calls this process "melancholic identification" (Tycer 2008: 26). Unable to elicit much from the text, readers and viewers have to turn inwards to search for answers (cf. ibid.: 30). Thus, silence produces a paradoxical form of activation: The patient's resistant silence shifts into an activating silence as the therapeutic dynamic between her and the doctor topples. The longer the patient remains silent, the more the doctor speaks about his own sorrow and frustration until he has revealed more about himself than might be deemed "professional". Through an uncomfortable activation, silence leads both therapist and audience to limits of endurance and experience.

5. Transformations of Silence

It appears that the "talking cure" is haunted by silence. Therapists and patients fall into it; they gamble with its richness and despair over its barrenness. Silence may leave room for reflection, it may be a container for emotions, and it may be a defensive or an activating mode of behavior. As such, it is also employed by playwrights who make use of its potential for expression and for stimulating the audience. While *Duet for One* focuses on the communicative functions of silence that

ultimately bring Stephanie and Feldmann as well as the audience to mutual understanding, *4.48 Psychosis* stages a confrontation with a pervasive and disturbing silence that radically undercuts efforts at understanding and, instead, forces therapist and audience to turn inwards. This activating potential, which mirrors the employment of silence in therapy, is, of course, not limited to plays with a therapeutic frame; instead, it points to structural similarities between the communicative processes in therapy and in theater.

However, whether silence is introduced into the theatrical text through stage directions or the layout, it cannot easily or literally be transferred to the stage. Thus, silence must always be transformed. During the experience of reading or watching a play, the different medial means of representing silence produce tensions between text, performance, reception, and interpretation. Silence thus becomes a nodal point at which metadramatic self-reflection may come into play, highlighting the richness of non-verbal representation, pitting different forms of representation against each other, and reflecting the (im)possibility of communication and interpretation. Highly reflective and emotionally expressive, silence leaves room to think about its aesthetic implications while forcing the audience to confront despair and depression through their own frustration.

Bibliography

Arndt, Peer (2004): "Therapie und Theater", in: *Forum der Psychoanalyse* 20.4, 379–390.

Bucci, Wilma / Freedman, Norbert (1981): "The Language of Depression", in: *Bulletin of the Menninger Clinic* 45, 334–358.

Campbell, Alyson (2005): "Experiencing Kane. An Affective Analysis of Sarah Kane's 'Experiential' Theatre in Performance", in: *Australasian Drama Studies* 46, 80–97.

Elzenheimer, Regine (2008): *Pause. Schweigen. Stille. Dramaturgien der Abwesenheit im postdramatischen Musik-Theater*. Würzburg: Königshausen & Neumann.

Freud, Sigmund (2001a): "An Outline of Psychoanalysis", in: Strachey, James (ed. and trans.): *The Standard Edition of the Complete Psychological Works of Sigmund Freud*. Volume XXIII. London: Hogarth Press, 141–296. [1940]

Freud, Sigmund (2001b): "On Beginning the Treatment", in: Strachey, James (ed. and trans.): *The Standard Edition of the Complete Psychological Works of Sigmund Freud*. Volume XII. London: Hogarth Press, 121–144. [1913]

Freud, Sigmund (2001c): "Recommendations to Physicians Practising Psycho-Analysis", in: Strachey, James (ed. and trans.): *The Standard Edition of the Complete Psychological Works of Sigmund Freud*. Volume XII. London: Hogarth Press, 109–120. [1912]

Freud, Sigmund (2001d): "The Question of Lay Analysis", in: Strachey, James (ed. and trans.): *The Standard Edition of the Complete Psychological Works of Sigmund Freud*. Volume XX. London: Hogarth Press, 177–258. [1926]

Greig, David (2001): "Introduction", in: Kane, Sarah: *Complete Plays*. London: Methuen Drama, ix–xviii.

Hauthal, Janine (2007): "Medienspezifische und kommunikationstheoretische Modifikationen der Theorie des Metadramas und seine Entgrenzungen in Sarah Kanes '4.48 Psychosis'", in: id. (ed.): *Metaisierung in Literatur und anderen Medien. Theoretische Grundlagen, historische Perspektiven, Metagattungen, Funktionen*. Berlin: De Gruyter, 92–126.

Jones, Anne Hudson (1985): "Psychiatrists on Broadway, 1947–1982", in: *Literature and Medicine* 4, 128–140.

Kane, Leslie (1984): *The Language of Silence: On the Unspoken and the Unspeakable in Modern Drama*. London. Fairleigh Dickinson University Press.

Kane, Sarah (2001): *Complete Plays*. London. Methuen Drama.

Kempinski, Tom (2009): *Duet for One: A Play*. London: Samuel French.

Laermans, Rudi (1999): "Performative Silences", in: *Performance Research* 4.3, 1–6.

Reik, Theodor (1948): *Listening with the Third Ear. The Inner Experience of a Psychoanalyst*. New York: Farrar, Straus, and Giroux.

Reik, Theodor (1968): "The Psychological Meaning of Silence", in: *Psychoanalytic Review* 55, 172–186.

Ronningstam, Elsa (2006): "Silence: Cultural Function and Psychological Transformation in Psychoanalysis and Psychoanalytic Psychotherapy", in: *International Journal of Psychoanalysis* 87, 1277–1295.

Sabbadini, Andrea (2004): "Listening to Silence", in: *British Journal of Psychotherapy* 21.2, 229–240.

Saunders, Graham (2006): *"Love Me or Kill Me": Sarah Kane and the Theatre of Extremes*. Manchester: Manchester University Press.

Segrin, Chris / Abramson, Lyn Y. (1994): "Negative Reactions to Depressive Behaviors: A Communication Theories Analysis", in: *Journal of Abnormal Psychology* 103.4, 655–668.

Turk, Edward B. (2007): "Isabelle Huppert; or, The Gallic Valkyrie Who Bewitched Brooklyn", in: *Camera Obscura: A Journal of Feminism, Culture, and Media Studies* 22.2, 158–164.

Tycer, Alicia (2008): "'Victim. Perpetrator. Bystander': Melancholic Witnessing of Sarah Kane's '4.48 Psychosis'", in: *Theatre Journal* 60.1, 23–36.

Vega, Jason A. Wheeler (2013): "Silence, Now", in: *Journal of the American Psychoanalytic Association* 61.6, 1211–1225.

Watson, Ariel, (2008): "Cries of Fire: Psychotherapy in Contemporary British and Irish Drama", in: *Modern Drama* 51.2, 188–210.