The Shifting Sound of Silence:
A Constructivist Grounded Theory

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Abstract

The aim of the research is to answer the question: How *do psychotherapists use silence in clinical practice?* A literature review concluded that although there is a wealth of data on client silence, there was limited data that pertained specifically to the research question. This supported the employment of field research. *Aim/Methodology:* The study was underpinned by a constructivist epistemology, the theoretical perspective was interpretivist, and constructivist grounded theory was used as a qualitative methodology. The sample was achieved by purposive sampling, and twenty intensive interviews were conducted with American psychotherapists. The interviews were transcribed and analysed under the constructivist grounded theory approach, using the constant comparison method, memoing and sorting. *Findings:* A significant number of initial and focused codes were generated, supporting focused coding, and further conceptualisation of four main coding categories: conditions (*evolving disparity, rendering alliance, minding the gap*), cornerstones (*sensitising silence, productive comforting, productive discomforting, temperature gauging*), consequences (*deepening the treatment*), considerations (*timing, silently experiencing*). A constructivist grounded theory was proposed: *intersubjective–silence* and the effective use of silence in the clinical setting. The study indicated that silence is powerful and ambiguous and is best used later in treatment when there is strong therapeutic alliance in place. The individual comfort and needs of the client presented as more significant than any modality or theory. Silence was used to create space where the treatment could be deepened by the presence of the therapist and mutual introspection. Participants cited experience as a core variable in their relationship to silence. It is proposed that a contemporary approach to the use of silence should be addressed in training institutes. Further research into the concepts *benign witnessing* and *presencing* and the nuances between them has been recommended.

Keywords: psychotherapy, silence, intersubjectivity, psychoanalytic, grounded theory

The Participants

I am so grateful for all the participants who took time out of their busy schedules to prioritise and support new research. I am indebted to their kindness, insight, professionalism, and generosity. I was left feeling inspired and moved by the dedication and care that they continue to demonstrate towards their clients and the art of psychotherapy after many years working in the field.

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Dedication

I dedicate this journey and thesis to my family, Neela, JJ and Arun who had to suffer my anguish, and at times inaccessibility, but never ever ceased in encouraging me to keep moving forward.

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CHAPTER 1: Introduction to The Thesis

Nothing has changed the nature of man so much as the loss of silence.

Max Picard (1988, p. 221)

We should consider speech before it has been pronounced, against the ground of this silence which precedes it, which never ceases to accompany it, and without which it would say nothing.

Maurice Merleau-Ponty (1973, p. 45)

1.1 Introduction

This thesis reports the findings of a constructivist grounded theory study exploring the psychotherapist's use of silence in clinical practice. The research gained an understanding of the different perspectives on silence from the view of the therapist, how they perceived its impact on clients, and how they were implemented in practice. The theory developed from this study has relevance for all contemporary psychotherapists.

1.2 Background

The world, fuelled by people and technology, has increasingly more noise (Libbey, 2012). By sharp contrast, the practice of psychotherapy has a long association with the concept of silence. Clinical practice, when seen as a cultural setting, acts as a social regulator of both talk and silence (Lehmann, 2014).

From the perspective of confidentiality and the therapist keeping their silence, to the sense of roles: the client talks and the therapist listens – in a unique form of silence.

The clinical theory of silence finds strong support in Winnicott's (1945) concept of holding, and in Bion's (1962) comparable concept of containment/ contained, but more is inferred than is explicit. Kurtz (1984) succinctly highlights the importance of silence to the therapeutic process: "In this sense, uninflected silence is a container of the analytic process, distinct from content and irreducible" (p. 1).

The psychotherapy milieu has changed significantly in the last few decades with the impact of audit culture, regulation, and the focus on "evidence-based" interventions (King and Moutsou, 2010). Contemporary psychoanalysis (Gellman, 2012; Little, 2015; Mills, 2012) and psychoanalytically informed interventions such as brief Dynamic Interpersonal Therapy (Lemma, Target & Fonagy, 2011) and Mentalization-Based Therapy (Allen, Fonagy, & Bateman, 2008), whilst acknowledging the importance of silence, require a more active and collaborative approach. If therapists are being trained and conditioned to be more vocal and active what impact may this have on the use of silence?

The ability to work with unconscious communication remains a core competency of psychoanalytically informed therapy and silence is key (Lemma, Roth & Pilling, 2008). "The therapist can facilitate unconscious communication by knowing when to allow silence, so that free associations can emerge" (Lemma et al., 2008, p. 19). If framed less psychoanalytically: it might be good for the therapist to stop speaking to create space to allow something to settle (feelings and thoughts around the ramifications of what has been said) and material to emerge (more details or feelings and thoughts) – a potential space for the encounter to go deeper.

Gale and Sanchez (2005) are critical of contemporary attempts in psychotherapy to reinstate a value to silence, arguing that they have misunderstood it and imbued it with quasi mystical qualities. More recently Knutson and Kristiansen (2015) argue that silence can only be understood in the context in which it arises, and explore the understandings and meanings of silence, highlighting its negative connotations as well as being a gateway for healing. Salberg (2012) makes a common argument that both Freud and Ferenczi were much less orthodox in their use of silence, suggesting more flexibility and freedom than their post-war contemporaries.

Supervisors of psychotherapists and personal therapists are significant influencers on how the trainee develops their own personal style (Ladany, Hill, Thompson & O'Brien, 2004). When it comes to teaching it could be argued that psychotherapy has a strong oral tradition. It is challenging to find a firm written description of silence when viewed as a skill or technique, which supports the case for considering psychotherapy as an art, as well as an endeavour supported by science (Bugental, 1992).

Ferber (2004) argues that the phenomenon of silence in therapy has not elicited a great deal of research in the past 50 years. This study will address this gap and explore the use of silence in contemporary practice.

1.3 Research Question

In qualitative research good questions need to invite a process of exploration and discovery (Creswell, 2014). A single research question therefore retains a focus and openness to the concerns of the participants (Agee, 2009; Nathaniel, 2008).

The aim of the research is to answer the question:

How do psychotherapists use silence in clinical practice?

The objective of the research is to enhance understanding of contemporary psychotherapy, by offering timely and contextual new data, addressing the main research aim of exploring how the therapist uses silence in practice. I would hope that the outcome of the study would contribute to clinical theory and offer a view on the requirements for future training.

1.3.1 Research Aims

The aim of the research is to garner a better understanding, and to theorise, on the psychotherapist's uses of silence.

It is an aim of this study, that the research will contribute to the knowledge base of psychotherapy, and will offer some propositions for practice, education and training.

1.4 Operational Terms

It could be argued that a substantial aspect of this study was to obtain data from the therapists to develop a conceptual understanding of silence and how it is used in practice. However, in order to begin the thesis an effort has been made to be specific about key terms.

1.4.1 Silence

The general concept of silence is discussed in Chapter Two (Introducing Silence). The focus of this thesis is more specifically the therapists' use of silence in the clinical setting. The aim of the study is to answer this question and therefore to attempt a definition or conceptualisation of silence from the participants perspective. In its broadest terms, silence as an operational term is defined when neither the therapist nor client are speaking during a session.

1.4.2 Psychotherapists and Psychotherapy

A "psychotherapist" in this study is defined as a professional who conducts weekly, or more, formal one-to-one talking therapy with adult clients/patients (over 18 years of age). The term psychotherapist refers to qualified practitioners working under the licenced professional titles in the State and jurisdiction of the state of Illinois, USA:

Licenced Clinical Professional Counsellor (LCPC)

Licenced Clinical Social Worker (LCSW)

Licenced Clinical Psychologists (LCP)

Medical Doctor (MD) practising as a psychoanalyst

The study was originally going to be conducted in the UK, targeting participants from the UK Council for Psychotherapy (UKCP) trained and registered professionals. Due to an unforeseen family relocation the field research was conducted in Illinois, USA. The UKCP training takes approximately 3-6 years part time and requires 450 hours of practice, theory, and skills, and requires therapy and supervision throughout. In contrast each state in the USA can have varying professional titles and requirements for professional practice. In the state of Illinois all professionals referring to themselves as psychotherapists (conducting independent clinical

work) are licenced under one of the 4 titles LCPC, LCSW, LCP, and MD. An overview of the education and experience is provided in Table 1 by comparing the licencing requirements. The experience required is substantially higher than that of the UKCP. When considering a full clinical psychoanalyst, they are required to be an independent licenced practitioner prior to commencing the 5-year training programme. Within each of these licenced professional categories the individual practitioner will also identify with one or more theoretical orientations or modalities.

Table 1

Overview of Illinois licence requirements

LICENCE	EDUCATION	POST QUALIFYING HOURS	PROFESSIONAL EXAM
LCPC	Approved Masters (MA/MS) in Counselling Course	One year of supervised experience meaning: 1,680 hours over at least 48 weeks, including 960 hours of face-to-face client service.	National Clinical Mental Health Counseling Examination (NCMHCE)
LCSW	Association of Social Work Boards (ASWB) approved Masters in Social Work (MSW) or doctorate in social work (PhD)	MSW must earn 3,000 hours of supervised postgraduate experience. Doctorate level need 2,000 hours. While completing these hours, an average of at least four hours per month of supervision from an LCSW is required.	ASWB clinical examination

Table 1 continued

LICENCE	EDUCATION	POST QUALIFYING HOURS	PROFESSIONAL EXAM
LCP	American Psychological Association (APA) doctoral-level psychology degrees: Doctor of Philosophy (PhD) or Doctor of Psychology (PsyD)	3,200 hours of supervised experience. One of these years (1,600 hours) must be completed in an organised "health service training program," The remaining 1,600 hours can come from any combination of practicum placements during the doctoral program, predoctoral internship, and postdoctoral training. Of these 3,200 hours, at least 800 must involve direct contact with patients.	APA doctoral-level psychology degrees and associated examinations.
MD	Post medical degree training towards full clinical psychoanalyst	Specialist training as a psychoanalyst is approximately 5 years. Candidates treat three patients in psychoanalysis. Supervision initially is provided one hour per week per case, and later every two weeks or monthly.	Accredited by the International Psychoanalytical Association (IPA) and or The American Psychoanalytic Association (APSAA)

		One cases must be seen for a minimum of five years.	

The terms “therapy” and “therapist” will denote an abbreviated version of psychotherapy, psychotherapist, and psychoanalyst.

The American Psychological Association (APA, 2020) defines psychotherapy as involving communication between patients and therapists that is intended to help people:

- Find relief from emotional distress, as in becoming less anxious, fearful or depressed.
- Seek solutions to problems in their lives, such as dealing with disappointment, grief, family issues, and job or career dissatisfaction.
- Modify ways of thinking and acting that are preventing them from working productively and enjoying personal relationships.

1.4.3 Clinical Practice

The clinical setting is defined as the environment where one-to-one weekly or more, talking therapy is conducted by a therapist with an adult (over 18 years of age). Typically, in the professionals’ home, office, or organisational location.

1.4.4 Client

The terms “client” and “patient” will be used interchangeably to reflect the use in the literature and by the participants. Patient tends to be used more by medical professionals, clinical psychologists, and psychoanalytic practitioners (Nguyen, 2015). In my own practice I use the term client.

1.5 Research Design Rationale

A qualitative method was selected as it can capture expressive data about beliefs, values, feelings and motivations that underlie behaviours and practices more comprehensively and flexibly than a quantitative approach (Denzin & Lincoln, 2018). A qualitative approach offers the opportunity for in-depth explanatory data to be obtained from a small and specialised sample – quality over quantity.

Initial scoping of the literature highlighted that there was limited information on the therapists' use of silence. Grounded theory is considered by researchers as an appropriate method, when there is little known about the topic area, there are no grand theories that adequately explain the area of interest, and when there is a desire to elicit participants' understandings, perceptions and experiences of their world (Lyons & Coyle, 2016).
Constructivist Grounded Theory (Charmaz, 2014) was selected as it addresses many of the criticisms of first-generation grounded theory (Morse, Stern, Corbin, Bowers, Charmaz & Clarke, 2009). In addition to creating themes and concepts it seeks to understand difference and variation between research participants and to co-construct meaning with them. It also reflects my own constructivist and interpretivist epistemological outlook.

The term "data" is often heavily associated with positivist and objectivist connotations (Charmaz, 2006). Whilst referring data throughout the study it could be easily replaced by the phrase "information", suggesting a more nuanced, intelligent, understanding and wisdom, around human interaction and processes.

The principal data collection method in this study is the research interview. Similarly, although coining Charmaz (2014, p. 85) term “intensive interview”, it may be more accurate to understand the exchange as more of a hermeneutic phenomenological dialogue. The meaning of shared terms was not assumed. The interview would explore the meaning of all terms from the participants experience. Nomenclature was avoided and only discussed if first used by the participant.

1.6 Reflexivity

The practice of reflexivity is interspersed throughout this thesis, as a significant aspect of the constructivist grounded theory method, and more generally as my journey through the research process. As I submit this thesis and near the end of this most arduous but rewarding experience, I want to include some thoughts on the overall personal and professional ramifications of the study.

Despite four years of intense exploration the general concept of silence retains a sense of mystery and allure for me. The scope of this study required me to remain focused on the research question and it involved great discipline not to be seduced by the magnetism of the metaphysical when considering silence.

The impact of this research journey did not fully manifest until I recently returned to formal one-to-one client work. I knew instantly, upon the first contact, that conducting this research had changed how I viewed the client, my role as a psychotherapist, and what contribution I would make in co-creating the intersubjective space that we both experienced.

Whilst retaining all the main professional boundaries that constitute the therapeutic frame, every decision that I took was imbued by the renewed realisation that what truly matters in therapy is what matters most to the client; what will support the client feeling heard, seen, held, and ultimately cared for. The residue beliefs that I held when commencing this research around how I needed to practice in a certain way to be an authentic psychotherapist melted into what was best practice for the client.

This study has made me reconsider what an effective therapist offers. Taking best practice as a given, it is therefore the subtly in the use of silence, the challenge in how to respond, when, and with what, that surely elevates it to the beauty of art.

I was left reflecting on the image of two people trying to learn a graceful dance together, such as ballet. From experience and training, one may already know a few, or many steps ahead, but both need to create a degree of harmony if the full beauty of the dance is to be experienced together. One does not teach the dance but rather shares some moves, the true dance is ultimately the creative output of what manifests from the intersubjective encounter. As they conclude and part, each is enriched by the experience.

I hope by reading this thesis you will get some flavour of the potential for this dance and get a deep sense of my own growth and development as researcher, psychotherapist, and person.

1.7 Thesis Structure

The thesis chapters are organised as follows:

Chapter Two will consider the ubiquitous nature of silence. As such, it attempts to explore silence as a general concept and explores broad themes or aspects of silence across disciplines. This is achieved by utilising four main themes from which to present the concept of silence, and draws from an extensive range of literature and film.

Chapter Three will explore the background literature of the use of silence in psychotherapy. Using the concept of comparative psychoanalysis, it presents the literature under five main themes, concluding with the influence of post-existential thinking.

Chapter Four will review the primary literature and will discuss the limited number of primary research studies that explore the psychotherapist's use of silence.

Chapter Five will discuss the research methodology and outline how research decisions were made. An explanation of the theoretical approach for each element will be discussed, demonstrating an evolution of thinking.

Chapter Six will discuss how the research methodology is specifically applied in this study.

Chapter Seven will revisit the concept of silence, presenting its core properties as viewed by the study participants.

Chapter Eight will set out the grounded theory *of intersubjective–silence* and its categories and sub-categories in detail.

Chapter Nine will offer a dispassionate critique of the study and will discuss the relevant theory that relates to the grounded theory *intersubjective–silence*.

Chapter Ten will conclude the thesis, with an evaluation of the grounded theory *intersubjective–silence*. Further reflexivity will be discussed, offering implications for practice, education, and training. The limitations of the study will be discussed and recommendations for further research will be made.

Chapter Eleven presents an appendix supporting main aspects of the study, demonstrating a chain of evidence, best practice and transparency in the research process.

Chapter Twelve offers a comprehensive list of all references used throughout the study.

Except for direct quotes UK English has been used throughout.

CHAPTER 2: Introducing Silence

Silence is one of those mysterious intangibles that, the closer we look the more our understanding of them falls through our fingers like sand. Is silence an absence or a presence? An emptiness or a fullness? A negative space or a positive space? Something or nothing? Metaphysical or substantial? The prelude or the finale? However attached we might be to disjunctive reasoning the answer must be all of the above. This is because silence transcends logic and acts independently of reason.

(Bindeman, 2017, p. 1)

2.1 Introduction

In a major theoretical phenomenological exploration of silence, Dauenhauer (1980) proposes that silence is positive and complex. He suggests, as poets and thinkers in every age have realised, silence is not merely the absence of something else. Picard (1988), in his widely cited philosophical text, argues that silence belongs to every dimension of human beings, both in activity and the world they inhabit; an ontological given. As Kenny (2011) highlights, silence manifests in a spectrum of forms, and theoretical approaches to modes and functions of silence reflect that variety. However, the definition of silence poses a challenge because it is complex, ambiguous, and multifaceted (Nakane, 2012).

In her thesis, which explores a diverse spectrum of literature and art through a critical theory lens, Brown (2013) tries to answer the question why silence changes in different contexts. She concludes that it is what silence is *contrasted* to, within a given context, that changes its definition.

It is therefore unwise, she cautions, to try and generalise or presuppose some universal meaning for silence. She rests on the belief that: “silence comes to be figured as creator of space, what is at issue in these contexts is what is conceived of as being in this space of silence – Otherness, isolation, individuality, intersubjectivity” (p. 223).

The context and space for which the current thesis is concerned is the space of clinical practice and how the therapist uses silence within it. To support setting the frame, and before focusing specifically on therapy, it is worth exploring some broad themes or aspects of silence across disciplines.

Silence, Billias and Vemuri (2017, p. 3) argue: “is only observable if one pays attention to it; otherwise it is largely ignored”. They argue for an interdisciplinary approach to the study of the diversity of silence in form, structure, and complexity, beyond the boundaries or confines of any one discipline. As clients will have their own understanding, presuppositions, and relationship with silence prior to the therapeutic encounter, it is worth following Billias and Vemuri’s (2017) interdisciplinary approach to initially attempt to explore silence as a general concept.

The Oxford (2018) dictionary defines silence as:

- complete absence of sound
- the fact or state of abstaining from speech
- the avoidance of mentioning or discussing something.

These 3 definitions will be used to create broad themes, often interrelated, from which to discuss silence. When exploring the literature to support the introduction of silence, a fourth theme is included:

- seeking silence.

The theme of seeking silence reflects a significant genre of literature and behaviour where an individual or group seeks out silence through exploration or isolation. There is an implicit assumption that in doing so something positive will be experienced.

As I collated, read and reflected using the headings of these general themes, I became increasingly aware that each of them features significantly in the practice of therapy. As a researcher who has knowledge of the clinical setting, I will include some of my own reflections to the introduction.

2.2 Complete Absence of Sound?

When featured in movies and on TV the fictional therapeutic encounter is nearly always presented with the client and therapist talking in an otherwise silent environment. This has never been my experience as a therapist. There has either been background phones ringing, muffled voices, cars and sirens filling the city soundscape or the intermittent piercing sounds of birds chirping and dogs barking, or other beings moving around an office space or home. I recall listening to a recorded session that was conducted in an out-patient's clinic in London. The background noise of the London Underground trains screeching as they pulled into the station and the howling of police and ambulance sirens was incessant.

In addition to having the skill to tune these noises out and to focus on the client, the therapist must judge at what point to acknowledge and therefore to incorporate these extraneous noises into the session, or to offer pseudo-unchallenged listening, portraying the impression of ultimate listening.

When there has been a unique moment of near-dead silence, it was soon punctured by the painful awareness of my own worsening tinnitus. Whilst having seemingly above-average hearing, this ailment has been getting worse as I age, but is rarely noticeable other than when submerged in silence. This phenomenon highlights that there is an outer silence and an inner silence, or at least a silence that only I experience at a given time. I have five senses (six if one includes the mind) and they have an awareness of reality unique to me. In addition, I have no green pigment in my eyes, so I also see the world in a different colour from those who do.

Having spent extended periods in situations of solitary and collective elective silence, I also became aware of the inner "Witness" (Wilber, 2001, p. 51) or narrator, constantly chatting as I moved around the meditation centre. The quality of silence also seems dependent on the level of awareness or lack of awareness.

When seeking silence in remote retreat settings, I have often encountered the reality that these areas share their seclusion with some major noise-makers: air force jets practising low flying, army bases transporting troops and equipment, and the most persistent and noisiest of all: hot air balloons. Pat Collins (2012) mirrors this in his enchanting film *Silence*, about a sound engineer in Ireland who tries to capture the sound of silence, while all the time the noise of his family roots and echoes from his past resonate on screen.

There appears to be a romanticisation of the idea of silence and silent places. In his account of the invention of scuba diving, the pioneer deep-sea explorer Cousteau and Dumas (2004), designates the chronicles of their 1940s adventures as: *The Silent World*. When watching images of the diver one can be forgiven for interpreting it as indeed a silent world.
There certainly are no creatures who speak, but the reality of the noise levels that accompany scuba diving are evident to anyone who has experienced it: the hiss of the gases, the rasping of the breathing, and hum of the boats above.

The importance of silence is well known to musicians and composers. Rests are intentional silences in pieces of music and are indicated in traditional sheet music by symbols indicating the length of the silence or pause. Few contemporary discussions of silence neglect the work of John Cage (1912-1992). The experimental composer and music theorist famously composed a three-movement piece titled *4'33''* (four thirty-three). The score instructs the orchestra or any arrangement of musicians not to play.

The audience, if they remained aware, and not distracted by their frustration, would experience all the actual nuanced noises occurring during the performance. The audience's engagement is an open-process. It is an invitation by the composer, not a command. Cage breaks traditional boundaries by shifting attention from the stage to the audience and even beyond the concert hall. He argues: "There is no such thing as an empty space or an empty time. There is always something to see, something to hear. In fact, try as we may to make a silence, we cannot" (Cage, 2013, p. 8).

The often-misunderstood attempt at framing, of enclosing environmental and unintended sounds, in an effort to opening the mind to a new approach to listening and music, was not without much controversy and criticism (Gann, 2010).

Cage's (2013) inspiration for 4'33'' came from a visit to Harvard's anechoic chamber. Whilst seeking absolute silence, he was inspired by the fact that he could hear noise coming from his own body – life, "Until I die there will be sounds. And they will continue following my death" (p. 8).

In a serious attempt to find *absolute silence,* Foy (2010) retraces Cage's footsteps to Harvard and a collection of other places with a reputation for silence. He defines silence as zero decibels, but this is only the point at which someone with unimpaired hearing can no longer hear sound, and not a true scientific definition. His quest leads him to the anechoic chamber at Orfield Laboratories in Massachusetts. It is here at minus 9.4 decibels, A-weighted (dBA) that the Guinness Book of Records (2013, p. 402) awards the quietest place on earth. Whilst spending 45 minutes in the chamber, Foy (2010) also becomes aware of a noise, which he later discovers is tinnitus. After a significant multifaceted quest, Foy (2010) concurs with Cage's original conclusion:

> On some profound stratum the body knows that hearing is not only a tool for survival, it is a signal of life. To hear something is to be alive, to make a sound is to live. To be perfectly silent is to be perfectly dead (p. 177).

He argues that whether it exists or not, the idea of absolute silence is vital to humans. This essential silence is even more fundamental in a world fuelled by people and technology that has increasingly more noise. Departing from the perfect silence, he argues for a striving towards a relative quiet.

A lesser-known precursor to the work of Cage and perhaps of even more relevance to the research question is the *Symphonie Monoton–Silence* (Klein, 1947).

The audience is invited by Yves Klein (1928-1962) to listen to a continuous monotone sound produced by the orchestra followed by an equal length of silence. The aim was to transform the experience of silence into fullness. The experiment speaks to the therapist's and client listening to the silence; the nondual inseparability of the sound and the silence.

The concept of what silence is when there is relatively no noise or sound will be revisited in the review of primary literature (Chapter 4). I will now explore what initially is a much less complex theme, the absence of speech/language.

2.3 The Fact or State of Abstaining from Speech

Silence has been described as omnipotent, an essential and ubiquitous aspect in all communications (Billias & Vemuri, 2017). The current study is interested in how the therapist uses silence, principally when the therapist intentionally does not speak: verbal silences.

Picard (1988) speculates that silence is the vital background or substructure that gives meaning to speech communication. He contends that silence can exist without speech, but speech cannot exist without silence. He views silence very much as a primordial reality.

Žižek (2006), however, argues the opposite, that it is noise that is the primordial fact, and that creating silence is the first creative act. He cites Heidegger (1982) as knowing that there is no proper speech without this background of silence.

Dauenhauer (1980) proposes three core themes for the exploration of silence in speech: *intervening, fore-and-after,* and *deep silence*. He surmises: "silence appears sometimes as fragile and other times as sturdy, sometimes as benign and other times as malign" (Dauenhauer, 1980, p. 54). Intervening silence relates to the pauses and hesitations when someone is speaking. This silence is often necessary for the sender to be understood.

Silence can occur without sound as highlighted by a hearing-impaired person's appreciation of silence and employing it in sign-language. Fore-and-after silence is the space between the utterance and the close. Dauenhauer (1980) denotes that although similar to intervening silence, fore-and-after does not appear rhythmically significant. His third theme of deep silence and how it relates to intimacy, spirituality, and a philosophical silence will be discussed below. Arguably the strength of Dauenhauer's phenomenological analysis is not how he categorises the structure of silence in communication but rather that he highlights how fundamental it is in an encounter with others.

Goodman (1971, p. 15) poetically tried to grade the quality and meaning of silence in speech: "not speaking and speaking are both human ways of being in the world, and there are kinds and grades of each" and "the uses of not speaking and speaking are quite specific, and my hunch is that they are quite exclusive". His list identifies the following:

- dumb silence of slumber or apathy
- sober silence that goes with a solemn animal face
- fertile silence of awareness, pasturing the soul, whence emerge new thoughts
- alive silence of alert perception
- musical silence that accompanies absorbed activity
- the silence of listening to another speak
- noisy silence of resentment and self-recrimination
- baffled silence
- silence of peaceful accord with other persons or communion with the cosmos.

To support their exploration of silence, Billias and Vemuri (2017) offer seven key aspects: *the empty rhetoric, insolent silence, silence of hopelessness, the oppressed, of fear, of attentive listening, and silence which makes space for dialogue.*

Bruneau (1973, p. 17) defines silence as "signification ground for speech signs" and having a relationship with mental time, as it relates to perception, sensation and metaphorical movement. In the absence of empirical evidence, he hypothesises the importance of silence to human communication including attentive listening being conducive to developing interpersonal relationships. The idea of the silent witness, of being-with the client as they explore their trauma is a powerful one in psychotherapy, and will be discussed in more detail below.

The Nobel Prize-winning playwright Harold Pinter (1930-2008) is famous for his association with silence, including an early play of the same title (Pinter, 1969).

The use of silence throughout his work is so distinctive and particular it has become known as the Pinter Pause (Baker, 2008). Pinter defines two types of silence:

> One when no words are spoken. The other when perhaps a torrent of language is being employed. This speech is speaking of a language locked beneath it. That is its continual reference. The speech we hear is an indication of what we don't hear.
>
> It is a necessary avoidance, a violent, sly, anguished, or mocking smoke screen which keeps the other in its place. When true silence falls we are still left with echo but are nearer nakedness. One way of looking at speech is to say that it is a constant stratagem to cover nakedness (Pinter, 1976, p. 14-15).

Towards the end of his life Pinter expressed dismay at the artificial and meaningless use of silence and pause in his plays. Where he says basic stage instruction, others interpreted disturbing undertones leading to the term Pinteresque. He stated that when appropriate the subtle complexity of a pause can be as important as a line, but this should be considered whilst avoiding the propensity to fetishise silence (Cole, 2007).

Meaning can be given to utterance by silence, Merleau-Ponty (1968) argued but it is open to interpretation. Silence in communication and intersubjectivity is vulnerable to many interpretations.

Nakane (2012) suggests the use and interpretation of silence are fine-tuned activities. She highlights that in intercultural communication the study of the cultural variation of different pause lengths and speech rates can inherently lead to negative stereotyping: "silence that realizes illocutionary force and carries propositional meaning seems to exist almost

universally" (p. 166). The use of such silence can be culturally specific, and therefore can lead to misinterpretation (Enninger, 1991).

Interpretations of silence can have many implications for the sender, including: a sense of politeness, approval or disapproval, perceived knowledge, and dynamics of power (Jaworski, 1993, 1997).

Silence *is* communication precisely because listeners and observers will attribute and attach their meaning whether accurate or not to the sender (Johannesen, 1974). Interpretation of what is happening between the therapist and client is a central aspect of contemporary psychotherapy that places focus on intersubjectivity (Crossley, 1996; Gergen, 2009; Stolorow, 1994).

Often in practice, at key moments I would present quite a neutral face to the client as they present their material. A significant moment in the therapeutic process is when the client will challenge or bring into awareness this face. When the client is supported in distinguishing between a neutral face that they perceive as angry or judgemental, and one that is simply silent or still, a breakthrough can take place. An exploration of their interpretation of the silence can lead them to make the distinction between an earlier significant relationship and the here and now. This clinical example begins to support the proposition that silence is necessary for the restoration of authentic communication. It is logical, therefore why people would seek silence and or solitude, and this will be discussed below.

I would propose that silence can also enhance communication. There is a quality that comes about in a prolonged elected silence. My memory of two or three days into a nine-day elected silence with others was one of enhanced communication.

Eating at a table with others without speaking means that subtle awareness was brought to the slightest gesture or movement. Often it appears that someone would pass a condiment or breadbasket to someone knowing that is what they wanted.

Rather than some extra-sensory perception, it unmasked the depth of communication that is continually happening between others without the need for spoken words. It speaks to the possibility of a degree of stillness being necessary to fully hear the Other.

When considering the Other, Sartre (1945) said: “every word has consequences. Every silence, too”. He speaks to the wider implications of staying silent and the consequences. In the next section I will discuss wider implications of silence and staying silent.

2.4 Avoidance of Discussing Something

Having established that the meaning of silence in communication is open to interpretation, it may be fitting that the god of silence and secrecy was born out of a misinterpretation of a symbol. Happokrates (Harpocrates) the god of silence was the Greek interpretation of the Egyptian god Harpa-Khruti (Horus the Child), who was often represented as a small boy with a finger held to his lips, an Egyptian gesture symbolising childhood that the Greeks mistook for a hush for silence (Kennedy, 2010). He became a popular amuletic symbol during the Roman period (Pinch, 2004).

2.4.1 Secrets and Shame

Silence in the form of secrecy or confidentiality is a central aspect in psychotherapy practice. The therapist offers the client conditional confidentiality, in that anything that is disclosed, that does not present a significant harm to self or other will remain in the room, and the extended room of supervision (Londoño-McConnell & Larson, 2018).

For clients, therapy is sometimes the first place where their shame and trauma are discussed and borne witness to by another.

Trauma and the shame often accompanying it can prevent the survivor from speaking out (DeYoung, 2015). Breaking that silence is a significant point in the move from victim to survivor. People often fear the social stigma of asking for help and being seen as vulnerable, as the National Alliance on Mental Illness states: “the stigma attached to mental illness is very real and it causes many people to suffer in silence” (NAMI, 2018, p. 1).

2.4.2 Deadly Silence

The influence of public opinion on whether an individual will speak out was examined by Noelle-Neumann (1993) and proposed in her communication and political science theory: spiral of silence. She argued that the fear of isolation from a social group can influence the individual in staying silent rather than voicing minority or contentious opinion. Moy, Domke and Stamm (2001) supports Noelle-Neumann’s original argument but their own research suggests that it is the more immediate circle of family, friends and colleagues that are more closely linked to one’s willingness to speak out.

Through his interpretation of unpublished letters and documents within the Freud Archives, Masson (1984) controversially speculated that it was such a spiral of silence that caused Sigmund Freud (1856-1939) to withdraw in 1896, his initial enthusiasm for his seduction theory (that neuroses were caused by sexual abuse in childhood). Freud publicly retracted his theory, remaining focused on sexuality but substituting it in favor of the Oedipal Complex, opening the world of phantasy to be explored by analyst and client (Zaretsky, 2005).

Critics of Masson's speculations argued that Freud retracted the theory as he no longer believed that it was the *sole* cause of neuroses, and not that he was in denial of childhood sexual abuse (Gay, 1998; Paul, 1985).

When one of Freud's letters to Fleiss is read without the deletions it certainly offers a dramatic alternative reading to the history of psychoanalysis: 'my confidence in the father-etiology has risen greatly (Freud, 1898, p. 393). Privately he remained curious about "the intrinsic genuineness of infantile trauma" (Freud, 1897, p. 396), even proposing a harrowing new motto for psychoanalysis: "What have they done to you, poor child?" (p. 397).

The world, Masson (2017) contends, has shifted significantly since 1896 and the 1980s, and the concept of child abuse and trauma is widely acknowledged and statistically verified. The actual impact of childhood trauma, neglect, and abuse became more widely accepted in therapy through the seminal writing of pioneering analysts (Fleiss, 1973; Miller, 1995, 1997; Shengold, 1989). Regardless of Freud's reasons for dropping his seduction theory, he shattered the silence, and brought attention to childhood trauma and abuse in a ground-breaking way.

Freire (2017) reasoned that it was the system of dominant social relations that creates a culture of silence. It contributes to a negative, silenced and suppressed self-image internalised by the oppressed. He prized the necessity of the oppressed in finding the right to express their voice and how the oppressor would negate this right, therefore dehumanising them in the process. I think it is possible to appreciate this argument without capitulating fully to the Marxist theory from which it emerges.

He stated: “washing one's hands of the conflict between the powerful and the powerless means to side with the powerful, not to be neutral” (Freire, 1985, p. 122).

2.4.3 Silence Breakers

The very idea of neutrality has been questioned when it comes to silence. As Wiesel (2006), a survivor and writer on the Holocaust articulated: “We must take sides. Neutrality helps the oppressor, never the victim. Silence encourages the tormentor, never the tormented. Sometimes we must interfere” (Wiesel, 1986, p. 1).

The “me too” movement was started in 2006 by Tarana Burke to help survivors of sexual violence, particularly women of colour from low-wealth communities (Garcia, 2017). It wasn’t until 2017, when predominately white women within the film industry made accusations against powerful white male perpetrators that the movement garnered worldwide attention (Wellington, 2017). The scandal publicly exposed how much fear impacted the victims’ silence. It was only when a momentum of publicity gathered, that change began to happen with more people speaking out. The initial group of survivors who spoke up were named the silence breakers (Zacharek, Dockterman & Edwards, 2017). There was a pervasive atmosphere of who within the industry knew and inadvertently or advertently colluded with maintaining a culture of silence through fear.

2.4.4 Speaking Out

In his efforts to highlight what contributed to injustice and oppression, the civil rights leader Martin Luther King Jr. made many references to the appalling and destructive silence of good people (King, 2003).

The poetic discussion of silence was a theme in much of the Black, lesbian poet Audre Lorde's work (Lorde, 2000, 2017) and now seems prophetic. In her charge to transform silence into action she (Lorde, 1977), proclaims:

> I have come to believe over and over again, that what is most important to me must be spoken, made verbal and shared, even at the risk of having it bruised or misunderstood (p. 41).

> My silences had not protected me. Your silence will not protect you (p. 42).

> For we have been socialized to respect fear more than our own needs for language and definition, and while we wait in silence for that final luxury of fearlessness, the weight of that silence will choke us. The fact that we are here and that I speak these words is an attempt to break that silence and bridge some of those differences between us, for it is not difference which immobilizes us, but silence. And there are so many silences to be broken (p. 44).

The hold of silence is two-fold: the oppressed must be given the space to find a voice, and people witnessing injustice must speak out.

In considering psychoanalysis, Eder (2015, p. 385) argues: "contemporary psychoanalysis has brought the therapist-as-person back into the room. Perhaps it will also bring the patient and therapist back into the world in which they cohabitate" (p. 385).

Contemporary psychoanalytic therapy may have shifted from the idea of the therapist as a blank screen. There remains, however, a professional expectation that the therapist does not take sides. Arguably what separates the therapist from a client's colleague, friend or family member is the professional neutrality. Ideally there is a quality of silence that is offered, as opposed to opinions, advice-giving, judgements or strategies. The therapist supports the client in finding their own answers.

When considering the political climate and social justice, this neutrality has been somewhat challenged (Avissar, 2008, 2016; Eder, 2015; Glassgold, 2007; Greenslade, 2018; Loewenthal, 2015). The interrelations between political activism and psychotherapy are complex, and Avissar (2008) argues that political narratives were always at hand in many of the predominant psychotherapy theorists. He urges psychologists to: "serve as a unique voice within a violent and stormy atmosphere, one of empathy and compassion, of respect toward differences and reconciliation with the past and the other" (p. 173).

While Avissar's (2008) focus remains on what can be achieved working with individuals and groups towards reconciliation, Greenslade (2018) calls for action beyond the consulting room: "to have a meaningful, ethical impact on people's lives, we must operate beyond our therapy rooms and also intervene in the structural inequalities and experience of violence and discrimination that continue to pervade Society" (p. 196).

As a registered social worker, I was trained in critical theory and anti-oppressive practice, but in my role as a psychotherapist I feel deeply conflicted about this call to action. My professional silence is challenged.

Working from an existential-phenomenologically influenced contemporary psychoanalytic outlook, I would never locate the challenges and distress of the client solely within them. I have frequently acted as advocate or voice for clients at crucial times when they needed additional support to challenge outside agencies.

My activism remains grounded in and from the consulting room where I can support people in finding their voice to challenge the inequality or oppression that they experience, both internalised and as an external environmental reality.

2.4.5 Spiritual Silence

Elie Wiesel (1928-2016) employed silence throughout his work to highlight the Holocaust's silencing of a language, a culture, history, faith and identity. Silence because the horror was beyond language, a reality accessed only through direct, first-hand experience (Kelly, 2016). As Steiner (1998, p. 123) states: "to speak of the *unspeakable* is to risk the survivance of language as creator and bearer of humane, rational truth. Words that are saturated with lies or atrocity do not easily resume life".

The limits of language in describing emotional experience were highlighted by Orwell (1940, p. 3): "Everyone who thinks at all has noticed that our language is practically useless for describing anything that goes on inside the brain".

Wittgenstein's (2001) famous quote from *Tractatus* highlighted what he saw as the limits of language to describe reality, "what we cannot speak about we must pass over in silence" (p. 89). Rather than an avoidance of attempting to describe reality, the last line of his philosophical treatise reverberates; a window towards light and not the darkness of nihilism (Steiner, 1998).

In addition to silence highlighting the unspeakable, it can also denote the knowledge holder. Whilst the popularity of Wittgenstein's radical quote remains in the West, silence has long been seen positively and as a given in Eastern philosophy, as Watts (1999) summarises: "those who know do not speak, those who speak do not know" (p. 77).

In the Buddhist tradition, the silence that implied a deeper insight or knowledge was referred to as noble silence (Nago, 1991). There were questions that Gautama Buddha (Shakyamuni) refused to answer due to the belief that they would not lead to true knowledge. Silence is prized throughout the tradition as a way to challenge ordinary forms of language, thought and awareness (Harvey, 2012). Language itself is seen as inherently dualistic. Only through the transcendence of language and its distinctions can we enter an understanding of nonduality; ultimate or absolute reality (Garfield, 2015).

2.4.6 Silence as Punishment

In addition to the silence that results from oppression, it can also be used or perceived as a punishment. The powerful cutting off through silence was famously portrayed in the history of psychotherapy by the ending of the relationship between Freud and friend and protégé Carl Gustav Jung when he quotes Hamlet (Shakespeare, 2012, p. 405) in his final letter: "the rest is silence" (Jung, 1913, p. 257).

To cut someone off in silence is a form of negation. In the short term it can feel as though the recipient has been abandoned and that they are no longer held in mind. Silence can be used in an effort, consciously or otherwise, to express anger, disproval, or reproach. This is colloquially named the silent treatment (Williams, Shore & Grahe, 1998).

In a meta-analytical review of 74 relationship studies involving more than 14,000 participants, Schrodt, Witt and Shimkowski (2013) found that the silent treatment (demand/withdrawal) was tremendously damaging to a relationship. Both partners reported diminished feelings of intimacy, and a reduction in communication deemed healthy and meaningful. The silent treatment towards children by caregivers is viewed as abuse, adult survivors often report silence from others as a triggering earlier emotional trauma.

2.5 Seeking Silence

Alluding to the power inherent in silence Maitland (2008, p. 21) states: “perhaps we are wise to be terrified of silence – it is the terror that destroyeth in the noontide”. Its power is starkly contrasted as both positive and negative depending on the context.

Forced silence, the practice of placing a prisoner in solitary confinement, including in some cases relative silence, is seen as a punishment within an already punitive system (Polizzi, 2017). The negative psychological impact upon the prisoner’s mental well-being can be significant (Guenther, 2013). It is curious, therefore that people seek silence, and solitude for the opposite reasons.

In her classic novel *Middlemarch*, Eliot (2003) suggests to the positive power of silence: “if we had a keen vision and feeling of all ordinary human life, it would be like hearing the grass grow and the squirrel's heartbeat, and we should die of that roar which lies on the other side of silence” (p. 194).

2.5.1 Spiritual Seekers

The roar on the other side of silence can be interpreted as reality beyond intellectual concept or language. There is a strong tradition of religious adherents seeking silence as a method to get into a higher communion with a god, their higher self, or reality itself. In the Western occult tradition, Harpocrates represents the god of silence and the higher self and is explicitly represented in ritual: “and in this silence, a true consecration comes” (Crowley, 1989, p. 163).

Corbin (2018) chronicles the long history of silence and its importance to many religious movements. He argues that silence is within us and has been cultivated by great writers, thinkers and scholars and people of faith for centuries. He argues that in current times we are losing a sense of inner selves, and in the process changing the very nature of the individual. To regain the connection leads to a richer experience of life.

The Religious Society of Friends, widely known as the Quakers, have a tradition of communing in silence (Punshon, 1935). This experience is called expectant waiting: participants aspire to become inwardly still and clear for spiritual receptivity (Avery, 2011). They believe that direct communication with God is possible. As part of the research and reflection for this thesis I attended an unprogrammed worship meeting (now only 11% of meetings) and participated in the hour’s silence – bar several people who were inspired to briefly speak.

There were a few immediate discoveries. Firstly, it was an experience of relative silence, due to the noise of the pews creaking, coughing, sneezing, shuffling, and people arriving after it had begun. The focus quickly moved to my inner stillness and peace. Secondly, as someone who independently sits in silence to cultivate mental clarity, I was immediately struck how being in wilful silence with others has a quality that is strikingly different than when alone.

I experienced this as a connection with others in silence. An official at the meeting suggested that my experience of silence may be much broader as I did not know anyone. She suggested that the spaciousness is reduced for her as she knew everyone in the room.

The Quakers have a long history of concern for the mentally distressed, fighting for more kindness and compassion within institutionalised care (Cherry, 2013). In the UK many psychiatric wards are still named after prominent historical influencers.

Unlike the Quakers who believe they have the opportunity for the Divine to speak through them, many people are met with the challenge of silence when speaking to their god. The director Martin Scorsese (2016) highlights this beautifully in his film *Silence* when he brings to life the classic Japanese work of Endo (2015) of the same title, in a fictional account of trials, torture and persecution of missionaries in Japan and how they dealt with the perceived silence to their prayers when confronted with such pain and challenge.

2.5.2 Secular Seekers

Maitland (2008) brings attention to historical dominance and potential bias inherent in the consideration of religious silence but acknowledges the more recent (last 180 years) emergence of secular accounts. Predominant secular seekers like Thoreau (1998, 2016) make an implicit link between silence and creativity or at least the quality of a space that allows a deeper thinking to arise. In her essay the *Aesthetics of Silence*, Sontag (1969) explores how silence mediates the role of art as a form of spirituality: “the art of our time is noisy with appeals for silence. A coquettish, even cheerful nihilism. One recognizes the imperative of silence, but goes on speaking anyway” (p. 12).

Solitude as an important component of individual creativity and well-being at both and individual and societal level was articulated by Storr (1988). The connection of silence with sanity, creativity, enchantment, simplicity, and art was proposed by Lane (2006).

While hermits, monks and mystics may elect to live in solitude and silence, for some people silence and solitude is forced upon them as part of social exclusion. This can have a devastating and enduring impact upon their mental well-being (Bentall, 2005). In sharp contrast, for the more privileged, pioneers, adventurers and explorers can experience periods of elected extended solitude and silence.

Kagge (2017) offers an account of 50 days walking solo across Antarctic, becoming the first person to reach the South Pole alone: “on the ice, far into that great white nothingness, I could both hear and feel the silence (p. 12)”. His account of this journey explores the silence around us, within us, and the silence that he says we must create. He argues that silence, in the age of technology driven noise, is almost extinct, and yet it remains essential to our sanity and happiness. At times during the development of this thesis, I often felt like the lone explorer, in the wilderness of data, with silence all around me, fighting every temptation not to stray into unrelated emails, texts or social media vortexes.

In contrast to Kagge’s (2017) dramatic and vast experience of silence, Harris (2017) provides an exploration for those seeking to develop the skill of solitude within the confines of a city. As we live bigger and faster lives, he describes the benefits of solitude as a crucial ingredient for a richer inner life, generating creativity, and improved relationships.

Supported by arguments from psychology and brain researchers, urging dwellers that "stepping off the narrow sidewalk for even a few minutes, we may come across a new (and very old) definition of ourselves, one with less refence to others" (p 149).

2.5.3 The Age of Noise

The last century was dubbed by Huxley (2009), among other things the Age of Noise: "Physical noise, mental noise and noise of desire – we hold history's record for all of them. And no wonder; for all the resources of our almost miraculous technology have been thrown into the current assault against silence" (p. 218).

Into this century it is estimated that there is over 70% smart phone (mobile phone with internet access) market penetration in the UK and America (Deloitte, 2017). The estimate of how active the users both on smartphone and other internet access points is rapidly increasing (Nielsen, 2015; Qualtrics, 2017). The noise that Kagge (2017) refers to is the increasing lack of spaces where one is not interrupted by accessing technology. I reflected that for the client and indeed the therapist, the therapeutic hour maybe the longest period throughout the waking day that an individual may not access technology. I have been in many sessions when the message received-alert, or even the ringtone or vibrate denoting an incoming call from the client's device, is heard in the session. I have reflected what this tech embargo must feel like for the client and would it affect their desire to attend therapy and or create additional anxiety.

Urban-dwelling nightingales must sing so loud above the city noise that they are technically breaking the law (Brumm, 2004). In the digital milieu, Braman (2007) argues, silence is increasingly rare.

In open spaces we are surrounded by music and conversations of others, mobiles ringing with no discretion. She notes that silence has become such an issue, hotels often offer a silent room as a selling point, and proposes that: “studying silence is particularly valuable because it is so sensitive to stresses caused by information technologies that the loss of silence serves as an early indicator of possible sources of harm for Society” (p. 281).

The growing use of noise cancellation headphones speaks to the actual increase in noise pollution and the desire for the individual to have a private space. These headphones have a built-in microphone that measures the ambient noise around, then generates an exact inversion of that sound wave and adds it to the mix in the headphones. When a frequency meets its opposite – when the peaks of one match up with the valleys of another – the result is called phase cancellation. The two waves cancel each other out: silence.

There is an emerging literature on the need to go beyond noise, and to seek and embrace periods of solitude and silence (Batchelor, 2020; Harris, 2017; Le Claire, 2010; Maitland, 2014; Prochnik, 2011; Turkle, 2017;). These accounts all prize the many personal benefits of silence but are steeped in privilege. Many of the seekers have the time and resources to find relative silence in their chosen environment or have had the education, training, or teachings to support them find the coveted inner silence. I reflected on the challenge of inner-city living for low-income people and families where noise pollution and overcrowding are an everyday reality. In the poetic works of Eliot (2003, p. 92): “where shall the word be found, where will the word resound? Not here, there is not enough silence”. It is of course possible to find inner silence despite being surrounded by noise.

When considering the silence that is sought by the various seekers, de Mello (1985) arguably captures the essence in the simplest of prose: “silence is not the absence of sound but the absence of self” (p. 126). It is the absence of this egoistic aspect of self that allows for the silence, the stillness, to come forth.

The increased impact of audit culture, managerialism and regulation on clinical practice has been discussed (Gnaulati, 2018; King and Moutsou, 2010; Montgomery, 2018). As the pressure mounts on the clinician to be *doing* and to be accountable for it, I have reflected on whether this would impact their use of silence. Is silence seen as doing nothing and therefore avoided? As Hazanov (2019) frames it, the fear of doing nothing.

2.5.4 Boundlessness

The brief immersion into the concept of silence at times evoked an experience in me of boundlessness. It is as if silence is everywhere and nowhere at the same time. It is as if there is an intersectional aspect of silence and different disciplines, not quite capturing it, but contributing to it. The rest is silence.

2.6 Conclusion

The general concept of silence is clearly complex, multidimensional, and intersects with many disciplines, and therefore required an introduction. In this chapter I have introduced the concept by exploring a range of interdisciplinary sources grouped under four main themes: *complete absence of sound; the fact or state of abstaining from speech; the avoidance of mentioning or discussing something; and seeking silence*.

The exploration has highlighted the power of silence and the paradox of it being seen as both a punishment and a prize. It has the capacity to oppress and to liberate. Even prior to exploring the clinical use of silence, these are significant properties for the engaged psychotherapist to consider when entering the clinical setting.

In the next chapter I will explore more specifically the background literature on the psychotherapist's use of silence in the clinical setting.

CHAPTER 3: Silence in Psychotherapy

You know, you can be a silent witness, which means silence itself can become a way of communication. There is so much in silence. There is an archaeology of silence. There is a geography of silence. There is a theology of silence. There is a history of silence.

Elie Wiesel (2016, p. 6)

3.1 Introduction

The background literature on the therapist's use of silence is sporadic and at times eclectic. This chapter endeavours to take a systematic approach to bringing this information into some sort of useful focus, to sort and discuss the literature in chronological order. This method for review reduces bias and offers insight into how silence may have been used historically and how, by contrast, it is used today.

Where appropriate, this method has been supplemented by the inclusion of known concepts and theories that were not evident in the systematic literature search, but which, through the lens of my own clinical experience and knowledge, do have potential impact on our understanding of the therapist's use of silence.

When seen as a cultural setting, a clinical practice acts as a social mediator of both talk and silence (Lehmann, 2014). The use of silence in psychotherapy is multifaceted. This chapter will explore clusters of secondary research in the form of papers on clinical theory, general theory and case vignettes.

It will be argued that a shifting relationship with silence is directly reflected in the modification and development of psychotherapeutic theory, particularly within psychoanalytic thinking. Ogden (1996) offers a definition of contemporary psychoanalytic theory as:

> Analyst and analysand each participate in the unconscious intersubjective construction (the analytic third) but do so asymmetrically. Specifically, the relationship of the roles of analyst and analysand structures the analytic interaction in a way that strongly privileges the exploration of the unconscious internal object world of the analysand. This is so because the most fundamental purpose of the analytic relationship is to help the analysand make psychological changes that will enable him to live his life in a more fully human way (p. 884).

Silence is linked to how the therapist has viewed the client, their theory of mind and what is potentially happening between them. There is a shift from the objectification of the client through reductive interpretation using preconceived concepts and theory, to the intersubjective hermeneutic interpretation. A hermeneutics of distress, defined broadly as remaining open to multiple perspectives contextually situated and prizing the lived experience of the client over any imposed reality, label or doctrine (Bracken, 2014; Bracken & Thomas, 2005).

3.1.1 Comparative Psychoanalysis

When exploring the thought structure within any one school of psychoanalysis, Schafer (1979), argued that the task is so formidable that even the analysts within that school cannot agree which basic assumptions have been made, the interrelations between key propositions, or core methods.

He proposes that the concept of “comparative psychoanalysis” must deal with both the arising epistemological and methodological questions inherent within. Forty years have passed since Schafer’s observations, and psychoanalytical thinking has developed significantly, but the challenge remains complex when appraising the vast amount of historical data. Using the example of Greenberg and Mitchell (1983), comparative psychoanalysis will provide a conceptual framework within which confusion amongst competing theories and schools can be clarified. It will draw out the implications of different theoretical perspectives in the use of silence, offering the structure for its integration of theory and practice.

This has been arranged around five main themes:

- how the view of silence shifted from resistance to a technique
- the evolution of this technique
- the consolidation of technique
- contemporary silence
- humanism and existentialism.

I will now explore each of these themes in detail whilst discussing the associated literature.

3.2 From Resistance to Technique

The genesis of many of the fundamental psychoanalytic concepts and silence can be found in the work of Sigmund Freud (1856-1939). There is no dedicated heading for silence in any of Freud’s 24 volumes, as Liegner (1974) highlights, although terms such as shame, smell, stammer, speech and sex appear in every volume.

Freud (1912) considered client silence as a resistance (opposition) to the transference (the therapeutic relationship and analysis), and silence as a resistance to remembering painful or shameful experiences or fantasies. Silence was classically interpreted as a symptom. Verbal communication took precedence, therefore the more the client freely communicated, the more successful the therapeutic enterprise: the talking cure (Breuer & Freud, 1895). As Arlow (1961) succinctly states:

> The technical implication was that so long as the patient talked and the analyst interpreted, an increasing mobility of cathexis was achieved (the unconscious is emptied out), repression was lessened, and the patient got well (p. 46–47).

The fundamental shift in his approach occurred when, during the analysis of his first clinical case, "Emmy von N", he made the link between the analyst's silence and the willingness of the patient to free-associate, a technique whereby the client is encouraged to say the first thing that comes to mind (Freud, 1895a). Freud revised his view of silence as being exclusively about resistance to opening the potential of the analyst using silence as a technique. The popular term and core technique associated with classical psychoanalysis is the "blank screen"**.** This was the idea of the analyst as a non-intrusive projection screen for the client's unconscious fantasies and conflicts. The earliest reference to the term is found in Jelliffe (1930): "The analyst becomes a blank screen upon which are projected pictures of the patient's infantile life" (p. 351).

The term became a pop culture phrase and lost its potency as its meaning was diluted. Freud did not explicitly use the term, but it was commonly accepted that it was originally related to two rules of psychoanalytic technique, firstly that of an analyst as a "mirror", a non-intrusive presence who avoids getting in the way of the client's projections. The analyst evades any attempt to bring a particular moment or problem to light and refuses to decide the fate of the patient or to "force our own ideas upon him, and with the pride of a Creator to form him in our own image and to see that is good" (Freud, 1919, p. 164).

Secondly, with the rule of abstinence, Freud stated that "the treatment must be carried out in abstinence" (Freud, 1915, p. 165), "we ought not give up the neutrality towards the patient, which we have acquired through keeping the counter-transference in check" (Freud, 1912, p. 115).

Despite psychoanalytic theory developing and diverging significantly from classical psychoanalysis, the idea of the "blank screen" remains a strongly-held belief about psychoanalytically informed psychotherapy generally (Malcolm, 1980). The literature reflects that from the period of 1914 to the 1950s, the psychoanalytic literature broadly reflects and complements Freud's initial theory of interpreting silence as resistance (Bergler, 1938; Reik, 1924).

3.2.1 The Silent Patient

Ferenczi (1916) is noted as writing the first paper dedicated to silence: *Silence is Golden.* He connected silence as the hoarding of words as a defence against anal drives. He made the more accessible hypothesis that the client likens the retention (silence) with strength.

Ferenczi (1916) made a significant technical recommendation that when educational measures to encourage free association have been expended, the client's silence should be opposed with that of the analyst's: *the absent analyst*. Glover (1927) elucidates on this idea:

> To meet silence invariably with silence is to court a sort of silent combat, which confirms the obstinate or aggressive type of patient in his view that analysis is a kind of psychological pugilistic encounter to be settled by the scoring of points. On the other hand, this is precisely the type of patient to whom it is necessary to demonstrate that he is attempting to convert analysis into a fight, in fact that this is the outstanding evidence of his negative transference (p. 513).

It is worth noting the early connection of silence and negative transference, a link that I will return to throughout. As the rigidity and adherence to Freud's original ideas lessened, so did Glover's (1955) view on silence:

> On the other hand, rapid interpretations at this stage is, as a rule a gamble in probabilities, and falling back on ritual silence is sometimes a counsel of despair. On the whole, an elastic attitude is desirable (p. 31).

The concept of resistance has been criticised for its unassailability, but Holowchak (2012) argues that interpretation was meant to be delivered as hypothesis. There are numerous ways in which the client's silence as resistance has been interpreted, but there is no clear consensus. What appears strikingly absent in these discussions of the silent client is the potential pain and distress that the client may be experiencing (Loomie, 1961).

Despite reference to the necessity of love within the analysis, it can read as if a cold clinical technique takes precedence over a more human understanding.

In his early writings, Freud demonstrated that he was far from silent, as he employed questioning, hypnosis, and direct instruction (Freud, 1895a, 1895b). Whilst being hardened in his desire to promote psychoanalysis, in person he demonstrated a much more human and flexible approach (Roazan, 1992). The silent analyst was how subsequent analysts and training institutes interpreted the optimal therapeutic atmosphere, and was very much how analysis was caricatured for years to come (Malcolm, 1980). As will be discussed in Section 3.6, it is around this time that a more humanistic approach to psychotherapy was being developed in part as a response. I will now consider the specific use of silence by the therapist.

3.2.2 Silence as Technique

The earliest and most comprehensive explorations of silence to be found in the English literature is offered by Reik (1926). As such, it is worthy of a full critique. In remarkably clear and contemporary language, possibly enhanced by the English translation, he offers his insights into the therapist's use of silence: "I believe it would be more correct to say that psychoanalysis shows the power of the word and the power of silence" (Reik, 1926, p. 173). He argues that so much has been said about the "talking cure" that the emotional effect of silence has been almost completely overlooked. Reik (1926) goes beyond the silent pauses of the client to explore the impact of the silence of the analyst on the analysand (client). He proposes that the silence of the analyst is contextual between varying clients and within each individual session. Its definite significance is ascribed by the client according to their feelings. In the beginning he viewed it as a positive experience:

> Certainly the patient takes it as a sign of calm attention, but this itself seems to him to be a sign of sympathy. When we care to be attentive to someone, then this act reflects our pleasure and esteem for him. One cannot fail to recognise that this silence as such gives the patient confidence, and seems to encourage him to express himself freely (p. 175).

However, the analyst's silence slowly changes its meaning for the client. A client's words are evaluated differently when spoken than when visualised. The analyst's silence strengthens this reactive effect and serves as a sounding board. In this instance silence has a stronger effect than words, and the client attributes a conscious significance to the silence. Reik (1926) argues that the silence of the analyst as emotional expression only becomes conscious to the client when their first serious resistance appears. He suggests that the suspension of the conventional elements in human relationships is what characterises the analytic situation.

I would agree that in many ways it is. However, by way of illustration, I would argue that this dynamic of transference can be experienced outside of therapy, for example, when someone says more than they initially feel comfortable with and are met by silence. An immediate feeling of being judged or criticised could arise in the teller due to the interpretation they have made of the listener's silence, often not conscious, but resulting in a negative reaction inwardly or externally expressed in retaliation. Reik (1926) posits that the analyst's response to the client's first resistance can be detrimental to the alliance. It implies that there is a necessity for a level of rapport before this crucial juncture in the process.

The silence changes from the initial calm listener to that of a determination not to speak by the analyst. This can be disturbing for the client.

The obvious power imbalance in this technique is self-evident but the potential for the unintentional and intentional abuse is subtler and will be discussed in more detail later. Reik (1926) believes that the impatience with the analyst propels the client forward to say more about their experience, to access more history and memories. The analyst's continued silence increases the annoyance and impatience of the client impacting on the "censorship barrier".

The client begins to say things that they have held back, as a space is created where material previously considered offensive or immoral can be verbalised. The analyst's continued silence becomes an indication of a threatened or already experienced loss of love, and unconsciously takes on the character of punishment. Reik (1926) suggests that it is a deliberate attempt by the analyst to bring negative feelings to the surface (negative transference). This is a precarious time in the process which, if not addressed effectively, can result in the client not wishing to return to therapy. Again, there is the sense that in addition to the transference relationship, there is a real relationship that supports the client in understanding what is going on.

Silence is not simply being mute, he argues: psychoanalysis teaches that there are different levels of intensity in silence. Silence has essentially two meanings, one contradictory of the other. It is interpreted as a sign of calm sympathy or an expression of intense hostility. Reik (1929) argues silence cannot be considered independently of speech but that there is an inherent antinomic relationship, since there is meaningless speech and meaningful silence. This meaningful silence is central to the context and dynamics of depth psychotherapy and is what most delineates it from "normal" conversation.

People often speak because they cannot bear the silence. In the same way, compulsive speech can be an instrument of secrecy – withholding or concealing truth. To the analyst, the unexpressed matters which dominate the relationships of the client at the deepest level can be audible even in silence. Practice shows that behind the fear of silence rests the unconscious fear of a loss of love. Reik (1926) states “there really is not absolute silence, there is only a growing silent [sic] of the most apparent sounds” (p. 183). Silence and speech are not absolute opposites: there is a bridge to each, and we cannot discuss one without comparison to the other.

Concluding with some philosophical reflections, Reik (1926) suggests that silence comes before speech. Speech arose from silence as life from death. If we are here on leave from death, then speech is only a momentary interpretation of the eternal silence. He describes silence as pregnant with unsaid words, with psychoanalyses signifying a breakthrough into the zone of silence (all that is repressed) of the individual. Speech conceals what silence reveals.

Significantly for this study, and despite its depth, Reik (1926) acknowledges that the paper only explores the psychic effect of silence and does not address when it is suitable or not to use silence. It does, however, explicitly discuss the motivation and use of silence by the analyst that arguably is unsurpassed in the psychoanalytic literature. I have reflected over many years on the oral nature of psychoanalytic theory and how much of the technique is experienced during training analysis and therapy. This is accentuated when considering silence, as it seems so central to technique, but in contrast is frugal in the literature. A further significant contribution was made by Reik (1948) as he developed his work on the emotional expression and listening of the analyst conceiving the phrase and concept “listening with the third ear”, a work that will be discussed later.

3.3.3 An Unhealthy Silence?

In a curious and obscure short paper in the journal *Diseases of the Nervous System*, Maloney (1947) makes a case for the danger of the analyst remaining silent by citing the propensity for cardiovascular disease and other somatic illnesses in senior analysts. He concluded, “Though necessary for the welfare of the patient, it is psychosomatically unhealthy for the analyst to remain silent” (p. 16).

Despite being a Freudian, he clearly liked to talk. As one client recalled: ‘He also needed to lay out his entire theory during our first encounter so that it could begin to sink in’ (White, 2000, p. 18). It is insightful to hear a first-hand experience of silence. White continues:

> More than once, I caught him dozing. That he was asleep changed his preceding silence in my eyes from a sharp, therapeutic instrument into an obtuse abnegation. I bored him. This man who claimed to love me was zoning out on me (p. 20).

Whether a rationalisation or not, Moloney’s interpretation dramatically highlights the intersubjective nature of silence and how it can be powerful in evoking strong emotion on both sides: “I know what you're thinking,” he shouted [Maloney]. “You're probably mad as hell. And you have a right to be. You have a right to unqualified love. No time limits, no lapses, eternal, unqualified love” (White, 2000, p. 20).

Ideally, the unconditional love of the analyst is implicit by the preordained nature of the relationship-healer and the wounded. When the therapist’s use of silence is seen as counter to that in the form of withholding, judging, criticising, a negative transference arises.

The point of healing is when the client comes to realise at a visceral and emotional level that their interpretation is influenced by their experience of the withholding of their own mother or caregiver.

3.2.4 The Capacity to Be Alone

The impact of the avid therapist in causing the patient to retreat was highlighted by Weisman (1955): “A talkative therapist not only permits the patient to abide in silence, but, in effect, allows his own verbal facility to exaggerate the communitive gap between them” (p. 260). He proposed that the patient should understand why sometimes the therapist talks and why he too is silent: “In this way the constructive use of silence is emphasised, in contrast to the disabling silence of the psychoneurotic conflict” (p. 260).

In a short but influential paper Winnicott (1958) stated that the capacity of the individual to be alone was a highly sophisticated phenomenon with many contributory factors and was closely related to emotional maturity. It is an example of how a short paper with no clinical evidence can have a profound and enduring impact on psychotherapy. It raises the consideration of psychotherapy as part philosophy of mind and as an art.

The psychoanalytic literature Winnicott (1958) argued, focused on the *wish or fear* of being alone, but not on the *ability* to be alone. Far from being evidence of resistance, silence at times was an achievement on the part of the client. The capacity to be alone is paradoxical, as it requires the infant or small child to achieve this while in the presence of the mother (or caregiver). He draws from the work of Klein (1946, 1957) and object relations, to suggest that the capacity to be alone depends on the existence, in the psychic reality of the individual of a good object, an internalised good object.

The ego immaturity of the infant is balanced by the ego support from the mother until the ego supportive mother is introjected, enabling the child to be alone without reference to the mother or mother symbol. This concept immediately links to the later work of Bowlby (1969, 1973, 1980, 1988) and attachment theory. The observation of silence as an indication of the client's ability and need to be alone in the session opened silence as a form of communication.

3.2.5 Silence as Communication

In the independent tradition of the British School of psychoanalysis, Balint (1958) in an influential paper proposed: "Perhaps if we can change our own approach – from considering the silence as a symptom of resistance to studying it as a possible source of information – we may learn something about this area of the mind" (p. 338). He had previously divided the patient's silence into a regressive, aggressive and barren silence, and a tranquil, quiet silence of integration (Balint, 1955). Often the meaning for the patient was the exact opposite for the subjective experience of the analyst.

1958 American Psychoanalytic Association Panel

The panel at the Midwinter Meeting of the American Psychoanalytic Association (APA) in 1958 was the next time silence would receive serious consideration in the literature. Its output was a cluster of six papers published in 1961, four of which had significance to the developing understanding of the therapist's silence.

The tone of the panel was set by its chair, Loewenstein (1961), who described silence as inevitable and as significant as speech both as a positive and negative mode of communication – a phase in the curative process.

He makes a significant observation that unlike the expression available outside of analysis, during the session there is an expectation that the client will translate all facets of object relations (past and present) into speech. He posits, therefore, that it is understandable that some aspects manifest themselves in a disturbance of verbalisation or by nonverbal communication in the form of silence. He qualifies this by adding that silence need not always be a symptom of disordered object relations indeed: “But in discussing the silent patient, let us not forget that silence, in analysis as well as outside of it, is at times a necessary mode of object relationship” (p. 6). Loewenstein’s (1961) comments mark a shift in the view of resistance, opening the idea of silence as an essential aspect of the therapy and communication.

Zeligs (1961) defined silence is a complex psychic state not easily classified or systematised. Silence communicates nonverbally a mood, attitude, aggressive or libidinous thought or feeling. In a long, ambitious and pioneering paper he endeavours to make more meaningful the multiple and perplexing “states of silence which form part of every psychoanalysis” (p. 7). Highlighting again the lack of attention paid to silence within the psychoanalytic literature, he indicates a softening of the view that if the patient is not speaking then the analysis is impossible, but that there remains a lack of systematic formulation of the analyst’s use of silence.

The importance of the unconscious is prized by Zeligs (1961): “When the patient’s speech is inhibited and silence prevails, the analytic aim is not merely to get the patient to speak but to try to make meaningful for him the unconscious reasons for his inability to speak” (p. 17).

He makes the link between the empathy, listening and speaking that emanate during a period of silence as representing adult derivatives of the primary object relationship. The client's self-assurance develops as they sense that the analyst's silence grants them the right to be silent. An abstinent yet benevolent atmosphere promotes reality testing by eventual verbalisation. He viewed the timing, "dosage" and tact of any interpretation as important as content.

Zelig (1961) also offered what he considered to be the attributes of a hostile and depriving analytic situation, one where the analyst's silence denotes impatience, boredom, indifference or hostility; sensed and considered by the client as disapproval, rejection, or condemnation. With the inherent power imbalance between highly educated analyst and patient, this clearly becomes a precarious proposition. Firstly, it requires the analyst to be more than human, avoiding natural responses of boredom and indifference during moments of client silence. It also requires the transference of these "benevolent qualities" in a way that the client can experience.

As will be discussed later, this is challenging enough when face-to-face with the client, but unless otherwise stated, psychoanalysis to this point includes the use of the couch (Lingiardi & de Bei, 2011). While some clinicians sit where the clients can still view their face and expressions, more often, like Freud, they sit out of sight (Goldberger, 1995). The perception of silence therefore relies on the concepts of transference and countertransference. As psychodynamic psychotherapy (often weekly sessions) emerged out of psychoanalysis, the significance of the face of the therapist and how it relates to mirroring and attunement became more significant (Stern, 1985).

Considering the emerging knowledge of transference and countertransference at the time, Zelig (1961) amplified the continuous role which both the analyst's and client's silence play in the psychoanalytic process. He cautioned that unless the analyst was aware of the technical and characteristic meanings and uses of silence, they were at risk of unconsciously employing their original silences. It is noteworthy that he uses the term "interpersonal" to describe the relationship mediated by silence: "this early (preverbal) phase of object relations is progressively strengthened by the empathetic content of the analyst's silences and verbalisations and ultimately made meaningful by his interpretations" (p. 41).

Transference and countertransference and how they relate to silence will be discussed in more detail below.

Returning to the panel, Greenson (1961) focused mainly on the silence of the patient but significantly expanded on the original interpretation, he makes the case that often the patient communicates despite the resistance. He set a tone that reads with more feeling and attentiveness to the nuances and depths of the client's experience beyond the traditional clinical terminology and jargon. He argues that silence can be about more than just a resistance and may in fact be the content that the client is trying to convey, unconsciously repeating a historical event in which silence was a significant feature. "Silence may indicate an identification with a silent object" (Greenson, 1961, p. 80), an occurrence that happens frequently with clients who identify with the silent analyst.

Greenson (1961) proposes that silence is often a reaction to an interpretation, positively when the client is surprised by the insight, or when they need time to mull over what has been said.

More negatively and frequently, the silence indicates the disappointment in not being understood, silence as a defence and retaliation. He concludes by making an important distinction between the type of silence the analyst can offer: impatient silence as they wait for the client to speak or pleasant silence. The response from the client when the analyst consciously shifted their position while in silence was telling about the varying qualities of silence: “I have the feeling your silence is different today. You seem to be smiling” (p. 84).

In an enduring and widely cited paper, Arlow (1961) highlighted the now-common practice of using silence to support the maturation of the transference. He argued that silence in analysis was different from other silences, and the silence of the analyst was quite a different silence from that of the client:

> The silence of the analyst is only part of a general set of conditions whose primary aim is to facilitate communication, verbal or otherwise, derived as completely as possible from sources within the patient. All other aspects of the analyst’s silence which are discussed in connection with technique are secondary to this consideration and relatively nonessential (p. 47).

Like Greenson, Arlow (1961) began to conceptualise silence having riches in the context of communication. When viewed from an intersubjective experience, silence is the most effective tool at the disposal of the client to stimulate countertransference. In turn, the analyst’s experience, and interpretation of this countertransference can lead to an understanding of a significant past event and/ or experience with past objects.

The use of the term “unconscious fantasy” and the general phrasing within the paper resonates with the work of Klein (1935, 1946, 1957), projective identification and object relations: “In the transference situation, silence may represent a token, a fragment of an experience with earlier objects. By remaining silent, the patient may attempt unconsciously to get the analyst to play a specific role” (Arlow, 1961, p. 51-52).

The majority of papers discussed so far have been published in the USA and would be considered in the ego-psychology school (school of psychoanalysis originally associated with Anna Freud) of psychoanalysis. What is striking is how many of the papers are peppered with the language of object relations, a collection of theories that are more associated with the British School of psychoanalysis. Specific papers on silence from the British School of psychoanalysis, meanwhile, have been virtually non-existent.

Etchegoyen (2005) in his widely respected book on theory offers a potential Rosetta Stone to understanding the therapist’s use of silence within varying schools of psychoanalytic thinking, and possibly beyond. It is the interpretation that influences how silent the session may be.
He cites Melanie Klein’s (1882-1960) break with classical psychoanalysis (she may not have considered it a break) as the reason for not being subject to the rule of silence. But more specifically the focus and the interpretation of the client’s anxiety (point of urgency) within the session led Klein to talk more. He contrasts this with Anna Freud and the school of ego psychology in the United Stated as being “very silent analysts” (Etchegoyen, 2005, p. 339). At the beginning of the treatment, the general rule was to observe or comment but not to interpret. He posits that perhaps the key to this technique is not silence but rather not interpreting, patiently waiting for the regressive transference to establish.

The literature highlighted the initial view of client silence as a resistance, and how this developed into the fundamental idea of the analyst being silent as a technique. It also showed the emerging thinking of the client's silence as being a form of communication and that the analyst needed to be aware and curious with regards its inherent meaning.

I will now further explore the literature and how the therapist's use of silence has evolved as technique.

3.3 Evolution of Technique

3.3.1 Analysis of the Transference

In the discussion of Arlow's (1961) paper, the current (late 1950s) understanding of transference and countertransference was alluded to. From the 1950s the thinking on silence began to develop within the psychoanalytic literature.

Greenacre (1954) offers a non-technical definition of transference: "If two people are repeatedly alone together some sort of emotional bond will develop between them" (p. 671). She argues that even though they may be strangers engaged in relatively neutral occupations, it will not be long before a predominately friendly or unfriendly tone will develop between them. Even if this is not expressed it will be retained as a silent judgement. She relates the speed for which the intensity of this development is enhanced by the frequency of periods in each other's company.

Whilst recognised as a universal tendency, Auchincloss and Samberg (2012) more specifically define transference as: “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” (p. 2). They note that the psychoanalytic context facilitates the activation of more regressive transferences – that is, transferences that relate to childhood feelings about early parental figures.

Freud (1895b) had originally regarded transference as an obstacle to understanding the patient’s relationship to his primary objects, but through the work of Ferenczi (1909), he saw the value in transference-neurosis. He saw the patient unconsciously making the analyst play a role of a figure or object from the past as an essential tool for understanding the neurosis. He saw this as a form of resistance to verbalising difficult memories in addition to a mechanism for analyst and patient to grasp aspects of infantile conflict in the here-and-now (Diem-Wille, 2004, 2018). Silence was now beginning to be used explicitly by the analyst to support the development of the transference.

Analysts were also becoming more interested in the preverbal stage of infant development. Within object relations, silence was now essentially used for creating a therapeutic milieu that supported regression whilst in the supportive presence of the therapist (Fairbairn, 1952; Winnicott, 1958).

Klein’s (1952) theory emphasised the “total situation” focusing on the anxieties of the patient past and present, with particular interest in negative feelings towards the analyst that may be concealed. There was an increased focus on the analyst-patient relationship as the main source of information about the patient.

A technique called “working in the transference in the here-and-now” remains a central and distinguishing technique that continues to be controversial (Bollas, 2007; Joseph, 1985; King, 2004; King & Steiner, 1992).

Four types of transference interpretation were proposed by Roth (2001) indicating that the analyst is making frequent verbal interpretations of the patient’s material.

Sandler (1976, 1983) is credited for the integration of classical ego psychology with contemporary object relations theory (Kernberg, 2005). During this research I believe I have located the inception of the term “analysing the transference in the here and now” for USA clinicians, with little or no reference to the work of Klein (Bauer, 1993; Bauer & Mills, 1989; Gill, 1979; Gill and Muslin, 1976). It is therefore a way of working that influenced analysts more readily identified as classical Freudians and therefore the use of modified silence.

As opposed to being abstinent to promote transference neurosis, Bauer (1993) argued that the therapist actively examines the patient-therapist interaction, to support the patient in understanding the development, implications and maintenance of their interactional style. The relationship with silence is viewed quite specifically (Bauer, 1993, p. 97):

> Listening is not to be confused with silence. Silence for silence’s sake is often a result of misunderstanding technique, therapist countertransference, or both. In theory, the therapist is silent so as not to behave in a fashion that is unduly influences patient associations. In reality, such a stance often evokes fantasies or activates transferences [often negative] which require as much interpretation and working through as any other behaviour would (p. 97).

The definition of transference has evolved and is often used to mean any relationship that the patient has with the analyst: positive, negative, real, empathetic.

3.3.2 Countertransference

The term countertransference can have multiple meanings and emphasis, within different schools of psychoanalysis, with the main theme being the analyst's response to the patient (Auchincloss & Samberg, 2012). These responses can be conscious and unconscious to the patient's transference and unconscious conflict. The term was originally framed similarly to transference, in that it was viewed as misperception of the patient due to the analyst's psychopathology (Freud, 1910; Klein 1957).

This perception changed significantly in the 1950s when new and influential papers were published. The efficacy of the "blank screen" has already being called into question (Fenichel, 1941) and in the 1950s the beginnings of a more intersubjective experience for analyst and patient were being acknowledged, albeit with the overall emphasis remaining on the patient. Heimann (1950) in her ground-breaking paper offered countertransference as an instrument of research into the patient's unconscious, seeing it as created by the patient and part of their personality. The similarity to the term projective identification makes the use of this phraseology very subjective at times and suggests a significant degree of overlap. The terms form more relevancy when described in specific detail and relating back to related theories of infantile and psychological development.

However, as Sandler (1983) reminds us, psychoanalytic terms have multiple meanings that vary according to the context in which the term is used. It may be more supportive to view psychoanalytic thinking as a body of ideas in organic development since the beginning, necessitating the stretching of concepts to reflect the emergence of new ideas.

At around the same time but independently of Heimann (1950), Racker (1954, 1957) also proposed that countertransference was a specific response to the patient, separate from what the analyst brought to the session. Klein (2017) rejected Heimann's use of countertransference, although her followers subsequently did not (Bion, 1961) and Heimann never explicitly used the term projective identification.

Although interpretation is necessary when working with the analysis of the transference and countertransference, silence is also a supportive and necessary component.

3.3.3 Container–Contained / Holding

There are two terms that give an insight into the developing psychoanalytic theory and how that altered the therapeutic relationship. In particular the manner in which the analyst may now view themselves post the moving away from the concept of the blank screen, and also in the role silence may now play.

I will begin with Wilfred Bion (1897-1979) and his concept of the container-contained. Bion was known as a deeply creative originator of psychoanalytic thinking, born significantly from his association with Klein and working with patients considered psychotic (Bléandonu, 1999; Grotstein, 2007).

He communicated a deep appreciation of silence throughout many of his publications: “The psycho-analyst can employ silences; he, like the painter or musician, can communicate non-verbal material” (Bion, 1970, p. 15).

In contrast to some of the technical approaches to the silent patient, Francesca Bion (1995, p. 20) refreshingly quotes her husband Wilfred Bion:

> Restricting ourselves to verbal intercourse won't get us far with this kind of patient. What kind of psychoanalysis is needed to interpret the silence? The analyst may think there is a pattern to the silence. If he cannot respect the silence, there is no chance of making any further progress. The analyst can be silent and listen – stop talking so that he can have a chance to bear what is going on (p. 20).

This seems like a strikingly important point. The capacity for the analyst to bear what is going on. In all the techniques that have been discussed and that rely on silence, there is a sense that its use is a refined skill often subjective in its application. Bion, when patients were silent was known for using the phrase ‘that seems to be a meaningful silence’ (Grotstein, 2007, p. 29).

Bion (1970) was also known for his influential phrase “without memory, desire or understanding” (p. 41). This charge to how the analysts begins their session again implies that they remain in silence, with the analyst only speaking when there is an important clarification or interpretation to be made.

When analysts transcribe their sessions, they usually omit the silence and focus on the verbal interventions, adding to the allusiveness of the use of silence (Winnicott, 1986). One of Bion's most famous patients was known to be the writer Samuel Beckett (Miller, 2015). In trying to imagine a tongue-in-cheek (putting words in their mouths) version of one of their encounters – such is the interest in the meeting of these two minds – Mahon (1999, p. 1384) offers a rare example of how one analyst might imagine another's use silence and the impact on the patient:

Bion: (Silence)

Beckett: Yesterday's silence. How long did it last?

Bion: (Silence)

Beckett: You ignore me as if you believed time were not important. How long did it last is about time, a question of time, goddammit. Without time the speed of light could not be determined. Science and time are codependent. Science sets up this amazing experiment: two black boxes, light passing between them. Are you with me?

Bion: (Silence)

Beckett: You son of a bitch. With me or not, I'll go on. I can't go on. I'll go on. Going on and on is all we know. Even your silence attests to that: the non-verbal goings on of your preposterous being!

Bion: Get back to the boxes.

Beckett: Get back to the boxes. You break your silence for that majestic utterance.

It is a small extract from a longer piece called *Yesterday's Silence*, and it offers an insight, albeit imaginary, into the centrality of silence in their exchange.

Bion (1959) introduced the concept of a patient being able to investigate their own feelings by the powerful personality of the analyst as being to "contain" – mirroring the supportive or ideal response of a primary caregiver.

Bion's (1962) concept of container-contained is often used synonymously with Winnicott's concept of the holding environment. Although there are similarities and overlaps, a precise reading of both writers elucidates their differences. The holding-object is an intuitive and responsive background object that facilitates the development of the infant (Winnicott, 1960). The container-object is one that can bear and absorb the infant's emotional states (often aggressive from a Kleinian perspective), transforming and interpreting them for the infant (Bion, 1970). The container-object is, as Grotstein (2007, p. 163) terms it: "an existential coach" as opposed to an "emotional instructor". Appraising both terms comparatively, it seems that both concepts are required for the development of the infant: two important aspects of objects relations.

More broadly, the overlap in these terms offers the sense of silence to support the idea of a benevolent presence, emulating the idea of the nurturing mother or primary caregiver. Silence and a sense of inner stillness as opposed to reactivity can be attributed to the "good enough" parent and analyst.

Bion was a significant contributor to bringing Kleinian theory to the USA, and indeed he spent his later years in Los Angeles (Aguayo & Malin, 2013, p. 176).

Winnicott (1996-1971) was a paediatrician and psychoanalyst who deviated from Kleinian theory in his rejection of the death instinct and focus on the concept of envy. As opposed to the battle between the Life and Death instincts, Winnicott placed the localisation of self in body as the centre of personality development (Winnicott, 1955). Through his concept of good enough holding he helped define what he considered the good enough parent and analyst (Winnicott, 1960). The concept of holding went beyond the physical holding (it would have to in analysis as physical contact was not part of the treatment) to denote: "not only the actual physical holding of the infant, but also the total environmental provision prior to the concept of *living with*" (p. 589*).* The holding needed to be good-enough to support the infant develop its mind and sense of self, interdependent then independent of the caregiver. "In other words, it refers to a three-dimensional or space relationship with time gradually added. This overlaps with, but is initiated prior to, instinctual experiences that in time would determine object relationships" (p. 589).

Silence is not explicitly discussed in relation to the two concepts, but it is implicit in the necessity to support their application.

Winnicott (1963) stated that: "I am quite confident about the technique of silence which I am very willing to employ except in so far as the patient cannot believe in it" (p. 84). In a moving and human description of analysis with a patient that he describes as potentially violent in their reactions, Winnicott recalls being silent for a week of analysis and having the great difficulty of having to bear the patient's delusional transference.

Whilst many psychotherapists are not trained psychoanalysts, nearly every initial training explores psychoanalytic theory and concepts.

These two concepts have remained important beyond the limits of purely psychoanalytic parlance and therefore continue to colour practitioners' experience.

3.3.4 Empathy and Trauma

Empathy is a surprisingly controversial topic in psychoanalytic thinking and is often discussed under assumed names (Grant & Harari, 2011). Originally it was explored most predominately by Ferenczi (1928) highlighting how much "psychological tact" was involved in how the analyst would respond to the patient: "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" (p. 89). He defines tact as the capacity for empathy.

When considering empathy, the ambiguity of silence was vividly restated by Lief (1962), it can express and enhance empathy or may express and even enhance misunderstanding or angry disruptive feelings between people. More generally his thoughts on silence are worth quoting:

> Silence may indicate agreement or disagreement, pleasure or displeasure, anger or love. It may be expressive of a sense of fulfilment 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 (p. 80).

He makes the qualifying point that the patient almost always regards the therapist's silence as deliberate and calculated, positing that it is seen as an active and encouraging force more often than a negative. When silence is an intervention as opposed to connected to the analyst's countertransference it is empathetic and non-threatening.

He sees the therapist's silence as an important and meaningful intervention. When the analyst is benevolent and not antagonistic it offers the greater opportunity for empathetic exchanges and the facilitation of communication.

The theme of silence as communication was returned to by Khan (1963), a long-term colleague and collaborator with Winnicott. Khan (1963) brought together the concepts of transference and countertransference to allow himself to experience the patient's silence. To experience what could not so easily be put into words. Khan identified that within the analytic situation (regressive re-enactment of the childhood experience) non-verbalisation and silence were the vehicle of mood and affectivity – silence was articulate and active, and the analyst could allow themselves to experience this.

There was a powerful sense that Khan (1963) was able to experience empathy with the affect by connecting: "pain, loss, and dejection in the silences" (p. 174). He was very specific about his role as analyst in the silences – to provide a sentient, concentrated, alert attention. It was a specific kind of listening with one's "mind and body" (p. 174). The analyst comes to understand silence as a royal road to the patient's traumatic experiences (Ritter, 2014).

3.3.5 Further Developments

The development of patient silence being viewed as both resistance and as a communication was acknowledged by Pressman (1961a). He articulated the now-common belief in the analyst's silence as "creating the optimal milieu for the analytic work" (Pressman, 1961b, p. 168) and free association, but he offered an original contribution as the first analyst to attempt a systematic study of this silence.

He demarcated the analyst's silence into 4 themes: *dynamic effects of the analyst's silence in the analytic situation; the meaning of the analyst's silence to the patient; contra-indications to the analyst's silence; and forces tending to disrupt the analyst's silence.* It is only the last theme that contributes something new to the current review.

Pressman (1961b) viewed the analyst's silence as a matrix for the analytic situation, with the analyst interrupting for further consideration or interpretation: "the keystone of the unique object relationship in the analytic situation" (p. 180). He highlighted that the analyst may interrupt other than for objective reasons with a given patient at a given time to satisfy specific needs, including a fear of the negative response of the client: "the unconscious avoidance of the development of the negative transference – anxiety, frustration, aggression, anger" (p. 181).

The action of the analyst not remaining silent, disrupting the actual analysis itself: this is a fear of the negative transference. As Winnicott (1963) stated, it can be extremely challenging for the analyst to bear the patient's negative or delusional transference. There is an inherent desire in the individual to be liked, to be the object of hate or disaffection, however temporary, can be jarring and something to be avoided.

For the remainder of the decade there was a small, infrequent, and eclectic occurrence of literature, often citing papers and concepts previously discussed.

Calogeras (1967, p. 541) presented the current analytic view of silence as: "a multi-faceted psychic state serving many mental processes and systems of the mind with many degrees of complexity and depth" (p. 541).

He argued that the handling of silence has not in general kept pace with the advances in techniques and that silence is a phenomenon with many degrees of shading and colouring.

Whilst recognising the potency of the analyst's silence to stimulate the unconscious fantasies of the patient, Aull and Strean (1967) attempt a summary of the limited literature to date. Using brief case vignettes to support their argument that patients respond differently to the analyst's silences, but that the same patient also experiences silences in different ways depending on the current state of their transference (relationship with the analyst) and resistance patterns. They caution against the traditional use of excessive and prolonged silences (Glover, 1955), for their tendency to place the patient in a state of hyper-suggestibility due to the scarcity of the analyst's words, therefore destroying analytic neutrality. It is notable that countertransference is referenced more frequently as a positive aspect of the analysis reflecting the shift in theory as encapsulated by the assimilation of the work of Heimann (1950) and Racker (1982).

The literature from the 1960s concludes with a unique and controversial contribution by Spotnitz (1969), which he referred to as "modern psychoanalysis". He was certainly revolutionary in his ability to work with those patients previously seen as untreatable, such as narcissistic disorders and "schizophrenia", and his work was seen as a precursor to interpersonal psychotherapy (Sherman, 2008).

Spotnitz (1969) argued that "silent interpretive analysis" is being conducted consistently from the beginning and whilst the analyst's silence can be gratifying and supportive, continued talking by the patient consumes considerable energy.

They also require replenishment in the form of interpretation; a novel way to contrast the use of silence and interpretation of the analyst. Spotnitz suggests that a schizophrenic patient can withstand more silence than the psychoneurotic and is prescriptive in the dosage of intervention.

Minimum dosage of silence at the beginning of treatment 2 to 5 units viewed as verbal feeding, equivalent to an infant consuming a mouthful of milk, until the narcissistic resistance is resolved. The shared silence can be useful for the patient if they are comfortable, relaxed and anxiety levels are low. However, Spotnitz (1969) warns that protracted silence is undesirable for a seriously disturbed person who is tense, suffering or in a state of conflict. This one caution richly highlights the intersubjective nature of his approach, for the analyst has to analyse the patient's current state within the silence, ascertain why they are not speaking, and if he wants to, support them in verbalising.

3.4 Consolidating Technique

The literature in the 1970s remained sporadic and consisted mostly of summaries of previous work and general pronouncements on silence.

The prudent use of silence as one of the most potent technical tools available to the analyst's therapeutic encounter is reiterated by Brockbank (1970). The complex phenomenon of silences, he argues, means that silence as the unconscious intrapsychic resistances of the patient, and the object-related here-and-now transactional relationship between patient and analyst are not mutually exclusive. This may somewhat explain the challenge thus far of separating the discussion of the silent patient from the silence of the analyst when reviewing the relevant literature.

Whilst barren in rich data, the psychoanalytic view remained supportive of silence and its role in therapy, as Blos (1972) surmised: “silence is a ubiquitous phenomenon in all psychotherapy” (p. 362). I doubt that this statement would be as true in 2020 when considering time-limited and highly directive psychotherapies such as Cognitive Behavioural Therapy (CBT) and Dynamic Interpersonal Therapy (DIT).

Shafii (1973) attempted to make links between Eastern philosophy and meditation practice and the relative stillness of movement a patient experiences whilst on the couch. He proposed that the experience of silence is a mysterious experience, with language and words struggling to express the non-verbal experience of silence. It was his reflection that silence can serve as a curative function that contributed the most: “Thus cumulative trauma which is experienced in silence is re-experienced and mastered again in silence” (Shafii, 1973, p. 442).

The idea of the patient’s silence itself being communication was gathering momentum and was robustly reiterated by Liegner, (1974). In her paper she makes a profound observation that could easily be overlooked, but its implications for classical analysis and psychoanalysis in general could not: “There appears to be an obsessional need to fit every patient to the Procrustean bed of classical technique rather than to utilize techniques that would fit the patient's needs (p. 233)”.

She argues that in a sense all successful therapy should be open to pragmatism, but whilst she states that it is important to use whatever methods help the patient make progress, she refers to Spotnitz’s (1969) technique specifically when working with the cases that she cites. In a circular reference in the later edition of his work, Spotnitz (2004) refers to Liegner ‘s (1974) charge that getting the disturbed patient to speak is preferable than them remaining mute.

During this process the content of the patient's communication is not the primary concern. Spontnitz (2004) describes silence as a difficult activity that can be a catalyst or permits growth in the pre-oedipal personality and reminds us that non-verbal communication continues even when voluntary silence is maintained.

The decision to intervene, Spotnitz (2004) argues, is a matter of theoretical significance, and he alludes to the artistry involved in the process, observing the principle of parsimony in communication: "interventions are made primarily to resolve resistance" (p. 177). Whilst recommending patience, he argues that an attitude of cool and reserve is desirable until the patient develops the capacity to release hate tensions comfortably in emotional language and what sounds like the ability to engage more fully in a therapeutic alliance.

Whilst sharing a focus on the more negative aspects of the patient's material, he contrasts significantly from the Kleinians with the busy (at times) activity of interpreting the unconscious phantasies of the patient.

Hargrove (1974) produced an obscure and brief paper on using verbal interaction analysis to explore empathetic understanding in recorded psychotherapy sessions. As original research, it will be discussed in more detail under the review of primary literature (Chapter 4).

3.4.1 Robert Langs

The two major contributions to the understanding of therapists' use of silence came from the same source, New York analyst Robert Langs (1928-2014). As light as Blos's (1972) paper is in new content, Langs (1973) cited it in his tome on technique at the beginning of a comprehensive section on silence. He is unequivocal about the place of silence in psychoanalytic technique: "among the repertoire of interventions available to the therapist, paradoxically, silence is undoubtably the most basic, the most undervalued, and the most misunderstood" (p. 367). He views its use as twofold: listening to the patient, and as a nonverbal communication that can convey multiple meanings including acceptance to rejection. He offers a dictum that many therapists follow to this day: that the therapist should begin every session in silence. Langs (1973) argues that it is the patient's privilege to set the tone, adaptive context, and to direct the focus of the session. To know what is on the patient's mind and with what he is concerned requires silence.

To wait for someone to speak first is logical in communication technique and listening. The challenge comes when ascertaining for how long the therapist remains in silence. There is a point when the initial inviting space of the listening silence can be perceived as a forceful pressuring for the patient to speak.

Langs (1973, p. 368) reveals what the patient may not fully appreciate: "The therapist, while silent, is very busy" (p. 368). He states that the therapist is silent until he "must speak" and he "intervenes" with silence to permit full expression of unfolding material. His clarity and directness in some way demystifies the use of silence and is a haven in a fairly arid literature landscape. I reflected on whether the medium of a book offered him a less restricted terrain from which to express his ideas and experience.

He offers an analysis of the use of silence as a constructive nonverbal *communication with the patient.* Langs (1973) proposes: “toleration of the patient’s hostility, seductiveness and or pathology – tolerance without criticism to support the therapeutic alliance, prior to ultimate confrontation and interpretation” (p. 375-380).

A comprehensive discussion of the pitfalls in the therapist’s use of silence was proposed by Langs (1973), suggesting: inappropriate and excessive use, expression of anger, unnecessary and inappropriate deprivation, inappropriate sanction of the patient’s maladaptive responses, defence for the therapist, and a multitude of countertransference-evoked reasons. He cautions that: “whilst silence is one of the most fundamental therapeutic tools, its misapplication can derail the therapy” (p. 386). This highlights again the power inherent in the more traditional analytic relationship and the harm that could potentially be done by silence. Langs argues that talking too much or too soon is a far more common difficultly, born out of the therapist’s own “unresolved, pathological narcissism – their love of their own thoughts, ideas, and concepts” (p. 387).

Silence is essential in supporting the patient to express themselves, Langs (1973) summarises, and to be understood on all levels. When used appropriately, it contributes to a warm and accepting therapeutic milieu and alliance, mediating reasonable separateness between therapist and patient. The difficulties of using silence relate to its excessive or insufficient use. Some patients are excruciatingly sensitive to its use and others are reactive to its inappropriate use. The therapist’s use of silence is “a complex, multi-levelled, conscious and unconscious communication reflecting its use as a tool to further the therapeutic process; deviant applications reflect unresolved conflicts in the therapist” (p. 390).

The initial ideas on silence were further developed by Langs (1978a) and he positioned it as one of six basic interventions: “It embodies the analyst’s wish to listen, contain, understand, and offer constructive help in keeping with the patient’s appropriate needs” (p. 635).

Later in the decade Langs (1978b) offered another significant contribution to technique in a work that focused on the listening process: “If you learn to listen, everything else will follow – you’ll be able to create and understand the rest yourself” (p. 10). The use of silence is more implicit than explicit in this work, but he offers a crucial insight into his embracing of Kleinian theory: “Kleinians do not sit well with classical analysts, but my growing interest in interaction led me to the Kleinian literature, because it is interactional” (p. 9).

3.4.2 Kohut and Self Psychology

The 1970s were also marked by the publication of two major works by Kohut (1971, 1977) giving voice to the ideas that he was developing and crystallising into what he called self-psychology.

The references in the first of Kohut’s (1971) work, on the silence of the analyst, appear in the main to continue to support the use of silence to develop the transference: “The analyst was accepted as a silent presence or, in the later mirror variant of the relationship, as an echo of what the patient had expressed (p. 251)” and “in the earlier phases of the analysis, he experienced the analyst not as a separate, distinct person whom he either loved or hated, but as a silent replica or extension of his own infantile narcissism” (p. 252). As opposed to meeting silence with silence, Kohut discussed the technique of repeating or summarising precisely what the patient had said to counter the patient’s anger at his silence.

As Kohut's (1977) work developed away from more classical analysis and toward his own school of self-psychology so did his conception of empathy and with it the traditional use of silence:

> Man can no more survive psychologically in a psychological milieu that does not respond empathetically to him, than he can survive physically in an atmosphere that contains no oxygen. Lack of emotional responsiveness, silence, the pretence of being an in-human computer-like machine which gathers data and emits interpretations, do no more supply the psychological milieu for the most undistorted delineation of the normal and abnormal features of a person's psychological makeup than do an oxygen-free atmosphere and a temperature close to the zero-point supply the physical milieu for the most accurate measurement of his physiological responses (p. 253).

He argued that neutrality should be appropriate to the context and that the analyst's behaviour should be one of a psychologically perceptive person, towards someone who is suffering and has entrusted themselves to the analyst for help. He advocated for humanity, warmth, appropriate empathetic responsiveness. It was a radical and controversial departure for "Mr. Psychoanalysis" as he was affectionately referred to, necessitating his vigorous defence of his ideas on empathy, even up to the last weeks before his death (Siegel, 1996).

The most complete and accessible articulation of Kohut's (1984) ideas was published posthumously, and the analyst's silence continued to be used when needed: "This patient's need, by contrast, was for a silent presence. She would talk to the twin, but the twin did not have to respond to her. As a matter of fact, just being together with the twin in silence communion was often the most satisfactory state" (p. 196).

Silence became related to the selfobjects as represented at times by the analyst with their "listening presence, silent mirroring, silently present calmness and strength" (p. 100).

3.4.3 Freud Wars

The literature in the 1980s again did not offer much attention to the therapist's use of silence but it was a significant decade for challenges to the orthodoxy of Freud.

The controversial work of Masson (1984, 1988) was discussed in Chapter 2. His challenge to the work and ideas of Freud was amongst a barrage of criticism colloquially known as the Freud Wars (Forrester, 1997).

In a widely cited clinical text, Basch (1980) highlighted the propensity for the beginner analyst to hide behind the concept of "analytic silence".

He reiterates the impact on the patient of raising their anxiety and leaving them dependent on their inner reserves. Whilst this technique can have its place, Basch (1980) argues that without the patient understanding the benefit of free association, it is ill-advised. He especially cautions against silence early in treatment, a direct rebuttal of Langs' (1973) guidance, highlighting the complexities of establishing consensus on technique.

The value of an empathetic, attentive silence was reiterated by Kurtz (1984). He proposes that: "the analyst's use of silence can grow from a self-conscious technique to a highly integrated manifestation of his being" (p. 1). He distinguishes between what he terms inflected and uninflected silences. Inflected silences are part of language and as subjective as verbal utterances.

Uninflected silence is a container of the analytic process distinct from content and, evoking Wittgenstein (2001) in this area, therefore irreducible. Whilst the remainder of the piece focuses on the silence of the patient, noting that silence offers the possibility of love, Kurtz distinguishes himself as the first analyst to begin to look at this other interpretation of silence: the silence that the whole analytic process arises within, a potentially more existential view.

3.4.4 The Relational Turn

The four psychologies of psychoanalysis were defined by Pine (1988) as *drive, ego, object relations*, and *self*, and have been discussed in their relation to the therapist's use of silence. They are broadly represented by the schools and theory of classical Freudian, ego psychology, Kleinian and object relations theory, self-psychology. The 1980s were an active time for the emergence of new ideas and directions for psychoanalysis and psychoanalytic thinking. It is necessary to delineate further by adding the latest and emerging school or turn of relational psychoanalysis.

Greenberg and Mitchell (1983) published a book that sought to offer an interpretation of the often complex and conflicted theories of object relations.

It was ground-breaking and was hugely influential in training institutes in the USA. The book contained the seeds of what Mitchell (1988) would further develop into his concept of relational psychoanalysis.

Relational psychoanalysis has its roots in the interpersonalist school of Sullivan (1953), and rejects the focus of drive theory in favour of object relations, a social theory of mind, relationality and intersubjectivity; a prioritising of relating over the unconscious and intrapsychic exploration (Mitchell & Aron, 1999).

The work of Sullivan (1953) was influential on the development of intersubjective and interpersonal. However, much of his work was published posthumously and does not therefore reflect the chronological development and influence.

3.4.5 Intersubjectivity

Atwood and Stolorow (1984) are credited with formally introducing the term "intersubjectivity", creating a synergy between the philosophy of phenomenology and existentialism.

They never explicitly discuss the use of silence in their work but instead *pose a challenge* to the classical approach and analytic abstinence (Stolorow, Brandchaft & Atwood, 2004). The contrast between the emerging intersubjective and the more classical approaches is the sense that the focus is on the needs of the patient before any adherence to rules or rigid technique (Killingmo, 1997). Stolorow (2018 personal correspondence) offered the following insights:

> "As with self-disclosure, I would try to investigate the following questions:
>
> What is the likely meaning of the therapist's silence for the patient?
> What is its likely meaning for the therapist?
> Are the interacting meanings for patient and therapist likely to facilitate or obstruct the therapeutic process?"

In the context of a hermeneutics of trust (closer to the patient's perspective and emotional availability), the analyst's silence is not a dead silence but a very active and embodied one.

The analyst remains open to their own unspeakable-ness, vulnerability, fallibleness and finitude – their own traumatic living memory (Orange, 2011; Vasquez 2014).

The terms relational, intersubjective, and contemporary psychoanalytic thinking are often used interchangeably. Enthusiasm for their development has not come without robust challenge, with the main argument being that it comes from a misinterpretation of Freud's theory (Masling, 2003; Mills, 2012).

The complex relationship between psychoanalysis and psychotherapy was discussed by Gill (1954), delineating psychoanalysis as analysing the transference and psychoanalytic psychotherapy manipulating it. He updated his thinking (Gill, 1994) and proposed that all aspects of the analytic situation are contributed to by both parties, alluding to a more constructivist view of the therapeutic encounter. He consolidated the distillation of his thinking in Psychoanalyses in Transition (Gill, 1994), and articulates what thus far has only been alluded to, that the neutrality of the analyst, so often caricatured, is a behavioural neutrality; the analyst is silent. He argued that silence that is used to frustrate the patient is not neutral, and the very idea of the silent analyst as doing nothing is a misconception. He makes a definitive pronouncement on the use impact of silence:

> My thesis is that the therapist should embrace the principle that whatever he does or does not do is an action that will have its interpersonal meaning, that he has a major responsibility to search for this meaning, and, in interpreting that meaning, to recognise that his response (and here silence is a response) is a stimulus to bring about a response on the analysand's part. And the analysand's response will not simply be an irrational reaction without any basis in the ongoing interaction (p. 47).

Building on the work of Kohut, Gill was setting the foundation for a two-person psychology that involved mutuality, the construction or co-construction of experiences.

Independently or at least without reference to the other intersubjective theorists, Ogden (1994) was developing his concept of the “analytic third”, the unconscious intersubjective asymmetrical construction being a third subject of analysis.

3.5 Contemporary Silence?

The 1990s offered a handful of eclectic papers that added something to the understanding of the therapist's use of silence.

In a widely-cited personal view, Sabbadini (1991) presents silence as an intersubjective concept full of contradictions: container, barrier, shield, bridge. The analyst may respond inappropriately with excessive silence or become over-interpretative, flooding the patient with words – a potentially deadly over-feeding. He acknowledges the difference between the analyst’s silence and that of the patient. Again, the focus for the use of silence is placed on its appropriateness: will it disturb, interfere or complement? He suggests that silence is meaningful and worth listening to because it is rooted in unconscious fantasies: “The unconscious is timeless. The unconscious is silent” Sabbadini (1991, p. 414).

Working with silence, O’Toole (2015) argues, gives the therapist unique access to the privacy of the self within the context of the therapeutic relationship.

In a rather obscure but sharp editorial, Trad (1993) offers a general summary of the positive aspects of silence as a profound human experience.

He highlights that the right to remain silent is enshrined in American law as much as speech, and that silence is as important as words in psychotherapy. He pinpointed trust as a primary aim of psychotherapy and its emblem, the ability of the patient to share silence with the therapist; secure enough to be vulnerable, exposed, and to be silent. He suggests three purposes for the use of silence in therapy: *to share interpersonal experience; for the patient's self-revelation; and for the self-reflection and contemplation of patient and therapist.* I would add *the self-revelation of therapist*, for it is a shared journey of growth and discovery. The therapist may not necessarily share this with the client but take it to supervision and their own writings. Trad (1993) eloquently describes the importance of silence and the understanding of countertransference reactions:

> Ironically, then, psychotherapy depends almost as much on the power of silence as on the power of words. Understanding how silence communicates is an art and one that is acquired gradually. It is born from restraint, a purposeful holding of the tongue as we allow our companion to fill in the space between us with words. In some ways, silence requires a balance between egos—a domain where neither the patient nor the therapist dominates. Those who have fostered this delicate skill have reaped the rewards of silence—and, as we have seen, there are many. As psychotherapists, our goal should be to help our patients become as well acquainted with the sound of silence as they are with the sound of words (p. 169).

The term “listening into silence”, is how Wilmer (1995, p. 723) described the “search for meaning and an elemental clue to empathy and associations” (p. 723). In at times an uncharacteristically personal account (for the literature) of silence, he relates the experience of individual life story as impacting whether silence is experienced as comfort, loss of identity, dangerous or deadly.

He implies that the analyst’s capacity to listen and empathise with silence is related to their own relationship and experience of silence. It is notable that it is one of the first times the noise of the world outside of the session has been alluded to. Citing several works from beyond therapy he foretells the growing interest and loss of silence in an increasingly noisy world. He reminds us that Picard (1988) censured the psychological therapies for examining the phenomenon of silence as material for an infinite amount of ready-made explanations adding to the general noise of words. The interest in silence remained with Wilmer (2000) beyond his retirement and he continued to write about the importance of silence across disciplines.

The different reactions of the patient to the analyst’s silence in various stages of treatment was highlighted by Trad (1995) in his laconic editorial, reiterated and expanded upon by Berger (1995). The use of clinical examples, from the work of Searles (1978, 1979) with borderline patients, highlights the strong emotional responses caused by the analyst’s silence and therefore demonstrates both its potency and the necessity for the analyst to be judicial and artful in its use. Searles (1979) highlighted the requirement of the analyst to be attentive to the fact that the kind of silence we are manifesting at any moment may be anything but dispassionate.

Whilst an effort has been made to review the development of silence and by default the therapeutic relationship, it is important to note that therapists may have held subsequent views in parallel or contrast to the later developments. As Leira (1995) succinctly summarises a more classical view of silence:

> Silence in the relationship, in stillness and in speech, may become a medium for communication, for separation and individuation, for regression and integration. Through wordless interaction, silence takes form. This process may illustrate two main forms of transference, projective transference, and dependent transference (p. 64).

3.5.1 A New Millennium

As a new millennium begins, it is over 100 years since the inception of formal psychotherapy. We see the publication of the only three significant papers on primary research. The two most substantial contributions of primarily research were published by Hill, Thompson, & Ladany (2003) and Ladany, Hill, Thompson, & O'Brien (2004), and will be discussed in Chapter 4 (Literature Review). With the inclusion of Hargrove (1974), it is striking that these are the only peer-reviewed studies on the therapist's use of silence – arguably highlighting either the denial of its significance and or the complexity of the subject.

The concept of the analyst's active but silent "witnessing" of the patient's trauma was introduced by Poland (2000). He carefully delineates the experience of mixed levels of relationship towards a clear witnessing of the patient's separateness, their intact otherness and distinct integrity:

> There are many times when the analyst feels *in part* emotionally *apart* from the patient. Witnessing is just one of many ways this may happen, but it is a special one. This respectful attention on the analyst's part, this silent but active presence, this silence of engaged nonintrusiveness rather than of abstinence, this listening in a way other than to seek for what can be interpreted, complements the analyst's interpretive function. The two, interpreting and witnessing, go hand in hand, each facilitating the other (p. 18).

In my own extended practice beyond the treatment room, I found the term "witnessing" extremely useful in theorising what I was doing when listening to people's experiences of trauma and war. The silent witness is a powerful metaphor for an intersubjective exchange.

Another quality of the therapist's silence is discussed by Knoblauch (2011). Stillness, he argues, can communicate an array of meaning, often impacted by the nuances of length, contributing to attunement.

In an overview from a self-psychology perspective, Elson (2001) argues that silence in the process of psychotherapy involves the identification and sharing of its salient features so that a mutuality of understanding or acceptance of difference is achieved:

> In silence, in deciphering and then sharing its contents, patient and therapist discover their common humanity and are strengthened and renewed. Silence is a powerful tool in the therapeutic process.

> In the mutual discovery of the specific meaning of silent periods as they arise, therapist and patient immerse themselves in the creative experience of restoring, renewing, or perhaps initiating strengths and capacities inherent in a cohesive self (p. 359-360).

She sees silence having the potential to heal, as a fertile factor from which the self can be strengthened and enriched, a place from which distortions of the self can be reflected upon and potentially transformed – empathically attuned silence. Elson draws attention to the importance of attunement, misstatement, and repair as an integral aspect of patient-therapist relating and the therapeutic process.

She also cautions that with "difficult" patients, silence can be misunderstood and abused. When referring to difficult patients it can be deduced that she is referring to people with borderline traits or psychotic patients who can find silence excruciatingly uncomfortable and/or punishing. She brings both the humanity and intersubjective into dual focus.

Silence as communication in psychodynamic psychotherapy was reiterated by Lane, Koetting & Bishop (2002). Their paper along with Poland's (2000) and Elson's (2001) highlight that psychoanalytic thinking has left the confines of psychoanalysis and is embraced by clinical social work, general psychiatry and clinical psychology. The concepts and thinking in the USA have less school or disciplinary possessiveness than in the UK. Lane, Koetting and Bishop (2002), state that the silence of the therapist is also communication, but a highly skilful one that needs to convey involvement and engagement. In notable contrast to using the term "difficult", they refer to patients who "need important emotional connection and support", as finding the therapist's silence as potentially disruptive.

APA 2012 Roundtable

In 2012, a roundtable took place in the Quarterly Psychoanalytic review publication of the Division 39 (Psychoanalysis) of the American Psychological Association. It featured five brief essays on silence and psychoanalysis. Motivated by the observation that silence seemed to have dropped out of the psychoanalytic discussion, and although short, they contained noteworthy comment on silence in the current milieu.

The caricatures that remain around the varying schools and silence are highlighted by Salberg (2012, p. 18), the Freudian neither speaking or asking questions, the Kleinian who is always interpreting and talking, and the Kohutian mirroring and rephrasing what the client has said: "no wonder we may be missing a bit of silence around here" (p. 18). Whilst she argues that there is a grain of truth in these caricatures, she cites examples of disruption in Freud's at times noisy session, and Ferenczi's flexibility with silence and speech.

To listen, the analyst must be quiet, Druck (2012) argues, urging a move away from dichotomy towards simultaneity. In doing so, our focus changes, the analyst can be real and unreal at the same time. Silence therefore is in a continuous interplay with speech; quiet becomes the context for talk within the session. Druck (2012) makes an essential point that because of its continued association with neutrality, absence, in service of optimal frustration of the patient, silence has been demonised.

It now represents all that is seen as the worst part of Freudian work. The evolving theoretical frame of co-constructed and intersubjective transference can at times still view the silent analyst as removed or detached.

Druck (2012) proposes that we look beyond theoretical context and focus on how quiet facilitates and maintains analytic process. The interplay of speech and quiet supports an atmosphere within which the patient and analysts can feel comfortable, safe and understood. The analyst's decision whether to break the silence is not always conscious, he summarises. "Thus, silence can be seen as part of a communicative dimension in an intersubjective context at a given moment in a particular analysis" (p. 20). This optimal silence contributes to a gap, a space which holds the potential for thoughts and unconscious affects to emerge.

The increasing pressure of time constraints and the expectation of patient engagement is stressed by Gellman (2012). She highlights that: "silence is an element that often drops out of our professional case presentation in favour of more dramatic and active tales of therapeutic action" (p. 21). Silence can remind us, she asserts, that as we inhabit busy and noisy worlds, there is a need to slow down, to listen for different kinds of silences and to track its changes and our responses, that inform intersubjective clinical choices.

Several vignettes of the silent patient were offered by Libbey (2012), and she is specific in how she views the role of silence in therapeutic change. Silence is:

> transformational interludes, when many separate images, ideas, and feelings were coalescing, without visible movement or audible sound. The period of silence was the final forerunner to giving his own voice to this new integration, as well as a final forerunner to successfully leaving treatment and living it (p. 24).

She gives the impression that the silence is where the patient assimilates and integrates the interpretation: a digestion of the therapeutic material.

The distinction between silence and quiet is made by Reis (2012). He sees the silence of the analyst not speaking and related to technique, whereas quiet, is a more expansive term referring to the lived experience of the relationship between analyst and patient. Here, engagement takes priority over the application of a method. Contrasting with the negative connotations of silence as withdrawal or resistance, he sees the necessity of "slow listening" to demarcate the psychoanalytic conversation from the day to day social one. The session may be the first place the patient experiences a space where speech is not demanded of them: "sitting quietly with another person over time is one of the most intimate acts available to us as people" (p. 25).

3.5.2 American Psychoanalytic Association Panel

Another panel was held at the Winter meeting of the American Psychological Association and was summarised by Vega (2013). The panel discussed a wide range of aspects on silence much of which has been already covered in this review.

It was proposed that when we are not talking to each other, we are in dialogue with our internal objects. This terse statement could summarise the lion's share of what has been discussed in psychoanalytic thinking and silence. This "necessary" and "imperative" silence of the analyst is an invitation for the patient's unconscious to reveal itself – the ability of the therapist to bear the silence in the confidence that the patient can strengthen the patient's ego.

The psychoanalytic approach was recast by Akhtar (2013), from the renowned talking cure to that of a listening cure. The publication focused on the gradations of listening to the silent patient.

He offers some reflections on the silence of the analyst, reminding us that the silence can be the container that facilitates the processing of what the client struggles to mentalise [or metabolise], the incoherent to the coherent.

Little (2015) argues that quiet is the background of being, speaking to an area of aliveness prior to doing. She argues from her experience that what patients need more than therapeutic participation is therapeutic presence: “a listening presence that allows them to establish a private relationship to the deepest parts of their psyche” (p. 35). She suggests that the silence of the analyst can open up an enriched encounter of the world. She makes the theoretical links between the American interpersonalist tradition and that of the British independents in their non-authoritarian approach, with a close listening to the texture of individual experience, a mutual respect for the autonomy of self and other, as opposed to preconceived technical dogma. Silence is the facilitator to shared aloneness, being together in a therapeutic bond that enables listening to the silent things within, and ultimately to find each other within this space.

The positive and negative implications of using silence were explored by Mullard (2015), and the results from the primary research will be discussed in Chapter 4.

3.5.3 Lacanian View of Silence

The demarcation of the work of Jacques Lacan (1901–1981) and the Lacanian approach to psychoanalysis from mainstream psychoanalysis can be traced back to his expulsion from the International Psychoanalytic Association (IPA) in 1953.

This split from the primary accrediting and regulatory body of the profession led to the Lacanian approach remaining a dissident form of psychoanalysis. Within academia, a de-clinicalised reading of his work remains popular, and has influenced contemporary discourse in areas including otherness, subjectivity, sexuality, and psychoanalytic criticism (Roudinesco, 1997; Žižek, 1989, 2009).

A recent publication of four essays has endeavoured to explore the Lacanian relationship to silence, academic philosophers Pluth and Zeiher (2019) state in their work "although he hardly seems to mention it, we're convinced that silence is in fact a major Lacanian concept". Whilst worth inclusion, it is because of the timing of this publication, combined with Lacan not being viewed as mainstream in terms of psychoanalytic theory and practice, that he is included under this unique section of the literature review.

The use of punctuation was a core practice of Lacan's, and the abrupt ending of sessions was one of the reasons he was deemed controversial and was expelled from the IPA (Roudinesco, 1997). Silence can be exploited as a form of punctuation. When considering the centrality of linguistics in Lacan's thinking, speech and silence are of equal value, with silence being seen as central to the restoration of subjective wholeness (Pluth & Zeiher, 2019). It is challenging, for the analyst to avoid being put in the position of subject-supposed-to-know, but the use of silence can mitigate this and places the focus onto the unconscious of the analysand.

Laurent (1989) evokes a powerful image when he describes the Lacanian psychoanalyst "not as a passive rock, he is rather a tornado, he must have a point of emptiness at his centre" (p. 138). In one of the few references to the use of silence by the analyst, Lacan (1966) states:

> "For that is what he does for the subject's speech, even by simply welcoming it, as I showed earlier, with an attentive silence. For this silence implies [*comporte*] speech, as we see in the expression "to keep silent" which, speaking of the analyst's silence, means not only that he makes no noise but that he keeps quiet instead of responding" (p. 290-291).

Lacan sees the analyst's silence as a choice, as action, an intervention. As with much of Lacan's own recorded practice, it is provocative with the intention of eliciting transference, whilst striving to avoid hasty comment or suggestion (Pluth & Zeiher, 2019).

3.5.4 Silence and Silencing in Psychoanalysis

Towards the end of the write-up process, a new publication was the first book in recent decades to attempt a comprehensive treatment of silence in psychoanalysis (Dimitrijević & Buchholz, 2021). The diversity of contributions explores an eclectic range of associated themes including clinical and research perspectives, as well as in philosophy, theology, linguistics, and musicology, and reflects the ubiquitous influence of silence in Western society. Following more traditional or classical psychoanalytic theory, the book retains a predominate focus on the silent client. Whilst offering interpretation of the client's silence as resistance, and the efficacy of countertransference and silence as a condition of listening, the publication offers little focus on the therapist's use of silence. This publication joins many others in calling for further research to be carried out, but fails to offer any new data, or substantial exploration of the therapist's use of silence. It therefore strongly supports the legitimacy of this thesis.

This concludes the review of the background literature, primarily from psychoanalytic sources and thinking, as it related to the therapist's use of silence. I will now briefly discuss the influence of the humanistic and existential perspectives on silence. It should be noted that I am not attempting an in-depth chronological exploration of the use of silence within these approaches as I have with the psychoanalytic discourse. Rather it is a broader consideration, addressing salient issues relating to silence, and the development of relationality and intersubjectivity, that I have become aware of through my own training and professional experience.

3.6 Humanism and Existentialism

The background literature sourced and reviewed, reflects how psychoanalysis and psychoanalytic/ psychodynamic thinking, when considering silence, dominated the literature. It is worth now discussing some core challenges to psychoanalytic thinking and the potential impact it has had on the therapist's use of silence.

3.6.1 Humanistic Influences

The field of therapy was dominated by psychoanalysis when Rogers (1942, 1951, 1961, 1980) proposed a radically different approach to the therapeutic attitude: non-directive therapy. Building on a mounting criticism of the absent, non-responsive analytic attitude, and the political challenges to power, patriarchy, and hierarchy, he proposed an attitude that required expressed empathy in an "unconditional positive regard" towards the client (Rogers, 1951). Inherent in this attitude is the requirement for the therapist to be relatively more responsive to the client than analysts had been previously.

The concepts and techniques of transference and countertransference were seen as one-sided, lacking mutuality and appropriateness and therefore the associated use of silence not central to practice. Rogers (1942) says of silence:

> In an initial interview, long pauses or silences are likely to be embarrassing rather than helpful. In subsequent contacts, however, if fundamental rapport is good, silence on the part of the counsellor may be a most useful device (p. 165).

The term “counseling” (UK: counselling) was introduced by Rogers and the “patient” replaced with “client”, creating distance from psychoanalysis, medicine (Rogers lacked a medical degree necessary for American analysts of the time) and being more humanistic in the process (Thorne, 1992).

In much the same way that the silent analyst was parodied, the techniques of client-centred therapy are often lampooned as an active parroting of what the client says, and not reflective of the nuances of empathy that Rogers espoused (Gendlin, 1962). However, the parody has some merit in how it alludes to the more active listener in the therapeutic relationship. There is a requirement of continued checking with the client. To achieve what Sundararajan (1999) refers to as the preoccupation with preserving the purity of the client’s meaning:

> It is important to test constantly your ability to see the world in the way the speaker sees it. You can do this by reflecting in your own words what the speaker seems to mean by his own words and actions (Rogers & Farson, 1957, p. 12).

Yalom (2001) argues that Rogers's early work, despite the echoing, reinforced the idea of the restrained therapist, but that his later work developed a more humanistic and interactive relationship. When reflective listening is employed by the therapist, as Rogers eventually intended, it can lead to the recovery of silence (Sundararajan, 1995). Gendlin (1962) argued that it represented not simply a cessation of words but rather also a silence within, both in therapist and client: the silent edge of more.

The specific use of silence as a technique in counselling was explored by Tindall and Robinson (1947). They categorised counsellors' pauses (silence) as: *for the purpose of organisation of thought; used deliberately in attempt to force the client to contribute; to terminate a phase in the counselling session*. Counsellors who were more conscious of silence, they argued, were more aware of its impact on the session and therefore how it could be used effectively.

3.6.2 Existentialist–phenomenological

The Austrian psychoanalyst Otto Rank (1884–1939) had a significant impact on both the work of Rogers and American existentialist therapists (Kramer, 1995). May (1996) and Yalom (1980) credit Rank as the most important precursor of existential psychotherapy. Rank (1936) argued for the importance of the emotional life of the patient in the present, coining the term "the here and now".

The existential–phenomenological approach to psychotherapy and counselling is based primarily on European philosophy (Cooper, 2003). Due to its diversity of thought and emphasis, it is not possible to define the field of existential therapy in any one way, but it has had an influence on how psychotherapy is practiced and the understanding and use of silence (Moja-Strasser, 1996).

I will therefore draw out key contributions from the literature. There is no prescriptive technique in existential therapy, but dialogue (philosophical enquiry) or conversation that can support the client make sense of their world is a core focus (May, Ernest, Ellenberger & Aronson, 1958).

As van Deurzen (1997) confirms: “keeping silent can be the most powerful way of having discourse” (p. 40). So, silence is only a technique as much as a dialogue could be described as a technique or skill. The therapist is there to support and “serve” the client in their exploration. While acknowledging the limits of the terms, Deurzen expands:

> There is much evidence from a century of psychotherapy that the realities of what is usually referred to as “transference” and “countertransference” can only be neglected at one’s peril. Existential work can be no exception to the rules of human relationships which dictate that where two people interact together specific dynamics between them evolve (p. 219)

Lomas (1999) argues that the neutrality of the analyst is a myth and that psychotherapists are increasingly concerned with how people should live. When considering Freud’s (1923) charge of listening with evenly suspended or free-floating attention, it can be hard to reconcile this and his preoccupation with the Oedipal complex.

Regardless of the nuances around these concepts there is stronger consensus around the idea of the therapeutic relationship being about dialogue and conversation: an immediately more intersubjective experience than a patient being analysed by an analyst. As Yalom (2001) succinctly puts it: “blank screen. Forget it. Be real” (p. 75).

It has been argued that Freud worked phenomenologically until his views hardened on the centrality of the Oedipus complex (Gay, 1998). Psychoanalytic interpretations are seen as reductive, fitting the patient material with preconceived theoretical concepts. By contrast, existential interpretation is seen as hermeneutic in its approach to prioritising the client's lived experience. This may have some broad validity but a careful reading of any of the main theorists sees that they all have alternative core concerns that they believe the client should focus on, including: *authenticity, death, and leading a meaningful life.* It can be assumed that the therapist will need to verbally bring these areas into awareness, impacting upon silence and listening.

Silence, when viewed more philosophically, retains an important function in existential therapy, as Moja-Strasser (1996) states:

> The silence or pause between words and lines creates the tension which is able to transport us into a state of wonder. So it is in the therapeutic dialogue, where silence is as important, if not more so, than the spoken words…if we are not able to welcome the client's silence, we are indeed ineffective. It shows that we are unable to stay with the anxiety that their silence generates, anxiety that is an essential component of any act of creativity (p. 99).

and:

> The therapist's silence allows the necessary space for the client to tune into themselves and get in touch with their deepest concerns. The corollary to the therapeutic dialogue is that by remaining silent the therapist allows the client to develop that "inner hearing" which is nothing else but tuning in to oneself.

> In this way the therapist becomes the musical instrument with which the client's creation resonates. They both tune in to themselves, and also into the intermediate world that is created between them (p. 100).

Gale and Sanchez (2005) are critical of contemporary attempts in psychotherapy to reinstate a value to silence, arguing that they have misunderstood it and imbued it with quasi-mystical qualities. Without philosophy, they argue psychoanalysis cannot offer an adequate understanding of silence in clinical practice. Silence is an integral part of language and therefore a component of all speech: “It makes hearing and listening possible, and thus is essential to discourse because all authentic discourse involves another” (p. 216). As opposed to chatter (Heidegger, 1962), silence often bears the existential characteristic of authenticity, including being-with. In this sense it can be understood as part of full speech.

Drawing extensively on the work of controversial philosopher Martin Heidegger (1889–1976), Wilberg (2004) argues that listening is not a technical skill or ability, it is inextricably linked to “Da-sein (t)here-being”: we hear, not the ear. He argues clearly that what we are capable of hearing is determined by our capacity to be fully present and *here* with ourselves, and at the same time fully there and “with” the other. The therapist’s artful connection with silence is central to this thinking. They focus on the disciplined cultivation of a basic inner bearing, someone who is able to fully be and *bear with* others in pregnant silence.

Silence as a gateway for healing has been proposed by Knutson and Kristiansen (2015). Although Scott (2009) concurs, he argues that silence and stillness are poorly understood compared to the lived philosophy of the ancient Greeks and healers.

Western culture has devalued the idea of silence and stillness being in support of healing and it is in fact a crucial part of psychotherapy and needs to be reflected upon in training. He pinpoints the natural desire to eradicate pain, a mind-set of how silences and stillness can be of any help, situated in the milieu of the "nonsense" of regulation, audit culture and managerialism: the need to be doing something, rather than nothing. The medico-scientific paradigm leaves little room for the alchemical healing power of silence. When considering its use in this way, silence is something that can spontaneously arise in the therapist's quality of mind (Back, Bauer-Wu, Rushton, & Halifax, 2009).

3.6.3 Rapprochement

A rapprochement between classical psychoanalysis and the emerging humanistic and existential influences, Khan (1997) argues, came from within its ranks in the work of Heinz Kohut and Merton Gill. He argues that they provide:

> a hugely important middle way between the schools of warm support and those of neutral transference analysis, a middle way that combines the advantages of warm engagement with the advantages of working actively with the relationship itself (p. 15).

There remain many core distinctions between existential and humanistic ways of working therapeutically and contemporary psychoanalysis. However, one that I would highlight that is directly related to silence is the therapist's welcoming, willingness, and capacity to work with negative transference.

3.6.4 The Therapeutic Relationship

The impact of humanistic and existential theory on psychoanalysis was to influence intersubjective and relational perspectives. It also opens the possibility for the therapist to be working in varying types of therapeutic relationship even within one given modality. In her seminal work, Clarkson (2003) offers five types of relationship as a conceptual matrix to make sense of all the competing, contrasting, and even contradictory views on the human condition and what to do about it. Each relationship has its own implicit relationship to the therapist's understanding and use of silence. What is clear is the use of silence, regardless of modality, remains more of an art than any science.

3.6.5 Post-existentialism

Loewenthal and Snell (2003) argue that the influence of existentialism and phenomenology on psychotherapy needs to be reappraised in the context of our current technology-driven society. It needs to consider postmodernism and its "radically sceptical questioning attitude of mind" (P. 3). To be truly post-existential, they argue for starting with practice; existential ideas and theories have implications rather than applications, psychological therapies are cultural practices, and the political/ideological is everywhere. This constellation of ideas and approach has begun to solidify into an approach referred to as "critical existential-analytic" (Loewenthal, 2021).

3.7 Conclusion

In this chapter I have explored the background literature on the therapist's use of silence. There is an important history that tracks the understanding, development and use of silence in psychotherapy. Silence was seen initially as a resistance by the client to going deeper in the analysis. However, this shifted, and silence became seen as something that could be utilised as a technique, with the analyst acting as the blank screen.

In due course this technique gained credibility as orthodox practice. Theorists began to consider the counterpart: the patient's silence and its potential for communication. The technique evolved into a concern about what was occurring for the client as well as the therapist and with this, ideas of what the therapist may be doing in the relationship.

The technique consolidated with the work of Langs and self-psychology, and tensions emerged between responsiveness and restraint. The emergence of relational and intersubjective approaches began to prize the relationship over instinctual drives, and framed transference as collaborative and co-created. Contemporary psychoanalysis spoke to the lack of attention to silence, accentuated by the ever-increasing milieu of noise.

The review concluded with an exploration of the influence of humanistic and existential theory on psychoanalysis, the potential rapprochement and influence on the therapeutic relationship. As is typical of much of psychoanalytic writing, most of the papers were written from a conceptual and abstract manner, with some including case vignettes.

In the UK, attempts have been made to develop competency frameworks for specific therapy modalities. The basic psychoanalytic/competences include the ability to work with unconscious communication. The centrality of silence is clearly stated: “The therapist can facilitate unconscious communication by knowing when to allow silence, so that free associations can emerge” (Lemma, Roth & Pilling, 2008, p. 19).

As noted by authors in subsequent decades, there is a notable absence of literature specifically addressing the therapist’s use of silence. This background review had endeavoured to discuss the predominance of supporting papers, collectively regarded as secondary research. In the next chapter I will move on to discuss the primary research.

CHAPTER 4: Review of Primary Literature

Silence, I discover, is something you can actually hear.

Haruki Murakami (2006, p. 138)

Language is situated between the cry and the silence. Silence often makes heard the cry of psychic pain and behind the cry the call of silence is like comfort.

Andre Green (1997, p.205)

4.1 Introduction

The purpose of the literature review will be to support the realisation of the Research Question (Chapter 1):

How do psychotherapists use silence in clinical practice?

It will explore the existing understanding of the therapist's use of silence in the clinical setting. A systematic search process is proposed to reduce bias, and to optimise the potential to locate and retrieve relevant data across variants of the same discipline. A systematic review of literature has remained popular in evidence-based health-related research (Neill, Roland, Jones, Thompson, & Lakhanpaul, 2015; Boland, Cherry & Dickson, 2017). These reviews have been especially effective when exploring studies of similar design, such as Randomised Control Trials (RCTs). The success in this area has resulted in the myth that systematic reviews are only effective in this area, and due to many being similar in design, they can mistakenly be viewed as exclusively positivist in philosophical outlook (Pettigrew, 2001).

The potential for the bureaucratisation of data analysis has been highlighted by Marshall (1985), and Borgnakke (2017) has noted that the current development of systematic reviews is being transformed and reduced to technique.

Therefore, it is proposed that the literature review remain informed by the distinct stages of the established review whilst modifying and enhancing selection to best meet the needs of the study. “In a very real sense, every piece of research is unique and calls for a unique methodology. We as the researcher, have to develop it” (Crotty, 1998, p. 14).

When considering the analysis of the included studies, a synthesis informed by meta-ethnography is proposed. Meta-ethnography has been used in several health and society-related peer-reviewed studies and appears to be gaining popularity within and outside of health research (Borgnakke, 2017; Campbell, Pound, Pope, Britten, Pill, Morgan, & Donovan, 2003; Popay, Roberts, Sowden, & Petticrew, 2006; Lucas, Cabral, Hay, & Horwood, 2015).

Meta-ethnography, Noblit and Hare (1988, p. 3) suggest, is more than a technique and “in some ways is a methodology born in the sociology of knowledge” (p. 3). It is a method for systematically searching and interpreting the literature; and can explore assumptions and approaches as well as findings. It is explicitly interpretative and constructivist. In the process of synthesising disparate papers, it compares themes and concepts in a manner that is reflective of the constant comparison method of grounded theory.

These key features of the methodology support the epistemological (constructivist) and the theoretical perspective (interpretivist) underpinnings of the study and create synergy with the methodology of the primary research and method of constructivist grounded theory.

4.1.1 Objective

The objective of the review is to search for published or peer-reviewed papers that describe the experience of the psychotherapist using silence in the clinical setting. The search question asked will be the same as the single research question:

How do psychotherapists use silence in clinical practice?

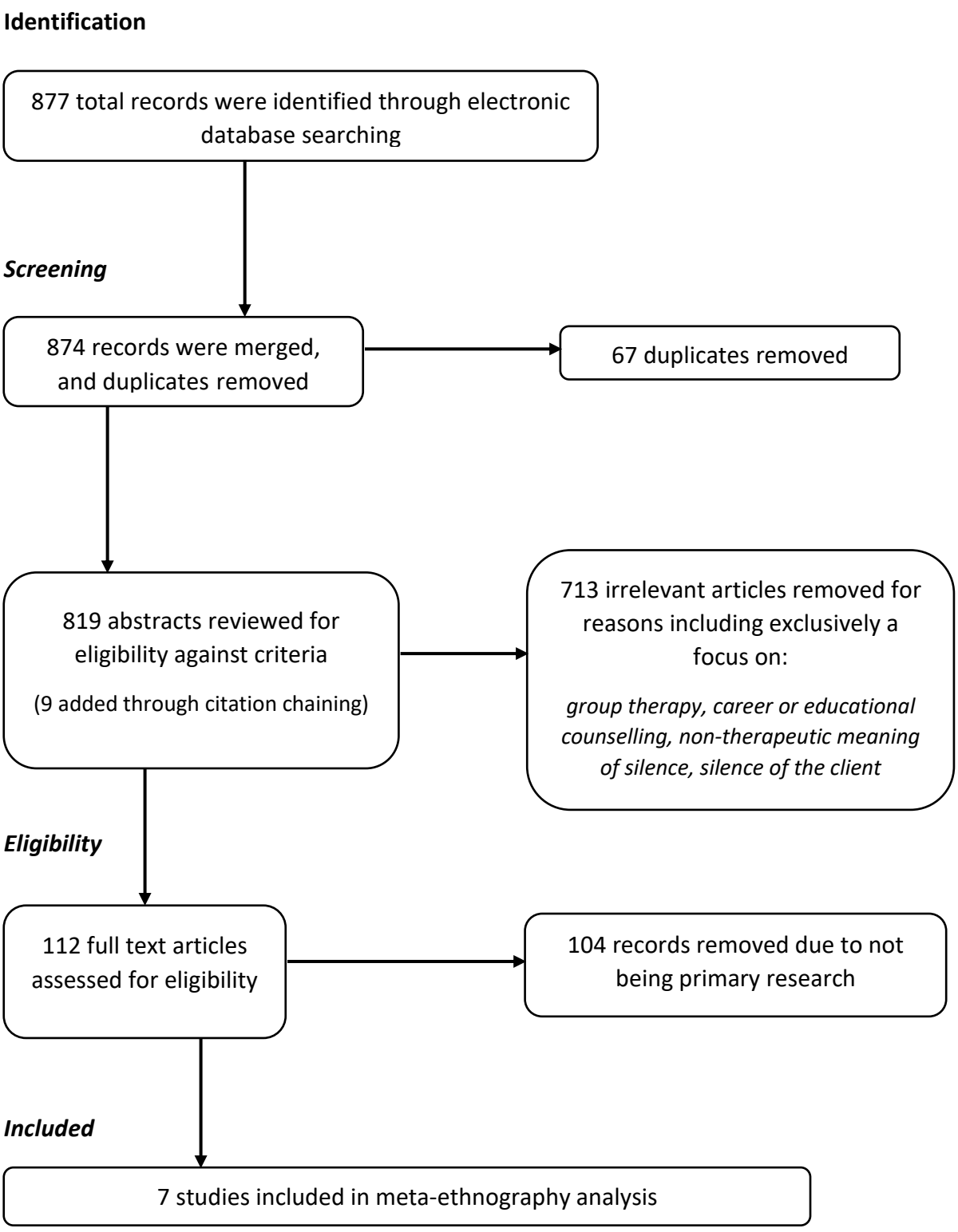
It would be premature to define silence as "therapeutic silence", but the silence that the study is interested in takes place within the clinical setting, when the therapist is with the client in session. Professional silence such as confidentiality and inter-professional silence will be excluded.

4.2 Methodology

In an effort to be transparent about the selection and inclusion of data, Moher, Liberati, Tetzlaff, Altman, and The PRISMA Group's (2009) Flow of Information will be used as an outline to how the literature review was be approached:

Figure 1

Flow of information chart



Adapted from Moher et al., (2009) Flow of information.

4.2.1 Search Strategy: *Identification*

The search strategy will provide sufficient detail in supporting others to replicate and critique its quality (Counsell, 1997). The strategy was trialled and finalised on the PsychINFO database before being used on a range of databases (See Appendix 1 – search strategy). After a total number of records were identified and recorded in the search, they were screened, and duplicates were removed.

4.2.2 Inclusion and Exclusion Criteria: *Screening*

The inclusion and exclusion criteria were informed by an initial scoping exercise and experimentation, with searches across a range of databases and media. The title and abstract of the records located in the search strategy were screened against the inclusion and exclusion criteria (See Appendix 1 – search strategy).

4.2.3 Critical Appraisal: *Eligibility*

The full text of the articles was sourced, downloaded and stored in citation reference software (Mendeley). The articles were then be explored in detail for eligibility for inclusion in the analysis. The critical appraisal remains a contested area with standardised systematic reviews (Noyes & Lewin, 2011). A tension remains between the necessity for rigour, relevancy and the avoidance of a stifling of creativity. Given that much of what counts for psychotherapy research is based on a tradition of secondary research and theoretical papers, there remains an onus on the study to offer a repeatable and verifiable appraisal of such sources. Primary research will be appraised for quality (rigour, value and credibility) using a Mixed Methods Appraisal Tool (MMAT) (Hong, Pluye, Fàbregues & Bartlett, 2018).

4.2.4 Results: *Included*

A total of 112 papers were retained for full-text review. Of these, seven were identified as meeting the inclusion criteria.

Articles are drawn from the discipline of psychotherapy; all researchers were doctoral-level registered psychologists. With the exception of Mullard's (2015) PhD dissertation, articles were published in peer-reviewed journals in the USA. The publication instalments were: Hargrove (1974), Hill, Thompson and Ladany (2003), Ladany, Hill, Thompson and O'Brien's (2004), Mullard (2015), Regev, Kurt and Snir (2016), Hill, Kline, O'Connor, Morales, Li, Kivlighan and Hillman (2019), and Cuttler, Hill, King and Kivlighan (2019). The publication dates do not reflect that the Hill et al. (2003) study was conducted after the Ladany study. All seven papers report empirical or field research, conducted in the USA, with predominantly white male participants. Hargrove's (1974) study was focused on verbal communication and empathetic understanding, the remaining studies all focused on the therapist's use of silence in therapy.

I will now give a brief overview of each paper before a more detailed discussion in Section 4.3.

Verbal Interaction Analysis of Empathic and Nonempathic Responses of Therapists

Hargrove's (1974) is a brief standalone paper. The aim of the study was to investigate the relationship of the temporal characteristics of therapists' verbal communication of empathic understanding in psychotherapy. The data was procured from one hundred five-minute samples from 35 tape-recorded sessions of psychotherapy conducted in outpatient settings, Hattiesburg, Mississippi, USA. The data was analysed using verbal interaction analysis. The study was published as a one-page format in a peer reviewed journal.

Whilst this poses a challenge to offer a fuller critique, the findings as they relate to the therapists' use of silence, were deemed worthy of inclusion.

Therapist Perspectives on Using Silence in Therapy: A Qualitative Study

Ladany et al. (2004) conducted telephone interviews with 12 clinical psychologists living in northern eastern USA. The aim of the study was to examine the therapists' perception of their use of silence to gain insight into how they may use silence in their therapeutic work. Participants were all white (seven men, five women), doctoral level psychologists predominantly describing themselves as psychodynamic or integrative practitioners. The telephone interviews were conducted using a protocol that included questions around the use of silence. Interviews were recorded, transcribed, and consensual qualitative research (CQR) (Hill, 2012) was employed to analyse the data. CQR is a constructivist methodology with similarities to grounded theory in its generation of core ideas, domains, and categories. The analysis relied on a team of four researchers to analyse the data and audit the procedures and results, potentially reducing inherent bias.

Therapist Use of Silence in Therapy: A Survey

The results from Ladany's et al. (2004) study was utilised by Hill et al. (2003) to develop a survey using 5-point Likert scales. The aim of the study was to use a quantitative method to extend Ladany's et al. (2004) qualitative study, exploring the therapists' perspective on the use of silence in psychotherapy. Part I of the survey asked about a silence event in a recent session, part II asked about general considerations for using silence in therapy, and part III asked therapists about background information as it related to silence, concluding with questions on demographics.

The “Silence Survey” was mailed to doctoral-level licensed therapists in the USA who primarily identified as psychodynamic, targets were obtained from the APA register. Of the 81 respondents 54 were male and 27 female, 77 Caucasian, 3 African American, 1 not identified. The ages ranged from 34 to 78.

Therapeutic Silence: The Positive and Negative Implications of Using Silence as a Clinical Tool In The Therapeutic Dyad

The aim of Mullard’s (2015) doctoral study was to describe the lived experience of silence by licensed psychotherapists. 13 face to face interviews were conducted with licensed psychotherapists in the USA. Interviews were recorded, transcribed, and analysed using grounded theory to generate concepts relating to the use of silence. The study draws frequently on the work of Ladany et al. (2004).

Silence During Art Therapy: The Art Therapist's Perspective

Regev et al. (2016) conducted semi-structured telephone interviews to examine the perceptions and experiences of therapists regarding their use of silence. 15 psychotherapists practising art therapy in Israel were interviewed, their interviews were recorded and transcribed. Data was analysed using the CQR methodology.

Silence Is Golden: A Mixed Methods Investigation of Silence in One Case Of Psychodynamic Psychotherapy

Hill et al. (2019) conducted a detailed study on one case from a community clinic in the USA. The clinic offers low-fee psychotherapy in return for research participation. The aim of the study was to examine what occurred before and after silence events in session. The participant was a 33-year-old, gay, African American. 183 silence events, from the first 5 and

last 5 sessions of a 73-session single case of psychodynamic psychotherapy were analysed. Cross tabulations were used to examine the relationships amongst categorical variables, and hierarchical linear modelling (HLM) was used to predict post silence collaboration.

Productive Silence Is Golden: Predicting Changes in Client Collaboration from Process During Silence and Client Attachment Style in Psychodynamic Psychotherapy

Cuttler et al. (2019) employed a quantitative approach to extend the findings of Hill et al. (2019) to a larger sample of clients and therapists, exploring attachment styles and level of involvement. Participants came from a university-based research clinic in the USA. The process and outcome of the first silence event was investigated for each of the 86 clients and 26 doctoral students in individual psychodynamic psychotherapy. The data was analysed using descriptive statistics to characterise the silence events. Cross tabulations analyses were used to examine relationships among the categorical variables, and because clients were nested within therapists, Mplus regression model with cluster-robust standard errors was utilised.

The characteristics and quality assessment of the studies are included in Table 2:

Table 2
Characteristics and quality assessment of studies included

Author(S)/Date	Setting	Aim	Design	Sample	Methodology	Main Focus	Quality Assessment
Hargrove (1974)	Outpatient settings	To investigate the relationship of therapists' verbal behaviour to the communication of empathic understanding in psychotherapy	Qualitative analysis of existing psychotherapy sessions	35 taped psychotherapy sessions	Verbal interaction analysis	Therapists verbal communication	*
Hill et al. (2003)	Mailed survey to independent practitioners USA	To extent Ladany's (2004) study exploring therapist's perspectives on silence in therapy	Quantitative survey	81 primarily psychodynamic therapists in independent practice	5-point Likert scales	Therapist's use of silence	****
Ladany et al. (2004)	Telephone interviews North-eastern USA	To explore the therapist's use of silence in therapy	Qualitative telephone interview	12 therapists (clinical psychologists)	Consensual qualitative research (CQR) methodology (Hill et al., 1997)	Therapist's use of silence	****
Mullard (2015)	Face to face interviews USA	To study positive and negative impact of silence in the therapeutic dyad.	Qualitative one-to-one interviews	13 licenced therapists	Grounded Theory (Strauss & Corbin)	Therapist's use of silence	**

Author(S)/Date	Setting	Aim	Design	Sample	Methodology	Main Focus	Quality Assessment
Regev et al. (2016)	Telephone interviews Israel	To examine the perceptions and experiences of therapists regarding their use of silence	Qualitative analysis of semi-structured interviews	15 psychotherapists practising art therapy	Consensual Qualitative Research (CQR) methodology (Hill, 2012)	Therapists experience of silence	***
Hill et al. (2019)	USA community clinic providing low-fee psychotherapy in return for research participation	To examine what occurred before, during, and after silence events	Quantitative descriptive statistical analysis of the silence events	183 silence events from the first 5 and last 5 of a 73-session single case of psychodynamic psychotherapy	Hierarchical linear modelling (HLM)	Predicting post silence collaboration	****
Cuttler et al. (2019)	USA University based research clinical offering low-fee psychodynamic psychotherapy	To extend the findings of Hill et al (2019) to a larger sample of clients and therapists and to explore attachment styles and involvement	Quantitative descriptive statistical analysis of silence events	86 clients and 26 doctoral students in psychodynamic psychotherapy	Mplus regression model	Process and outcome from first silence events	****

4.2.5 Limitations

The presentation of Hargrove's (1974) study, although published in a peer-reviewed journal, is lacking in substantial detail (one page of A4), but the salient points remain of interest as they relate specifically to the use of silence and outcome. Ladany's et al. (2004) study remains important, as one of the few empirical studies to investigate therapist perceptions about using silence. The transferability of the study is questionable due to the small sample size (n=12) of predominately white male, psychodynamic practitioners. Hill's et al. (2003) research reflected a predominately white male demographic similar to Ladany et al. (2004), although the theoretical approaches were broader. Respondents were required to recall a retrospective silence event, requiring the participants to rely on memory from historical events.

Saturation was the reason given for Mullard's (2015) sample size (n=13) being below what is recommended by Creswell (1998) (n=20-30) for a grounded theory study. His dissertation was not published and therefore suffers from a lack of broader peer review and scrutiny. It also contained many presuppositions as part of the goal construction and may have been a stronger example of a grounded theory study if one or two main themes had have been explored in greater detail, and further conceptualisation of the data had taken place.

Although the majority (n=12) of participants in Regev's et al. (2016) study worked with adults, the focus was on the use of silence during art therapy. The robust design of the study and the focus on the therapist's use of silence justified its inclusion in the review of primary literature.

Hill et al. (2019) analyses one case of psychodynamic therapy where the therapist is positive towards the use of silence and the client was silent frequently. Whilst yielding significant data from the silence events, the restricted sample means that conclusions are tentative.

Although seemingly adequate for the data, the measures used for coding silence have not been widely tested.

The modality (open-ended psychodynamic), therapists (doctoral students) and clients (non-psychotic adults) were very specific in Cuttler's et al. (2019) study, potentially limiting the opportunity for generalising. The study was primarily focused on collaboration at the expense of other process measures such as anxiety and insight.

Arguably all seven studies in terms of limitations echo Ladany's et al. (2004) critique of their study in that they offer: "tentative hypotheses to consider for future research rather than necessarily reflecting the current state of affairs regarding all therapists' use of silence" (p. 88). However, each new study offers useful markers, themes, and insights for further exploration.

All seven studies stated or implied the areas connected to silence that they wanted to explore in the interview, and or analyse. Ladany et al. (2004) is arguably the closest study to address the research question. However, their study commenced with an interview protocol consisting of questions that were drawn from review of literature. The current study will commence without a fixed protocol, focusing on the participants' views and experiences of using silence in the clinical setting. The subsequent interviews will endeavour to theoretically sample, seeking to further understand the participants concerns and not that of the researcher. This addresses some of the limitations of the primary literature and therefore supports the argument that this is an original study.

4.3 Data Synthesis and Interpretation

There has been some debate about whether it is acceptable and feasible to synthesise qualitative data derived from different theoretical perspectives and analytical approaches; some authors argue for similar methodologies whilst other are more pragmatic (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005). A common dictum of Glaser (2007) is "all is data", which relates to the need to consider data for conceptualisation and not description (Glaser, 2001). When viewed therefore from a constructivist and interpretivist perspective, the final concepts or lines-of-argument remain of interest.

Meta-ethnography, as originated by Noblit and Hare (1983) was used to systematically interpret the seven studies. To facilitate the exploration of the findings four themes or points of focus were constructed: The Conception of Silence, Motivation for Silence, Appropriate Use, and Learning Silence. The use of narrative discussion, Hawker, Payne, Kerr, Hardey and Powell (2002) argue, can make a credible and accurate summary difficult. Therefore, a summary of the main lines-of-argument has been included. See Table 3. Each of the four points of focus will now be discussed in more detail.

4.3.1 The Conception of Silence

In Hargrove's (1974) brief reporting, he proposes that silence behaviours best predict empathy. Silence is an active event, Hill et al. (2003) suggests, generally with positive outcomes. Ladany et al. (2004) propose that silence is a multifunctional intervention, with multiple conceptions and is used for different interests. All studies suggested that the use of silence in practice can have both positive and negative impact upon the client.

Whilst the positive aspects of silence are described as generative, Mullard (2015) vividly highlights the destructive aspects of silence and the capacity to rupture the therapeutic relationship leaving it, where possible, in need of repair. Clients can experience silence as positive, Regev et al. (2016) found, but also abandoning and anxiety provoking.

Silence changes across the course of therapy – reflecting the shifts in the therapeutic relationship, Hill et al. (2019) proposed, and their study was more specific in relating feelings of abandonment with anxiously attached clients. They found that silence can reflect the different processes at different moments in the psychotherapeutic process. The therapist, they argue, serves as a container, in psychodynamic terms, providing a safe space for the client to internalise what is being discussed in the therapy session.

Building on Hill's et al. (2019) study, Cuttler (2019) suggests that silence can be a helpful intervention with some clients especially when there is engagement during the silences.

4.3.2 Motivation for Silence

Although the relationships were stated as modest, Hargrove's (1974) study suggests that silence behaviours are more indicative of high levels of therapist empathic understanding. Therapists in the high-empathy group took longer to respond to clients than the low group. The therapists identified as empathetic allowed clients more time for expression. They also interrupted much fewer times, and when they did so, it was for longer periods. It implies that high-empathetic therapists use silence more and that there is a quality around the therapist's capacity to listen to the client. Mullard (2015) referred to positive listening, following an established therapeutic alliance, as "witnessing presence" (p. 111). Hargrove (1974) concurs with the other studies that as opposed to being empty, silence is pregnant.

Ladany et al. (2004) offers a connection with Hargrove's main argument, in that their data suggests that therapists use silence to convey empathy, respect or support. Silence was used by all therapists to demonstrate understanding and to create conditions that would facilitate therapeutic work.

Silence was also used to provide therapists time for their own reflection and analysis prior to responding to the client. The large presence of psychodynamic practitioners (n=8) may support the predominance of this theme.

Therapists also used silence to encourage the client to take responsibility and control. Assuming that silence, when used skilfully (highly subjective), challenges the client to take a more active role in finding their own answers, it is possible to hypothesise that this would potentially lead to less dependency on the therapist and more self-efficacy for the client. Therapists generally indicated that a sound therapeutic alliance was a prerequisite for using silence and they typically educated their client about how they used silence.

Therapists were asked to choose a recent silence event by the Hill et al. (2003) study. There was a variety of reasons given, including: to facilitate reflection, encourage responsibility, facilitate experiencing of feelings, not to interrupt the flow, to convey empathy, respect, and support. Therapists generally felt that silence was helpful. Results demonstrate that therapists are active during silences, thinking about clients, the therapy and how to help them make best use of the process.

Ladany et al. (2004) and Hill et al. (2003), despite differences in methodology, had similarities in their findings. Both studies found that therapists used silence to help clients reflect, to take responsibly, to support the expression of feelings, and to avoid interrupting the flow of the session.

The research conducted by Mullard (2015) sought to investigate the impact of therapeutic silence in the psychotherapy process. Whilst providing valuable insights from the experience of the therapist and building on the work of Ladany et al. (2004), without the voice of the client to offer first-hand accounts of the impact upon them, the focus remains one-sided. Mullard (2015) argues that the greatest strength of his study was how well his findings confirmed Ladany et al. (2004), stating confirmatory evidence over all the domains encountered. It is curious therefore why he only references the important companion study, Hill et al. (2003) three times in the discussion.

The therapists in Regev et al. (2016) stated that silence offered the client space for deeper awareness, recognition of creative work, and reflective capabilities. They collectively framed it as a unique space for the processing of content related to transference and counter-transference. Being silent and present was seen as a conduit to intimacy and closeness.

Cuttler et al. (2019) and Hill et al. (2019) concur that for the psychodynamic psychotherapist silence is a valuable tool for encouraging deep client exploration, and client silence may indicate that important material has been identified.

4.3.3 Negative impact of silence for client

The negative impact of silence was not discussed in Hargrove's (1974) study, having linked it exclusively with a predictor of empathy. This might be indicative of the time when the study was conducted, when the motives of therapists, doctors and authority figures in general were seldom deeply scrutinised.

Ladany's et al. (2004) respondents believed that if not used skilfully, the use of silence could increase the client's anxiety, feelings of abandonment, and negative transferences (feeling of being insulted, criticised or devalued) often related to perceived early childhood trauma.

Mullard (2015) states that silence is destabilising, can reveal inner trauma and appears to allow powerful transference reactions in the client with sometimes dramatically damaging results. It has to be noted that this is surely how the transference and reaction to the silence is handled, as opposed to the silence on its own. It is worth considering that he deems client withdrawal or wanting to flee, as a breakdown of the therapeutic alliance. From clinical experience I would argue that this is the point when the therapeutic alliance can forge a deeper connection, as the client's feelings are attended to. Mullard did not appear to pick up on this, but said that participants uncovered feelings of neglect and abandonment in the client when faced with silence from the therapist. Considering he put this under destructive silence, I have assumed that he deemed this a negative outcome. Furthermore, he describes the "premature" use of silence as abusive.

Participants believed, Regev et al. (2016) found, that silence could create feelings of anxiety in the client due to a sense of helplessness and lack of control. Both parties could experience silence as unpleasant if the clients were unfamiliar with experiences of silence. Therapists would intervene if they believed that the silence was unpleasant for the client.

Hill et al. (2019) explored attachment styles and how they predicted outcomes from silence events. They identified that clients with higher levels of attachment anxiety, if unaware of the therapist's reactions, were more prone to experience silence as abandoning.

If client or therapist was disengaged during silences Cuttler et al. (2019) argued, then client collaboration would be decreased. They prize the importance of the therapist's intention and behaviour during silences.

4.3.4 Appropriate Use

Ladany's et al. (2004) participants indicated that following the formation of a strong therapeutic alliance, therapeutic silence should only be used primarily with clients who exhibited greater ego strength and coping capacity. Some participants indicated that they would not use silence with clients who had features of personality disorder, were very disturbed or psychotic, highly anxious, paranoid, highly suspicious or felt persecuted, angry, danger to themselves or others, overwhelmed, or were new to therapy. Despite the perceived benefits, there was some discussion on the reduced likelihood of using silence in brief therapy due to the time pressure. The results indicate that no specific recommendations can be made in terms of when to use silence during the course of therapy.

The results from Hill's et al. (2003) study indicate that therapists were aware that silence can be misunderstood and needs to be used with caution. They were thoughtful and judicious about using silence. They used silence with clients who were actively problem-solving but were hesitant about using silence with all other clients. They found that the therapist uses silence to observe the clients and thought about the therapy. Hill et al. (2003) surmises that psychodynamic practitioners, remaining consistent with their theoretical orientation, use silence more than other modalities, to reflect on the therapy and to support the formulation of interpretations.

The most salient and consistent characteristic throughout Mullard's (2015) study was the need for basic trust and an intact therapeutic alliance as a pre-condition for the use of silence. This raises the question around negative transference, seen as a positive by the researcher and significant to psychoanalytic thinking. The very occurrence of negative transference is often based on a temporary lack of trust and strain on the therapeutic relationship. In the present moment, the client can see the therapist as a malevolent presence reflecting objects from the client's past. The exploration of this phenomenon and the exploration of the therapist's intention can lead to a clarification that can have significant outcomes for the client. For example, if the client interprets the therapist's silence to mean anger and judgement, when in fact the therapist is simply intently listening.

The use of silence at the beginning of a session, Regev et al. (2016) found, could be anxiety-provoking for the client and was to be avoided. Changes in the use of silence over time were noted, with silence more likely to be used the longer and deeper the therapeutic relationship. When the client and therapist were deemed present and attentive, greater was the likelihood of collaboration.

Hill et al. (2019) concurred with Ladany et al. (2003) that therapists who utilised silence as an intervention reported generally only using it once a strong relationship was established. Providing time for the client to reflect and connect with their feelings was seen as an important aspect of productive silence.

Cuttler et al. (2019) reiterate that not all silences are the same. They are prescriptive in concluding what they believe the therapist needs to be doing during productive silence: being attentive to working hard internally, being curious about what is going on with the client, behave invitationally during the silences through adopting an encouraging and facilitative attitude toward the client, and attuned to how clients are handling the silences through noting nonverbal behaviours.

4.3.5 Learning Silence

Although not included as a main line of argument, the studies provided some interesting insights into how therapists learned to use silence. Both Ladany's et al. (2004) and Hill's et al. (2003) studies found that therapists had received minimal education about using silence during their graduate training. Participants stated that they subsequently learned using silence through clinical experience and supervision. As Mullard (2015) highlights, the challenge for this aspect of learning is that the therapist's own counter-transference to silence may not get explored until in the presence of a client. I reflected on the ethical implications of this and how dangerously unprepared the therapists appear in the face of silence. In Regev et al. (2016), participants stated that experience with diverse populations throughout their training contributed to the use and understanding of silence.

Table 3
Summary of lines-of-argument I

Study	Focus one: ***conception of silence***	Focus two: ***motivation for silence***	Focus three: ***appropriate use***	Focus four: ***negative impact***
Hargrove (1974)	Silence behaviours best predictors of empathy	To allow more time for clients to express themselves	Not applicable	Not applicable
Hill et al. (2003)	Silence is an active event, generally with positive outcomes	Therapists use silence to enhance the therapeutic relationship	Therapist typically uses silence thoughtfully and judiciously with stable and functioning clients	Heightening anxiety and negative transference reactions
Ladany et al. (2004)	Silence is a multifunctional intervention, with multiple conceptions and is used for different interests	To demonstrate understanding and to create conditions that facilitate therapeutic work	Sound therapeutic alliance a pre-requisite. Use of silence selective to client presentation	Increase anxiety, feelings of abandonment and negative transference
Mullard (2015)	Generative or healing silence moves the therapeutic process forward. Destructive power of silence can rupture the therapeutic alliance requiring repair	To facilitate greater self-awareness and create positive emotional separation between therapist and client	Strong therapeutic alliance a pre-condition for the appropriate use of therapeutic silence	Destabilising, revealing inner trauma and causing powerful transference reactions

Table 3
Summary of lines-of-argument (cont.)

Study	Focus one: ***conception of silence***	Focus two: ***motivation for silence***	Focus three: ***appropriate use***	Focus four: ***negative impact***
Regev et al. (2016)	Silence creates space for client and therapist to go deeper.	To offer the client space for deeper awareness, recognition of creative work and reflective capabilities. Processing of content related to transference and counter-transference	Silence more likely to be used the longer and deeper the relationship and depends on the needs of the client. Therapist would intervene if silence deemed unpleasant for client	Silence can be experienced as abandoning and anxiety provoking
Hill et al. (2019)	Silence changes across the course of therapy, reflecting changes in the therapeutic relationship. Silence can reflect different processes at different moments in the psychotherapy process	Silence was to serve as a container providing a non-rushed, safe place for the client to internalise what is being discussed	Silence was utilised when a strong therapeutic relationship was established	Longer silences resulted in dissociation and defensiveness resulting in less connected-ness
Cuttler et al. (2019)	Silence can be a helpful intervention in psychotherapy if used appropriately with some clients	Silence provides space for client emotional and expressive processing	Productive silences were especially effective with lower attachment anxiety	Collaboration decreases if therapist or client not engaged

4.4 The Case for Field Research

The seven research studies discussed in the review of primary literature have some overlap with the research question, see Table 4.

Table 4

Research explored in the review of primary literature

STUDY	ANALYSIS OF DATA	RESEARCHER FOCUS
Hargrove (1974)	100 silence events, 1 therapist	empathy
Hill et al. (2003)	81 questionnaires	validate categories from Ladany study
Ladany et al. (2004)	12 telephone interviews	perceptions of why therapists use silence
Mullard (2015)	13 interviews	generative and destructive silence
Regev et al. (2016)	15 interviews	perceptions of therapist
Hill et al. (2019)	183 silence events, 1 therapist	collaboration and attachment style
Cuttler et al. (2019)	1 case of psychodynamic therapy	collaboration

From a grounded theory perspective of the seven studies, Ladany et al. (2004) was arguably the least contaminated by the interests of the researcher. In terms of total sample to date, 124 individual therapists have been explored for data. Whilst recognising that qualitative analysis is interested in the quality and relevancy of concepts and themes over quantity, given the vast variation in the approach and practice of psychotherapy, this number remains low.

Many of the studies make the case for the need for more research and these are summarised in Table 5.

Table 5

Recommendations for further research

STUDY	RECOMMENDATIONS FOR RESEARCH
Hill et al. (2003)	therapists make decisions about whether or not to use silence in therapy; their perceptions on using silence would be valuable (p. 514) more research is needed about the effects of silence in therapy (p. 523)
Ladany et al. (2004)	the generalisability of silence (p. 88) the quality and quantity of silence (p. 88) more fully examined as an interactional variable (p. 88)
Mullard (2015)	types of silence (p. 130) predicting potential patient responses (p. 130) therapist characteristics (p. 130)
Regev et al. (2016)	the meaning of silence in other cultural contexts (p. 94) impact of personality and orientation (p. 94)
Hill et al. (2019)	immediate impact of silence in session (p. 586) utilising facial and non-verbal cues and gestures to describe the process (p. 586)
Cuttler et al. (2019)	silence events longitudinally (p. 575) varying modalities (p. 575) varying severity of pathology (p. 575)

In the study deemed the most relevant to the research question, Ladany et al. (2004) concluded that the reasons why the therapist used silence were more important than whether silence occurred. Although silence has been identified as important in psychotherapy, in the most recent study on silence Cuttler et al. (2019) argues, research on the use of silence in psychotherapy remains limited.

4.5 Conclusion

In this chapter I have presented the methodical search and appraisal of the primary literature research as it relates to the research question.

The literature review identified seven papers where primary research was conducted into the therapist's use of silence. The diverse data was synthesised and interpreted into four main lines-of-argument: *conception of silence*, *motivation for silence, appropriate use, and negative impact of silence for client.* The additional consideration of how therapists learned to use silence was also included.

While these studies broadly met the criteria for inclusion, there was only moderate overlap with the research question itself. The review of primary literature therefore strongly supports the argument: data on the therapist's use of silence is limited. This further supports the position in this study that further field study is both ethical – and appropriate.

In the next chapter I will discuss the research design that formed the foundation of the conducted field research and subsequent analysis.

CHAPTER 5: Research Design

In a very real sense, every piece of research is unique and calls for a unique methodology. We as the researcher, have to develop it.

Michael Crotty (1998, p. 14)

5.1 Introduction

The research methodology adopted in this inquiry was stated in the Introduction (Chapter 1, Section 1.5) as Constructivist Grounded Theory (Charmaz, 2006, 2014, 2019). This chapter will outline the research design employing Crotty's (1998) four design elements to bring transparency to the decisions that influenced the research design. It will outline the core fundamentals and processes of Constructivist Grounded Theory as they were understood and utilised in this study and will discuss some limitations and potential challenges.

The research was conducted at a time and in a context when the very concept of what constitutes truth was coming into question (Kakutani, 2018; Kavanagh & Rich, 2018). When considering the evolving realm of qualitative research, Lincoln, Lynham and Guba (2018) argue "It is also clear there is no single truth. All truths are partial and incomplete" (p. 106). They argue that in research there is no single conventional paradigm to which all social scientists may subscribe, rather:

> We occupy a historical moment marked by multivocality, contested meanings, paradigmatic controversies, and new textual forms. This is an age of emancipation, freedom from the confines of a single regime of truth, emancipation from seeing the world in one colour (p. 106).

When considering the tension between the negative concept of truth decay, and the more positive development of research challenging the dominate narratives to make room for more diverse and underrepresented voices, it places even greater necessity upon the research to be clear and methodical. Žižek (2005) argues "Philosophy does not ask whether there is truth, no, the question is what do you mean when you say this is true". This quotation defines how I am endeavouring to construct a transparent theory of enquiry for the study.

How one articulates the research process can be characterised as procedure and techniques, but also it can be described as a "logic-of-justification" (Smith & Heshusius, 1986, p. 8). What follows is my logic-of-justification for the foundational components of the research design.

5.2 Research Design

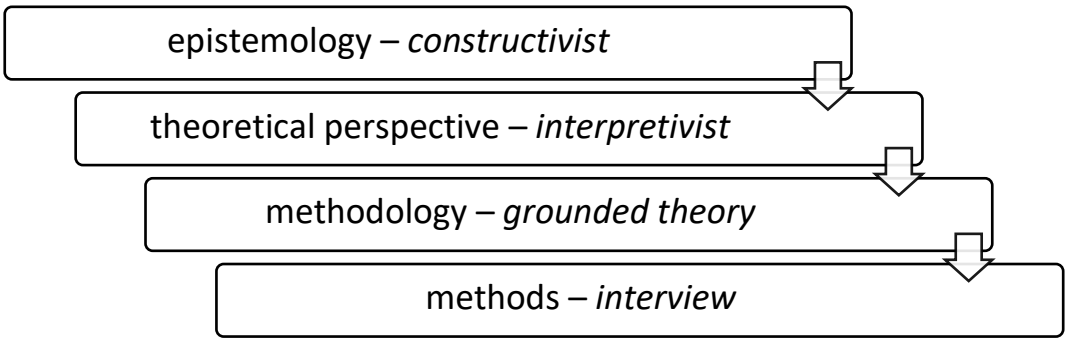
The often-confusing nature of the terminology found in research literature is highlighted by Crotty (1998). He argues that theoretical perspectives, epistemologies, methodologies and methods are "thrown together in a grab-bag style as if they were comparable terms" (p. 3). He offers a framework as guidance for the social research process that prizes the researcher's stance or epistemological outlook as underlying the whole research process. He replaces the traditional divide between quantitative and qualitative approaches with a charge to be consistently *objectivist* (positivist) or consistently *constructivist* (subjectivist).

Importantly for this study he proposes that the terms: *epistemology, theoretical perspectives, methodology* and *methods* represent distinct hierarchical levels of decision-making within the research design process, see Figure 2.

Crotty's framework remains widely quoted in contemporary qualitative research design guidance (Denzin & Lincoln, 2018; Creswell, 2018). On the first appearance it can seem reductive and superficial, but the full reading of the text offers an in-depth explanation of each subsequent area. It is a tool employed here to bring clarity and transparency to the research process. I will therefore use his four distinctions to represent the discrete and interconnected hierarchical levels of decision-making within the research design process.

Figure 2

Interconnected hierarchical level of research design decision making



The four distinctions are *one* way of organising the research design. They represent a view or lens through which the research can be appraised. The awareness and reflexivity of the research is paramount throughout this process. I will now discuss each of the distinctions in more detail.

5.2.1 Epistemology – *Constructivist*

The terms used in research design are frequently used in different and often contradictory ways (Crotty, 1998). All endeavours to find a satisfactory *epistemology* are concerned with how we know what we know, offering a philosophical grounding in what kinds of knowledge are possible, and how we propose that it is adequate and legitimate (Creswell, 2018; Maynard, 1994).

Underpinning Crotty's (1998) model is the necessity for reflexivity at each stage of the process. Ramalho, Adams, Huggard and Hoare (2015) argue that reflexivity is a key element in ensuring the groundedness of a theory and that the researcher's epistemological outlook needs explicitly acknowledged and explored at the earliest stages of research design.

I was mindful that I needed to be clear about the use of philosophical terms when it comes to the research design. Prior to this articulation I felt it was imperative to return to the basics, in my own words, of what I think I know and what I can articulate.

Personal Reflection

I am a conscious being, aware (at times) of my age, race, sex, gender, sexuality, and cultural conditioning. I have knowledge and experience of psychotherapy training, theory, and practice in international settings. I have experience of silence, generally, in elective conditions, and in clinical practice. I have endeavoured to reflect and note any assumptions that I would hold about the use of silence.

I have interviewed psychotherapists and asked them about their experience of the use of silence in clinical practice. The interviews and analysis of data were performed through the filter of my personal conditions and assumptions. Often these were significantly different from those I was interviewing. I am part of the research process, not detached from it.

I am not in the session with the therapist and their client, nor can I be in their mind. Therefore, the knowledge that I am presenting is constructed through the memory and thoughts of the participant, communicated through language and interpreted by me to create a conceptual story of what might be going on when the therapist uses or does not choose to use silence. A story of sorts. If there was a video camera in the session, it would capture the therapist in periods of silence – with the client speaking and at times without. The reasons for this could be assumed but not known.

When considering the use of silence, I assume that the story is real for the participant who is telling it. It contains meaning and explanation of actual processes and experiences. There will also be unseen factors at play that the interview does not capture. I will compare elements of that story with elements of other participants' stories to see patterns, convergences, and divergences. I will try and construct what might be the most relevant aspects of their collective story and how it might be relevant for other psychotherapists.

Constructivist

I view what I know as a researcher as being constructed and, in the engagement with a participant, to some extent co-created (Lincoln & Guba, 2016). This view allows for the potential of multiple possibilities and understandings and directly addresses the power inherent in dominant paradigms that can oppress sections of society, including by gender, race, ethnicity and sexuality.

Lincoln, Lynham and Guba (2018) suggest that the constructivist paradigm assumes a relativist (relativism) ontology, a transactional epistemology, and a hermeneutic, dialectical methodology. Users of this research paradigm are orientated to the production of reconstructed understanding of the social world.

If a claim is made that the epistemology is constructivist, Crotty (1998), argues that it should be more than rhetoric and that "we should reflect deeply on its significance" (p. 64). It seems therefore contradictory that he should present ontology (what is real) with epistemology (how we know what we know) under a single heading: epistemology. Using social constructionism, Crotty (1998) reduces the significance of ontology by stating that it is both realist and relativist, "to say that meaningful reality is socially constructed is not to say that it is not real" (p. 63). In other words, a subjective interpretation of a combination of objective and subjective realities.

Social Constructionism

Within constructivism, social constructionism (Berger & Luckman, 1991, 2015) proposes that knowledge is social in origin. It is not predetermined by some natural order – nurture over nature. It explores the process whereby people continuously create, through their actions and interactions, a shared reality that is experienced as objectively factual and subjectively meaningful (Berger & Luckman, 1991).

As the theory developed, it progressively drew more "attention to the role of language in the construction of explanatory categories and exposes the way in which research practice creates rather than reveals evidence in support of such categories" (Willig, 1999, p. 37).

Hacking (1999) questions exactly what is being constructed: ideas, objects, concepts that have the propensity to be vague and free-floating in meaning. He argues that the subjective idea of something and the actual event can both hold validity.

When considered pragmatically, social constructionism can show that knowledge is historically and culturally situated. As a result, it can raise consciousness by contributing to a foundation for a healthy scepticism (Stanley & Wise, 1983). It can also support the challenge to meta-narratives and ideologies that traditionally have oppressed people. In practice I found it particularly relevant when addressing ideas around gender, race, religion, and mental illness. However, its later development seems to have excluded the significance of appropriately critiqued scientific data, and common sense reducing everything to nominalism (Hacking, 1999).

Social constructionism has some significant weaknesses. Willig (1999) posits that it offers little by way of an alternative, with no principled basis for the replacement of knowledge by more liberating concepts. Social constructionist accounts of reality support us in describing certain regimes of truth, but they lack an analysis of origin and maintenance.

Cromby and Nightingale (1999) argue that a wholly discursive (and hence relativist) social constructionism is unable to address adequately the categories of:

embodiment – the human body as site for birth, growth, ageing and death, pain and pleasure

materiality – the elemental, physical nature of the world in which we are embedded; thing-ness and solidity

power – accepting that the concept has multiple and sometimes mutually exclusive definitions, social constructionism fails to theorise it adequately and include its influence.

These three areas would be of central concern to the contemporary psychotherapist.

Radical Constructivism

I had reflected on my dissatisfaction with the weaknesses of social constructionism and in a previous study (Montgomery, 2018) had turned to radical constructivism (von Glaserfeld, 1984, 1986, 1990, 1995, 2007) to support epistemology.

In radical constructionism knowledge is not seen as a commodity passed from one mind to another. Rather, the individual interprets experiences and makes links with their own experience to what is viable and possible (von Glasersfeld, 1986). It posits both that knowledge is built by the individual, and that this adaptation and construction of knowledge constitutes what is known by the knower, rather than knowledge of an outside objective truth. It is because of the assumption that reality is inaccessible that relativists believe that it need not be postulated or considered. Radical constructivism as a theory of learning argues that objective reality cannot come to be known (not that one does not necessarily exist) so positivist and post positivist views are arguably untenable.

I had previously considered radical constructivism a useful pragmatic approach that avoided any metaphysical discussion around reality. “Give up the requirement that knowledge represents an independent world”, von Glaserfeld (1995, p. 6) urged, “and admit instead that knowledge represents something that is far more important to us, namely what we can do in our experiential world”.

Radical constructivism challenges the notion that there can be any absolute foundation of knowledge (Madill, Jordan & Shirley, 2000). When considering the validity of what was constructed, the primary focus was on viable interpretations of experience. The shift to this post-epistemological way of thinking has multiple consequences. The most important of these is that the customary conception of truth as the correct representation of states or events of an external world is replaced by the notion of viability (von Glasersfeld, 1995).

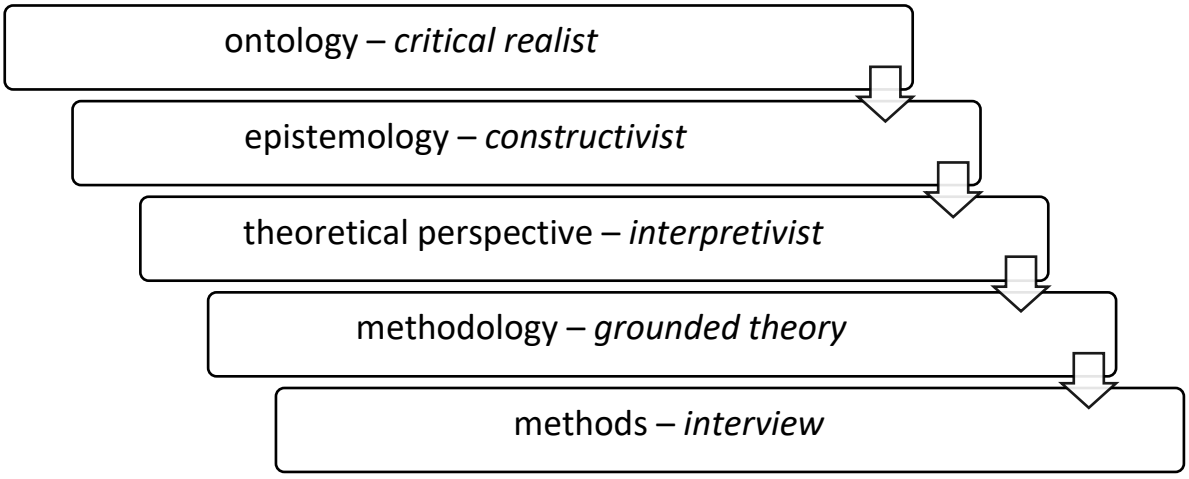
Epistemic Fallacy

When I reflected on truth decay and the climate from which the study is conducted, I no longer felt that it was appropriate to be vague about what is real. I thought, therefore, that it was important to reconsider epistemology and to bring more attention to ontology. I consider this a maturing of my own understanding and of the project research process.

Bhaskar (2008) argues that it is an epistemic fallacy to conflate epistemology and ontology. He argues that we simply cannot reduce statements about the world (ontology) to statements about our knowledge of the world (epistemology). In his (retrospectively-named) theory of critical realism, he revindicates ontology as preceding epistemology. I will therefore re-position Crotty's four distinct stages into five, employing critical realism as the ontology for the study, see Figure 3.

Figure 3

Five stage of research decision-making



5.2.2 Ontology – *Critical Realist*

Willig (1999) urges critical psychology to move towards a wider historical materialist analysis for society and proposes critical realism as a suitable theoretical framework. Critical realism is becoming recognised as a significant meta-theory for the social sciences (Hoddy, 2019). It offers a new direction for psychology and the social sciences, Houston (2001) argues, presenting a radical alternative to postmodernism and other constructivist approaches. The body of work that contributes to critical realism is broad and at times philosophically dense. I will endeavour to articulate the salient points as they relate principally and directly to the social sciences and more specifically this study.

Social constructionism positioned the importance of language in how we understand our world. Critical realism retains the importance of language, but also studies the things that operate outside of language, for example the direct effect of social or bodily processes on people (Sullivan, 2019). Most critical realists accept the reality of mental states and attribute the importance of these for causal explanation in the social sciences – positions rejected, argues Maxwell and Mittapalli (2010), by traditional positivism and constructivism.

Dialectic

Critical realism offers a dialectic integrating two seemingly opposing propositions:

> an ontological realism (there is a real world that exists independently of our perceptions, theories and constructions) while accepting a form of epistemological constructivism and relativism (our *understanding* of this world is inevitably a construction from our own perspectives and standpoint) (Maxwell, 2013, p. 5)

Critical realism argues against the implicit ontology of mainstream philosophy, which pictures the world as unstructured, undifferentiated, and unchanging. It puts forward a contrary view of reality as structured, differentiated, and changing (Bhaskar, Danermark, & Price, 2018).

More specifically, in social sciences it argues that social structure is a necessary condition and always pre-existed any round of agency, but human agency in turn is necessary for the production and transformation of social structure. Appropriately to psychotherapy and this study, critical realism views social science as an open system – as contrasted with the closed system of the natural sciences, in which variables can be more closely controlled within the laboratory environment (Bhaskar, 2014). In critical realism all social events are believed to occur simultaneously on four planes: *material transactions with nature; social interactions between people; social structure; and the stratification of the embodied personality.*

Stratified Reality

Critical realism posits that a reality independent of human perception exists, and while knowledge of it is fallible, theorists make some attempt at defining it. Collier (1994) describes critical realism as *depth realism* in its efforts to theorise how that reality may be ordered. For the purposes of this study and to support a depth of analysis it is important to have a sense of what this order may be.

Critical realism considers reality as a stratified, open system of emergent entities (Bhaskar & Lawson, 1998). It is structured vertically with three key dimensions:

The Empirical – human experience of events

The Actual – all events whether experienced or not

(events are the result of exercised mechanisms and causal powers)

The Real – the unobservable mechanisms and structure which generate events.

The Real level is central to critical realism because despite it not being open to direct perception, it is nonetheless viewed as real: "the domain of the real is distinct from and greater than the domain of the empirical" (Bhaskar, 1998, p.xii). Critical realism argues that the natural world comprises a range of heterogeneous systems, each with their own distinct mechanisms. We cannot fully predict the outcome of any intervention: mechanisms produce tendencies which we endeavour to understand and explain. The acknowledgment that knowledge is fallible avoids the constructivist position of all accounts being equally valid. We gain a transitive view of the world tainted by constraints and ideology within society. However, this view with further analysis may in turn come closer to the true reality of things – the intransitive world.

Critical realism's stratified reality addresses the concerns of social constructionism to adequately address embodiment, materiality, and power. It avoids the potential nihilist dead end of relativism, and posits that it is possible for social science to refine and improve its knowledge about the real world. When applied, it has a clear emancipatory potential. The critical realist ontology proposed in this study is more than a mere philosophical proposition. It will influence how the data is analysed and how in turn it is finally appraised.

Criticism

Any attempt to discuss ontology can often result in philosophical wrangling, which is why radical constructivism was previously so appealing. Whilst avoiding spending excessive time on the debates, it is worth highlighting a main criticism of critical realism and its potentially mutually exclusive definitions of ontology (Cruickshank, 2004).

Some commentators argue that critical realism offers the potential for researchers to "sit on the fence", creating the illusion of an objective reality (Taylor, 2018). Critical realism supports the researcher in identifying, exploring and seeking to understand structures and mechanisms that cause events. The researcher can contextualise aspects of the objective world and constructs from the social world that determine or influence any potential link of causation. It offers the opportunity for a deeper contextual analysis of processes, events and experiences.

Coda

Rather than offering the use of critical realism as a starting point, I have demonstrated how my thinking has evolved from a social constructivist and a radical constructivist position. Critical realism, as with any philosophy of the nature of reality that is dualistic, is not perfect nor complete. For the purposes of this study, however, I have argued that critical realism addresses some core weaknesses of social constructionism and radical constructivism. It addresses and supports a deeper reflexivity when considering the data and asks the important question "what must be true for this to be the case?"

5.2.3 Theoretical Perspective – *Interpretivism*

When analysing the verbatim transcripts from client sessions or interviews, the level of part sentences or seemingly incoherent communication that appears to make sense to the participants is striking. After including non-verbal communication, it is clear that there remains a high level of interpretation in all communication. Something is uttered and through interpretation it is seen to make sense or not.

The theoretical perspective of this study is therefore interpretivist and aims to replace the scientific notions of explanation, prediction and control with the interpretive notions of understanding, meaning and action (Carr & Kemmins, 2002). The argument has been made that "all research is interpretive: guided by a set of beliefs and feelings about the world and how it should be understood and studied" (Denzin & Lincoln, 2011, p. 13). By being transparent about the epistemological and ontological views, and being explicit in articulating the researcher's reflexivity, the interpretivist perspective should be seen as explicit throughout the study (Luca, 2016).

Returning to Crotty's (1998) design model – which considers epistemology as the theory of knowledge embedded in the theoretical perspective and thereby the methodology – I will now discuss the methodology.

5.2.4 Methodology – *Constructivist Grounded Theory*

Methodology is the plan of action, the strategy, process, or design inherent in the selection and deployment of specific methods. It is the linking of the choices and use of methods to desired outcomes (Crotty, 1998).

Qualitative research was chosen as it flows naturally from the epistemological foundation and the interpretivist theoretical perspective. Denzin and Lincoln's (2005) initial and generic definition remains relevant to this study: "qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them" (p. 3).

After the review of various qualitative methods, I had contemplated a more purely phenomenological approach to exploring the participants' experience and had considered using Interpretative Phenomenological Analysis (IPA).

IPA aims to offer insights into how the therapist, in context, makes sense of a given phenomenon (Smith, Flowers & Larkin, 2009). Whilst the IPA studies that I read were interesting, I realised that they produced mainly rich, textual description, often stopping before the point of deeper interpretation (Hefferon & Gil-Rodriguez, 2011).

I was more concerned with a conceptual understanding of the events, processes and occurrences; not just the individual but at a group level (psychotherapists) (Willig, 2013).

I also wanted to keep the possibility open for generating a theory, in the sense of an abstract understanding, linking abstract concepts and seeing the relationships, endeavouring to understand the world more comprehensively. Therefore, I explored grounded theory as potentially the most suited methodology to fully meet the aims for the study.

Hoddy, (2019) highlights the lack of methodological guidance for researchers keen on conducting studies consistent with critical realism's ontological and epistemological assumptions. He demonstrates how grounded theory techniques can support the data collection, coding and analysis stages of a critical realist research project.

The diverse and often competing range of methods claiming to be grounded theory can make the methodology inherently complex. Bryant and Charmaz (2007, p. 11) deliberately evoke Wittgenstein in their use of the term "family of methods" to describe the contemporary grounded theory milieu. They argue however, that there is a set of methods essential to the research design for the final output to be considered a grounded theory. These would include the constant comparison method, initial coding, memo writing, theoretical sampling (collecting new data to fill out theoretical categories), focused coding and categorising, and theory-building. These specific elements are discussed in more detail in Section 5.3.

Birks and Mills (2015, p. 6) highlight the "methodological gaps in seminal first-generation grounded theory texts", leaving students to figure out what is going on ontologically and epistemologically. Many of the grounded theory strategies can be viewed as neutral and are transportable across epistemological and ontological chasms inherent in the range of research methodologies, strategies and designs (Holton & Walsh, 2016).

However, Henwood and Pidgeon (2003) argue that classical grounded theory's apparent philosophical foundation in a process of "pure" induction (of theory from data) hides an epistemological dilemma.

Glaser (2002) states, rather naively given its foundations, that classical grounded theory is not bound to any given philosophical approach and is simply a method that can be used with any epistemological perspective. Charmaz (2014), whilst agreeing with the transportable nature of grounded theory strategies, argues that epistemological and ontological stances are presupposed in how they are used. She argues that positivist assumptions are implicit in earlier presentations of grounded theory, including the positivistic nature of Glaser and Strauss (1967, 1999).

Charmaz's (2000, 2003, 2006, 2008a, 2008b, 2014, 2016, 2017, 2018) presentation of constructivist grounded theory can be credited for addressing many of the concerns raised about earlier versions of grounded theory. It retains the inductive, comparative, emergent and open-ended elements but offers more flexibility and resists a more mechanical application. Constructivist grounded theory builds on the pragmatist underpinnings (exploring action and meaning) (Blumer, 1969; Kuhn, 2012) of first-generation grounded theory and advances interpretivist analysis that acknowledges these constructions. It potentially offers a "portrayal of the world, not an exact picture of it" (Charmaz, 2014, p. 17). While remaining focused on conceptualisation and theory generation, constructivist grounded theory retains room for the voice of the participant.

5.2.5 Methods – *Field Interview*

Crotty (1998) defines research methods as procedures or techniques used to gather and analyse data related to the research question. I will briefly discuss the core methods employed in the field research.

Data Gathering

The method of interview was favoured, since to meet the research objectives the experiences, opinions, attitudes, values, and processes of psychotherapists would have to be captured (Gray, 2018; Josselson, 2013). Intensive interviewing was considered the most efficient way to collect the data. Constructivist grounded theory describes intensive interviewing as "open-ended yet directed, shaped yet emergent, and paced yet unrestricted" (Charmaz, 2014, p. 85). It is adopted precisely because it facilitates open-ended, in-depth exploration of an area in which the participant has substantial knowledge and experience. Constructivist grounded theory adheres to the principle that data collection methods flow from the research question and where we go with it.

In an effort to place emphasis on conceptualisation and hypotheses, classical grounded theory recommends not taping the interview (Glaser, 1998). Constructivist grounded theory, however, evokes a tension between a need for theoretical construction, rich description, transparency and accuracy. While remaining sensitive to these tensions, it was therefore decided that it was necessary to record and transcribe the interviews.

There were many reasons for this decision: because I do not have the instant conceptual capacity of Glaser; to ensure accurate capture of participants' voices in case it was deemed prudent to include them; to be transparent in the research process, so that I could both experience being the interviewer and being able to review a record of the interview process, and to offer the opportunity for replication – at least in theory.

When comparing the two approaches, I concur with Charmaz (2014), a one-time student of Barney Glaser and Anslem Strauss, on her statement that "by using notes instead of transcripts, I moved quickly to abstract theoretical concepts but lost rich details that would have enlivened the abstraction" (p. 92).

Constructivist grounded theory is interested in constructing inductive conceptual categories, and when considering constructing theory, Charmaz (2014) recommends addressing four theoretical concerns when collecting data: *theoretical plausibility, direction, centrality, and adequacy.*

Data Analysis

Constructivist grounded theory was employed to analyse the transcribed interviews. Due to the unique and comprehensive methods involved in the constructivist grounded theory process, they will be discussed in the following Section 5.3. It is the data analysis approach that makes grounded theory unique as a qualitative approach.

5.2.6 The Foundation – *Enhanced Reflexivity*

Reflexivity is defined by Robson (2002) as "an awareness of the ways in which the researcher as an individual with a particular social identity and background has an impact on the research process" (p. 22). Holding the view that the data is constructed as opposed to discovered "fosters researchers' reflexivity about their actions and decisions" (Charmaz, 2014, p. 13).

Giddens (1976, 1984), introduced and developed the idea of the "double hermeneutic" to indicate the twin process of interpretation between participant as part of a social phenomenon and researcher.

The researcher can support or hinder the participant interpreting their own experience, which in turn is interpreted further as the story is also constructed, through comparison with other participants (Rennie, 2000). Grounded Theories are constructed through past and present interactions and involvements, with people, perspectives and research practices. Charmaz (2014) therefore, calls for greater attention to data collection, the examination of research relationships, situations, and representation of research participants. Constructivist grounded theory includes the epistemological and theoretical outlook and values of the researcher, their starting points, evolving viewpoints and decisions throughout the research process.

Reflexivity is what supports the constructivist grounded theory being grounded (Charmaz, 2014). The aim of reflexivity is not to eradicate the researcher's subjectivity from the subsequent theory, but to allow the data to be prioritised over the researcher's assumptions and previously acquired knowledge and experience, including any literature that has been reviewed (Ramalho et al., 2015).

Moving from a relativist ontology to one of critical realism has enhanced my reflexivity. Critical realism is primarily concerned to enhance our reflexivity, that is, to give a better account (theory) of what it is that we do in the world (practice) (Bhaskar, Danermark, & Price, 2018).

5.3 Constructivist Grounded Theory Methods

There are essential components required to delineate Constructivist grounded theory from other research methods. I will now briefly discuss these under discrete headings whilst emphasising that the constructivist grounded theory process is non-linear requiring, a back and forth between elements and stages.

5.3.1 Constant Comparative Method

The method of constant comparison is used to view data against data and codes against codes throughout the enquiry. This process supports the integration and streamlining of data collection and analysis. The constant comparison method will result in recording/adjustments to best reflect events and the participants' experiences, meanings and processes.

Gaps in the data are identified, as data was compared with data, and this opened the possibility for theoretical sampling.

5.3.2 Coding

Constructivist grounded theory has developed over time with Charmaz (2014) more recently focusing on three main phases of coding: initial coding, focused coding and theoretical coding. I will now discuss each briefly.

Initial Coding

When commencing initial coding, Charmaz (2014) recommends staying close to the data, trying to see actions and avoiding applying pre-existing categories. McLeod (2013) emphasises the need for immersion in the data. This is achieved firstly through line-by-line coding, a heuristic device that supports the further development of more focused questions. It also supports the fragmentation or breaking open of the data (Glaser, 1998). Grounded theory begins with the parts and builds to the whole, in contrast to a narrative analysis that starts with the whole and then explores the parts (Dey, 1999; Willig, 2013). The final analysis may be similar, but the starting point is different.

The strategy for advancing analytic coding breaks the data into their component parts or properties, looks for tacit assumptions, explicates implicit actions and meanings, crystallises the significance of the points. In keeping with constructivist grounded theory, there was an emphasis on actions that were embedded in codes.

The data was read and analysed word by word, line by line, paragraph by paragraph, incident by incident. Analytical questions were asked of the data and are including in Section 6.6.1.

Focused Coding and Categorising

The process of focused coding is considered the second major phase in coding. Codes appear more frequently among initial codes, or more significance emerges between other codes. These focused codes and categories are used to support the sifting, sorting, synthesising and analysing of large amounts of data (Charmaz, 2014). The distinction is made by Dey (1999) that coding computes (calculates) meanings, whilst the construction of categories which imputes (represents) meanings.

Data analysis in grounded theory can be difficult, complex, ambiguous, and creative. Part of the inherent complexity is the lack of detailed descriptions of the process and the synonymous use of terms such as code, concept, category, and property (Glaser, 2011).

In turn, the focused codes are used to help develop core themes. Rossman and Rallis (2003) define a category as a word or phrase that explicitly describes a segment of the data, in contrast to a theme which is a phrase used to describe more subtle or inferred processes.

A shift or sharpening begins between rich description to conceptualisation, and towards the ability to construct a theory (Glaser, 2005). The use of gerunds is employed to support the conceptualisation of what was going on in the data (Russell, 2014). Although coding is described in distinct categories the process of coding is not linear. Later coding returns to earlier stages and back and forth for comparison and refinement.

Preconceptions and Forcing the Data

Throughout the classical grounded theory literature, researchers are instructed to avoid forcing the data into preconceived codes and categories (Glaser, 1992, 2012, 2014; Kelle, 2005).

Charmaz (2014) emphasises ongoing reflexivity, and provides strategies for revealing preconceptions, and returns to the use of analytic questions, including: do these concepts help me understand what the data indicates, and if so, how do they help? Her focus remains on actions and processes over topics.

Theoretical Coding

Grounded theory differentiates itself from other qualitative methodologies in its aim to conceptualise and construct theory (Gordon-Finlayson, 2019). In the third coding type, previous theories and analytic schemas were considered in order to support the enhancing of abstraction. Theoretical coding is a sophisticated level that follows the codes that have been selected during focused coding (Charmaz, 2014). This process of coding moves steadily away from naming and describing, and towards a conceptualising of the data, potentially applying analytic schemes to enhance abstraction. Theoretical codes support the analytic story in a theoretical direction, showing the relationship between core concepts and themes.

Charmaz (2014), like Glaser (1978, 1992), believes that theoretical codes preclude the need for axial coding as they weave the fractured story back together.

Theoretical sensitivity is required in order to "understand and define phenomena in abstract terms and to demonstrate abstract relationships between studied phenomena" (Charmaz, 2014, p. 161). It is the theoretical sensitivity that helps build the analytic codes with clear empirical indicators, distinguishing them from other concepts. Using this approach, the theory established is co-constructed between the researcher and the participants and offers interpretation of the studied phenomenon.

5.3.3 Memo Writing (Memoing)

An integral aspect of analysis is the writing of informal analytic notes, called memos in grounded theory (Glaser, 2014). Memos (memoing) were written spontaneously (not mechanically) during the analysis, beginning with memos on the literature review, field notes, then coding memos, theoretical memos and throughout the research process (Charmaz, 2014; Glaser, 2014).

Sorting

Whilst grounded theory often cites the sorting of memos as a discrete stage in the data analysis, constructivist grounded theory offers a more fluid method. The sorting of codes, categories and memos was a process conducted throughout the analysis, with an eventual slowing down of this process, and a sense of saturation of concepts indicated that the analysis was near completion.

5.3.4 Theory Construction

When considered from a constructivist perspective, theories reflect what the author brings to their research as well as what they do with it. Therefore, in addition to the significant process of theoretical coding, the importance of memoing, integration of previous knowledge, and reflexivity are essential component parts in constructing theory.

The proposed theory is an interpretation of a co-constructed viable fit as to what the processes and actions are when using silence in the clinical setting.

5.4 Limitations and Potential Challenges

Most criticism of grounded theory is directed at the shortcomings of first-generation theorists and centres around the lack of epistemological clarity, potential objectivist underpinnings, and questioning if what is produced can constitute a theory (Hussein, 2014; Olesen, 2007). Most of these criticisms are addressed by the development of second-generation grounded theory and, in the case of this study, by using constructivist grounded theory. Glaser (1992, 2003) criticises constructivist grounded theory for what he argues is simply a remodelling of classical grounded theory, referring to it and all other versions except his as Qualitative Data Analysis (QDA).

Thomas and James (2006), however, whilst acknowledging the later developments of constructivist grounded theory, remain critical about the regulation of the narrative of both the participant and the discussant in the research exercise. The use of constructivist grounded theory in this study has aimed to present the data, including the reflective voice of the researcher and the voice of the participant. It sets out to meet the stated aims of the study, which included the generation of theory (interpretation and explanation of a process).

5.5 Conclusion

In this chapter I made the argument that ideas of what constitutes the concept of truth and the need to challenge old research paradigms causes some tension.

To mitigate this tension, I have contended that it is incumbent upon the researcher to bring clarity to their research process. I have employed a framework that outlines how I made core decisions in the research process. The emphasis has been placed within a constructivist view, influencing a discrete and hierarchical decision-making process.

The ontology is *critical realist*; epistemology is *constructivist*; the theoretical perspective *interpretivist*; the methodology *constructivist grounded theory*; and the methods *field interview*.

Reflexivity was demonstrated to be the foundation on which these decisions were ultimately made, and a core component throughout the research process. In Chapter 6, I will discuss how the research design was applied in practice.

CHAPTER 6: Applying the Research Design

Methods alone – whatever they might be – do not generate good research or astute analyses. How researchers use methods matters. Mechanistic applications of methods yield mundane data and routine reports. A keen eye, open eye, discerning ear, and steady hand can bring you close to what you study and are more important than developing methodological tools.

Kathy Charmaz (2014, p. 26)

6.1 Introduction

The previous chapter positioned constructivist grounded theory as the methodology for this project and outlined the core theoretical elements. Biggam (2008) argues that credible academic research should be methodical and transparent, and this chapter aims to reflect this as it outlines the application and processes of the constructivist research design. The thesis-writing process is seldom reflexively considered, Weatherall (2019) argues, and "non-positivistic ways of doing research require a reconceptualization of the writing process" (p. 103). Employing the constructivist world view I have tried to move beyond the normative pattern of a conventional scientific-like structure and draw out the most salient aspects of the study for the remainder of the thesis. In this chapter under the core sections: *Data Collection; The Participants; Ethics; Researcher Reflexivity; and Data Analysis,* I will outline the main aspects involved in the field research.

6.2 Data Collection

This section will discuss the main procedures in the recruitment of participants, the interviews, transcribing, and analytic steps in the study.

6.2.1 Recruitment

Sampling should never be the product of ad hoc decisions, Rapley (2013, p. 49) argues: "it needs to be thoughtful and rigorous". A planned three-fold recruitment strategy was therefore deployed to pinpoint and gather potential participants: *advertising in the various professional bodies available media; direct email via their database; and direct email to select targets.* The advertising strategy is summarised below in Table 6:

Table 6

Advertising strategy

SOURCE	METHOD
Chicago Centre for Psychoanalysis	newsletter and select email
Chicago Institute for Psychoanalysis	advert and select email list
Chicago Psychoanalytic Society	newsletter and email list
Illinois Counseling Association	advert on website
Illinois Mental Health Counsellors (IMHC)	advert in newsletter
Illinois Psychology Association (IPA)	email to members

Illinois Society for Clinical Social Work	email to members
The Institute for Clinical Social Work	select emails
LinkedIn	direct email

Prior to the commencement of any recruitment, the professional gatekeepers for each organisation were consulted, ensuring compliance with their organisation's ethics procedures and regulations. All the professional bodies required individual membership before access to media and full databases.

6.2.2 Snowballing / Challenges

The subsequent yield from advertising activity was below expectation. For a sample database of 700 potential targets there was on average response rate of two, with one interview consequently taking place. After evaluating this issue and discussing it with local professionals, I came to understand that there is an extremely high request rate and therefore cannibalisation of the potential participants.

The reasons for this are that many clinical psychotherapy qualifications conclude at doctoral level and the researching of colleagues is seen as an easy alternative to higher-risk studies conducted with client populations.

The issue of low response was surmounted by using snowball sampling (recruitment) utilising a small pool of initial participants to nominate other participants who met the eligibility criteria for the study (Morgan, 2008).

Participants at the completion of the interview generally seemed enthused about the experience and were very supportive in making recommendations to colleagues. 12 out of the 20 participants were eventually recruited using the snowball method of sampling. It was the personal professional recommendation that opened the door to subsequent interviews.

I remained mindful of the limitations of snowballing in its potential to naturally generate similar or 'likeminded' professionals. I endeavoured to thwart this by asking participants for specific recommendations from different modality or theoretical orientations. Whilst I believe snowballing was an appropriate and effective strategy the connections between participants, however tenuous, should not be overlooked.

6.2.3 Interviews

Two initial interviews were conducted as a form of pilot study (Nunes, Martins, Zhou, Alajamy & Al-Mamari, 2010). The experience of the interviews resulted in only minor changes being made to the demographic sheet to accommodate local vernacular. The initial open-ended questions seemed to elicit immediate discussion on silence, and therefore there was no need to adjust the initial questions. The two interviews were of sufficient quality to be included in the final data.

In contrast to the challenges in accessing the sample, participants were unequivocally enthusiastic about the project topic and the interview experience. Several commented that as professionals they are used to listening to *others* speak, so it was a novelty to talk about how they worked in such detail. I felt the potential neutrality of the research area (silence) and having a foreign accent also may have helped put the participants at their ease.

The recording device was only started after the introduction and completion of the consent and demographics forms. The participants were invited to speak for between 60 and 90 minutes. In practice many scheduled the interview between client visits, which potentially left less than an hour. However, more than half the interviews were longer than 60 minutes, resulting in nearly 22 hours of recorded dialogue, with an average recording being 65 minutes in length.

Intensive interviews were conducted using open questions to facilitate an exploration of the research participant's concerns, with an objective of obtaining detailed responses on their perspective, meaning and experience (Charmaz, 2014). The initial opening question was a variation on:

> "I am interested in exploring your experience and understanding of using silence in clinical practice."

The opening question was supported by neutral prompts such as:

> "Can you please say a bit more about that?"

> "What was your process at that time?"

> "How did you become aware of that?"

I took guidance from the words of an expert interviewer (Gladwell, 2019) as an overall orientation on attitude:

> Alert people to parts of their lives that may seem banal to them, but in fact are not. The job of the writer isn't to supply the ideas in an encounter, it's to be patient enough to find the ideas in any encounter (p. 3).

The participants all gave their permission, as part of the informed consent, to be audio-recorded and the data transcribed and anonymised.

I reflected on how I perceived the cultural differences between the USA and UK. Practitioners seemed highly qualified but significantly less formal, being brutally honest and open about their vulnerabilities and challenges in practice. There was a perceived closeness between me and the participants, that felt culturally different from what I have experienced from interviewing psychotherapists in the UK. I was mindful that Illinois is consider part of the Midwest of America, noted for its friendliness.

The interviews were clustered in three main phases.

Phase 1 data collection

Two initial interviews were conducted to support the refining of all aspects of the interview strategy and procedures. As part of this process, forms were revised and minor amendments made to the demographics form, incorporating any feedback and acquired knowledge of cultural idiosyncrasies.

Phase 2 data collection

In phase 2 of the data collection a total of eight interviews were conducted. The data collection ran in parallel with the coding of data and analysing using the comparison method. This resulted in several tentative categories or themes beginning to emerge.

Some initial theoretical sampling (focused sampling) was conducted by following up on what previous interviews had revealed. Some questions were asked relating specifically to the data.

I reflected that from the very early stages of the interview process, the data appeared to self-correct as the subsequent interview questions were completed. This had the impact of what may have been an area of premature interest not being supported by subsequent interviews. I reflected that this was an experience that got stronger as more interviews were conducted.

Phase 3 data collection

In this phase, ten interviews were conducted, and coding continued. As interviews progressed, the researcher was more active and more direct questions were asked than in previous interviews, linking questions with emerging codes and themes. Once tentative theoretical categories were developed, further focused sampling (theoretical sampling) was conducted using interview questions that related specifically to the data already collected and the developing codes and categories. The method of asking "what questions have not been asked of the data?" was employed. This process helped me illuminate and define properties, boundaries, and relevance of this category or set of categories (Charmaz, 2014).

6.2.4 Transcribing

Prior to transcription, the original recordings were listened to for general quality, orientation and to experience the interview as an observer (Easton, McComish & Greenberg, 2000).

Kowal and O'Connell (2013, p. 66) argue "both basic and applied researchers in the social sciences must approach transcription with a very critical eye (and ear)". They argue that the interpretation of transcripts should always be verified by a return to the original recording.

Once transcribed by a third-party company, the recordings were listened through again, and the transcript corrected for noted queries and inaccuracies. Most of the queries were on uncommon words mainly from psychotherapy theory and the names of key theorists.

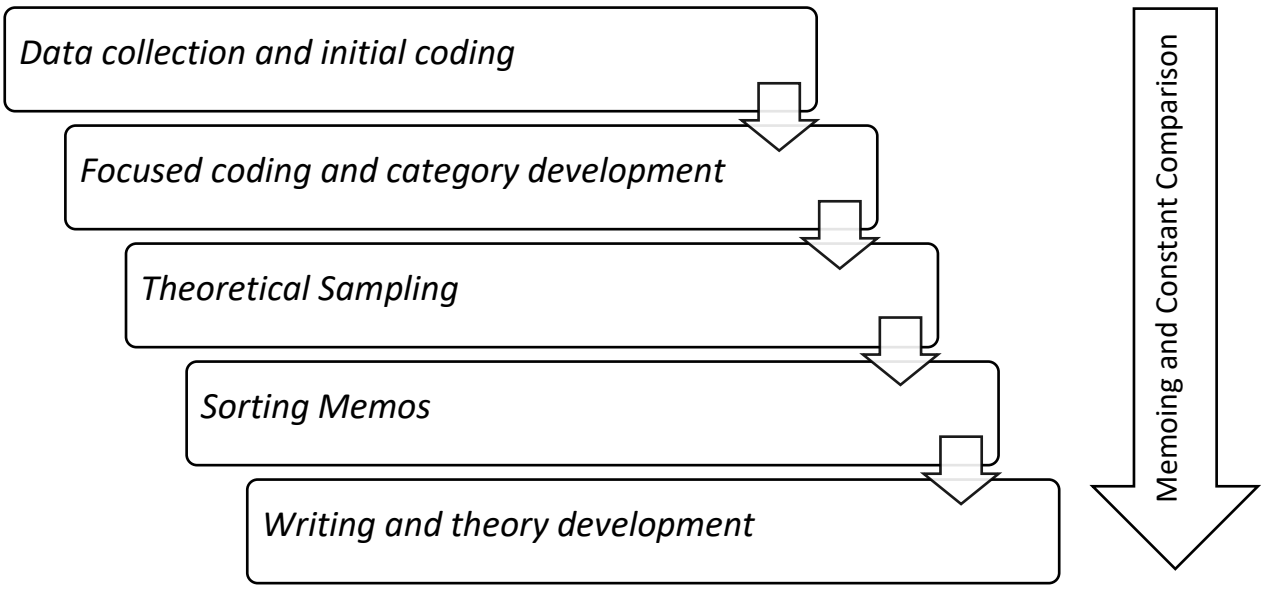
I reflected on how my own sensitivity and knowledge in the area of clinical theory enabled the participants' voices to be fully understood.

6.2.5 Analytic Steps

The detailed discussion of elements of the data analysis is discussed in Section 6.6. The essential movements in constructivist grounded theory are shown below in Figure 4:

Figure 4

Main movements in grounded theory data analysis



6.2.6 Cognitive Enhancement

The software used for data analysis does not "do" the analysis, but as Gibbs (2013) cautions, the use of technology is never neutral. The structure and function of the software immediately places limitations by default. This was a core consideration when deciding whether to use further technology. A potential contradiction arose between the predictable effect and possibly limiting functions of the programme and qualitative analysis that is open-ended and unfolds in unpredictable ways. The contradiction was resolved by separating the analytic strategies (what I planned to do) from software tactics (how do I plan to do it) (Wolf & Silver, 2017).

The package NVivo was utilised to help facilitate the storage, structure, and analysis of the data (Jackson & Bazeley, 2019). The final versions of the transcripts were loaded into NVivo for data analysis. See Figure 5 showing a screenshot from data loaded into NVivo and initially coded. Figure 6 shows a screen shot of more focused coding in NVivo.

Figure 5

Screenshot of initial coding in NVivo

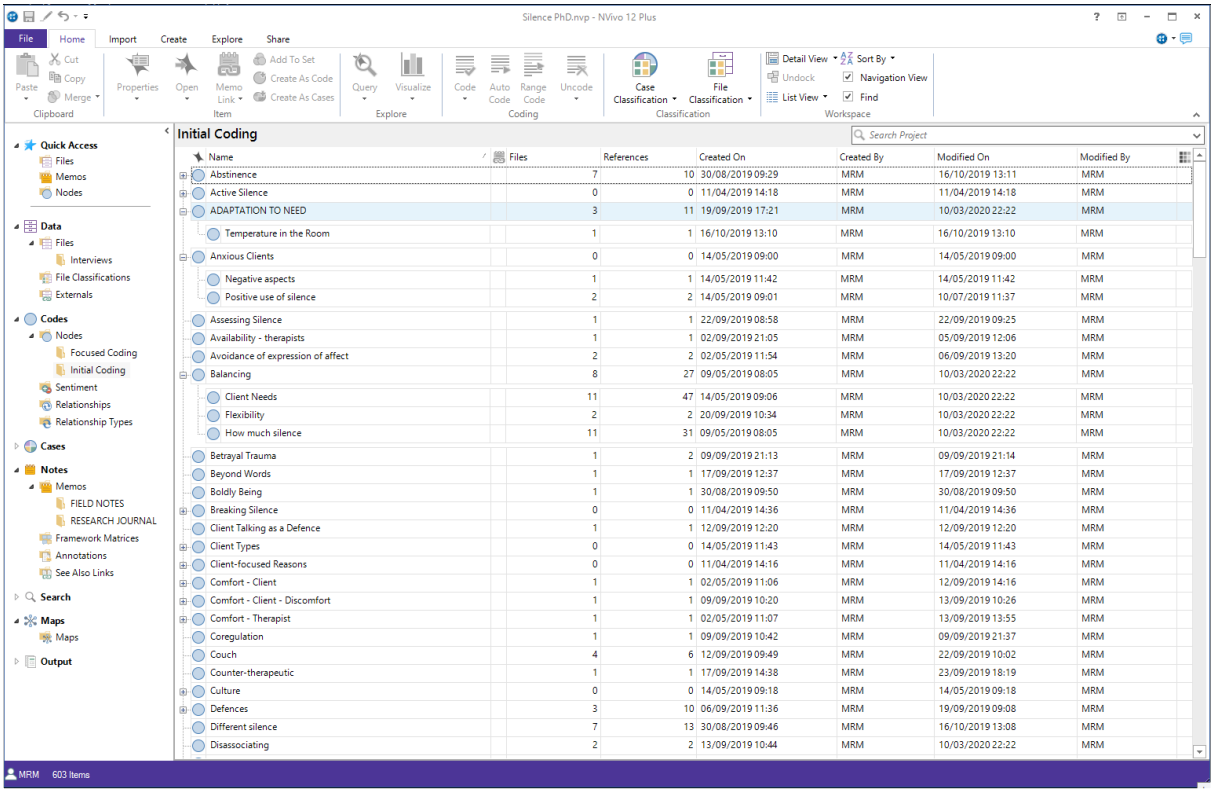
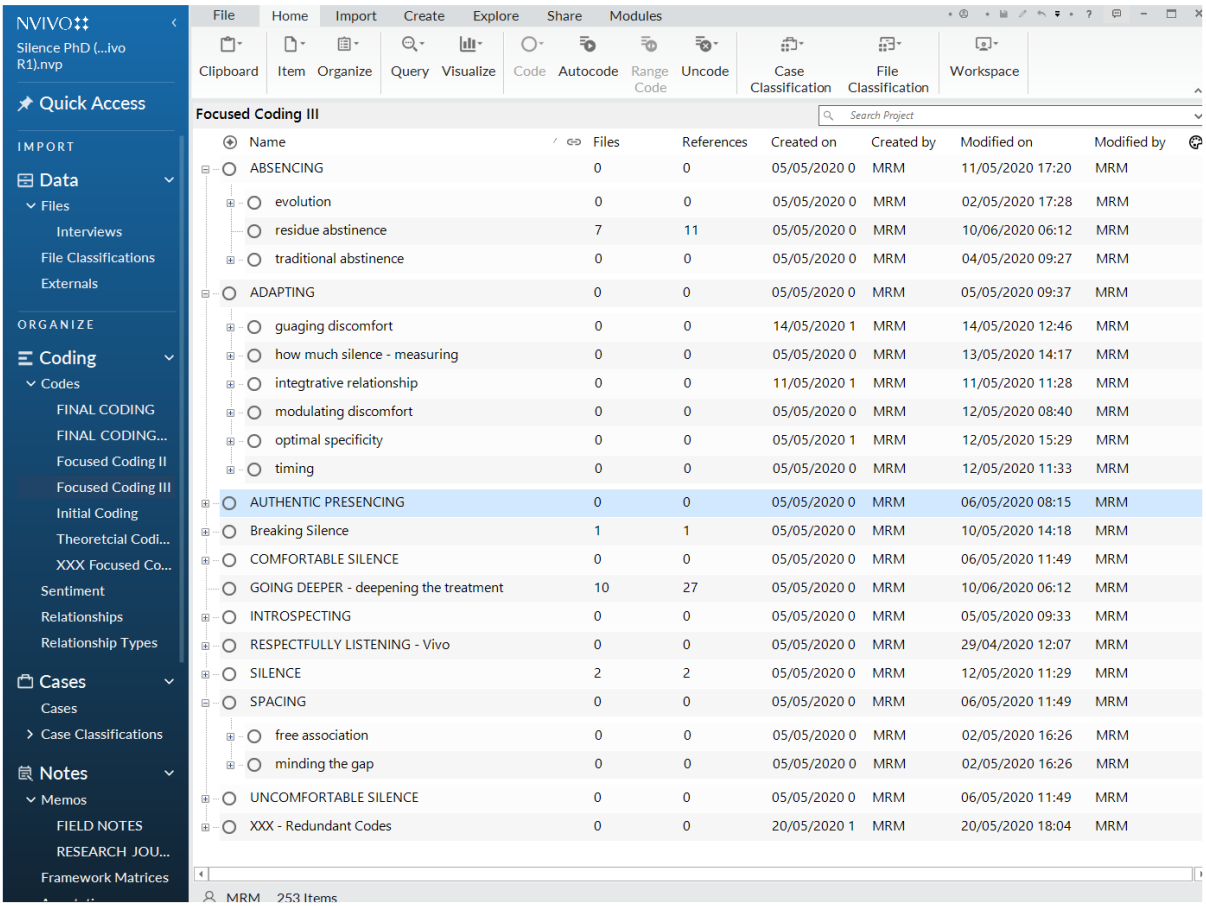


Figure 6

Screenshot of focused coding in NVivo



To mitigate the perceived limits of the software package and its fixed structures, index cards, pens, and highlighters were also used. All tools were viewed as cognitive enhancement during the process, including Microsoft Word and Excel, pen and paper (Clark, 2010). I reflected that all cognitive enhancements had inherent limitations and restrictions.

The physical manipulation of the cards used throughout the data analysis felt much more in keeping with the flow and interaction between the therapist and client, and much more open and less restrictive than if using data analysis software. The software was updated to reflect the results of the card sort. See Figure 7 showing the manual manipulations of card, pens and paper.

Figure 7

Image of showing the utilisation of cards, pens and paper

6.3 The Participants

The data collection was initiated by using purposeful sampling of targets who met the sample criteria (Suri, 2011). The power and logic of purposeful sampling, Patton (2002) argues, lies in selecting information-rich cases for in-depth study: “Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry, yielding insights and in-depth understanding” (p. 230).

6.3.1 Participant Criteria

From professional knowledge, experience, and comparison of psychotherapy practice in UK compared with the USA, Illinois-based psychotherapists had a broader remit in their work. Often their practice would facilitate adults, children and adolescents both in group and one-to-one settings. The UK would generally be more demarcated in these areas. I reflected that I believed the lack of similar demarcation in the US between adult and child psychotherapy resulted in the psychotherapists having a broader and more of a continuum in their knowledge base. The point of transition from child to adolescent and adolescent to adult is not a precise point in time. The wider remit of their work arguably offered a more comprehensive view of their clients.

The criteria for inclusion were intentionally broad to elicit as much response as possible. The number of years practising was not stipulated. Psychotherapist participants in the study met the following criteria:

- saw adult clients on a one-to-one weekly or more basis
- licensed to practise psychotherapy in the state of Illinois, USA
- currently seeing clients in clinical practice.

The aim was to focus the study on similar practitioners with comparable training and educational requirements. The following were excluded from the study for reasons of relevance:

- exclusively family or child therapists
- educational counsellors
- career counsellors
- therapists working primarily in a group setting.

6.3.2 Number of Participants

The time to stop gathering data is when the properties of the theoretical codes are saturated with data (Charmaz, 2015), the sample size would be determined by this dictate.

However, given the time limitations and upon review of the literature on sampling, a working target sample of 15-30 interviews was set (Mason, 2010). There is quite a lot of variety in what is believed to be the minimum requirement, so it is unsurprising to find that actual sample sizes vary considerably in qualitative research (Baker, 2017).

The study meets Malterud, Siersma and Guassora's (2016) criteria for the least number of participants. The study is narrow, the participants are highly specific, has some support from established theory, the interview dialogue should be strong, and the analysis includes in-depth exploration of discourse details. The final sample size for this study was 20 completed interviews.

6.3.3 Participant Demographics

The dialogue and exploration of the demographic information proved to be an excellent introduction to the interview and supported in creating rapport between the participant and researcher. Of the 20 participants gender was identified as:

Table 7

Gender composition of participants

Gender Identified	**Participants**
Female	12
Male	8

In the United States the title of psychotherapist is used by professionals who are licensed at a state level in one of 4 main fields. The requirements for entry vary significantly for each region, For the State of Illinois, where the research was conducted, there are 4 licensing categories for independent practitioners (can see clients without mandatory supervision) of which the participants comprised:

Table 8

Composition of professional licences

Psychotherapists Professional Licence	**Participants**
Licensed Clinical Social Workers (LCSW)	5
Licensed Clinical Professional Counsellors (LCPC)	6
Licensed Clinical Psychologists (LCP)	7
Medical Doctors Psychiatrists & Psychoanalysts (MD)	2

Despite efforts to ensure a broader age range in the study the average age of participant was 62. Whilst it was disappointing not to include a younger demographic it did result in the total years of practice experience being 560 years. The average years of practice experience was 28. The highest years was 45 and the lowest 6.

Given that experience was not a criterion for inclusion, it could be argued that more experienced practitioners are more sympathetic to requests for participation in research.

Over 30 varying theorists were mentioned by participants often residing outside of their self-identified modality which were:

Table 9

Composition of modalities

Primary Stated Modality	**Participants**
Behaviouralist	1
ACT/CBT	2
Integrative	6
Psychoanalysis/Psychoanalytic	7
Psychodynamic	3
Rogerian Client Centred	1

6.3.4 Participant Descriptions

It is all too easy for the individual humanity of anonymised participants to be obscured by the precise procurement of meaningful data. To reduce this phenomenon, participants have been given pseudo names. A brief, edited and anonymised mini-biography and description of each is offered below. The demographic descriptions are taken from the participants own answers and terminology and are therefore not consistent.

Freda (INT3.1) identified as a 67-year-old white heterosexual female. She has an MA in community counselling and maintains a part-time private practice. Her license is LCPC and her primary modality is integrative. She sees people for one 50-minute session per week (but some less frequently), with an average of 28 sessions per client. Freda has been in practice for 15 years. Her Christian faith forms an important part of her practice. She will often pray during silences.

Alison (INT3.2) is a 62-year-old white CIS female. She holds a PhD in clinical psychology and is registered as an LCP. Alison describes her work as integrative, seeing clients weekly for 45 minutes per session. She has been in practice for 33 years. Her relationship with silence is influenced by her study of Buddhism and meditation.

Kerry (INT3.3) is a 74-year-old Caucasian heterosexual female with a PhD in clinical social work and licenced as a LCSW. She describes her practice as psychoanalytic and integrative, seeing clients for 55 minutes once or twice a week. She has been in practice for 30 years. She used to work in a unit with Otto F. Kernberg and remembers studying with him, over several months, how to be with a client in silence.

John (INT3.4) is a 71-year-old white straight male. He has a PhD in clinical psychology, is licenced as an LCP and states CBT as his main way of working with people. John sees clients for 60-minute sessions once a week and the length of treatment is between one to 25 years. He works in private practice after many years working in hospital settings. He has over 45 years' experience and believes that over the years he has learned what works best for people, as opposed to the theory he was taught in graduate school. John uses silence principally to offer the client space to think.

David (INT3.5) was a 69-year-old Caucasian heterosexual male. He has a PhD in clinical psychology and is licenced as an LCP. David described himself as a third-wave behaviouralist. He works in a local hospital and retains a small private practice at his home. He viewed his practice as brief-therapy, seeing clients for an average of 12 sessions for 50 minutes each. He believes that because the number of sessions are so short, he needs to be seen to be making an intervention and therefore despite valuing its use he cannot allow too much silence.

Maria (INT3.6) is a 46-year-old, Latinx heterosexual female with a PsyD in clinical psychology and is registered as an LCPC. She uses systems and integrative theory in her practice. She has been practising for 10 years and sees people weekly for 50-minute sessions in a community services setting. Maria highlighted some of the cultural differences in silence, stating that in her culture there is much less tolerance for silence.

Melanie (INT3.7) is a 61-year-old bisexual Caucasian female with a PhD in clinical psychology and registered as an LCP. Melanie works interpersonally and analytically with clients, whom she sees for one or two sessions of 55 minutes per week.

She has been practising for 33 years. Melanie feels that silence is very useful when working with people who have experienced trauma.

Ester (INT3.8) is a 52-year-old Caucasian heterosexual female. She has an MA in clinical mental health and works in private practice using ACT and CBT as her main modality. Ester sees clients once or twice a week for 60-minute sessions. She has been in practice for 20 years. Ester says she needs silence in order to start to be present for her clients.

Neil (INT3.9) is a 42-year-old white heterosexual male and the youngest participant. He holds an MA in counselling psychology and is a registered as an LCPC and describes his practice as psychodynamic relational. He has been in practice for 10 years, seeing people weekly for 50 minutes in a private psychotherapy centre. Neil values the therapist's use of silence and believes that it contributes to the deepening of the treatment.

Betty (INT3.10) is a 47-year-old white heterosexual female. She has an MA in Psychoanalytic Psychotherapy and is registered as an LCPC. She sees clients between for one to three sessions of 45 minutes per week in a private psychotherapy centre and has been in practice for 10 years. Betty spent part of her clinical career in London and was able to offer her comparative insights between practice in the UK and the USA. Although sceptical of the use of silence as a hardened technique, Betty believes that it is the attitude of the therapist during silence which is of the most importance.

Richard (INT3.11) is a 73-year-old white heterosexual male. He is a medical doctor who has specialised as a psychiatrist and psychoanalyst. Richard sees clients once or twice per week for between 45 and 60 minutes.

He has been in practice for 40 years, working with clients in hospital settings and privately at his home. He has realised that he is uncomfortable with silence and orientates to fulfil more couples work where the therapist is more verbally active.

Harvey (INT3.12) is a 58-year-old white gay male. He has a Master's in social work and is registered as an LCSW. Harvey sees clients weekly for 50 to 60 minutes for up to 24 sessions in a federally funded centre serving LGBTQ+ clients. Harvey was the only psychotherapist who described his work as Rogerian, and the voices of his clients are central to his work and views on silence.

Jill (INT3.13) is a 61-year-old sexually fluid white female. She holds a Master's in social work and is registered as an LCSW. Her modality is relational / self-psychology, and she sees clients one or two times a week for 55-60 minute sessions. She has been in practice for 35 years seeing clients in a psychotherapy centre and privately at her home. Jill believes that there are varying qualities of silence between the therapist and client, impacting connectedness and presence.

Peggy (INT3.14) is a 52-year-old bisexual white female. She holds a PhD in clinical psychology and is registered as an LCP. Peggy describes her practice as integrative relational and sees clients for one or two sessions of 45 mins per week. She has been in practice for 29 years and currently works in a private psychotherapy centre. Although trained in psychodynamic theory, she has come to question the concept of neutrality and the blank screen, opting for a more integrative way of working with clients.

Jenny (INT3.15) is a 60-year-old white heterosexual female. She holds a Master's in social work and is registered as a LCSW. Her modality is integrative and she sees clients for one or two sessions of 50 minutes per week in a private psychotherapy centre. Jenny has been in practice for 30 years. She loves to pause in silence to aid her in thinking more deeply about what the client has said, and what, if anything, she needs to say in return.

Ezra (INT3.16) is a 64-year-old heterosexual Jewish male. He holds a PhD in social welfare and is registered as a LCSW. He describes himself as a contemporary psychoanalyst and sees clients privately for between one to four 45-minute sessions per week. Ezra has been in practice for 41 years. Ezra views silence as a language beyond words – punctuations that communicate emotion and meaning.

Frankie (INT3.17) is a 72-year-old white heterosexual female who has been in practice for 45 years. She holds a PhD in human development and is registered as an LCP. She describes her practice as psychodynamic, relational, and developmental and sees clients for one to four sessions per week of 45–60 minutes each. Frankie highlighted in some detail the multifaceted nature of silence and how her understanding has evolved over her many years of practice.

Sol (INT3.18) is a 68-year-old heterosexual Jewish male in practice for 35 years. He is a medical doctor specialising in psychiatry and psychoanalysis in hospital and private practice settings. Sol sees clients for one to four 45-minute sessions per week. He thinks silence is important, the place for free association essentially, offering people the opportunity to investigate themselves more deeply.

Clive (INT3.19) is a 71-year-old Caucasian heterosexual male. He holds a PhD in behavioural sciences and is registered as an LCP specialising in psychoanalysis. Clive sees clients for one to four 45-minute sessions per week. He has been in practice for 31 years and is an active teacher and writer, seeing clients in hospital and private settings. He does not believe that silence has value in psychotherapy and makes a link to this view with his relationship with his extremely silent father.

Anna (INT3.20) is a 76-year-old Caucasian heterosexual female and is the oldest participant. She has been in practice for 20 years, holds an MS in counselling clinical mental health and is registered as an LCPC. She works with clients in private practice for one to two 60-minute sessions per week. Although she describes her practice as psychodynamic, she values the use of EMDR when working with trauma and she uses silence quite consciously during this process.

A complete list of interview codes and interview dates is contained in the Appendix 2.

6.4 Ethics

The University of Northampton's (2021) *Research Ethics Code and Procedures* were employed to guide and structure all aspects of the project. The principles of: *honesty, rigour, transparency and open communication, care and respect* were the foundations from which the research was based. As Burnett (2016) highlights:

> Ethics is not merely a matter of minimal compliance with codes and guidelines. Properly ethical research demands that ethical considerations should be in the forefront of our thinking and routinely inform all that we do (p. 6).

In addition to the codes of practice provided by the professional bodies of which I am a member (American Psychology Association, 2017; British Association of Counselling and Psychotherapy, 2018; National Association of Social Workers, 2019; UK Council for Psychotherapy, 2019), Regent's University London's (2016) *Research Ethics Policy* was core when considering the ethical implications of this study:

> committed to ensuring that its research activities involving human participants and personal data are conducted in a way which: respects the dignity, rights, and welfare of all participants in research; minimises risk to participants, researchers and third parties; appropriately manages personal data; and maximises the public benefit of research (p. 2).

The ethical considerations associated with this project have been identified as:

- informed consent
- ongoing consent
- duty of care throughout
- safety of participants and of the researcher
- transparency of use of data
- anonymity
- confidentiality and its limitations in qualitative research
- protection and storage of data.

Careful thought was given to the power dynamics when considering interviewing senior psychotherapists. I ensured that I verbally expressed concern for the participants regardless of their seniority, and time was allocated at the end of the interview to offer space to discuss how they felt and to close the session properly.

The University of Northampton Ethics Committee approved the project on 2nd August 2018.

6.4.1 Informed Consent

Each participant was approached seeking an initial expression of interest to participate in the study via email and or advert. If this was positive, then they would be provided with a copy of the two-part Informed Consent Form (see Appendix 3) prior to the interview. Part I was an Information Sheet providing information about the study and the commitment required of participant and researcher. Part II was a Certificate of Consent providing the participant the opportunity to select how their data would be used. Prior to commencing the interview, the participant was given a final chance to ask questions before being asked to sign the Certificate of Consent.

6.4.2 Ongoing Consent

King, Horrocks and Brooks (2019) emphasise that consent goes beyond the signing of the form: it is not a one-off event. Consent requires the interviewer to read non-verbal and verbal cues and to ascertain whether questions are being too intrusive. I quickly became aware just how emotive and personal the material was for the participants and remained mindful throughout of how much they were disclosing both professionally and personally.

The right to withdraw from the data collection at any time without penalty or embarrassment was stated in the consent forms and reiterated before commencing the interview. The final verbal approval was sought before the use of a recording device.

The participants were given the option of completing a demographic information sheet (See Appendix 4). They were requested to only complete the information that they were comfortable disclosing and to phrase the answers in their own words and terminology.

As an interview flows and the data "spills", it is possible that a participant may disclose information that they did not consider prior to commencing the interview. Therefore, at the conclusion of the interview, participants were also asked how they felt about the experience, and for a final time, about their disclosure being included in the study (Josselson, 2016).

Flexibility was offered to the participant to remove any disclosure and to see the transcribed interview. None requested to do so. Upon review I found many potentially identifying or sensitive details and proactively removed these, replacing the data with "[redacted]" for continuity and readability.

6.4.3 Data Management

In compliance with University of Northampton's (2020) *Research Data Policy*, a Data Management Plan was created and is included in Appendix 6. This plan demonstrates the consideration given to the ethical and professional handling and storage of participants' data.

6.5 Researcher Reflexivity

Introducing a reflexive practice into qualitative research, May and Perry (2013) argue, enables both an examination of the grounds upon which one makes claims about the social world and offers an exploration of the strengths and limitations of the knowledge presented. A general reflexive approach was applied throughout the study, an ongoing deliberation on what I am doing and why (Etherington, 2004; Levitt, Lu, Pomerville & Surace, 2015). Part of this process was recorded in a methodological journal: simple notes on how I learned and applied constructivist grounded theory, and what came up for me as the study progressed. Further comments on reflexivity are contained throughout the rest of the study for a concentrated discussion, see Chapter 10, Section 10.3. When the field research had begun and analysis commenced, the use of memos (a core grounded theory method described below) was employed to record spontaneous and lucid reflections on the data.

I had a desire to ensure that the study was not divorced from my values as a psychotherapist. Reflexivity is central to my practice and therefore an essential part of the study. This fitted perfectly with constructivist grounded theory as it views the research as constructed rather than discovered and therefore fosters researchers' reflexivity about their actions and decisions.

6.5.1 Preconceptions

Glaser and Strauss (1967, 1999) emphasised the dictum of "no preconceptions" when approaching the data. This felt like an impossible charge, given the fact that an initial literature review was conducted and I have some existing knowledge of the field.

It did make me very aware of my own preconceptions and assumptions and there was a rapid letting-go with more and more of a focus on the core concerns of the participants whilst acknowledging what I was bringing to the process and how this may have impacted on the data. I found Dey's (1993, p. 229) summary of the approach central to engaging optimally with the data "open mind not empty head".

I would concur with Urquhart's (2013, p. 24) view on line-by-line coding "that detailed consideration of the text in front of us – helps free us from preconceptions."

6.5.2 Process as Reflexivity

Memoing and the Constant Comparison Method are mechanisms within constructivist grounded theory that apply to reflexivity and require reflection on inner dialogue and analytic thinking. Reflexivity also addresses the challenge of having conducted an initial extant literature review at the proposal and implementation stages of the study (Dunne, 2011).

I reflected on the difference between conducting a smaller previous study with six participants versus 20. My personal enthusiasm for emerging categories or ideas was self-corrected by conducting further interviews. A seemingly important question that might have naturally arisen from previous interviews may be reduced to relative insignificance by the subsequent answers in the next set of interviews. Conversely, codes began to stand out by their natural frequency whether the researcher had a conscious interest in them or not. This experience increased my confidence in the methodology and sample size.

6.6 Data Analysis

6.6.1 Initial Coding

Initial coding was conducted, staying open to what was going on in the data (Thornberg & Charmaz, 2013). The data was read and analysed word by word, line by line, paragraph by paragraph, incident by incident. Analytical questions that *also* remain universal to constructivist grounded theory versions were asked of the data including:

> *"What is this data a study of?"; "What category does this incident indicate?"; "What is actually happening in the data?"* (Glaser, 1978, p. 57; Glaser & Strauss, 1967)

> *"What theoretical category does this datum indicate?"* (Glaser, 1978, p.23)

> *"What is the participant's main concern?"* (Glaser, 1998, p.140)

> *"What process(es) is at issue here?"; "How can I define it?"; "How does this process develop?"* (Charmaz, 2006, p.51)

> *"What do the data suggest? Pronounce? Leave unsaid?"; "From whose point of view?"* (Charmaz, 2014, p. 116)

An additional question was asked:

> "*What must be true for this to be the case?"* (Bhaskar, 1986)

After coding two interviews using NVivo and having attained more familiarisation with the software, a decision was made to delete all the coding data and to start again. This was to support the natural flow of coding now that familiarisation with the software was achieved.

In this procedure the coding was commenced in reverse order: beginning with interview 4 and concluding with 1. As a result, a core natural coding rhythm emerged, and it became apparent that my initial two interviews retained residue of what I was interested in. As the interviews progressed 3 to 4, this residual bias (an interest in certain themes) fell away, leaving a much freer focus on the concerns of the participants. See Table 10 for an example of initial coding.

Table 10

Example of initial coding

Interview: Clive (INT3.19)	
DATA	*INITIAL CODES GENERATED*
So, my point is it has a lot to do with the needs of the patient. I do think that we, as therapists want to try to adapt to the needs of the patient, whether they want, they need to see our presence, have a sense of who we are, hear from us or whether they want us to hold back and be relatively silent and give them space to talk and explore.	client needs adapting to needs of client importance of presence giving client space holding back hear from us balancing silence

The initial coding produced 603 initial codes on the first main pass of 20 interviews. Analysing the codes at this preliminary level, there are already as Hatch (2002, p. 155) would phrase it, patterns of stable regularities and varying forms:

- *similarity* (in events, incidents, processes)
- *difference* (predictably different ways)
- *frequency* (happen often or seldom)
- *sequence* (happen in an observable order)
- *correspondence* (in relation to other events, incidents and processes)
- *cornerstones* (key explanatory concepts)

It became clear that the data could be provisionally sorted into two major categories or areas: *client-focused reasons*, and *therapist-focused reasons* for using silence.

When employing constructivist grounded theory, it can be sometimes confusing to read the term “emerging”, due to its association with classical grounded theory and the positivistic connotations. However, Charmaz (2014) clearly defines this when referring to codes, writing “a grounded theorist creates qualitative codes by defining what he or she sees in the data. Thus, grounded theory codes are emergent” (p. 342).

6.6.2 Memoing

Memoing was commenced from the beginning of the study, during the initial literature review, and throughout the coding and analysis process. Memoing captured my reflexivity and development of thought throughout. It served as a record of initial assumptions and ideas about the data and served as a record of the development of my thinking as initial codes emerged and themes were constructed. The memos were clustered in four main types:

1. *Literature memos* – detailing thinking arising from conducting the review of literature sources:

Table 11

Example of a literature memo

Barber (2009) – rejected study
literature – memo 20.07.18
Barber (2009) interviewed 7 newly qualified therapists. The data was analysed using Thematic Analysis (TA) and five themes were identified: *Felt experience as client, the cognitive experience, silence as a control mechanism in childhood, silence taught as a therapeutic skill and silence seen as adding to the therapeutic process.* The aims of the research are too broad for a sample size of 7 and the research draws a lot of hard conclusions from limited data. The paper was not peer-reviewed and lacked sufficient details to make a thorough evaluation of its worth and therefore inclusion. However, upon reading, the study was also deemed of insufficient value to request additional detail from the author. Outcome: paper read but excluded. Note: review again after the field study is completed.

2. *Field memos* – captures thoughts and experiences whilst conducting the interviews:

Table 12

Example of a field memo

relative silence
<u>field</u> – memo 20.07.19
I am struck once again by the noise levels in the consulting room. As the interviewer, it took me a few minutes just to screen out the noise of the standalone cooling fan. It was startlingly loud but necessary because of the heat of the day. I felt slightly inauthentic not mentioning it to the participant but did not want to insult their working environment. My mind kept coming back to it as the fan continued to oscillate in volume. Major sources of noise so far have included: *air-conditioning, standalone fans, road traffic, loud pets, and muffled voices through the walls.* I realise that there are many layers to the quality of silence. There is the space that the therapist creates by their being silent and the context from which that takes place. I realise now that the actual silence in the clinical setting is absolutely relative. I reflected on whether this level of noise would make the silence more comfortable in contrast to a silence where one could hear a pin drop? Relative silence is something to consider in the write-up.

3. *Coding memos* – recording the creation and development of codes:

Table 13

Example of a coding memo

balancing
<u>coding</u> – memo 30.04.19
Balancing is a code that appears to be emerging throughout the data. Balancing of how much silence the therapist needs to use at any given time and balancing what the client needs. This is potentially a key theme to be explored further as data is compared. It could very possibly be one of the principal concerns of the participants. I need to keep exploring this as I continue to move towards focused coding. Balancing also seems to be linked with the therapist's and client's sense of comfort/discomfort with silence. There is something to be explored here.

4. *Theoretical memos* – recoding the development of theoretical codes and supporting the building of theory.

Table 14

Example of a theoretical memo

Space – deep
<u>theoretical</u> – memo 27.06.20
The consequence of the therapist creating a space through the effective use of silence results in the deepening of the treatment. Although I don't like the medical term "treatment" I feel that "deepening the treatment" (in vivo coding) captures what the consequences are of effective silence. The silence creates a quality of space. Space giving, a room or space where the client can go deeper through introspection. Space taking when appropriate, by the therapist, where they can pause and think about the client, what impact the relationship and material is having upon them and why. And the category of space being, the sense of a presence (a strong pattern in the data) and witnessing. A quality of being there for the client that is arguably unique for depth psychotherapy. Not trying to fix or solve simply being. There is also a sense that this being is housed in connectedness between therapists and client. I like the idea of changing room; the attendant is just outside the door waiting to see if the person needs further assistance. Interventions could be viewed like the client trying on the clothes to see if they fit.

Memoing spurs theoretical sampling by highlighting questions that had not been asked of the data and highlighting potential gaps or omissions.

6.6.3 Focused Coding and Category Development

The result of initial coding is to identify the most significant and or frequent codes that make the most analytical sense (Thornberg & Charmaz, 2013). The next stage of coding – focused coding – uses these codes, identified or constructed to support the further analysis of the data. Further exploration and analysis begin to support the construction of tentative categories and preliminary themes.

Early maps were generated in NVivo and on cards to describe the data as opposed to high conceptual and theoretical codes that will follow. Below is an example of more focused coding:

Table 15

Example of focused coding

Interview: Clive (INT3.19)	
DATA	*FOCUSED GENERATED*
So, my point is it has a lot to do with the needs of the patient. I do think that we, as therapists want to try to adapt to the needs of the patient, whether they want, they need to see our presence, have a sense of who we are, hear from us or whether they want us to hold back and be relatively silent and give them space to talk and explore.	adapting presence sitting back space-giving

6.6.4 Theoretical Sampling

Theoretical sampling is the interplay between data collection and analysis, on obtaining data to illuminate categories, and it is what distinguishes grounded theory as an analytic approach in qualitative enquiry (Thornberg & Charmaz, 2013).

Charmaz (2014, p. 27) offers a basic methodological principle: “our data collection methods flow from the research question and where we go with it” (p. 27).

Despite being a hallmark of grounded theory, Drauker, Martsolf, Ross and Rusk (2014) argue researchers often indicate that they use theoretical sampling to choose new participants, to modify interview guides, or to add data sources as a study progresses, but few describe how theoretical sampling is implemented in response to emergent findings. I would argue that the cyclical processes involved in grounded theory, the constant comparison of data with data, incidents with incidents, make it challenging to demarcate each element. I have endeavoured to offer some sense of the process of theoretical sampling below.

Diversity

I was cognisant of the two previous studies conducted on silence as discussed in Chapter 4, review of primary literature (Hill et al., 2003; Ladany et al., 2004). The researchers were mindful that the participants in these studies were primarily older White men, which was reasonably reflective of psychology when they were conducted. As the current study progressed, I became aware that the sample was obtaining a more even balance of male and female participants but lacked more diversity.

The benefit of diversity in research was demonstrated by one interview conducted in an LGBTQ+ focused service, offering rich and unique data and giving a secondary voice to harder-to-reach populations. In another interview a participant alluded to the different relationship to silence that her own culture had, compared to how she might be in session.

Theoretical sampling, therefore, was attempted to obtain younger and more diverse voices for the study by amending the recruitment strategy and snowball sampling through requesting participation from under-represented groups. This had limited impact despite my best efforts.

Although limited in the diversity of sample, cultural sensitivity to the differences between the researcher's cultural experience of silence, the host country and potential variance within a multiplicity of cultures remained throughout.

Session logistics

In the early stages of the study one participant suggested that the low amount of therapeutic practice sessions (brief therapy) impacted his use of silence. The frequency and average number of sessions (length of treatment) was therefore added to the demographic questions and explored in subsequent interviews.

Childhood experiences

Some participants had dramatic early childhood experiences that they described as consciously impacting their relationship with their use of silence. I was very aware that as a psychoanalytically informed psychotherapist I became excited by this data, but my bias was quickly corrected when following the constructivist grounded theory process.

Whilst early experiences were important for many participants, the direct influence on their use of silence was not shared by subsequent participants when further theoretical sampling was conducted.

Psychoanalysts

I became aware that participants who described themselves as psychoanalysts had often, partially or completely, rejected the more classical rules around abstinence and silence. I therefore conducted more theoretical sampling to try and recruit psychoanalysts who continued to practise in the classical way. Although senior analysts were eventually recruited, whilst appreciating the theoretical use of silence, none of them continued to practise in the classical tradition. I reflected that I had some assumptions around psychoanalysis and silence that were formed from my experience and knowledge of UK trained analysts who give credence to classical psychoanalytic theory.

Comfort

Comfort became an area of theoretical sampling as the study progressed: both the therapist's comfort with silence as well as the client's. When reviewing the initial interviews, "comfort" was mentioned in the first paragraph of the first interview. Theoretical sampling was used to ask some more focused questions around the area of comfort.

6.6.5 Theoretical Coding

Glaser (2019) remains critical of grounded theory that does not follow his classical approach to analysis and theory creation. His main concern is that other methods provide a descriptive analysis of data and stop below the necessary conceptualisation. Charmaz (2014) supports conceptualisation and theorising as a core concern of constructivist grounded theory.

Therefore, much effort was made during the study to lift the analysis beyond a point of description to one of conceptualisation and theory generation.

The focused coding analysis generated some significant categories, codes, subcategories, and properties. Following a period of theoretical analysis, four overarching coding categories were constructed that supported the organisation of the data in a way that was more theoretical.

The four new coding categories were: *conditions, cornerstones, consequences, and considerations.* These categories did bring to mind Glasser's (1978, p. 78) "Six Cs" causal coding family but they should not be conflated. Whilst familiar with the various coding families, after prolonged analysis it was deemed more representative of the findings to create new broad coding categories to avoid forcing the data into pre-conceived ideas and categories. This mirrors how Glaser (1978) and Charmaz (2014) urge researchers to develop theory.

"(Pre)conditions" suggests what needs to be occurring for the theory to take place. "Cornerstones" represents the heart of the theory and attempts to represent the core processes taking place. "Consequences" alludes to what is the outcome of the theory. "Considerations" refers to categories that merit attention as impacting the occurrence of the theory. These four coding categories earned their way into the study and in turn helped support generation of the theory through logical demarcation and relationship. Following the strong prevalence of conditions, cornerstones, consequences, and considerations, the categories were considered as facilitating further analytic edge with more precision and clarity.

The writing and sorting of memos was a core process and catalyst for conceptualisation and theorising from the data (Kelle, 2013).

6.6.6 Rendering the Theory

When the theoretical coding was completed to the stage of a working theory, the analysis was reviewed and the write-up commenced. The concept of drafting in the context of the study could be viewed as a grounded theory concept with the properties of: *writing and re-writing; gaining further insights; making clearer connections between categories, and implications.* As Charmaz (2014) states "Thus, writing and rewriting become crucial parts of the analytic process" (p. 289). The write-up process contributed significantly to the rendering of the final theory. As codes and categories were described, they were further refined and amended.

6.7 Conclusion

This chapter has described the application of a constructivist research design. It has set out in detail the core elements involved in the use of constructivist grounded theory, exploring the key elements of *data collection, the participants, ethics, research reflexivity and data analysis.*

Reflexivity around the research design choices and implementation has been offered throughout. In the next chapter I will outline the first part of the research findings.

CHAPTER 7: Silence Revisited *(Findings I)*

Let me come to be still in your silence,

And let me talk to you with your silence.

Pablo Neruda (2004, p. 35)

7.1 Introduction

The research methodology and the application of the research design were discussed in Chapter 6 (Applying the Research Design). This chapter is one of two discussing the findings from the data analysis. This chapter will offer the initial findings of the analysis, discussing silence as interpreted by the participants, initial themes (prior to a more detailed analysis) that were constructed from the data, and a description of the main focus of the study. The chapter can be viewed as a companion to Chapter 2 (Introducing Silence), now introducing the initial considerations of silence as a general concept by the participants, prior to presenting the more focused findings (use of silence in the clinical setting) in the next chapter (Chapter 8). The conceptualisation of the dominant properties that the participants associate with silence, could be tentatively regarded as the meaning-making aspect of the analysis, and the initial themes as the action-orientated aspect. In the final theory there is some overplay between these aspects reflecting the synergy between meaning-making and action-orientating in psychotherapy practice.

The focus of the data analysis has been on the comparison of concepts, categories, subcategories, and their properties as opposed to a descriptive comparison and presentation of the data. This defining aspect of grounded theory over other qualitative methods continues to be stressed by Glaser (2019) and Charmaz (2019, p. 167): “Through conceptualizing what we learn, constructivist grounded theorists can offer new understandings”. Constructivist grounded theory also retains room for the voice of the participant and the reflective voice of the researcher. Therefore, extracts from the interviews are included in the findings to add vibrancy and colour to the categories and not as way of verification via the data.

The findings are therefore an explanation and presentation of the constructivist grounded theory – *intersubjective–silence.* To offer a clean presentation of the theory, critical discussion of the findings and related theory will be outlined separately in Chapter 9 (Discussion).

7.2 Silence Revisited

The complex nature of silence as a general concept warranted a brief discussion in Chapter 2 (Introducing Silence). More specifically, silence in psychotherapy was reviewed in Chapter 3 (Silence in Psychotherapy), and the review of primary literature in Chapter 4.

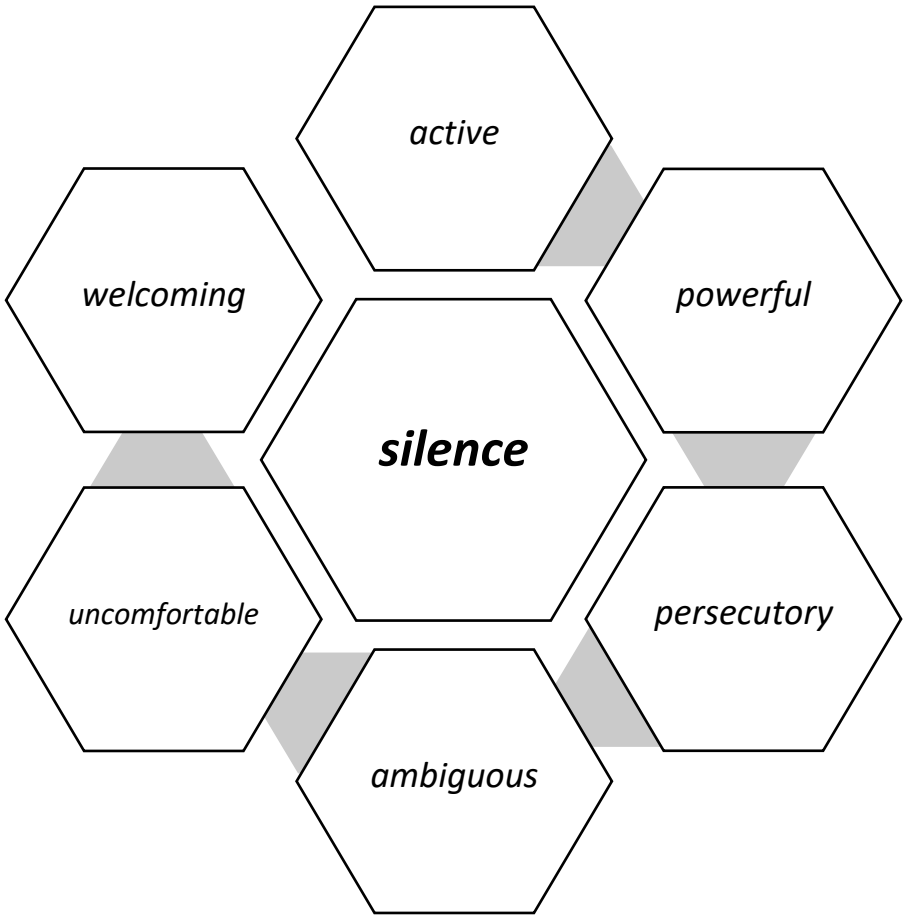
The research question was interested in the participants' use of silence in the clinical setting. The literature review identified that there was a knowledge gap in this area. It was clear from the first interview that the topic of silence remained multifaceted and complex. The therapists highlighted the often ambiguous and allusive nature of silence:

> "It isn't any one thing because silence can be different. You can be silent and quiet, you can be silent and present, you can be silent and spaced out and thinking about something else. You can be aggressively silent; you can be kindly silent" (Betty, INT3.10).

Before offering the detailed presentation of the constructivist grounded theory *intersubjective–silence,* the findings and specific detail around the therapists' use of silence, it is worth briefly discussing some dominant properties that the participants attributed to silence as a general concept. Figure 8 shows the main ideas or properties that the therapists associated with silence.

Figure 8

Dominant properties that the Participants associate with silence



7.2.1 Ambiguous

Therapists were aware that there were different types of silence including: “aggressively silent”, “icy”, “frozen”, “terrified”, “hostile”, “welcoming”, “absent”, “mutual”, and “kindly”. When considering how they believed the client experienced silence, it was considered ambiguous: it could be interpreted to represent many things at different times. Clients can project onto that silence what they think it represents and what they think the therapist may be thinking. They can make judgements as to the type of silence the therapist is providing. These can be accurate projections or inaccurate, but both are impactful experiences. The silence can be experienced as holding and supportive or persecutory and abandoning:

> “and in that anxiety and the question about belonging, very often silence arises, this question of will I be held here, will I not, right” (Harvey, INT3.12).

> “there’s an ambiguity, there’s something to fill and often turn out to do the converse of Orwell, often people will fill it with themselves and so what happens is that their anxiety comes out, you know” (Ezra, INT3.16).

> “There’s a silence and somebody says well, I can tell you’re judging me. It’s less likely to happen later on in the treatment because they already know me well enough and what I’m like to trust that I’m not judging them mostly, and they’ll ask for more space” (Peggy, INT3.14).

7.2.2 Uncomfortable

Therapists made frequent associations with silence and comfort and were often categoric in their efforts to avoid uncomfortable silences. These silences were seen as intersubjective, indicating at times, a mutually-felt sense of discomfort:

> "silence is so uncomfortable, you know, for the patient or the therapist" (Jill, INT3.13).

> "It's uncomfortable for me. I mean, there's a tension that's that sort of interactive tension. I mean I think we all feel this, you know, we're sitting with somebody and we stop talking and it's like oh wait, we're just sitting here" (Frankie, INT3.17).

7.2.3 Powerful

It is perhaps the ambiguous nature and discomforting potential of silence that led to the therapists viewing silence as having a quality of power. They described being judicious in its use and mindful of the impact upon the client and themselves. They had clear prerequisites for its use and were sparing in the amount of silence that they would use:

> "how powerful silence is and how people are desperate to fill it; they are not comfortable with it" (Freda, INT3.1).

> "to feel it you can't help but understand how powerful it is" (Jill, INT3.13).

7.2.4 Persecutory

The therapists described how mindful they were about how the clients could experience their silence. The two extremes of this spectrum could be categorised as *persecutory* and *welcoming* silence. Persecutory silence was silence that was experienced as judgmental or punishing. Often this type of silence could be associated with existing patterns in the client's ways of relating. It was believed that clients could experience the silence as abandoning or withholding in quite primal ways. There was a sense that this type of silence was experienced as a disconnecting from the potential mutuality experienced prior to the silence:

> "For others, that could be agonising; they could feel abandoned, they could feel embarrassed" (Melanie, INT3.7).

Therapists also described clients using silence at times in a way to punish or persecute them. As highlighted in Chapter 3, the silent patient received a lot of attention throughout the psychoanalytic literature.

7.2.5 Welcoming

Therapists who were aligned with the use of silence described their efforts to provide a positive or welcoming silence. This silence was described as being intersubjective and dependent on a range of conditions. They believed that this silence was a reflection of care and attention afforded to the client:

> "I think there's some silences that come out of 'let's see what rises to the surface' and it's a caring, compassionate, productive silence about working together and being in sync" (Kerry, INT3.3).

"I feel as though I'm silent in a welcoming kind of way, like I feel very much like I'm with the person" (Melanie, INT3.7).

"You can be kindly silent" (Betty, INT3.10).

7.2.6 Active

It was a ubiquitous belief that silence was an active space. Some therapists described activity such as taking notes and praying in the silence. In addition to silence seen as communication, therapists described what might be happening for the clients or therapists. This activity could be reflection, thinking, introspection, processing, or simply time to consider what to say next:

"I felt like in silence there are things being communicated. It's not dead space" (Frankie, INT3.17).

7.2.7 Breaking Silence

This study is interested in the therapists' use of silence, but during the interviews they also revealed why they would consciously break the silence when required. These reasons centred around assisting and helping the client, to support them in verbalising and at times to avoid uncomfortable silences. They would ask questions for clarification and to support the client in exploring the subject more deeply. They might return to something the client said earlier or in a previous session. I reflected that whilst not the focus of the study, when to speak is as much of an art as when to employ silence. Importantly many therapists believed that talking was important at the beginning of treatment, a time when it was necessary to ensure that the client felt safe and that a strong rapport was created:

"in order to build rapport, I tend to think that talking is important" (David, INT3.5).

"I might notice if they're uncomfortable with the silence, you know, they're fidgeting and you know, I might help try to say something to help them with that a little bit" (Jenny, INT3.15).

7.2.8 The Art of Psychotherapy

The idea of the artistry of psychotherapy emerged very quickly, as it became clear that many of the processes involved in the use of silence were not always conscious. Often participants had to try and elicit what had not been consciously considered, in terms of what they did, and why and when they did it.

I reflected that when considering any art form there are aspects of the artist's individual process, that when explored further, can be elusive and a challenge to isolate and describe. When reflecting on the interview process and their relationship with silence, comments were made such as:

"We got into things that I hadn't thought about in a long time, or ever" (Kerry, INT3.3).

"It hasn't been something that I've thought about as much in the past 20 years" (Ester, INT3.8).

"I think you've kind of enlightened me. Going through this has made me think about it; I'm going to be more observant of how I do things, you know" (Jenny, INT3.15).

On reflection on their training and experience, people described how their views of silence have changed over the years. Many said they do not practise the way they were trained, and that experience had changed their views on silence:

> "I think in lots of training, I guess silence like other things, you have to be presented in a strict way before you learn the exceptions. There's always casualties, unfortunately there's always casualties along the way" (Sol, INT3.18).

7.3 Initial Themes

The strength of grounded theory is the focus on the concerns of the participant as opposed to those of the researcher. I reflected on how I commenced the study with an interest in intentional silence and retained some preconceptions in my interest in how it might be used to elicit negative transference. However, three broad themes emerged from the coding that shattered those initial concerns and captured what I believe are some of the main areas of concern for the participants: *comfort, adaptation, and space.*

7.3.1 Comfort

The participants' concern with uncomfortable silences, comfort, and discomfort, both theirs and the client's, was an overwhelming pattern throughout the data. After the theme developed and through further data analysis, it was noted that the preoccupation on comfort was discussed from the beginning, with the first paragraph of the first interview:

> "People are generally really uncomfortable with it, really uncomfortable with it. They really don't like it" (Freda, INT3.1).

7.3.2 Adaptation

The second broad theme was adaptation, the explicit discussion of how the therapists balanced and adapted the use of silence to the needs of the individual client.

Whilst a consideration, the type of client did not have significance but rather the individual type of client within the category:

> "And while I'm still very comfortable with the use of silence I think I think about it in a different way now because I really try to tailor each treatment to the very specific needs of very different patients" (Melanie, INT3.7).

7.3.3 Space

The theme of space was also a strong pattern in the data. It demarcated a positive form of silence where specific practices and processes took place. Space and the type of silence associated with it contrasted starkly with silence that was seen as abstinence or absence:

> "If the therapist talks too much they interfere with the client's feeling. So, I guess it's a tool but it's also the environment that you have to provide. You have to provide a pretty silent environment to give the client space" (Jill, INT3.13).

> "silence and space are very related" (Alison, INT3.2).

The precipitous creation of firm themes and categories was avoided by conducting further data analysis. The development of a grounded theory required activity to cycle backwards and forwards between theoretical sampling of available data and constant comparative analysis.

Categorises and concepts were compared, additional questions raised, and importantly data was sought to answer questions and clarify categories.

7.4 Effective or Therapeutic Silence

Whilst Charmaz (2014) argues that constructivist grounded theory can have multiple themes, an overall core concern of the participants appeared to connect the emerging themes and categories. This was the concern of the therapists that intentional silence was effective or therapeutic:

> "It made me kind of stop and think okay, am I being too silent in this situation and is it being effective?" (Maria, INT3.6).

This core category was conceptualised as *intersubjective–silence*. Silence provides the client and therapist the space or room to change. In the next chapter, Chapter 8, I will discuss in detail the categories and subcategories of *intersubjective–silence*. Table 16 shows *intersubjective–silence* categories and subcategories using this coding family as structure.

Table 16

grounded theory intersubjective–silence categories and subcategories [Version 11]

coding category	categories and subcategories
(pre)Conditions	**evolving disparity**
	rendering relationship
	minding the gap
Cornerstones	**sensitising silence**[+]
	- intentionally modulating
	- optimal specificity
	- increasing tolerance
	- traumatising
	productive comforting[+]
	- co-creating comfort
	- influencing therapist
	productive discomforting[+]
	- co-creating discomfort
	temperature gauging[+]
	- soft signalling
	- verbalising
	- intuiting
Consequences	**deepening the treatment**[+]
	- room of their own
	- benign witnessing
	- taking stock
Considerations	**timing**[+]
	- treatment timing
	- treatment length
	- treatment frequency
	silently experiencing

7.5 Conclusion

In this chapter I have examined the concept of silence as viewed by the study participants. I have drawn out and discussed the most salient ideas around how they view silence currently and how that has changed over the course of their practice.

The initial themes created from the data analysis were highlighted and discussed, and the core category of effective silence was introduced and conceptualised as *intersubjective–silence*. In the next chapter I will present the grounded theory in more detail.

CHAPTER 8: Intersubjective–Silence *(Findings II)*

He knew the precise psychological moment when to say nothing.

Oscar Wilde (1891/1993, p. 14)

8.1 Introduction

In Chapter 7, I outlined the initial findings from the data analysis. I revisited the general concept of silence, exploring it through the lens of how the participants conceptualised silence. I identified the constructivist grounded theory generated in this study from the analysis of the data – *intersubjective–silence*. In this chapter I will now explore the categories and sub-categories of *intersubjective–silence* in more detail. The theory has been arranged around four main coding categories: *(pre)conditions, cornerstones, consequences, and considerations*. I will now discuss each in turn.

To guide the reader through a detailed range of codes, categories and properties I have presented the *categories* and *subcategories* in italicised lower case and underlined *codes* or properties.

8.2 (Pre)Conditions

There are three main and interrelated (pre)conditions which were identified as existing when *intersubjective–silence* was reported or intimated: *rendering relationship, evolving disparity,* and *minding the gap.* See Figure 9.

Figure 9

Three main (pre)conditions

8.2.1 evolving disparity [pre-condition]

I will begin by discussing *evolving disparity* as it impacts the other two (pre)conditions so significantly. The study found that all therapists had experienced some aspect of a shift in their relationship to silence in clinical practice. They reflected on what had changed from when they were first trained and began to practise to how they currently use silence. They elaborated on this *evolving disparity* as an active and continual process of experience, reflection, and change.

There was a sense of *evolving disparity* from a more traditional and formally intentional use of silence to one that is more fluid and focused on the needs of the client, over any theory or training experience. However, there was always the potential of a propensity to return to a more traditional way of working. Many discussed how participating in this study and interview process led them to re-consider and reflect more deeply on their connection to silence. Table 17 shows *evolving disparity* and its sub-categories and codes. The number of codes is reflective of the volume of data in this area.

Table 17

evolving disparity – (pre)condition

SUB-CATEGORIES	CODES
traditional abstinence	interpreting silence manipulative techniquing neutrally posturing withholding responsiveness
evolution	humanising theory personally emerging transitioning training practically experiencing
residue abstinence	absencing techniquing

traditional abstinence [sub-category]

The therapists disclosed an understanding and an appreciation of silence as a therapeutic technique – as Betty (INT3.10) described it: "one of the conventions of the trade", even if that is not how they use it now. *Traditional abstinence* was for many therapists what they are evolving from. What they described could be viewed as a one-person psychology, the sense of the therapist as the 'all-knowing' (Ezra, INT3.16) observer or expert. Consistent with the background literature review, there was a strong sense of a focus on interpreting silence and on what that may convey in terms of the client, rather than the impact that the therapist's use of silence might be having.

When considering the negative transference that can occur when the therapist is intentionally silent, several therapists described it as potentially "iatrogenic". The use of silence to "force" or manufacture a response was seen as counterproductive. They argued that if there was potential for that type of transference, it would arise anyway. Therapists considered traditional abstinence as potentially a manipulative techniquing using words such a "power-play" and "game playing".

Historically silence was often something that they thought they "should" be doing, as opposed to what was best for the client. Practice was described as more firmly embedded in theory and training:

> "It sometimes felt to me like there were theories and they were adhered to in the same way as one might adhere to a religion" (Betty, INT3.10).

The code of neutrally posturing was associated with traditional absence. For many therapists, this concept has its roots in classical psychoanalysis. They used terms such as blank screen, abstinence, neutrality, relationally distant, and tabula rasa to describe the idea of how the therapist was with the client.

For the therapists who had more exposure to psychoanalytic training, they used a familiar nomenclature such as neutrality, transference, remoteness, resistance, and regression when reflecting on traditional abstinence. The silence described in traditional abstinence had properties such as withholding responsiveness, blank screen, absence, neutrality. By a process of evolution these properties were now considered mainly negative by the therapists.

evolution [sub-category]

Therapists described an *evolution* from how they were originally trained or had thought about the use of silence away from *traditional abstinence* precipitated by shifts in clinical theory, personal and practical experience, and from how their original training orientation presented silence. This *evolution* was in synergy with how they perceived psychotherapy was being practised in America. Chicago-based theorists Heinz Kohut (1913-1981) and Merton Gill (1938-1994) were discussed as having influenced the progression from classic psychoanalytic thinking to a more relational and contemporary way of being-with a client:

> "There has been a huge shift in American psychoanalysis from this extremely reserved person who said something, every once in a while, and most of the verbal stuff was coming from the patient" (Richard, INT3.11).

The mention of Heinz Kohut was frequent in some of the discussions, as Chicago was his home and therefore his influence and practice of self-psychology was perhaps more prevalent than that of other regions.

I reflected on how Carl Rogers (1902-1987) was only mentioned in name by a few participants, especially given that he shared a university with Kohut and how some therapists described their work as being very client-centred:

> "Yeah, that's actually Rogerian client-centred work, that it's my job to learn a language that works for each client" (Harvey, INT3.12).

When considering the *evolution* in theory, it could be described as the process of humanising theory. Regardless of stated modality, the therapists described an *evolution* from theory that was one-person to a much more relationally focused therapy. A cold, manipulative technique seemed out of place in this context.

The therapists echoed the theory by describing a move towards a more humane way of relating, a strong pattern of collaboration surpassing the all-knowing and powerful therapist:

> "That remoteness is a re-enactment I think actually for the therapist of not wanting to connect, of not having capacity to show up interpersonally with humanity and vulnerability. And I want to bring humanity and vulnerability to all things I do" (Harvey INT3.12).

Therapists who were familiar with the technique of excessive intentional silence, often a trait of *traditional abstinence*, viewed it as a manipulative technique and potentially described as cruel and unnecessary. Therapists recounted case studies where analysts may have been encouraged to match the clients' silence with their own, for sessions at a time. The whole efficacy of withholding responsiveness was questioned, and a much more nuanced client-focused response disclosed:

> "I mean, what is possibly the benefit of withholding the love and care, you know?" (Peggy, INT3.14).

Therapists described an evolving awareness that it was more effective and humane to adapt to the needs of the individual client than to stick to a formalised consistent theoretical stance:

> "I think silence should be used whenever possible. It doesn't matter about the theory" (Maria, INT3.6).

Therapists described a personally emerging understanding and appreciation of silence. As consistent with most therapists, they were insightful and reflective of their own journey. Many described an appreciation and understanding of *traditional abstinence* and its motivations even if they no longer practised that way:

> "I think some of my views about silence correspond with this evolution in my, I hope it's an evolution and not a devolution, in my view of how I see myself as a therapeutic agent" (Melanie, INT3.7).

Some therapists voiced concern they may have become too "lax" in their engagement with clients, stating that they wished they could be more silent. They supported this belief by citing details of incidents where they would have used silence differently.

Interestingly for therapists who had confidently evolved from *traditional abstinence*, there was a concern that at times something may also have been lost in this *evolution*. Several therapists commenced their interviews "confessing" how they "should" be using silence more:

> "So, in my efforts to become more interactive and more relative, I think I've swung too far" (Peggy, INT3.14).

Upon reflection, therapists were able to elaborate on how their relationship with silence had evolved in subtle and nuanced ways:

> "It feels very different to practise the way I do, even if in terms of some of the silences they would look exactly the same, but I feel as though I have much more discretion about how I use silence now" (Melanie, INT3.7).

There was little or no recall of the use of silence being formally taught in their core trainings. It was described as being more implicit. For those who have an experience where silence was explicitly explored, they described transitioning training, as a moving away from those original concepts and traditional abstinence:

> "They would use words like therapeutic silence and I really didn't ever use it as a specific technique in the sense that I wouldn't be purposely silent, thinking that the silence itself is going to be necessarily the best way to handle a certain issue" (John, INT3.4).

Some, despite retaining the title psychoanalytic or psychodynamic practitioner, had rejected the properties of *transitional abstinence* altogether:

> "I questioned a lot of the assumptions of psychodynamic theory and practice and with that, you know, such as for example, neutrality, I don't believe that is a possibility anymore, and with neutrality comes the idea of sort of being the blank screen, which I don't believe in any more" (Peggy, INT3.14).

The core psychoanalytic concept of analytic neutrality was also deemed a fallacy by many therapists who now identified with a more relational and or integrative way of working. Again, there was the sense that there had been a one-person psychology that had evolved into two-person:

> "I think the general idea that silence is not neutrality, that in an absence of a response is a response" (Sol, INT3.18).

Therapists described a learning that was borne out of practically experiencing, which included reflection and insights. They often cited their own 'mistakes', observing the impact they were having over clients and learning from them, some even going as far as to say that withholding was damaging to the client. This process, as with much that has therapeutic depth, is forged in hindsight:

> "I think in the earlier part of my career patients would have accused me of being withholding and I don't think I had enough awareness at that point to realise in fact that's what I was doing. And I rationalised it under the heading of I'm trying to do as I was taught, but I think in retrospect that you know, it was a withholding and not helpful. It was not helpful to most of the patients I think about" (Sol, INT3.18).

residue abstinence [sub-category]

The study found that there was a development in the therapist's use of silence away from a more formal and traditional abstinence, to the silence associated with *intersubjective–silence.* However, this is an ongoing development, moment by moment, session by session. As *evolving disparity* denotes, this is a shifting process.

They described an ongoing tension for the therapist, and a necessity to be vigilant, of slipping into a more withholding or absent silence: absencing.

They implied the motivation for absencing, sometimes not consciously, as a potential defence, or simply less than skilful practice. There was also potential to fall back into role-playing, or a way of being-a-therapist, that deflects back onto the client:

> "You can never completely drop abstinence and like, there's always a part of the therapist that is playing that game and that needs to be examined as well. So, it's a remnant of a patriarchal strain in psychoanalysis that, you know, I still catch residue and remnants of it in my own work, and my clients will point it out to me and I'll be like yeah, that's really shitty, you know" (Neil, INT3.9).

> "Well, there is some kind of asymmetry and some kind of abstinence. I think it's a different kind of abstinence than the traditional orthodox one, but you don't have licence just to be thoughtless." (Peggy, INT3.14).

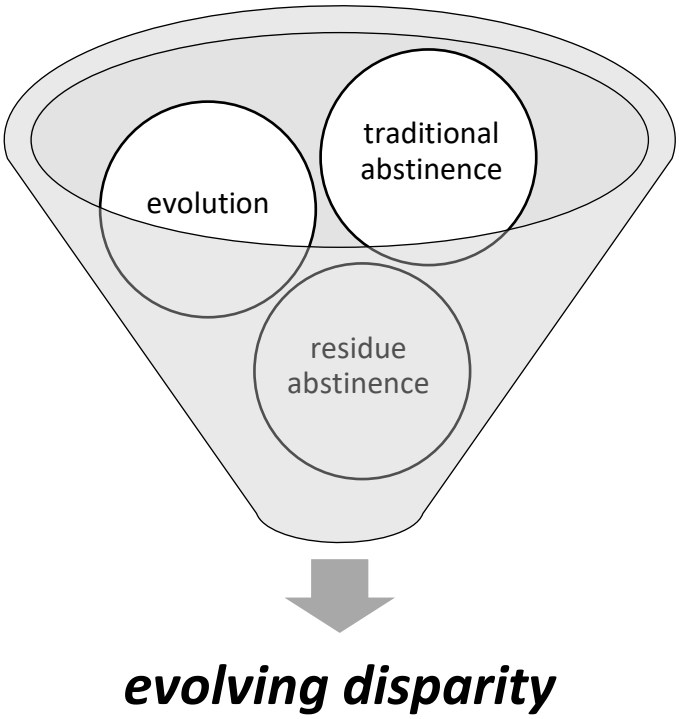
> "I might or might not speak to that aspect of their feeling, not just waiting for them to drown, as it were, in the silence which can become absence" (Ezra, INT3.16).

Some therapists did discuss techniquing; specific times when they would use silence more overtly as a technique. The way of working described always retaining a focus on potentially what the client needed on order to feel safe and comfortable and it was tailored to their individual therapeutic needs, in the moment.

This tension is bridged by *evolution*, the sense that the therapist's understanding of silence continues to evolve between *traditional* and *residue abstinence*. There remains the process of ongoing *evolving disparity*, as a condition for *intersubjective–silence.* See Figure 10, for *evolving disparity* and its sub-categories.

Figure 10

evolving disparity – (pre)condition



8.2.2 minding the gap [pre-condition]

The third condition that was identified as existing when *intersubjective–silence* is present is the therapist's actual intentional silence. The active process of the therapist's use of silence is conceptualised as *minding the gap*. Table 18 shows *minding the gap* and its associated properties.

Table 18

minding the gap – (pre)condition

CONDITION	PROPERTIES
minding the gap	free associating holding back

The psychoanalytic concept of free association was raised and discussed by the therapists. However, free associating in this context refers to an open space where the client and therapist create room – *intersubjective–silence* – to allow thoughts and feelings to freely arise. Unlike the free association that may be linked to *traditional abstinence,* it is not a forced or manipulative technique but rather a co-created space – a silence that allows whatever to come up. There was a sense of both therapist and client mutually free associating and of a shared space in the wider context of the space of the room itself, and open space:

> "wanting them to say what comes into their mind" (Freda, INT3.1).

> "So, to me, if you allow silence you kind of open space, like the whole room is the silence" (Alison, INT3.2).

> "So, I consider that letting myself just think and feel what comes up naturally – which is free association in some ways, right" (Jill, INT3.13).

Therapists reported *minding the gap* as an active process to create a silence and space where there is more freedom for the client and therapist. They described using phrases like "sitting back", "not filling", "not jumping in", "waiting to allow material to arise" – holding back. This was often against their internal pressures to respond or naturally jumping in and filling the gap with chatter or simply interrupting the client. This active process of creating silence is arguably what demarcates a therapeutic encounter from what has been described as a normal conversation. It denotes the complexity for the therapist when attempting to have a natural and authentic communication whilst offering the client the necessary therapeutic space.

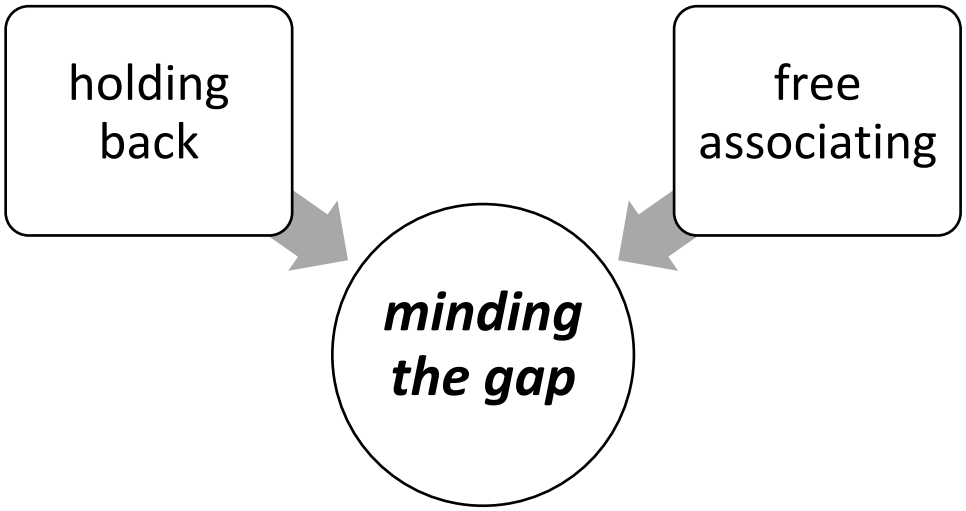
Therapists also described times when they were not able to sustain *minding the gap* and regretted jumping in, sometimes because of defensiveness, others from a simple lack of discipline. Figure 11 shows minding the gap and its properties.

> "I had an impulse to jump in and decided to let the silence be" (Alison, INT3.2).

> "I'm holding back a little bit before sharing those hypotheses to see if the patient will themselves come up with what they were thinking or what might be going on" (David, INT3.5).

Figure 11

minding the gap and sub-categories



8.2.3 rendering relationship [pre-condition]

The importance of the therapeutic relationship was discussed throughout the study. Many therapists described themselves as integrative even if that is not how they were initially trained or had commenced their practice. The sub-category of *rendering relationship* is *alliancing*, and refers to the specific aspect of the relationship connected with the therapist's use of silence. Table 19 shows *rendering relationship's* sub-categories and codes.

Table 19

rendering relationship – (pre)condition

SUB-CATEGORY	CODES
alliancing	authenticity caring collaborating safely trusting

alliancing [sub-category]

Therapists who did value the use of silence were vocal in the need for *alliancing* to be present before doing so. The sub-category captures the active process of *rendering relationship* in any given moment and it is this *alliancing* from which silence can safely occur:

> "I think of my primary task as creating alliance and so, for people who are either new to the process or really uncomfortable with any kind of silence are more likely to jump in and make some kind of bridge" (Melanie, INT3.7).

In keeping with the (pre)condition of *evolving disparity* there was a sense of an *evolution* in the therapeutic relationship; a sense that therapists were more inclined to be authentic, natural, and responsive, as opposed to neutral and withholding. Many therapists described this authenticity as an important catalyst for therapeutic change. It was the demonstration of authenticity and caring that supported putting people at ease:

> "...a mechanism of therapeutic action is the actual real relationship but you're also thinking about it all psychodynamically and trying to understand it" (INT3.14).

Whereas in *traditional abstinence* the caring may have been implicit in the treatment, in *alliancing*, caring is very much made explicit by many of the therapists. It was felt that clients needed to know that they were in a caring relationship before it was therapeutic to use silence. Again, this was expressed as important equally by integrative and psychoanalytic practitioners:

> "I put so much emphasis on the relationship and on the patient knowing that I care" (Clive, INT3.19).

The central quality of therapeutic relationship described by therapists was collaborating. What was now occurring between therapist and client was described as a "two person-psychology", "interactive", "relational", "collaborative", "co-participatory experience". Whether the client experienced it as that remains undetermined, but it was certainly a view of practice that was consistent with *evolving disparity*:

> "I think there's some silences that come out of let's see what rises to the surface and it's a caring, compassionate, productive silence about working together and being in sync" (Kerry, INT3.3).

> "…that willingness to kind of be an explorer with them, I think we really build a relationship together" (Betty, INT3.10).

Therapists made many associations with the need for safely trusting as a key aspect of *alliancing*. There was a sense of the mutuality of safely trusting as client and therapist worked together and the relationship developed. Safely trusting was viewed as an essential quality of *alliancing* and therefore a condition for *intersubjective–silence*:

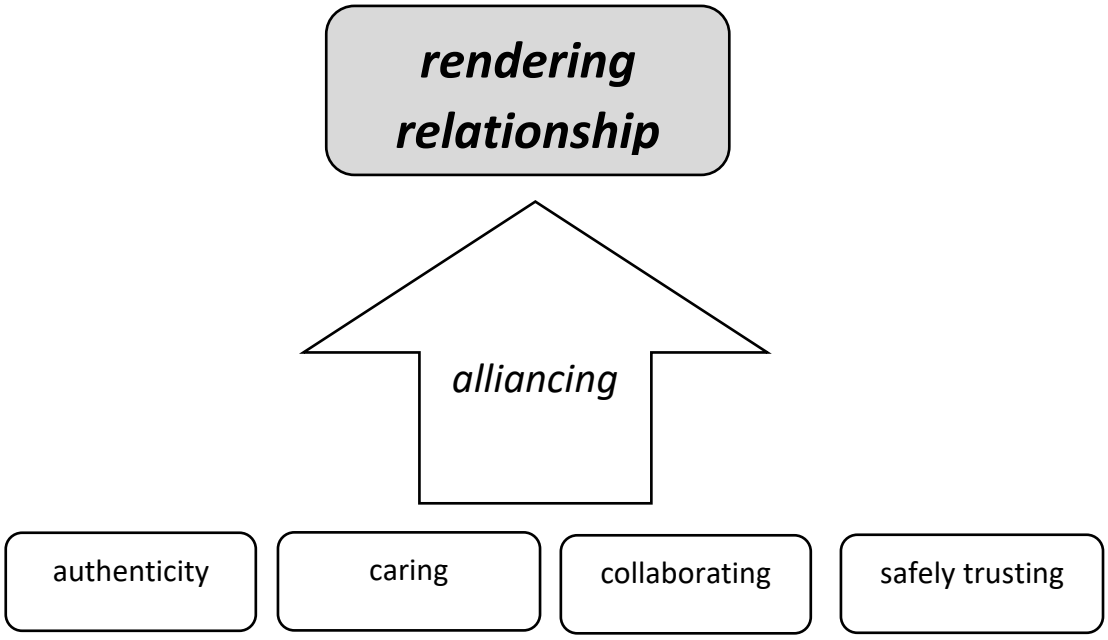
> "...we build trust and safety first" (Harvey, INT3.12).

> "Well, so the first thing is the alliance and creating the sense of safety" (Peggy, INT3.14).

Figure 12 shows the condition *rendering relationship,* the sub-category *alliancing,* and its properties.

Figure 12

rendering relationship and sub-categories



8.2.4 Summary of (Pre)Conditions

In this section I have discussed three (pre)conditions that the therapists identified as being necessary for *intersubjective–silence* to be present. *Evolving disparity* is the ongoing process of moving away from the use of silence that is identified with *traditional abstinence*, a more formal and one-sided technique. There is an ongoing evolution in therapists' experience and disparity from how they were initially trained and/or practised. There remains, however a tension between a more open and flexible use of silence that focuses on the therapeutic needs of the client, and a *residue abstinence,* which can be perceived as absence or withholding.

The active practice process, *minding the gap,* captures the therapist's resisting, of the natural desire to fill the gap with chatter. Finally, therapists prized the necessity of *rendering relationship* with the client before the use of silence. A strong sense of *alliancing* was necessary before it was deemed appropriate or safe to use intentional silence associated with *intersubjective–silence.*

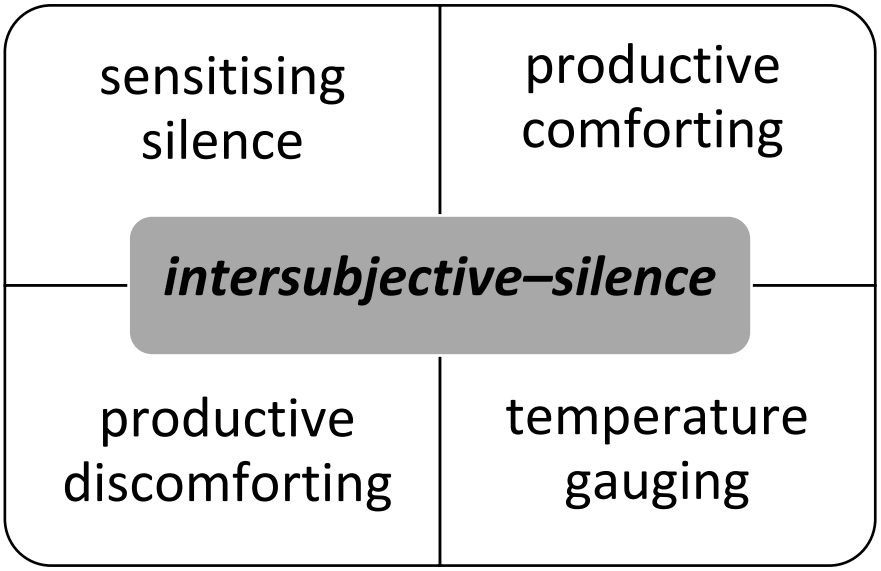
In the next section I will discuss the four cornerstones of *intersubjective–silence*.

8.3 Cornerstones

The therapists' core concern when using intentional silence was how to ensure that it is effective or therapeutic – *intersubjective–silence.* In what could be considered the very heart of the grounded theory, this section will outline the four cornerstones of *intersubjective–silence*. It will endeavour to capture, construct, and conceptualise what the therapist is doing in context, moment by moment to ensure *intersubjective–silence.* Figure 13 shows the four cornerstones of *intersubjective–silence.*

Figure 13

Four cornerstones



Within this study the four cornerstones of *intersubjective–silence* are: *sensitising silence, productive-comforting, productive-discomforting,* and *temperature gauging*. Table 20 shows the four cornerstones and sub-categories.

Table 20

four cornerstones of intersubjective-silence and subcategories

CORNERSTONE	SUBCATEGORY
sensitising silence	increasing tolerance intentionally modulating optimal specificity traumatising
productive-comforting	influencing therapist co-creating comfort
productive-discomforting	co-creating positive-discomfort
temperature gauging	intuiting soft signalling verbalising

I will now present each of the cornerstones in more detail.

8.3.1 sensitising silence [cornerstone]

The balancing of silence, how much and how often, was of significant concern for the therapists. The ability to do so is the first cornerstone of *intersubjective–silence.* Therapists resolved the issue of balancing by *sensitising silence* to the specific needs of the client.

They described intentionally modulating the amount of silence which was influenced by what they believed, both they and the client could tolerate. There was often an intention to work towards increasing tolerance by extending the use and or length of silence over time:

> "I think again there's a balance of how much to talk, how much to allow the silence to happen" (David, INT3.5).

Figure 14 shows the cornerstone *sensitising silence* and its sub-categories. Table 21 shows the sub-categories and codes.

Figure 14

sensitising silence – cornerstone

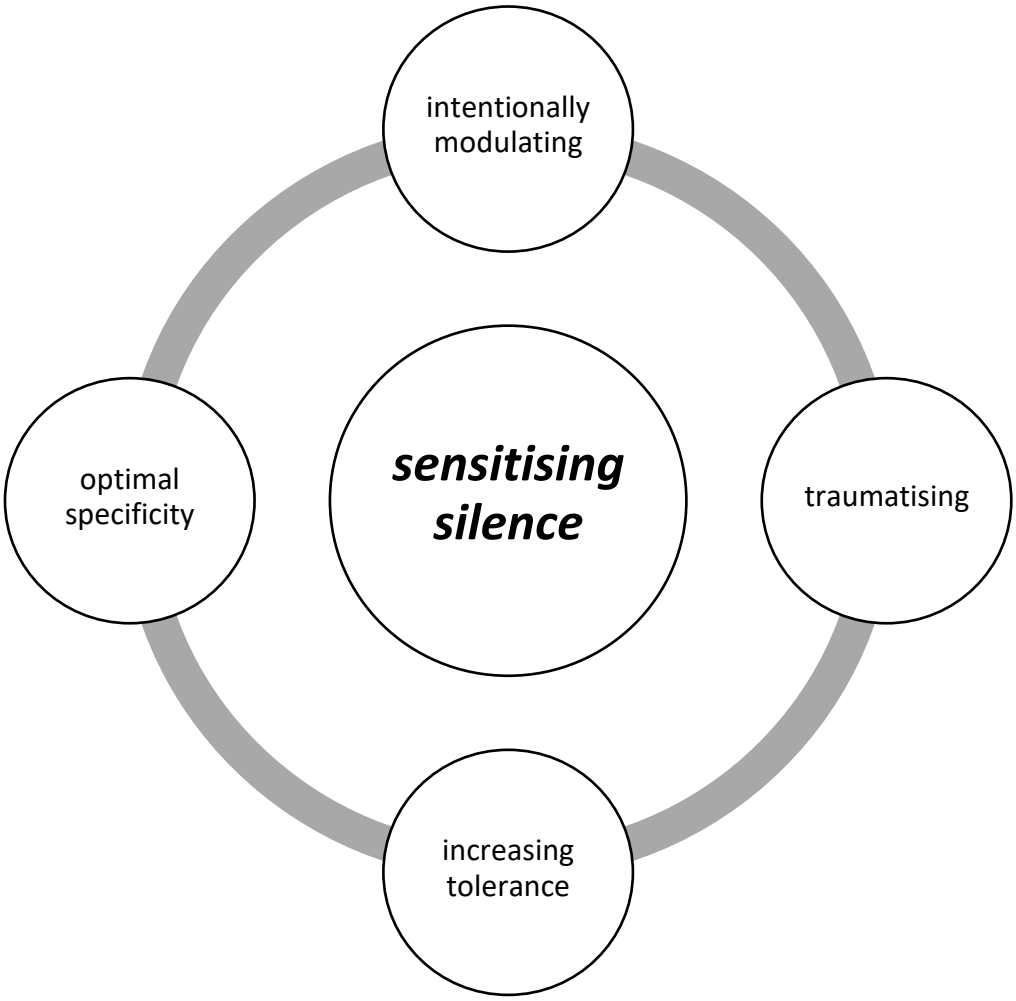


Table 21

sensitising silence – cornerstone

SUB-CATEGORIES	CODES
optimal specificity	adapting depending responsiveness
intentionally modulating	balancing avoiding discomfort comforting
increasing tolerance	higher tolerance lower tolerance tolerating therapist
traumatising	sensitivities to silence unhelpful silence useful silence

optimal specificity [sub-category]

The process of adapting the use of silence to the needs of the client in a specific time and context was a significant pattern throughout the data. The prevalence of this pattern contributed to the focus of the study moving away from how and why silence is used, to the principal concern of the therapist, namely what makes its use effective – *intersubjective–silence.*

Therapists described a process of adaptation – adapting depending on the needs of the client, in the moment. It was found that many therapists prioritised the client needs over any theory or assumptions about specific client groups. Previous studies have made blanket claims about certain client groups and how they relate to silence (Hill et al., 2003; Ladany et al., 2004). This claim is refuted by this category, for this data set. This is a significant grounded hypothesis, arguing that one's capacity to sensitise to the specific needs of the individual client is more important than any preconceived ideas about a client group or theoretical presuppositions around silence.

The power of this concept is demonstrated when considering specific client designations, for example a traumatised client or one diagnosed or labelled schizophrenic. Therapists stated an awareness of the importance to be additionally mindful when using silence but stated that the use of silence was both helpful and unhelpful at different times with the same client grouping. When considering the use of silence, the importance of the (pre)conditions of *evolving disparity* and *rendering relationship* being present, took precedence over any stated rule:

> "I've had schizophrenic clients who were doing quite well with their medications, were very, very insightful and did benefit from that so I guess it just depends on their level" (Maria, INT3.6).

Several therapists discussed the self-psychology concept of optimal responsiveness, the process of the therapist actively responding to the needs of the client as being most therapeutically expedient, in contrast to abstinence or withholding. The adapting of intentional silence to the particular needs of the individual client was conceptualised as *optimal specificity*:

> "It's not that I've become more silent, I've been more comfortable with whatever the person kind of needs" (John, INT3.4).

> "It depends on the person, it depends on the dyad, it depends on the relationship, it depends on what the person needs either in that phase in their life or in that moment in the therapy" (Betty, INT3.10).

> "It's also really dependant on the patient, you know. There are patients who need you to be silent" (Betty, INT3.10).

intentionally modulating [sub-category]

The therapists stated that *sensitising silence* involved them *intentionally modulating* the amount of silence used with the client. They were very much concerned with balancing the most effective amount of silence. This was seen as a complex and multifaceted process:

> "I'm always sort of balancing the issue of silence and how much silence to let go on with" (David, INT3.5).

> "I think again there's a balance of how much to talk, how much to allow the silence to happen" (David, INT3.5).

The therapists universally stated a key motivation for *intentionally modulating* was to ensure that the client was comfortable - comforting. The desire to avoid uncomfortable silence, and discomfort, both in themselves and client was disclosed candidly throughout the study – avoiding discomfort. There was a notable emphasis on ensuring that the client remained comfortable by limiting the silence and therefore discomfort. Therapists were expressive in how they often avoided discomfort, for them and the client, and were quick to comfort when they felt the client needed it most.

The appreciation and tolerance of discomfort seemed to have a tentative correlation with an active participation in intentional silence:

> "I also try to modulate their discomfort, so I don't let them get super uncomfortable" (Alison, INT3.2).

Therapists described clients with whom they may use silence more, using terms such as "resilient", "emotionally regulated", and "self-reflective".

There were many vignettes offered by the therapists when they described, with the benefit of hindsight, a desire to have used more silence. Some described the propensity to make the client comfortable to the point of gratification, others described moments when they were "too supportive" and "not as disciplined" as they would have liked:

> "I can think of times when I try to say too much in those spaces" (Jenny, INT3.15).

There was a connection between the therapists' capacity and willingness to sit with angry clients and their use of silence. Often the therapist's silence can exacerbate the client's anger, therefore to sit with it would be experienced as decidedly uncomfortable.

Intentionally modulating represents the very definition of delicate skill balancing because therapists also recognise that it may not be therapeutic if a client gets overly comfortable. The issue of retention was raised by the therapists and the implicit tension associated with not creating a space so comfortable that no real therapeutic work is being done:

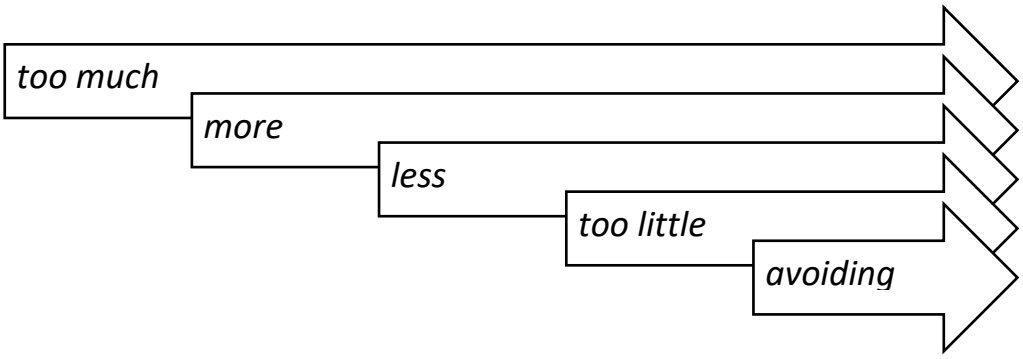
> "If they're too comfortable they're not doing anything, but if they leave, they're definitely not doing anything" (Peggy, INT3.14).

Whilst the study did not show that therapists avoid using silence with specific client types, it did indicate that there were certain situations when they would be avoiding or limiting its use. Some therapists termed this as when the client was "dissociating" while others used the less jargonistic term "spacing out". It was during these states that the therapist thought it best to "bring them back" or "not sit with that silence for so long".

Figure 15 shows they would modulate silence on a scale ranging from being aware of using too much silence to avoiding its use altogether.

Figure 15

Modulating silence



increasing tolerance [sub-category]

Therapists disclosed how they were aware of *sensitising silence* around how much silence could be tolerated. It was not a binary position of being able to tolerate silence or not, but rather an awareness of how much silence could be tolerated in any given moment by client *and* therapist. If not possible in the present session it was believed that tolerance of silence could be something to be worked towards:

> "He doesn't have quite the same tolerance for it just yet" (Ezra, INT3.16).

The capacity to tolerate some periods of silence was viewed positively by the therapists and seen by some as an indication of their (client and therapist) development and progress:

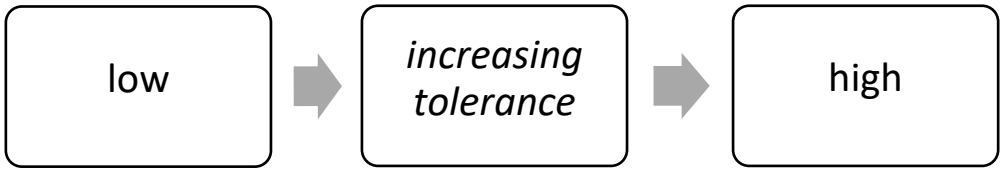
> "And so, it's important to practice tolerating a little bit of silence so that we start to make space" (Harvey, INT3.12).

> "I think that if a person who can tolerate silence is less anxious, able to be more self-reflective. I think it is a marker of a somewhat more integrated, healthier person" (Peggy, INT3.14).

The therapists who valued the use of silence and had sufficient experience in its use were also aware of the value in *increasing tolerance*. They described the active process of increasing the amount of silence, over time, from low to high, see Figure 16.

Figure 16

Increasing tolerance



It appears that *increasing tolerance* was achieved, when the conditions were in place, by a gradual exposure by both parties to silence. Some client education on the efficacy and potential benefits of silence was achieved through ongoing discussion and explanation:

> "I might say to them it's okay to be a little uncomfortable, this is a new place. See what happens if you just take a breath into that" (Jenny, INT3.15).

Therapists were also aware and vocal throughout the study about their own capacity to tolerate silence:

> "I have to sometimes sit with my discomfort at being silent and to look at that and to allow the discomfort to be and to allow it like exposure just to gradually dissipate" (David, INT3.5).

traumatising [sub-category]

The preponderance of references to trauma and silence in the study ensured that it retained a category of its own. Silence and trauma were discussed by many therapists offering a range of contexts and considerations. There was a consistent acknowledgement that they were aware that clients who had experienced trauma were more likely to have sensitivities to silence.

Therapists discussed *sensitising silence* by being cognisant of clients who had experienced trauma and through this awareness and action avoided *traumatising* them further:

> "I work with a lot of trauma clients for some of whom that silence is really challenging" (Harvey, INT3.12).

The ambiguous nature of silence can be particularly frightening for people who have strong memories of historic trauma. The importance of the consideration of *timing* (see Section 8.5.1) is highlighted sharply when considering silence and trauma:

> "Silence is something that when we get to that point in a therapy it can be sort of calming and soothing and reassuring and relationship-building, whereas early on, silence is something that makes people really anxious, particularly people who have experienced trauma because they don't know what's going on and when you don't know what's going on it's scary and it may be life-threatening" (Kerry, INT3.3).

I reflected on how striking it was that silence was deemed *both* unhelpful silence for some clients and useful silence for others, both individually and within time and context, reiterating the concept of *optimal specificity*:

> "not speaking could be facilitated, but it could also be traumatic" (Richard, INT3.11)

> "Silence is helpful because people need the time to get past the automatic shuttered door that they've been living with and allow themselves time to open that door and just take a quick look and see whether or not they can articulate that and maybe go further. And so, there is a fair enough use of silence in that process in an ongoing way" (Melanie, INT3.7).

8.3.2 productive comforting [cornerstone]

There was a consistent pattern in the data to indicate that a level of comfort was necessary for the therapist and client in order for *intersubjective–silence* to occur. Productive comforting has two major sub-categories, see Table 22.

Table 22

productive-comforting – cornerstone

SUB-CATEGORIES	CODES
influencing therapist	experience and confidence meditation and mindfulness positively viewing professional influencing
co-creating comfort	holding insight not pushing rapport welcoming silence

influencing therapist [sub-category]

For *productive comforting* to be present, both the therapist and the client need to have a capacity for being comfortable in silence. There were core factors described that would influence the therapist's capacity or desire to employ intentional silence.

The condition of *evolving disparity* is discussed in Section 8.2.1, where I described the shift from a relatively formal technique into a more fluid use of silence predicated by the needs of the individual client.

The most significant factors associated with the sub-category *influencing therapist* were simply experience and confidence in their use of silence gained over the course of their clinical career.

They stated becoming more comfortable with the client's silence, more able to sit with what was happening for the client, becoming less inclined to feel the need that they had to be doing "something":

> "I think the more confident I have become as a therapist the more able I'm able to tolerate silence, appreciate it and use it" (Kerry, INT3.3).

> "In the past if there was silence I would become anxious and afraid that I wasn't doing my job and that I had to fill in the space with something that would indicate that I'm a good therapist" (Kerry, INT3.3).

> "I think basically though a lot of my use of silence and my comfort with it just has come out of simply practicing for as long as I have and for also continuing in my education" (Melanie, INT3.7).

The relationship between silence, meditation and mindfulness was raised by many therapists. In the context of the study, mindfulness was clarified by the therapists as the action of sustaining awareness of one object, feeling, emotion, task, or environment in the present moment. Participants often viewed meditation as the method of resetting the body and mind in a relaxed silence whilst bringing attention to the breath.

Therapists who were familiar with these practices were on a spectrum of engagement from having taken a course or regular practice, through to periods on meditation retreats. They stated a personal relationship with meditation and mindfulness that sustained their own capacity for silence and being-with the client, and a deeper appreciation of silence within the session. Many therapists shared an experience of silent mediation practice that they believed supported and enhanced their work as a therapist:

> "I'm a 15-year meditator and deep into a mindfulness practice that kind of privileges saying less, saying less is saying a lot more" (Neil, INT3.9).

The positive personal view or positively viewing of the use of silence had a notable influence on the therapists' use of silence in the clinical setting. For some therapists, early childhood experiences strongly influenced their personal view of silence. Therapists stated a causal link between their experiences in childhood and the way that they practised. However, a negative experience in childhood did not always result in a negative view of silence in practice.

Some therapists voiced a negative experience of silence with a parent, and this meant they avoided repeating the experience in the clinical setting. Others were conscious that their negative experience of silence in childhood had resulted in them being highly unlikely to use intentional silence in session.

Several therapists were deeply affected by their childhood experiences and this was mirrored by how vocal they were about how uncomfortable silence was for clients. I became excited at the prospect of this finding, but it was not repeated throughout the study.

I reflected how, when remaining true to the grounded theory method, it is not enough for the incidents to be of interest to the researcher but rather concepts need to earn their way into the data by being of interest to the participants. For *productive comforting* to occur, generally the personal view of the use of silence needed to be positive – positively viewing.

Therapists highlighted how there were professionally influencing factors that contributed to their viewing the use of silence positively. Except for a few incidents, therapists were unable to recall any significant silence-related training incidents that they retained and that had an influence upon them. Rather, they described more intimate experiences in study and support groups, specific supervisors, personal and training therapists, and various encounters that positively influenced how they used silence.

These were sporadic single incidents and examples within the study which, when compared, alluded to a process that could be described as they have been *caught* by silence as opposed to being *taught*:

> "She didn't talk too much, she talked very little and that had a huge impact on me, I learned so much from her" (Jill, INT3.13).

co-creating comfort [sub-category]

The study found that *productive comforting* requires the therapist and client to engage in the active process of *co-creating comfort*. The therapists stated conditions which they believed needed to be in place for them to use silence comfortably, and which the client would experience as comfortable.

Therapists expressed a desire not to intentionally make the client uncomfortable (positive discomfort will be discussed in the next section). *Productive comforting* like all the categories is seldom static and comes into being moment by moment:

> "That's why I don't want the client to think I have abandoned them by not speaking. I have to make sure that they're in a place that they're going to experience this silence as a blessing and as a comfort and as a space to be comfortable" (Freda, INT3.1).

Therapists appeared very cognisant of what the client needed for silence to be deemed comfortable. They discussed the need for the client to have a sense of holding – being "held" or feeling "contained" as important factors in their comfort. The sense was conveyed that this was a mutual experience: the therapist had to feel that they could hold the client and their material, and the client needed to experience that holding – *co-creating comfort*:

> "If you actually look at mothers and their infants, a lot of that time was spent in silence, in holding, in glances, in feeling, in touch" (Jill, INT3.12).

Without the client having some degree of personal insight and experience into the use of silence in session, therapists stated that they would be less inclined to use silence. Psychoanalysts uniformly stated that they would explain the use of silence for clients who lacked experience of the psychotherapeutic process. I reflected how this was in stark contrast to my understanding and experience of the British School, where it is normal for the analyst to jump right into working in silence and waiting for the client to speak:

> "If it is a client who seems to have no insight and sees silence as just as nothing is happening, and doesn't go beyond that, and is frustrated that nothing's happening, I might not allow as much silence" (David, INT3.5).

For the client to be comfortable, therapists implied that it was important that they were not pushing them beyond what they were comfortable talking about:

> "…that's one way of using silence, not pushing them when they don't necessarily want to talk but allowing them to make the first move, allowing them to realise they have some control in this particular situation that they're in" (Maria, INT3.6).

Therapists discussed the need for a rapport to be in place before they would be comfortable using silence. Rapport denoted a deeper mutual understanding beyond *alliancing*, indicating a sense of the pace in the co-created communication having been understood and assimilated:

> "I need to put them at ease, get to know them, have them get to know me, establish a rapport before I just clam up because then they don't know why I'm being quiet" (Freda, INT3.1).

The ambiguous nature of silence has been discussed throughout the study. The type of silence that the therapist needed to create in order for the client to feel comfortable was a welcoming silence.

The importance of *safely trusting* was discussed when considering the condition of *rendering relationship*. Therapists put great emphasis on the importance for building trust and a sense of safety in the relationship as part of alliancing.

When considering *welcoming silence*, safety and trust are essential components and have obvious overlaps with *rendering relationship.*

Welcoming silence goes beyond the properties of alliancing and relates to what therapists describe as the overall "atmosphere" or "environment" that needed to be provided for the client to feel comfortable with their silence. They felt the client needed a sense of their non-judgemental attitude, that they would be valued and held regardless of how difficult the material may be to witness. A silence that conveys a non-judgemental, safe space where the client could trust that the therapist could and would hold and witness their material:

> "I make them feel comfortable with me, safe with me to give them the courage to open up and dive into this real uncomfortable kind of material" (Kerry, INT3.3).

> "Thinking carefully about what creates a very safe, welcoming environment for whatever thoughts and sometimes horrific things people have to say" (Melanie, INT3.7).

> "They are able to see things about themselves that they might not see otherwise if they didn't have that atmosphere of comfort and security" (Clive, INT3.19).

8.3.3 productive discomforting [cornerstone]

The category of co-creating discomfort was generated throughout during data analysis, but is not included as a unique category in the final grounded theory of *intersubjective–silence.* Its presence as a category from which constant comparisons could be made was essential in the construction of the theory.

The properties of *co-creating discomfort* were framed as a negative mirror of the properties of co-created comfort.

See Table 23 for a comparison of their properties. (The therapists' discomfort was also coded and negatively mirrored many of the codes in *therapist comfort*.)

Table 23

Comparing co-creating discomfort vs. co-creating comfort

CO-CREATING DISCOMFORT	**CO-CREATING COMFORT**
abandoning	holding
anxiety	insight
iatrogenic	not pushing
dissociating	rapport
persecutory silence	welcoming silence

When commencing the study, I had the presupposition that some therapists would intentionally employ silence to create discomfort in the client, believing that it would generate a negative transference with therapeutic benefit. This way of practising and the category of *co-creating discomfort* is associated with *traditional abstinence*. The concept and associated codes appear frequently but are related to the participant discussing how they used to, or would not want to practice.

The study is proposing that this is not how the participants think about or use silence today in their practice. During the field research the therapists stated that they did not want to intentionally make the client uncomfortable or cause discomfort through their use of silence. Many stated however, that they retained a belief that there was benefit at times, from sitting with some discomfort – *productive discomforting.* When considering *co-creating discomfort* the data offers a clear distinction between a wilful use of silence to create discomfort and a more gentle and aware intention of sitting with some discomfort in the belief that it can be therapeutically appropriate. It is for this reason that *co-creating discomfort* is not included in the final theory *intersubjective–silence.*

The category of co-creating discomfort was seen therefore as quite distinct from co-creating positive discomfort.

co-creating positive-discomfort [sub-category]

There was a pervasive view by the therapists that they would not intentionally use silence to make a client feel uncomfortable, as a technique or as a method, per se. As part of *evolving disparity*, people recognised that they have moved away, in theory and practice, from this more one-person form of silence:

> "I think there was a certain hostility to the silence I was trained in, even though I mean the ultimate goal is therapeutic, and I get that" (Melanie, INT3.7).

The category of *productive discomforting* has one sub-category, shown in Table 24 with its associated codes.

Table 24

productive discomforting – cornerstone

SUB-CATEGORY	CODES
co-creating positive-discomfort	collaborating leaning-in positively emerging

There was an appreciation by many therapists that when the supportive conditions are in place, such as a strong sense of collaborating and comfort, then some discomfort could be experienced and tolerated by the therapists and client (co-created) with a positive outcome.

Therapists described the act of leaning-in to the discomfort together with the client. It was at times *their own discomfort* that they had to sit with:

> "I've had quite a few clients say, "This is uncomfortable" and I just kind of raise an eyebrow and see what happens next" (Neil, INT3.9).

> "What's the level of discomfort? Because sometimes it's really productive" (Alison, INT3.2).

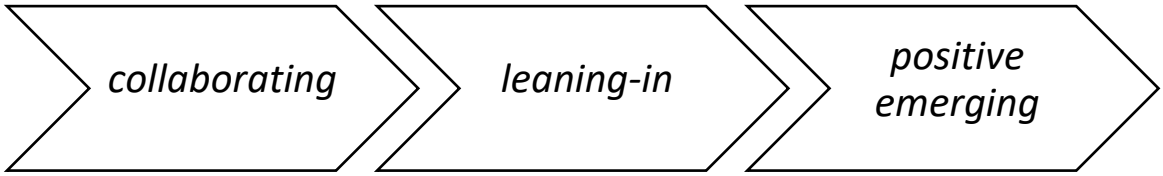
There was a sense that this leaning-in could lead to something positively emerging, a deepening of understanding for the client and therapist. Figure 17 shows the three codes of co-creating positive discomfort:

"I think there's a point where you want someone to be, it's okay for them to be a little uncomfortable, right, that's kind of growing edge" (Jenny, INT3.15).

"Deliberate silence that feels sort of provocative on the one hand and intentionally therapeutic on the other hand." (Kerry, INT3.3)

Figure 17

Co-creating positive-discomfort



Co-creating positive-discomfort could be described as a highly evolved therapeutic process and is heavily dependent on the capacity for the therapist to understand what is happening in the room, conceptualised in this theory as *temperature gauging*.

I will now discuss this last cornerstone.

8.3.4 temperature gauging [cornerstone]

The capacity of the therapist to gauge the temperature of the room is in many ways the pulse of *sensitising silence*, balancing between *productive-comforting* and *productive-discomforting*. Figure 18 shows the cornerstone *temperature gauging* and its properties:

"…so dependent on both partners in the therapeutic endeavour, so responsive, and requiring the reading of the non-verbal temperature in the room" (Ezra, INT3.16).

"...you've got to read the situation carefully" (Betty, INT3.10).

verbalising [sub-category]

There are three properties of temperature gauging shown in Figure 18. The most obvious way of gauging is the verbalising of discomfort by the client. This is coupled with the therapist's proactive verbal exploration or checking in with the client to represent the property of verbalising:

> "There are all kinds of silence and there is silence that needs to be intervened with and there are silences that have their own sort of creative thing going on. A person will let you know" (Frankie, INT3.17).

soft signalling [sub-category]

The more subtle aspect of *temperature gauging* is *soft signalling*. Therapists described a range of phenomenon that appears to require a sophisticated level of accurate interpretation. This includes fine motor expression, countenance, body language and tonality:

> "I can tell by what I've asked him and the look on his face that he really needs some time to think about this" (Freda, INT3.1).

> "And I wait until they look, unless they look uncomfortable" (Jill, INT3.13).

intuiting [sub-category]

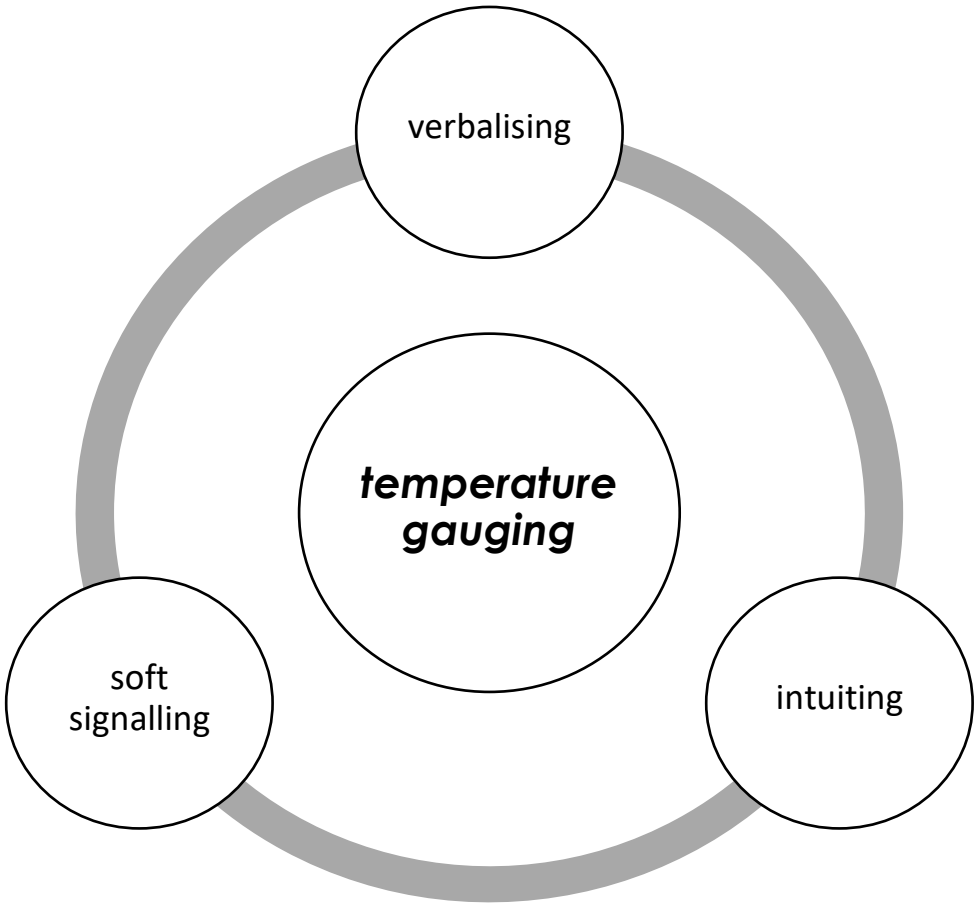
When pressed for more detail to understand this process, the therapist often stated that the *temperature gauging* was done intuitively, supported by clinical experience and a strong therapeutic alliance:

"so much of this is kind of intuitive or you're just moment to moment kind of sensing what's needed, to kind of stop and articulate it" (Jenny, INT3.15).

"A lot of it's intuitive you know, it was just trying to be alert" (Sol, INT3.18).

Figure 18

Sub-category temperature gauging and properties



8.3.5 Summary of Cornerstones

In this section I have discussed in detail the four cornerstones of *intersubjective–silence.* The significant concern of the therapist as to how much silence to use was resolved through *sensitising silence*. Therapists were very mindful of how powerful and ambiguous silence can be, and how it retains the potential to cause discomfort. They described *intentionally modulating* the amount of silence used with each individual client often avoiding uncomfortable silences.

The priority for the therapist was the specific needs of the individual client moment to moment. *Optimal specificity* was seen as more therapeutically beneficial than holding fast to any one theory or uniform way of working.

Optimal specificity and *intentionally modulating* supported the therapists' *productive comforting*. For some therapists they valued the therapeutic benefit of *positive discomforting*.

The capacity for the client to tolerate silence was a core consideration when using silence. Therapists who were aware of this dynamic stated that they actively worked toward *increasing tolerance*, in themselves as well as clients.

Through the process of *temperature gauging,* they were able to remain aware of the client's comfort levels and *intentionally modulate* the amount of silence. Many therapists saw the capacity to tolerate some silence as positive and working actively *increasing tolerance*.

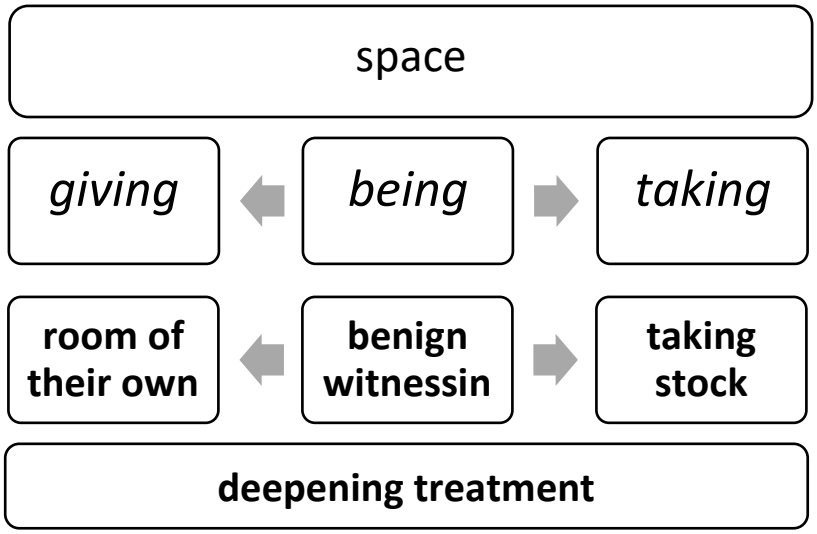
The consequences of these four cornerstones is contained in *deepening the treatment*. The next chapter will discuss this consequence in more detail.

8.4 Consequences

The constructivist grounded theory study proposes that the consequences of the effective use of silence – *intersubjective–silence* – is *deepening the treatment*. *Intersubjective–silence* creates space where therapeutic work can potentially occur; a space that has qualities of activity and not negation, absence or withholding. This space can be further delineated into space giving, space being, and space taking, conceptualised as *room of their own*, *benign witnessing*, and *taking stock*, See Figure 19.

Figure 19

Space in relation to the consequence deepening the treatment



8.4.1 deepening treatment [consequence]

The main consequence of *intersubjective–silence* is *deepening the treatment*. The concept of treatment can be viewed as imbued with strong connotations of medical treatment. However, in the context of this study it is used as R.D. Laing (1927-1989) framed it, “treatment is how we choose to treat people”.

It implies a deeper way of communicating, listening and being-with the client. It requires space mediated by silence in order to achieve this. Table 25 shows the sub-categories and codes associated with deepening the treatment:

> "Silence can be a very powerful means of deepening the treatment" (Neil, INT3.19).

> "Silence is a very important part of what I think of as the deeper treatments" (Frankie, INT3.17).

> "But then when we sit down, you know, there will be a moment of silence with most clients and I'll engage more kind of deeply in the question of what's on their mind or what are they looking to work on" (Neil, INT3.9).

Table 25

deepening the treatment – consequence

sub-categories	**codes**
room of their own	evoking responsibility client-introspecting
benign witnessing	actively listening attentiveness calming empathy presencing

	validating and respecting
taking stock	therapist-introspecting unknowing observing

room of their own [sub-category]

The therapists discussed, when the (pre)conditions and cornerstones were in place, using silence to offer clients a *room of their own*. There was a belief that the therapists were not there to give the clients all the answers but rather to support them in finding the answers themselves. Giving space – a *room of their own* – offered the client a chance to do this.

By not jumping in and allowing space, the therapist believed that they were evoking responsibility and control within the client, empowering them to find the answers and make the choices that were right for them – an appreciation of the therapeutic benefits of self-efficacy on the part of the client. Therapists saw effective silence – *intersubjective–silence* – as facilitating this process. See Figure 20 for *room of their own* and codes.

> "I don't have to always interject, and I don't have to always have the answer that I'd really rather the client come up with their own thought" (David, INT3.5).

> "…allowing them to realise they have some control in this particular situation that they're in" (Maria, INT3.6).

In addition to evoking responsibility and control, therapists described the space giving for deeper exploration – client-introspecting, an "introspective encounter" (Sol, INT3.18) that runs to the very essence of what therapeutic change is.

This client-introspecting had a general quality of giving the space to support the client going deeper in their own experience in feelings, processing, reflecting, and thinking. Therapists described giving the client enough space so that they were able to express their feelings, and also to experience their feelings as they arose. This was seen as deeply therapeutic:

> "If I see someone welling up with tears, I might wait for a few minutes to allow them to feel and then talk about their tears" (Ester, INT3.8).

Therapists described an awareness of the need for the client to have space for processing material that has arisen. They described emotionally charged material, grief, insight, sadness that needs some space to be exposed and to be witnessed. As a process of building trust, this material needs be handled appropriately. Many therapists described the ability to be-with this material as part of the process before deeper material could arise:

> "…to give space and time for something that's been a little below the surface – or a lot below the surface – time to emerge" (Melanie, INT3.7).

> "The patient feels held and valued by the therapist. They also get into their inner world more in that situation" (Clive, INT3.19).

The space giving of *room of their own* is also, at its most basic level, allowing the client time to simply think and reflect upon what has been discussed and what they are feeling. Many therapists described this as a practice, something in which, through time they could become more proficient. They alluded to the therapy process being about the client being more able to do the work themselves and silence being more comfortably used to achieve this:

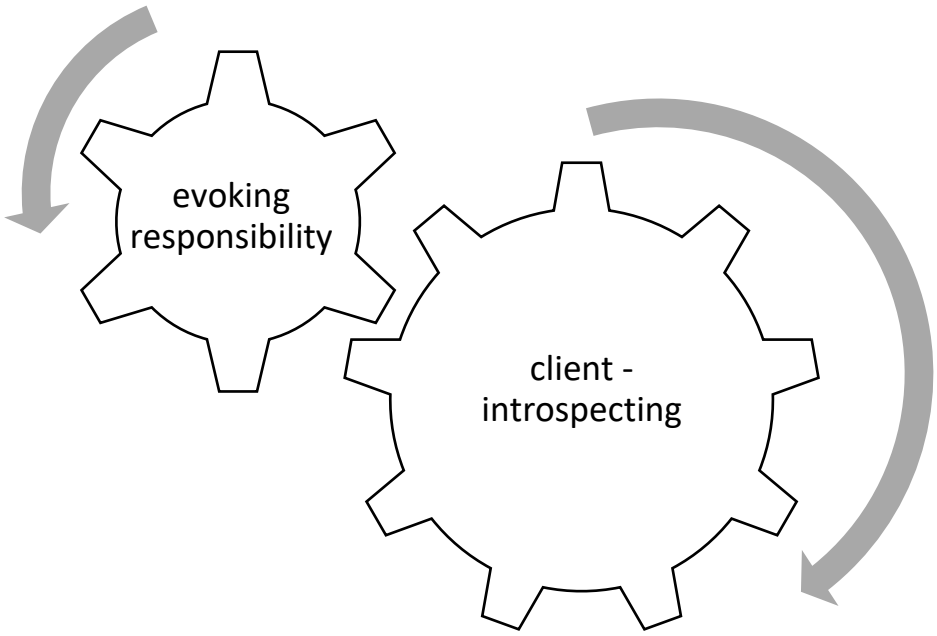
> "I think it invites and creates some practice for the client with self-reflection" (Neil, INT3.9).

> "I think that silence is a necessary aspect of the therapeutic relationship because the client needs the space to think out loud and they can only do that in silence" (Jill, INT3.13).

> "I really feel like they need to fish in themselves and find something." (Alison, INT3.2)

Figure 20

sub-category room of their own and dominant codes



benign witnessing [sub-category]

The concept of *room of their own* may initially imply that the client is in the room alone. However, when considered from the metaphor of a changing room, the store associate is often just outside the door waiting for the person's response. At the same time as the client is given space for a *room of their own*, the therapist is *benign witnessing*. There is again a sense of the intersubjective nature of *benign witnessing, room of their own* and *taking stock:*

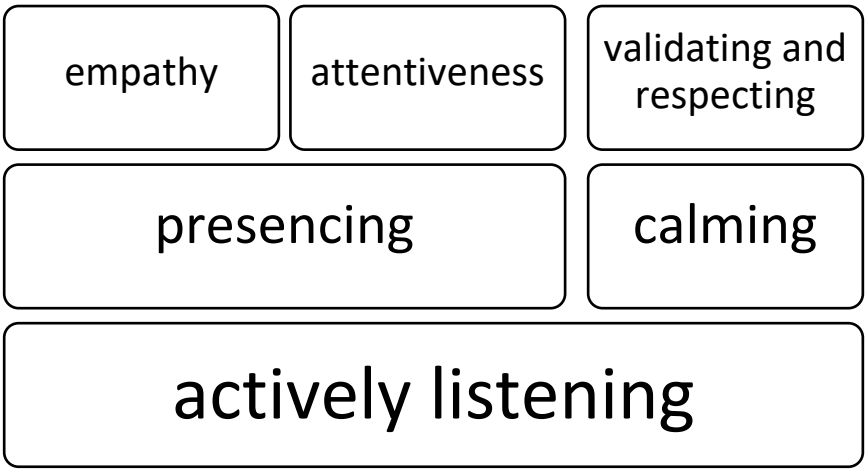
> "We can both sit in silence and drift into our own thoughts but there's a connectiveness that's really significant, that there is space for us each to free associate silently but it's not a disconnection. It's really subtle" (Jill, INT3.13).

> "That's very healing, they set it, they're in it, I'm in it with them and we're just both experiencing it and that can be very powerful, that really moves the therapeutic relationship forward" (Freda, INT3.1).

Benign witnessing has 6 properties that indicate how significant and definable this type of space giving is. See Figure 21.

Figure 21

Sub-category benign witnessing and properties



Possibly the most obvious activity that the therapist conducts during silence is to listen to the client. It is why it is safe to commence the study with the assumption that all therapists take time to not speak and to listen. However, there is a quality of listening associated with *benign witnessing* that is conceptualised as actively listening.

It denotes a quality of listening when the client knows that the therapist is listening and not being absent or drifting in their attention. It is this attentive listening that contributes to *benign witnessing* and is deemed therapeutic:

"…attentive listening" (Sol, INT3.18).

"And more than anything, people just need to feel heard, whether they have anything brilliant to say about it or not. It's very therapeutic" (Anna, INT3.20).

When the client is not speaking and there is silence, many therapists described the process of listening to silence. This process helped them listen to what may be being communicated by the client in the silence and to what may be going on for them:

"The point is to listen to the silence as silence – because language is more than just words" (Ezra, INT3.16).

Therapists described the need for attentiveness as part of *benign witnessing* – attentiveness to the client, to what is being said or not being said, and to what is going on for both parties moment to moment:

"They want some time and space to go through it in their mind more before they hear from you. But even then, I think they want to know you're really attentive and with them" (Clive, INT3.19).

Many therapists describe the need for attentiveness to be accompanied by care and empathy. Qualities attributed to witnessing, that denoted a non-judgemental attitude, and that difficult material be met with a calming and holding demeanour:

> "That kind of witness and acknowledgement was about being seen and validated deeply, being heard with empathy and care and a listening for the story of that person" (Harvey, INT3.12).

The properties of actively listening, attentiveness, calming and empathy reside in the capacity of the therapist. But there is also the sense of a co-created ability of the therapist to being-with the client in silence – presencing.

The ability for the therapist to be present together with the client – presencing – was deemed an essential ingredient of *benign witnessing* and ultimately *deepening the treatment.* It is the client's sense of the therapist's presencing that supports attentive listening:

> "There are ways you can communicate your connection to the client without speaking" (Freda, INT3.1).

> "There can be the silence where I think somebody is there, listening, interested, paying attention and then there can be the silence where I think somebody has gone on vacation and not there" (Sol, INT3.18).

> "We inhabited the silence together" (Frankie, INT3.17).

Like many of the codes and categories in this grounded theory, there is much overlap and interconnectedness. There is the sense that the properties of *benign witnessing* come together so that the client has an experience that is validating and respecting: validated by being witnessed and respected by the active silence of the therapist:

> "I was being respectfully quiet while he was silent" (John, INT3.4).

taking stock [sub-category]

The therapist discussed the use of silence for themselves as space taking – *taking stock*. There are three main activities that the therapists stated they were doing while taking stock: unknowing, observing, and therapist-introspecting.

Therapist-introspecting mirrors the properties of client-introspecting. It is space taking for the therapist to have time for feeling, processing, reflecting, and thinking:

> "I have a lot of things I do internally for myself and then at the same time I might be tracking what's happening to my client as we're doing that" (Jenny, INT3.15).

The therapists described the need for them to feel what is going on, in the room, for them, and the client. They also need to experience and feel what is evoked by the material. It was described as more than just going internally but also an awareness of the holistic experience of body, speech and mind and for the more relationally-focused practitioners, what was occurring between the therapist and client at any given time:

> "Maybe that would be another way I use it, to feel what's going on in the room" (Maria, INT3.6).

> "The use of silence is also important from the standpoint of being aware as a therapist of what you're feeling. You know, is it coming from our own experience in our own lives or is it coming from that we're experiencing what the client is actually experiencing" (Anna, INT3.20).

The need for processing was described as the therapist working through what the client was bringing. They gave the sense that there were varying levels to what the client might or might not be saying. This was linked with earlier material and past sessions:

> "I need some silent time for myself to figure out what's the story that they're telling, what's behind it" (Anna, INT3.20).

There was the sense that space taken through silence for reflecting on the material was an essential function of the therapeutic process:

> "If you allow yourself just to be silent, you pick up on why do I have such feelings about this patient, what's going on? So, I think silence helps with that" (David, INT3.5).

Therapists described a multifaceted process when working with the client and that *taking stock* afforded them the time for thinking. This thinking could be as basic as considering what to say next. There was a sense that *taking stock* contributed to the therapist's own self-care:

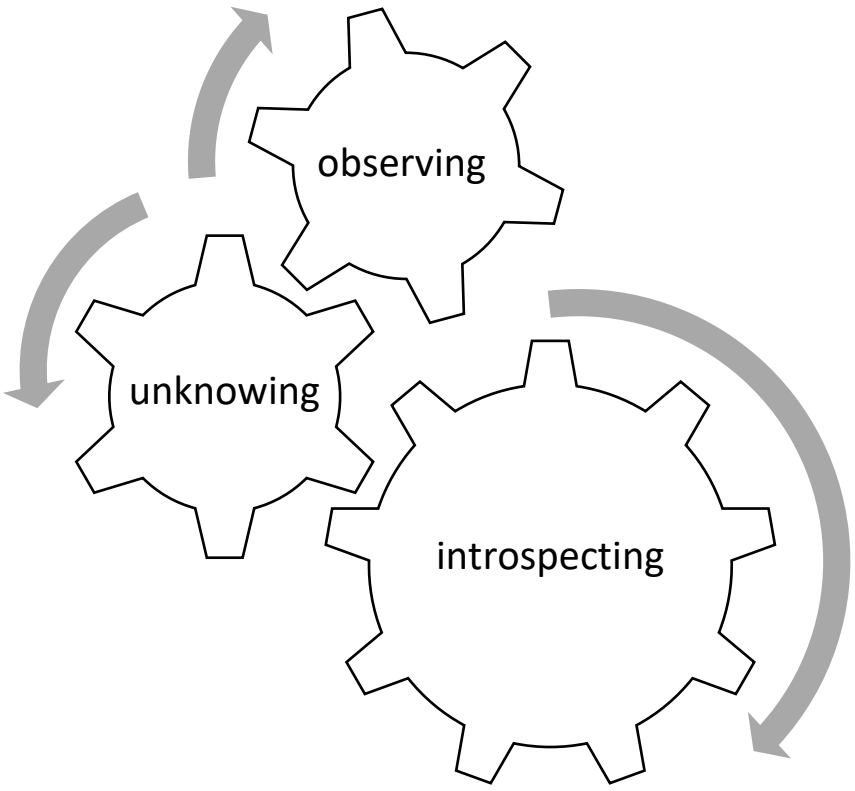
> "So, that's a use of silence, to take care of myself, to kind of give myself some thinking space" (Melanie, INT3.7).

Therapists also described *taking stock* as times when they were silent, simply because they were observing the client, or they were in a period of unknowing. They described at times a very human experience of sometimes simply being stuck for words or not knowing what to say next:

> "I think sometimes the silences come from the therapists not knowing what the hell they're doing and being scared and terrified to say anything" (Kerry, INT3.3).

Figure 22

sub-category taking stock and properties



8.4.5 Summary of Consequences

In this section I have discussed *deepening the treatment* as the main consequences of *intersubjective–silence.* Effective silence – *intersubjective–silence* – helps create space that leads to *deepening the treatment*. The therapist gives the client space, *room of their own*, from which they can evoke responsibility and control by not providing all the answers. The client also has time for introspection – client introspecting. They are not alone in this process, as the therapist is very much present and attentive – *benign witnessing*. The therapist also examines what is going on in their own experience in relation to the client by *taking stock*.

The sub-categories of *room of their own*, *benign witnessing* and *taking stock* are not mutually exclusive and together they contribute to *deepening the treatment*.

8.5 Considerations

The study found two considerations or variables that strongly influenced *intersubjective–silence*: *timing* and *silently experiencing.*

8.5.1 timing [consideration]

The consideration, or variable, *timing* represents the importance of when silence was used by the therapist. It had three sub-categories: *treatment timing, treatment length,* and *treatment frequency*. All three categories influenced when silence might be used by the therapist.

treatment timing [sub-category]

There was a highly prevalent view with most therapists that they would be less likely to use silence at the beginning of treatment.

The importance of *rendering relationship* was discussed as a condition (see Section 7.2.3) of *intersubjective–silence.* It was articulated by therapists that this *alliancing* was usually formed over an extended period of time. The client's capacity to use and benefit from the therapist's silence was considered something that could be orientated to over time. Whilst not always linear, it was believed that time influenced the level of trust and safety experienced by both client and therapist, a stated requirement for the use of silence:

> "In the beginning if they're not comfortable with me yet, I don't want to deliberately make them uncomfortable and silence can make them uncomfortable, so I probably wouldn't use a lot of silence unless I had a pretty good idea how they were going to respond to it" (Freda, INT3.1).

> "Early on, silence is something that makes people really anxious, particularly people who have experienced trauma because they don't know what's going on and when you don't know what's going on it's scary and it may be life-threatening" (Kerry, INT3.3).

treatment length [sub-category]

Therapists stated that they were more likely to use silence when the treatment is of longer length. This could be an organic extended treatment or one that was predetermined, often by insurance company allocation. Therapists suggested that the longer treatment period would give the sense that there was more space and time to use silence:

"If you have a relationship with a patient that goes over a longer period of time where you had the luxury of allowing silences to occur and seeing what happens during that period of silence and at the end of the silence, yeah, I would allow it to happen a bit more" (David, INT3.5).

"Time will impact, has impacted the relationship so, having seen somebody probably for longer than a year or so then you, and they have some established way of working together" (Frankie, IN3.17).

treatment frequency [sub-category]

The number of weekly sessions – *treatment frequency* – has also been included as a sub-category under timing, as it was a variable that influenced when the therapist would use silence. *Treatment timing* and *treatment length* require the therapist to be mindful and skilful of when to use, or to avoid using silence. The number of sessions – *treatment frequency* – is more of a fixed variable as it is predetermined at the beginning of treatment:

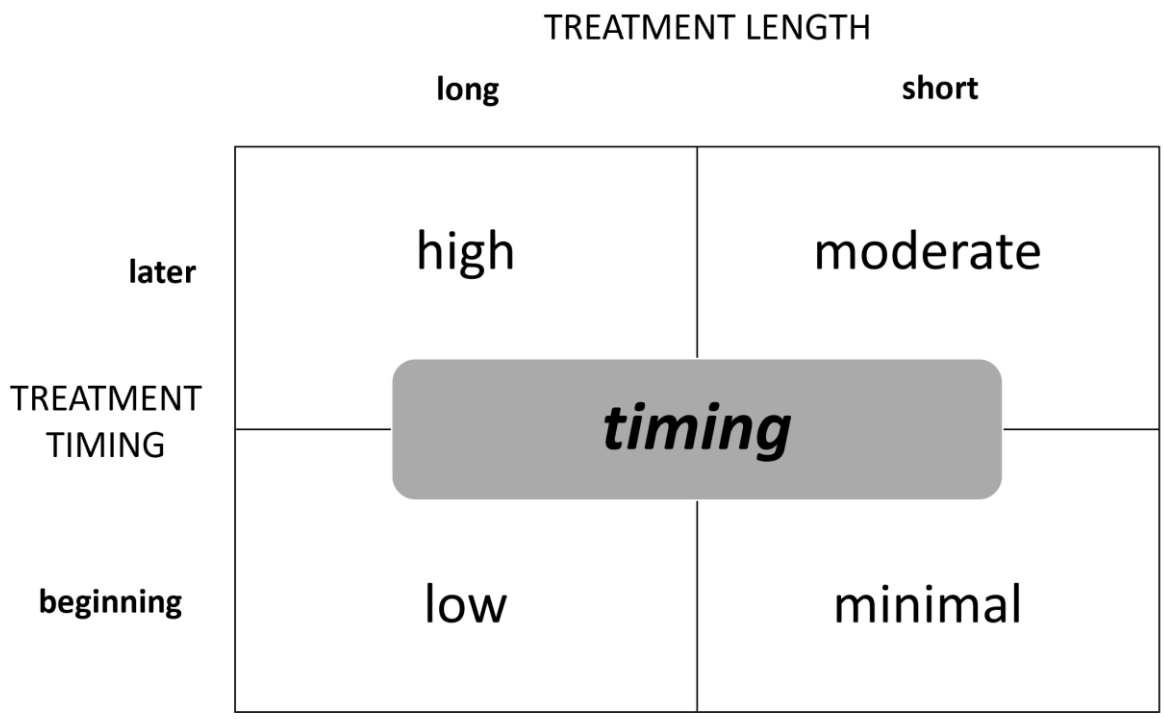
"Especially patients that are coming in for six sessions or whatever, when there's silence, there is often, you know 'Why aren't you saying anything? I don't understand what's happening here'" (David, INT3.5).

"I think silence can be, you know, can be a luxury and it's like I said, you don't have time to spend much time in silence if you're seeing somebody once a week" (Frankie, INT3.17).

Figure 23 represents the sub-categories of *treatment timing* and *treatment length* in a matrix. The matrix reflects the findings in the data that therapists are most likely to use silence later in treatment and when the treatment is longer. They are less likely to use silence at the beginning of treatment and when the treatment length is shorter.

Figure 23

timing – consideration



8.5.2 silently experiencing [consideration]

There were many factors that influenced the therapists' considered use of silence. As the study has shown, this is a complex and multifaceted process. A core contingency or variable influencing the therapists use of silence is conceptualised as *silently experiencing*.

The *evolving disparity* between how the therapist was trained or first considered silence was discussed (see Section, 8.2.1). *Silently experiencing* refers to the combination of the therapist's clinical experience and confidence, garnered over time and from learning from what works best for the client. They describe as learning from their "mistakes" or insight that what they once thought was helpful for the client is no longer. There was a strong sense that the cornerstone *sensitising silence* (see Section 8.3.1.) and its sub-category *optimal specificity* was a way of working that was learnt over time – *silently experiencing.* There was a sense that this experience included their own capacity to tolerate silence. A deeper insight into what was required by the therapist, an increase in comfort, often resulting in saying less and being-with more:

> "I think the more confident I have become as a therapist the more able I'm able to tolerate silence, appreciate it and use it" (Kerry, INT3.3).

> "I think basically though a lot of my use of silence and my comfort with it just has come out of simply practicing for as long as I have" (Melanie, INT3.7).

> "Do I become more comfortable with the silence? Yeah. What do I become more comfortable with? I become more confident that I don't have to help." (Richard, INT3.11)

The therapists' experience and confidence, gained over the course of their clinical career, were the most predominate influencing factors in their use of silence. It is clear from the participants that although this experience is present, their learning is ongoing, hence – *silently experiencing.*

8.5.3 Summary of Considerations

This section has discussed the two contingencies or influencing variables in the constructivist grounded theory *intersubjective–silence. Timing* and *silently experiencing*. *Timing* proposed that the therapist is most likely to use silence later in treatment and when the treatment was longer in nature. A higher frequency of sessions resulted in a higher likelihood that the therapist would comfortably use silence.

Many complex factors influenced when the therapist would use silence but in terms of their individual decision-making, *silently experiencing* was a strong influencing variable. Clinical experience garnered over time gave the therapists the confidence to use silence in the most effective way to meet client needs.

8.6 Conclusion

In this chapter I have outlined the constructivist grounded theory *intersubjective–silence*. I have presented the four coding categories of *(pre)conditions, cornerstones, consequences* and *considerations*, and their associated sub-categories, properties and or dominant codes.

In the next chapter I will discuss and critique the theory and introduce relevant theory.

CHAPTER 9: Discussion

It may be intended to be neutral but silence too can be plausibly experienced as anything ranging from cruel inhumanity to tender concern.

Merton Gill (1984, p. 168)

9.1 Introduction

The grounded theory *intersubjective–silence* was first introduced in Chapter 7, and a more detailed presentation offered in Chapter 8, including detailed descriptions of its categories and sub-categories. In this chapter I will now discuss the theory in its totality before introducing relevant literature for further evaluation. I will make the argument that this theory offers new knowledge about the therapist's use of silence and gratifies the knowledge gap identified in both Chapters 3 and 4.

9.2 *intersubjective–silence*

In this constructivist grounded theory, the core category of *intersubjective–silence* was constructed from an analysis of the data. When asked to consider their use of silence, the participants, who were all psychotherapists based in Illinois, expressed their main concern that the silence was effective, productive, or therapeutic. They did not want to use silence to make the client excessively uncomfortable or to increase anxiety for therapeutic reasons. They described a way of working that was collaborative, and silence that was co-created.

There was a sense of the therapists sharing space, mediated through the effective use of silence — *intersubjective–silence.* The theory endeavours to represent the complex, multifaceted processes that the psychotherapist employed to ensure that their use of silence was effective.

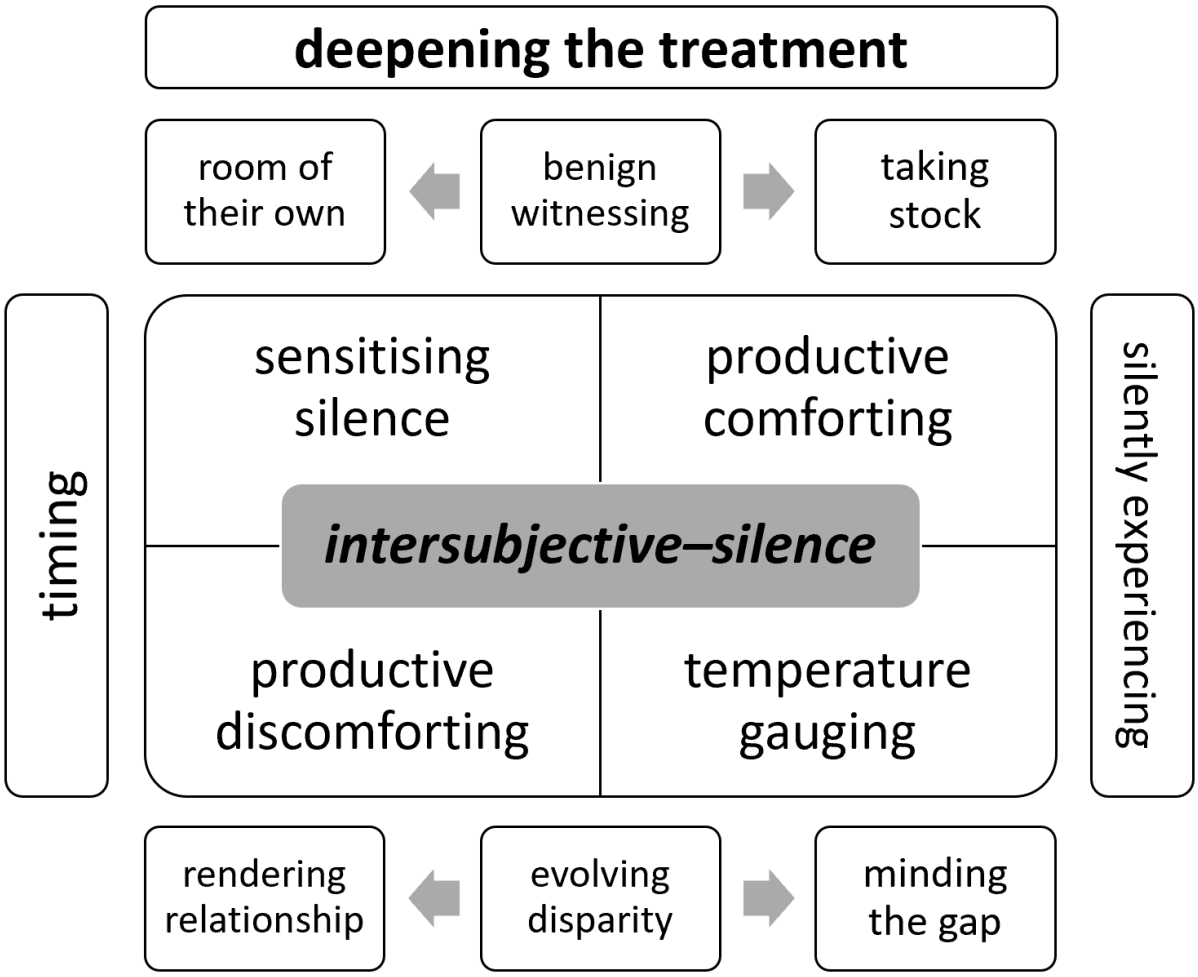
The full explanatory power of the theory *intersubjective–silence* is only fully understood by considering and appraising the associated categories and sub-categories. It is grounded in the data, and as such is an amalgamation of the elements of best practice.

There is a continuous flow moment by moment of the various elements of the theory. The use of effective silence is a complex and highly skilled process. This data demonstrates the complexity of what is happening in any given moment for *intersubjective–silence* to be in effect. The model that is presented here is visually appealing and simple. However, it is the opposite in practice, see Figure 24. The categories are in flux and are often not mutually exclusive. The complexity of the process maybe alludes to why researching the use of silence had been historically avoided.

The categories and sub-categories of the grounded theory *intersubjective–silence* were arranged into four main coding categories or coding themes: *(pre)conditions, cornerstones, considerations, and consequences.* The (pre)conditions for *intersubjective–silence* to be present are *rendering relationship, evolving disparity, and minding the gap*.

Figure 24

model of the grounded theory intersubjective–silence



The therapist needed to have established a strong working alliance with the client before silence was seen to be effective or intersubjective. The alliance was built on the foundations of the authenticity and caring attitude of the therapist, building a collaborative relationship, creating safety and trust. To offer intersubjective–silence the therapist must in the first instance be silent by holding back, not filling the silence or jumping in – *minding the gap*. It requires some degree of discipline on the part of the therapist, often going against natural instincts of communication.

A space can then be offered where free associating can take place – the open space where what needs to arise can do so. A significant finding in the data is conceptualised in the condition of evolving disparity, the sense that the therapists' use of silence has evolved from how they were originally trained or had thought about silence theoretically.

There was a sense of a transition away from traditional abstinence – away from a one-person psychology in which silence was done to a client, to a collaborative two-person psychology. Despite this evolution, the process of disparity was ongoing and ever-evolving, with the potential for therapists to revert to a silence that was deemed withholding as a residue possibility.

The cornerstones and heart of the theory *intersubjective–silence* provide an original finding in how the therapist thinks of, and employs silence, in the clinical setting. The cornerstones are *sensitising silence, productive comforting, productive discomforting,* and *temperature gauging.*

The therapist intentionally modulates the amount of silence that they and the client can tolerate. The experience and confidence of the therapist, coupled with a positive view of silence, will influence the therapist's propensity to use silence. When the therapist has a rapport with a client who they deem as having a degree of insight, they can begin to offer them a silence that is seen as welcoming.

This silence is seen as *productive comforting* when the therapist refrains from pushing the client and can hold their emotional experience moment to moment.

There are instances when the client experiencing some discomfort in silence is considered productive by the therapist – *productive discomforting*. The therapist and client collaboratively lean into the discomfort, with the belief that something therapeutically positive will emerge in doing so.

They achieve the skilled balancing between *productive comforting* and *productive discomforting* by *temperature gauging* the emotional intensity present in the room. The therapist uses a combination of their own intuition, the client's verbalisation, and soft signalling from the client's body language and facial expressions to decide how much silence is used. The therapist remains aware of the client's associations with trauma and silence and sensitises silence accordingly.

The theory considers the timing of when to use silence as significant. Therapists are more likely to use silence in longer-term theory and later in treatment. The experience of the therapist was also a major consideration. Therapists stated that they were more likely to use silence due to their experience and confidence, gained over the duration of their clinical careers and forged through trial and error.

The consequence of *intersubjective–silence* is *deepening the treatment.* Silence creates space – *room of their own* – where the therapist evokes the client to take responsibility and control of their therapeutic insight. It offers space where the client can become more introspective, giving time to process feelings, thoughts, and reflections. Space is also taken by the therapist – *taking stock* – so they too can experience introspecting.

The central concept of deepening the treatment is *benign witnessing* – the space created where the therapist actively listens to the client. By *presencing* and being-with the client they offer the client an attentive, calming, and empathetic presence that is seen to validate the client experience moment to moment.

The interviews were approached from a phenomenological hermeneutical perspective. I am defining phenomenological as being interested in the participants' meanings, values, relationships, and experiences, and hermeneutical as ensuring that consideration is given to the context (Bracken, 2017; Bracken & Thomas, 2005). Interpretation sits within the context of the participants' worlds. A phenomenological hermeneutical interpretation honours the totality of the participants' lived experience. The participants, by offering interview data, were able to support the construction of silence as they understood it, their use of silence, and the processes that they went through, with relatively clear and jargon-free language. As Rukeyser (1968, p. 467) reminds us "The universe is made of stories, not of atoms", and so *intersubjective–silence* is an overarching story that hopefully reflects the many stories, experiences and processes that the participants revealed. I acknowledge that in the main the participants stories were taken at face value or viewed by me as telling the 'truth', and there was limited engagement with a hermeneutics of suspicion (Ricoeur, 1977, Josselson, 2004). I reflected on this interview approach, and I believe that it was valid given the experience, openness, and self-critique from which the participants spoke. The space was maximised providing an opportunity for stories to be shared full of instances where they felt they had got it wrong and participants offered a frequent candidness about their avoidance of negative transference and desire to make the client comfortable. Through GT analysis these stories were broken down to units of analysis, constantly compared, and where appropriate constructed into code and categories.

When returning to the data after the rendering of the theory *intersubjective–silence,* the data reflects the appropriateness, and the interconnectedness of the various categories and sub-categories. There are whole passages within the interviews when the participant is reflecting on their use of silence that replicates much of the final theory:

> "Well, I think what comes to mind first is the disparity between the way I was trained which was primarily psychoanalytic or psychoanalytically informed and silence was very much identified as one of the therapist's tools **[evolving disparity].**
>
> The idea was that one does't necessarily try to make a patient comfortable: that would allow them to sit or in some cases, lie with silence, lie down with silence and that from their discomfort in some ways will emerge what needs to emerge.
>
> And while I'm still very comfortable with the use of silence, I think I think about it in a different way now because I really try to tailor each treatment to the very specific needs of very different patients. **[sensitising silence]** So, for some people there is a kind of comfort for them in knowing that I am patient. **[benign witnessing]** They can take time to sort of form their thoughts, articulate their thoughts and that won't be disruptive. **[room of their own]** For others, that could be agonising, they could feel abandoned, they could feel embarrassed. And I think of my primary task as creating alliance **[rendering relationship]** and so, [for] people who are either new to the process or really uncomfortable with any kind of silence. I am more likely to jump in and make some kind of bridge **[productive comforting]**" (Melanie, INT3.7).

> "How do I do that? Well, so the first thing is the alliance and creating the sense of safety **[rendering relationship]**. I think the better that goes, this is why I think, the comfort **[productive comforting]** like pays off and it's not just sort of like coddling people and allowing them to take the easy way out. There might be some of that, but I like to think that once the alliance is very strong then they can tolerate **[tolerating]** a little bit more, then they sort of… it's less likely that what you were talking about where there's a silence and somebody says well, I can tell you're judging me. It's less likely to happen later on in the treatment because they already know me well enough and what I'm like to trust that I'm not judging them mostly, and they'll ask for more space **[deepening the treatment]**" (Peggy, INT3.13).

9.3 Review of Relevant Theory

I will now discuss key aspects of *intersubjective–silence* and critically review the theory as it pertains to the various categories and sub-categories. The core theory under consideration is drawn from the review of primary literature (Chapter 4, Review of Primary Literature) that relates to the therapist's use of silence, and specific sources cited by the participants during the interview.

9.3.1 evolving disparity

Participants described an *evolution* in the way they thought about, and used silence, from when they were first trained. This was a significant and original finding. They described how a combination of their own practice experience and personal values impacted their use of silence over the course of their career. The data was thoughtful and revealing, with therapists open about their own vulnerabilities and learning process.

It was notable that the simple exploration of the use of silence, precipitated in the participants raising this evolution, with some describing having been taught by the key theorist Merton Gill (1914-1994), and the professional descendants of Heinz Kohut (1913-1981). This was not a coincidence as both men were located in Chicago and were attached to organisations in which many of the participants belonged: Kohut in the Chicago Institute for Psychoanalysis, and Gill, who was born in Chicago, was a professor at the University of Illinois.

Several described Chicago as the "home of self-psychology", discussing the enduring influence of Kohut's (1971) shift from traditional analysis to an emphasis on responsiveness and mirroring. Kohut (1981) presented the importance of his concept of empathy at a time when he was speaking from the heart of the psychoanalytic universe (Kahn, 1997).

Participants described how they valued theory that was more humanising. The potential for psychoanalysis to dehumanise the client was highlighted by Arlow (1971). Humanising theory was a dominant code in the category *evolving disparity*. Some participants drew attention to the disparity between Freud's actual warmth and humane analytic attitude and how it had become hardened and regimented by his followers into what was referred to as classical psychoanalysis (Blanton, 1971; Lipton, 1977).

The participants' view that they no longer believed in the neutrality of the therapist, the blank slate, or traditional abstinence was another important finding. It offers clear implications as to how the therapists saw themselves in practice and the shift in relating. This somewhat echoes the work of Gill (1982a, 1982b), a one-time advocate – indeed, purist – of not contaminating the transference by speaking.

In his later work Gill (1984, 1994) accentuated the awareness of therapy as an intersubjective process, therefore insisted that non-interaction was a fallacy and uncontaminated transference, a myth:

> Silence is of course a behaviour too. Nor can one maintain that silence is preferable for the purpose of analysis because it is neutral in reality. It may be intended to be neutral, but silence too can be plausibly experienced as anything ranging from cruel inhumanity to tender concern. It is not possible to say that any of these attitudes is necessarily a distortion (Gill, 1984, p. 168).

The emphasis that Kohut and Gill placed on intersubjective (Crossley, 1996) ways of working laid the foundation for what was to be a paradigm shift in psychoanalysis – the relational turn (Mitchell, 1988, 2000, DeYoung, 2003, Stolorow & Attwood, 2014). This turn was not felt and contained only for psychoanalytic practitioners. If not remaining aligned to psychoanalytic ways of working, many participants described an evolution into a more integrative way of working, citing Watchell (1997, 2011) as a key influencer. This could be defined as a focus on the client needs moment to moment, using theory as it was appropriate to the client. The therapist asks questions and makes comments that facilitate collaborative exploration – intersubjective.

As opposed to a possibly vague term, the focus on the use of silence offers a detailed insight into how this process works in practice – *intersubjective–silence.*

Whilst Kohut (1981) and Gill (1994) promoted empathy and warmth, they were still psychoanalysts in practice and therefore remained focused on the relationship and the unconscious. This is potentially why they made no effort to include the humanistic work of another influential Chicago-born and based therapist, Carl Rogers (1902-1987).

Participants stated that they evolved in their practice and theory through experience, trial and error, and learning from their "mistakes". Casement (1985, 2002), a proponent of such an approach captures what is required of the therapist: "a therapist has to discover how to be psychologically intimate with a patient and yet separate, separate and still intimate" (Casement, 1985, p. 30).

When considering the use of silence, there are no hard and fast rules: the study argues that it requires great awareness and skill on the part of the therapist, and trust on the part of the client. Casement (2019) argues that many therapists need time to "unlearn" what they were taught with regard to silence and responsiveness. He argues that there is perhaps a fundamental shift with understanding of silence as: "silence does not always have to be resistance or withholding" (Casement, 2014, p. 19). The category *evolving disparity* is unique in that being grounded in the data, it appears to capture what he describes. But it goes much further in making a distinction in the evolution away from traditional abstinence whilst highlighting that there always remains a possibility for the therapist to use silence punitively or in a way that the client may experience as withholding – *residue abstinence.* It remains an active evolving towards a collaborative way of working.

One participant referenced Tessman (2013), who interviewed psychoanalysts on how they were impacted by their training analysis. The study emphasised the centrality of emotional engagement (genuine caring relationship) as having the most lasting impact on the participants – not abstinence or technique. It also serves as a significant record of how much the practice of analytic therapy has evolved in America since the time the participants were analysed and at the time they were interviewed.

9.3.2 rendering relationship

The significance of the therapeutic relationship and the use of silence appeared throughout the data. The importance of the therapist-client relationship as defined by a strong therapeutic alliance has been widely recognised in assessment of effective practice (Fonagy, 2015; Lavik, Frøysa & Brattebø, 2018; Norcross, 2010; Prochaska & Norcross, 2014; Roth & Fonagy, 2004; Wampold & Imel, 2015).

But this study proposes the core properties of alliancing. It promotes an alliance that is based on an authentic and caring relationship that is collaborative in orientation, that creates a sense of safety and trust. There is compelling evidence to support the argument that caring can make a significant difference in treatment outcomes (Trzeciak & Mazzerelli, 2017).

As the data was compared and coded, initial categories were constructed. This brought to mind Clarkson's (2003) five facets of the therapeutic relationship: the working alliance; transference/countertransference; reparative; person-to-person; and the transpersonal. I resisted the potential to force the data into these attractive categories and continued to code.

What did become clear was that regardless of their stated modality, participants approach to the therapeutic relationship could be categorised as integrative, as defined by Luca, Marshall, and Nuttall (2019): “an individualized and personal approach to therapeutic work, anchored in the particular psychological needs of clients, identified through integrative assessments and formulations” (p. 1).

All participants described a way of working that was collaborative, echoing the relational or intersubjective turn in psychoanalysis (Aron, 1996; Greenberg and Mitchell, 1983; Loewenthal, 2014; Mitchell, 1988, 2000; Mitchell & Aron, 1999; Stolorow & Attwood, 2014).

Theoretical relational psychoanalysis, whilst arguably a clear evolution in psychoanalytic thinking, is not without its dissenters and continues to garner much debate around its theoretical assumptions (Carmeli & Blass, 2010; Mills, 2012, 2020). Central to the debate is the rejection of drive theory over the emphasis on relating as the primary focus (Mills, 2012).

Although some participants did reference key relational theorists, the collaborative aspect of the relationship was conceptualised as more of an orientation. As Orange (2009, p. 9) surmises “from a clinical point of view, intersubjectivity is not so much a theory as it is a sensibility”. (p. 9). Appraising the concept of *alliancing* more generally, it could be argued that the category reflects a general evolution and universal orientation to a more collaborative way of working in psychotherapy (Cooper, 2019; Cooper, Norcross, Raymond-Barker, & Hogan, 2019; Luca et al., 2019). What is significant about this finding is that it appears to be arrived at organically. Participants are suggesting that through trial and error a more collaborative way of working is more effective.

It may also mirror the influence of feminism on vestiges of patriarchy and perceived authority to a more mutative way of engaging in society (Seu & Heenan, 1998). This study offers support to the prediction of Prochaska & Norcross (2014, p. 46), "the future we foresee for psychoanalysis can be summed up by the terms interpersonal and integrative".

The centrality of *alliancing*, co-creating a strong therapeutic alliance before using silence was a dominant sub-category of *rendering relationship.* In terms of the conditions for using silence, therapists typically reported that as a pre- requisite, “a sound therapeutic alliance was needed” (Ladany et al., 2004, p. 84).

The need for basic trust and an intact therapeutic alliance as a precondition for the use of therapeutic silence was presented by Mullard (2015, p. 76) as the most salient and consistent characteristic revealed in his study.

Therapeutic silence is described as supporting the creation of safety and trust in the therapeutic relationship. The use of generative silence, Mullard (2015) argued, can deepen the therapeutic alliance, whilst destructive silence could disrupt it.

Regev et al. (2016) found that the longer and deeper the relationship the more likely that silence would be used. Hill et al. (2019) concurred with Ladany et al. (2004) and echoed this study, that therapists who utilised silence as an intervention reported generally only using it once a strong relationship was established.

They also highlight the importance of comfort, so central to the theory *intersubjective–silence*: "it is noteworthy that the most productive silences may occur later in therapy after a strong therapeutic alliance has been established and both therapists and client feel comfortable during the silences" (p. 585).

Some participants cited the use of silence as both a conduit and hinderance to building the alliance, highlighting that the effective use of silence is tailored to the individual needs of a client moment to moment.

9.3.3 free associating

The code free associating captured an important finding in the data. Although some participants used the term free association with its intended psychoanalytic meaning, through further data analysis it was conceptualised as something more broad: a space where the therapists, and the client, allow feelings, thoughts, and associations to freely arise intersubjectively – free associating. The category was constructed from the data, it was seldom a conscious, distinct concept for most participants, which suggests it could be an area for further exploration in training (see Chapter 10, Section 10.5).

Free association, Lothane, (2018) argues is "an inescapable topic in any discussion of therapy and theory" (p. 411). Despite its long associations with psychoanalytic theory, free association remains of interest to contemporary psychologists (Joffe & Elsey, 2014). Free association, Lemma (2003) suggests, is a primary vehicle for unconscious communication, "this requires, first and foremost, a capacity to bear silence so that free associations can emerge" (p. 181).

Lothane (2018) argues that Freud did not mean free and undisciplined but rather free meant spontaneous, freed from chains of self-criticism and other constraints imposed by normal conventional conversation. Again, free association seemed to harden after Freud into a more rigid one-person psychology (Lipton, 1977, 1983; Roazen, 1992): something that the participants rejected – *evolving disparity.*

The study proposes the evolution of the therapist's use and understanding of silence but reappropriates the concept of free association with a contemporary and intersubjective meaning. Where other theorists have offered pronouncements in this area, this study grounded the concept in the data.

9.3.4 productive-comforting vs. productive-discomforting

The therapist's focus on client comfort was a key finding in the study. Participants were very vocal about the need to ensure that the client was comfortable. One participant framed it in terms of the harm reduction model, in that if clients do not come back because they are too uncomfortable then no work can be done. The economic necessity for retention was implicit in the participants describing their private practice but was not the primary motive for comfort. Therapists were precise about their need to make the client feel comfortable in order to be able to engage in therapy. Martyres (1995) argues that allowing silences to continue beyond the patient's tolerance could jeopardise therapy.

Studies have found that progress in treatment can be hindered if the therapist remains silent, distant, and unresponsive (Bohart & Tallman, 2010). Silence has been associated with client drop-out and perceptions of the therapist being unempathetic (Ladany et al., 2004).

For silence to be productive, Hill et al. (2019, p. 585) argue both therapist and client need to feel comfortable during the silences. This offers a unique insight into how that comfort is achieved. It captures the process of productive–comforting, describing how this is co-created. It offers properties to define this intersubjective process. The therapist needs to have a rapport with the client, supporting the awareness of the client's level of insight, offering a welcoming silence where the client's emotional material is held.

The therapist is careful not to push the client beyond what is too uncomfortable. The theory *intersubjective–silence* conceptualises the process that the therapist and client engage in to support comfort.

Lemma (2003, p. 116) highlights that "it is commonplace for many therapists to feel uncomfortable with silence". The theory intersubjective–silence proposes that at times some degree of discomfort can be therapeutically productive – *productive discomforting*. This can manifest in a tension between the discomfort of the therapist and client, and what may occur as a result of this silence. As Lemma (2003), a psychoanalytic practitioner states "I try to avoid the temptation of launching into questions as a way of easing the tension that silence can give rise to" (p. 137).

This aspect of *intersubjective–silence* contributes to the theory offering a contemporary reframing of the use of silence grounded in the data. It argues that rather than forcing silence upon the client, it is very much a collaborative and intersubjective process, with the therapeutic needs of the client taking priority over any theory.

Geller and Greenberg (2012) make the link between the "unknown" and silence and the significance of tolerating discomfort: "To be able to trust in the unknown takes practice and the knowledge that tolerating discomfort can leave space for the emergence of poignant therapeutic material" (p. 148).

Upon a more comparative reading of Mullard (2015), he described his participants' discomfort with silence as "a surprising theme that emerged unexpectedly" (2015, p. 75). Several respondents expressed discomfort in the earlier years of practice and some due to a lack of adequate training. The therapist's own comfort with silence was also seen to be an intervening variable. In contrast to this study, therapists' comfort with silence was included in Mullard's (2015) final theoretical matrix whereas client comfort did not.

It raises the question as to whether the preoccupation with client comfort, a surprising and unexpected category in this study, is only a core concern of the current USA sample. This study offers an important finding in the importance of both client and therapist being able to tolerate silence and how the therapist works actively to increase this tolerance.

9.3.5 sensitising silence

The concern of the participants in being able to balance the right amount of silence was conceptualised as *sensitising silence*. Therapists varied the amount of silence used – *intentionally modulating,* adapting to the specific needs of the client – *optimal specificity*, and working to increase tolerance of silence for both client and themselves, *increasing tolerance.* They remained cognisant of the connections between silence and trauma – *traumatising*.

The participants 'general approach to silence is mirrored by Hill et al. (2003), in that therapists were "thoughtful and judicious about using silence" (p. 520).

Kohut (1987) noted "tolerance of silence by a psychotherapist in the right circumstances can be enormously helpful" (p. 66). Participants actively discussed the need to increase the tolerance of silence for clients and themselves. Geller and Greenberg (2012) reiterate the importance of tolerance:

> Tolerating the discomfort of silence or of the unknown is integral to a good therapy process, as it is through uncertainty that one can allow for the emergence of material or responses that could be important and relevant for the client (p. 148).

The importance of tolerating silence is discussed by a participant in Mullard (2015), who "carefully introduced therapeutic silence when he perceived the client could tolerate it" (p. 80), but notably it does not earn a category in his study.

intentionally modulating

The decision of whether to use silence or not, and how much silence, was a significant presenting issue for the participants. Intentionally modulating was the process of effectively modulating the amount of silence as a sub-category of sensitising silence.

Lemma (2003) highlights the importance in how something is relayed rather than the content. At other times "it is the silence that speaks volumes, whereas the words are like shallow vessels" (p. 176).

optimal specificity

This study offers a significant finding in the propensity of the therapist to individualise their use of silence. It suggests a complex, contextual and personalised use of silence, moment by moment by the therapist.

Ladany et al. (2004) describes silence as a multifaceted intervention, cautioning: "silence cannot be conceptualised as a single entity in therapy with a single therapist intention and single client perception" (p. 83). Whilst Ladany et al. (2004) offers a general pronouncement in the therapist's intent, the theory *intersubjective–silence* offers a detailed attempt at capturing the process. The data captures a process of adaptation that was notably prevalent throughout the study.

The English paediatrician and psychoanalyst Donald Winnicott (1896-1971), was cited frequently in the study for his paper, The Capacity to be Alone (Winnicott, 1958) and the concepts of adaptation (Winnicott, 1956), and holding (Winnicott, 1953). These ideas helped theorise how and why the therapists were now engaging in the process of adaptation to clients' needs.

The positive view of Winnicott and how he practised also offers a general insight into the therapeutic environment that the participants provided – prizing attunement and holding over more dry analytic interpretation (Anderson, 2014).

The terms containment and containing were also used by participants and interpreted as a general pronouncement on therapeutic process rather than a reference to the specific psychoanalytic term associated with Bion (1962).

Participants described a tension in the evolution of psychotherapy practice between restraint and responsiveness. There was a strong consensus that responsiveness was now the most appropriate and therapeutically beneficial response. Lindon (1994) has argued that the rule of abstinence interferes with psychoanalysis and should be replaced with the concept of optimal provision. The similar concept of optimal responsiveness and the work of Bacal (1998) was cited by several participants.

As an alternative to what Kohut (1971) termed optimal frustration, Bacal and colleagues presented the alternative as optimal responsiveness, extending the repertoire of professional behaviours: attunement, confrontation, empathic support, self-disclosure, validation or invalidation. Optimal responsiveness reconsiders and reconstructs the concept of countertransference, linked or associated in this study to the category of *taking stock.* In an example of collaborative theoretical sensitivity, the category was further refined by reading the originator of the theory, Howard Bacal (1998). His work developed and progressed from the concept of optimal responsiveness to the concept of specificity in psychotherapy (Bacal, 2014).

Specificity holds that what is therapeutic is the fit between the patient's particular therapeutic needs and the therapist's capacity to respond to them, both of which will emerge and change within the unique process of each particular dyad.

The sub-category of *sensitising silence* that relates to the capacity of the therapist to adapt the use of silence to the therapeutic needs of the client in any given moment was therefore uniquely conceptualised as *optimal specificity*.

Mullard (2015) did not conceptualise the process of adaptation but incidents of it were present in his raw data: "I think it really depends on the client and where the need is" (p. 81).

Some therapists were cognisant of client attachment styles when it came to silence and the therapeutic relationship. Hill et al. (2019) make a contribution to *sensitising silence* by suggesting that the therapist be aware of their client's attachment styles. Specifically, they suggest:

> If a client with higher levels of attachment anxiety is engaging in productive silence, the therapist should refrain from interrupting the silence, letting the client break the silence. If the client has lower levels of attachment anxiety, however, therapists should consider interrupting the client's silence even if the silence is productive. Therapists should be aware that their productive silences can be especially effective with clients lower in attachment anxiety (p. 575).

Anxiously attached clients could feel abandoned if they are not aware of how therapists are reacting during silences, which could open the potential for an experience of re-traumatisation for some clients.

Mullard (2015) made the broad claim clients who "experienced early trauma, primarily from attachment deficits appeared to exhibit the greatest difficulty in tolerating therapeutic

silence" (p. 95). Early attachment trauma was a significant intervening variable that appeared to predict the efficacy of therapeutic silence.

traumatising

Participants frequently made a link between trauma and silence. They were sensitive to the power of silence for someone who had experienced trauma. The category *traumatising* proposes that silence was utilised specifically and individually. This is a noteworthy finding in this study. Participants stated that silence could be supportive or detrimental depending on the client. They were unanimous in demonstrating the need for sensitivity around trauma.

Several participants referred to the Tri-phasic Model (Herman, 1992) and Polyvagal Theory (Porges, 2011) in the treatment of trauma, and with clients who have a hard time regulating emotional states with others. Although silence is not specifically mentioned in the theory, the importance of emotional safety and stabilisation achieved through social engagement is emphasised (Baranowsky & Gentry, 2014).

Mullard (2015) is the only study in the review of primary literature to discuss trauma. As a complement to his concept of generative silence, he proposes that "silence can also have a destructive nature" (p. 3). He identifies silence as holding the potential to cause significant trauma, especially if practised without a strong therapeutic relationship being established.

The theory intersubjective–silence uniquely conceptualises the therapist's sensitivity to silence and how its use is determined by the individual needs of the client. Participants demonstrated a high level of skill in being able to distinguish between instances when silence would support a client process trauma or exacerbate their emotional intensity. Whilst most

trauma theories that were referenced prize explicit emotional connection and actual dialogue, many participants also discussed the important of silence when working with clients with a history of trauma.

9.3.6 temperature gauging

The concept temperature gauging is an essential finding, offering a detailed explanation of the therapist's process as they remain aware of what was going on in the room in times of silence. They would be looking for moment-to-moment communication from the client as to their state of comfort. Often this communication was subtle and nuanced – *soft signalling*, received intuitively – *intuiting*, or verbally discussed – *verbalising*.

Lemma (2003) argues that "there are numerous vehicles for unconscious communication that are non-verbal, for example, posture, gesture, movement, facial expression, tone, syntax, and rhythm of speech, pauses and silences" (p. 178). The importance of noting nonverbal behaviours was highlighted by Cuttler et al. (2019), in that therapists need to be attuned to how clients are handling the silences. Whilst theorists have referenced the importance of non-verbal communication, it is argued that this is the first time the significance of *temperature gauging* is directly related to the use of silence.

9.3.7 deepening the treatment

The consequence of *intersubjective–silence* is to create space for the client – *room of their own*, space for the therapist – *taking stock*, and space where the therapist can be attentive to the client's needs in the moment – *benign witnessing*. The interplay of these three sub-categories is what comprises *deepening the treatment.*

Whilst some individual properties of these categories have been touched upon by previous studies, it is argued that this is the first-time the use of silence has been conceptualised in this comprehensive way, providing an explanatory power to what constitutes the effective use of silence and deepening the treatment.

Participants frequently used the words “deeper”, “deeply”, “deepening”, “deepens”. The theory *intersubjective–silence* conceptualises what is occurring in the therapeutic process that deepens the treatment. Deepening the treatment was an in vivo code, used by several participants.

The work of Hall (1998) and “deepening the treatment” (p. 29), was referenced by a participant but only makes a few references to silence in which she repositions a more interactive version of psychoanalytic technique, ‘listening with respect and being comfortable with not knowing the answers or even the questions involves the technique of silence’. Her work whilst moving away from traditional abstinence still reads like a two-person psychology.

The general importance and power of being-in-silence is promoted by Siegel (2007), who describes stillness as a stabilising strength that supports attunement. He argues that:

> Silence creates a rare opportunity to pause and drop into stillness, to become intimate with your own mind. When we start the journey to attune to our own minds by pausing into stillness, we enter a new realm of experience that can produce surprise at each moment (p. 72).

room of their own

The therapist's ability to use silence to offer the client space is captured in the sub-category *room of their own*. This is a powerful finding that cannot be understated in a milieu where therapists are increasingly under pressure conscious or otherwise to be *doing*.

Participants valued the space to allow the client to take more responsibility for generating answers and reducing dependency on the therapist to do the work. The space that is offered to the client helps facilitate them finding and experiencing their emotions and the supportive freedom from which to express them.

Hill et al. (2003), whilst not conceptualising the data, described therapists as using silence to "encourage clients to reflect, take responsibility, get into their feelings, and continue what they were thinking about" (p. 520).

In addition to creating space for the client to take responsibility, participants championed the use of silence to support the client to become more introspective. Space to feel, process, reflect and think. Ladany et al. (2004) alluded to introspection as a client-focused reason for the therapists to use silence, paying "attention to underlying thoughts so that clients can hear themselves" (p. 83).

In their work on the concept of therapeutic presence, Geller and Greenberg (2012), highlight the necessity for the therapist to hold back – *minding the gap* – and how this can support client introspection:

> Silence can also allow the client to work internally with what has been offered through the therapist's response or intervention, and the therapist's discomfort with this and filling the silence could actually impede the client's healing and learning process (p. 148).

Generative silence is described by Mullard (2015) as supporting the 'opening up of inner experience of the client' (p. 76). Hill et al. (2019) proposes that it is "important for therapists to use the silences therapeutically, allowing the client time to reflect and connect with feelings" (p. 585). The presence of the therapist Regev et al. (2016) stated, offered the space that gives the client a capacity to be alone in front of another.

Essentially, providing space through silence allows the client to connect to themselves. The space that is given and taken in *deepening the treatment* is clearly not mutually exclusive, with much overlap moment to moment. The capacity for the therapist to contain, or hold, both what is arising for the client and themselves, is what connects the concepts. As Regev et al. (2016) suggests, it is silence that promotes the sense of acceptance and containment.

benign witnessing

When examining psychotherapy, a lay observer may interpret the process occurring as often the therapist listening while the client speaks. A therapist is aware, however, that there could be a range of activities being conducted in that moment, including formulating, thinking, day dreaming, theorising, linking, remembering past material, self-monitoring, and boredom. An effective outcome of *intersubjective–silence* is *benign witnessing*. The theory, grounded in the data, defines this as the capacity of the therapist to be present, to actively listen, offering a calm, empathetic and inviting space where the client can feel safe, validated, and respected.

Listening in *intersubjective–silence* is conceptualised as *active listening:* the sense that the client is aware that the therapist is listening by their presence, subtle communication, and body language.

In addition to this process, *active listening* reflects the evolution from one-person psychology – the voice of the client now matters in and of itself – not simply as data to be reduced, labelled, and analysed. In her critique of the abuse of power in the analytic relationship, Valentine (1998) concludes with the succinct charge "it is time to listen to the patient" (p. 181).

Participants often referred to the process of "listening to the silence" as part of active listening and Lemma (2003) is explicit when she states "listening to silence is important" (p. 179). The therapist is listening to the client, themselves, and the spaces in between (Wilberg, 2004). The therapist is often active during silences, Regev et al. (2016) found describing the process of active listening as bringing awareness to the subtleties of interactions, including body language and facial expressions.

Empathy is a property of *benign witnessing*. Hargrove (1974) cited silence behaviours as the biggest predictors of empathy among the verbal interaction analysis variables. High-empathy therapists took longer to respond and allowed clients more time to express themselves and interrupted fewer times.

Whilst a property of *benign witnessing*, empathy did not feature as predominantly as it did in Ladany et al. (2004), who cited communicating empathy as the sole general client-focused

reason for using silence. In their companion study, Hill et al. (2003) delineate psychoanalytic-orientated therapists as using silence to facilitate reflection, and more humanistic therapists as using silence to convey empathy, respect, and support. *Intersubjective-silence* did not delineate by modality and the additional properties of *benign witnessing:* attentiveness, calming presence and validating and respecting were shared across the range of participants. In addition to *active listening*, the participants identified *presencing* as a fundamental property of *benign witnessing*. The qualities and positive outcomes of presence have been conceptualised by a spectrum of theorists: authentic presence (Bradford, 2007), bearing witness (Wiesel, 2006), evenly-suspended attention (Freud, 1923), being-with (Heidegger, 1962), co-presence (Laing, 1989), healing presence (Phelon, 2004), psychoanalytic witnessing (Reis, 2009); spacious intimacy (Prendergast & Bradford, 2007), therapeutic presence (Geller & Greenberg, 2012).

It is perhaps the experiential nature of presence, in the context of a world that is arguably vying for our attention, that makes multiple definitions so necessary. It supports the efficacy of the current study, highlighting the need to gain a greater understanding of the concept.

The sub-category of *presencing* captures a co-presence, an intersubjective sharing of silence where the client and therapist are very much aware of one another. Participants use multiple phraseology to explain their process including: “sit with”, “being-with”, “here and now”, “presence”. This presence sits on a foundation of safety and trust facilitated through a strong therapeutic alliance.

Presence is succinctly defined by Siegel (2007) as “the bare awareness of the receptive spaciousness of our mind” (p. 160). This is the mind that is aware of the client, the therapist,

and what is occurring intersubjectively within the session. Geller and Greenberg (2012) focused their research on trying to define therapeutic presence as a state of having one's whole self in the encounter with a client achieved by being completely in the moment "physically, emotionally, cognitively, spiritually, and relationally. They also view therapeutic presence as how the therapist monitors their own experience in therapy.

Benign witnessing goes beyond a state of being to evoke a relationship process. When present, the clients experience it as feeling met, felt and understood. Geller (2017) proposes that presence activates a neurobiological experience of safety which strengthens the relationship and which in turn supports the therapy to go deeper. Whilst the neurobiological component is potentially based on a degree of conjecture, it is consistent with the polyvagal theory (Geller & Porges, 2014; Porges, 2011) and tri-phasic models (Herman, 1992) of trauma treatment. Participants described how they would communicate their presencing while *benign witnessing* through the use of expressions and body language. It is through warm facial expression, Geller and Porges (2014) suggest, and a prosodic voice, emotional attunement, and in-the-moment engagement that a "present-centred therapist activates an experience of safety in the client" (p. 185).

Benign witnessing provides the therapeutic relationship with the type of depth and connection required for the client to feel safe enough to access their deepest feelings, meanings, concerns and needs, and to share these with the therapist. Participants described the importance of therapists maintaining a calm presence in the face of client pain and struggle. I reflected on the guidance of a highly experienced psychiatric mentor who stressed to me the importance of the therapist not participating in the client's anxiety.

Silence can also increase intimacy between the therapists and client. Being present silently with a client can create a sense of intimacy and closeness. The conditions of a safe and secure relationship, making this presence possible. Hill et al. (2019) reiterate that the therapist serves the client as a container, providing "a safe space for the client to internalise what is being discussed in the therapy session" (p. 585).

The importance of the therapist behaving invitationally during the silences was reiterated by participants – a *welcoming silence*. Cuttler et al. (2019) suggest that in order for the client to use the silence productively the silences must be perceived as supportive and attuned to them.

All properties of *benign witnessing* suggest an intersubjective experience for the client and therapist – moments of deep connection between the therapist and client each aware of the other.

taking stock

The theory of *intersubjective–silence*, suggests that silence also provides a space where therapists are *taking stock*. They are introspecting: feeling, processing, reflecting, and thinking about what is going on for them, the client, and the therapy process. This finding is not limited to any one modality and offers an integrative way of thinking about the therapeutic process and best practice.

Hall (1998) cites self-reflection in silence as a technique that can support deepening the treatment. Hill et al. (2003, p. 520) found that therapists were often active internally during silences, observing and focusing on the client and thinking about what was going on in the therapy and in themselves. Silence gave the therapist the space to respond to the client,

Ladany et al. (2004) suggested, and they focused on what was going on with themselves in relation to therapy, including what "fantasies or unconscious expressions for connections to what was happening in therapy" (p. 85).

In addition to the client, Mullard (2015) describes generative silence as supporting the opening up of inner experience of the therapist. Regev et al. (2016) stated that most therapists described silence as a moment when they can connect with the client and gather their thoughts. By giving the client space to connect with themselves, they in turn felt better connected to the client.

The sub-category *taking stock* was conceptualised to include the therapist's body. Hill (2004) captures an area that I believe many participants were alluding to:

> If we pay deliberate, silent attention to the body in a session, we can frequently find ourselves in a far more meaningful place of awareness. Silence and emptiness begin to show the way beyond the ego's preoccupations. Practiced in this way, psychoanalysis is indeed a spiritual discipline (p. 30).

In addition to conceptualising what leads to deepening the treatment, the theory is unique in how it transcends any one theory and offers an integrative language, from which to appraise best practice.

9.3.8 timing

The study strongly indicated that therapists were more likely to use silence later in the treatment process and when a strong therapeutic alliance was present.

This finding deviated from Hill et al. (2003), who found that therapists did not seem to ascribe to any simple formula about when to use silence.

They found that the use of silence was more dependent on situational variables in treatment than on specific times in sessions or treatment, as somewhat supporting the concept of *optimal specificity* discussed in this study. Ladany et al. (2004) also found that there were no specific recommendations that can be made in terms of when to use silence. This may reflect the continued evolution of therapy towards a more relational way of working or that the sample was more collaborative in orientation.

In contrast, Mullard (2015) saw timing as an "important factor in assisting patient growth" (p. 91). Almost all his respondents stated that the middle or working phase of therapy was when they were most likely to use silence.

The beginning of therapy was seen as the least appropriate time to use silence. Hill et al. (2019) stated that "it is noteworthy that the most productive silences may occur later in therapy" (p. 585). Whilst being mindful that it was an analysis of treatment sessions with a single client, Hill et al. (2019) indicated that later in treatment the client was able to engage more directly with the therapist and used the silences more as a time to reflect and connect with feelings.

Therapists appear to use silence later in treatment, but it is hard to separate this variable from the importance of the therapeutic alliance. Even in the best of therapeutic connections, a therapeutic alliance takes time to co-create and build.

9.3.9 silently experiencing

The findings suggest that therapists learned most of what they knew about using silence from clinical experience, supervision, and experimenting in gauging what level of silence clients were comfortable with.

Hill et al. (2003) hypothesise that silence is potentially an advanced skill that can only be learned through clinical experience. Ladany et al. (2004) suggest that therapists learnt how to use silence mostly through "clinical experience and supervision rather than through specific training" (p. 87). They emphasised the learning gleaned from the therapists' personal therapy. Therapists typically thought they currently used silence more flexibly, comfortably, and confidently than they had as beginning therapists.

Intersubjective–silence posits that the therapists' use of silence in trial and error over the years of their practice was a key influence on how they use silence today.

In the literature, Mullard (2015) argues that therapist characteristics and levels of experience do not appear to have previously been considered as a factor in the use of therapeutic silence:

> respondents, who reported a growing comfort in the use of silence after several years of experience, noted that they had come to understand the power of therapeutic silence and had learned, on their own, how to use it effectively (p. 120).

The participants' experience in training, personal history and supervision was wide-ranging and varied. Each of them had an influence on the use of silence both positively and negatively.

But again, participants stated, that after clients' needs, it was their confidence with using silence gained over time that most influenced their use. Regev et al. (2016) found that all participants stated that experience garnered over time generates more security in the use of silence as a process.

9.4 General Theory

The participants were asked to state their primary modalities on the demographic sheet, the results of which have been collated and included (see Appendix 5).

During the interviews, the participants also raised a wide range of theories and theorists. These incidents did not generate individual modality categories as the theory did not always relate specifically to silence. The breadth was deemed worth including to support understanding what influenced the therapist's general orientation. These have been collated by interview occurrence and total incidents and are included (see Appendix 7).

The participants made no assumptions about my theoretical knowledge or background, which meant they generously shared details of theory and theorists that influenced their practice. They raised a range of theory that supported the argument that the dominant approach to theoretical orientation was integrative. The training route required base training, followed by further specialisation in areas of interest. Post-training, therapists were free to integrate theorists of interest who addressed the needs of their specific client groups. The range of theory cited often supported their claim to be working collaboratively and relationally with clients.

9.5 Unseen Pressures

When the study was conceived, I had an original interest in the pressures that the therapists may be under to be doing rather than sitting in silence. This was born of experience in the UK and Germany, where organisations applied pressure for shorter, outcome-focused treatment plans. There was only one mention of the economic pressure for the therapists to be doing something rather than silence in the data:

> "If you, do you have to do utilisation reviews, they're going to say what interventions are you doing and if you answer well, I'm using a lot of silence they would say, we're not paying for that" (Peggy, INT3.14).

What was prevalent in the data was an unseen pressure to remain silent or be using silence more, whether the therapists did so or not. This was a notable finding given that participants had already described an *evolving disparity* and move away from *traditional abstinence.*

This led to me reflecting again on the ontology of critical realism (Bhaskar & Lawson, 1998). In particular, the proposition that social structure is a necessary condition and always pre-existing, and that human agency was necessary for the reproduction and transformation of social structure. I reflected on the critical realism dimension of "the real", defined by Bhaskar (2008) as the unobservable mechanisms and structure which generate events. Participants appeared to describe an unobservable mechanism still impacting the therapists' use of silence. I made an incorrect assumption that new students might employ less silence and was corrected by one participant, who stated:

> "They still have to be encouraged to loosen up, not to tighten up. If they stay buttoned up and like nervous, they start out feeling they have to be like a mask or a robot of a therapist, not a person… it doesn't come, it's not a problem the other way, even now, even if they identify as relational, there's still like a professional pressure" (Peggy, INT3.14).

> "…yeah, in graduate school, there's still some kind of stereotype or idea of this stiff therapist even and that's not just psychodynamic people, I think even the CBT people feel it" (Peggy, INT3.14).

Mullard (2015, p. 120), noted that "the neophyte clinician" is often more concerned with doing therapy correctly than in being a holding vessel for the patient to talk about their deepest material. He makes the important distinction that in the early years there can be a preoccupation with "doing" therapy as opposed to "being" a therapist.

There was discussion of unseen pressures to be silent and several participants commenced their interview with what seemed like an apology for not being silent enough:

> "I just think I should be better about that. I think I could afford to let there be more silence in my sessions" (Peggy, INT3.14).

The elusive nature of these unseen pressures was alluded to by participants:

> "always wanting to be doing the right thing" (Neil, INT3.9).

> “I mean, there were pressures, but I couldn’t honestly locate where those pressures were coming from’ (Betty, INT3.10).

There was also the converse sense that therapists could feel pressured to keep the client comfortable by being responsive, and some participants indicated that something could be lost in this process:

> “I think they’re very burdened by the idea that they’ve got to respond in such a way that it’s going to keep the patient there and that it’s a terrible failure if they don’t do that” (Freda, INT3.1).

> “This is one of the problematic developments in self-psychology, from my point of view, that the applied pressure to be responsive and there is a romantic fantasy that a therapist can provide perfect understanding to somebody by which therapists measure themselves so that in an effort to avoid self-criticism by feeling not empathic enough one is inclined to try to be as responsive as one can possibly be.” (Sol, INT3.18).

9.6 Conclusion

In this chapter I have discussed the grounded theory *intersubjective–silence* and what contribution it makes to providing new and unique knowledge. I have provided a review of relevant theory, and theory referenced by the participants.

Whilst some of the primary research referenced offers some complementary findings, in relation to the therapeutic relationship, and the timing the use of silence, it also highlights that *intersubjective–silence* is an original attempt at offering a complete overview of the therapist's process when using silence effectively.

In discussing the grounded theory *intersubjective–silence*, relating it to primary research, sources referenced by the participants, and further focused review of the literature, it is apparent that there are core findings that are unique to this study.

In the next chapter I will offer a conclusion to the thesis.

CHAPTER 10: Conclusion

Silence is therapeutic, and every artform, including psychotherapy, must deal with silence. It must. A master therapist is not a master therapist until he or she can deal and contain and hold and learn to love silence.

Dr. Bob Weathers (2014)

10.1 Introduction

The grounded theory *intersubjective–silence* was presented in Chapter 8 and discussed in conjunction with relevant literature in Chapter 9. In this chapter I will now evaluate the grounded theory, discuss further reflexivity, implications for practice, training, and the limitations of the study.

10.2 Evaluating a Constructivist Grounded Theory

This study addresses the considerable knowledge gap identified in the literature review (see Chapter 4) in how the therapist experiences silence. However, the study goes much further by proposing a grounded theory that represents what the study therapists consider effective or therapeutic silence – *intersubjective–silence*. It is argued that this is a significant contribution to knowledge; it both illuminates a shift in the understanding and application of silence from the Freudian use to a more contemporary psychoanalytic and integrative use of silence. It has implications for both training and practice. Before discussing these implications, it is worth taking the time to evaluate the theory in more critical detail.

Glaser and Strauss (1967, 1999) offered four ways to evaluate grounded theory: *a theory that fits the real world; works in predictions and explanations; is relevant to the people concerned; and is readily modifiable.* In keeping with constructivism, the epistemological underpinnings of the study, the findings need to be evaluated on whether they offer a viable fit with what might be going on in the world of the therapists, rather than confirming a version of reality.

Therefore, the best way to evaluate the findings would be to conduct further research as to whether the proposed constructivist grounded theory and categories fit with the experience of the participant. If aspects of it did not, then that would provide further data for the theory to be refined – demonstrating that the theory and or concepts are modifiable. As Glaser (1998) concurs, a grounded theory never fully reaches truth, but the more the data is analysed the more plausible the generated theory. As Reich (1973) put it, "scientific theory is a contrived foothold in the chaos of living phenomena" (p. 39) – none more so when attempting to define the therapeutic connection and process between two individuals.

Care in applying the grounded theory methodology correctly, Cooney (2011) argues, is the single most important factor in ensuring rigour. Using Charmaz's (2014) criteria for evaluating a constructivist grounded theory study, I will assess the resulting grounded theory for its credibility, originality, resonance and usefulness, and its ability to capture something of the experience of a therapist working in today's milieu.

10.2.1 Credibility

The three ethical principles of rigour (disciplined by honesty and integrity), respect, and responsibility were applied to all aspects of the research. Respect and responsibility were demonstrated in how the interviews were conducted and how the data was subsequently handled (see Chapter 6, Section 6.2). When evaluating the study, rigour is the foundation of credibility. This is demonstrated in the commitment to transparency in all stages of the study, with evidence being provided throughout each stage of the research process.

number of participants (sample size)

The final sample size was 20 interviews, providing over 22 hours of recorded dialogue. When considering grounded theory, the target sample size can seem arbitrary. Charmaz (2006) suggests that the aims of the study are the ultimate driver of the project design, and therefore the sample size. However, as a guide, 20 interviews fall within a recommended target size (Creswell, 2018; Mason, 2010; Thomson, 2011). The more information the sample holds, relevant to the actual study, Malterud, Siersma and Guassora (2016) argue, the lower the number of participants is needed.

The sample size was evaluated continuously during the data analysis and it was deemed credible for its capacity to answer questions asked of the codes and categories, in yielding new knowledge, and in meeting the aims of the research study. The transcribed data generated over 600 initial codes through line-by-line coding.

systematic comparisons

The development of the grounded theory *Intersubjective–silence* and all its categories and sub-categories required the systematic comparative analysis between categories and concepts. There was a seemingly endless cycle backwards and forwards, with additional questions raised and theoretical sampling conducted. The writing and sorting of memos was central to the development of the theory.

chain of evidence

Eisenhardt (1989, p. 548) argues that strong theory-building research needs to result in new insights, and that a good theory 'should display enough evidence for each construct to allow readers to make their own assessment of the fit of the theory'. Sample extracts from the interviews were included throughout the presentation of the findings (see Chapter 7 & 8). Appendix 8 contains a complete sample interview transcript.

It is believed that the substantive area in this study conceptualises and theorises the principal concern of the psychotherapists. This was achieved through an intersubjective exchange between the researcher, the participants and rigorous data analysis. The data was analysed through an interpretivist and constructivist lens, employing line-by-line coding. There remains a healthy subjectivity to my interpretation of the lived experience of the participants. The credibility and strength of the study, and ultimate theory, is further supported by the "chain of evidence" (Urquhart, 2013, p. 159) that it has produced and is accounted for. This supports the proposal that although the theory is interpretive, it remains grounded in the data.

saturation

There is limited value of member checks for research that is interpretative or that generates theory (Birt, Scott, Carvers, Campbell & Walter, 2016; Thomas, 2017). When considering alternative strategies to evaluate rigour for interpretative research, Morse (2018) focused on saturation (significant), theoretical coherence (useful), and audit trail (helpful). Saturation is defined as focusing on the conceptual, "the multiple strong examples of concepts presented in a logical coherent manner" (p. 812).

Saturation is more than a declarative statement (Morse, 2015). Saturation and indeed the definition of a "good enough" grounded theory is a study that is characterised by rich, empirical, original, and trustworthy data that reflect in depth the psychosocial process (Morrow, 2005; Morse, Stern, Corbin, Bowers, Charmaz, & Clarke, 2009). I believe that this study meets Morse's (1995) definition of saturated research as it is "written cohesively with confidence and competence", with comprehensive descriptions for each concept and pertinent examples. The theory is abstract and linked to literature (see Chapter 9).

instances

The categories cover a wide range of empirical observations. The list of categories and sub-categories for *intersubjective–silence* and associated references are presented in Appendix 9. All categories and sub-categories contain double figures in terms of supporting instances within the data. This provides evidence for strong patterns in the findings. The pre-merged categories, sub-categories, properties, and dominant codes are also included (see Appendix 10), further expanding the presentation of the chain of evidence.

There are strong logical links between the gathered data and the proposed theory and analysis. The thesis contains sufficient evidence to support these claims and to allow the reader to formulate an independent assessment of their credibility.

theory

The theory *Intersubjective–silence* is credible as a theory because it offers explanation and prediction of how the therapist uses silence. It also meets the alternative definition of a theory as a source of abstract understanding. It links abstract concepts together, seeing the relationships, and understanding the processes identified in a more comprehensive and abstract way. As a theory it opens the possibility of these concepts being a viable fit for other therapists.

10.2.2 Originality

The study addresses the gap in knowledge identified in the literature review (see Chapter 4) and offers new categories representing how the therapists use silence in the clinical setting. Evaluation by this standard alone supports the argument that the study makes an original contribution to knowledge. However, the study went beyond this by identifying the substantive area of concern for the participants as effective silence. This was conceptualised in the constructivist grounded theory *intersubjective–silence*. The theory effectively proposes how therapists use silence to effectively deepen the treatment.

The conceptualised categories and sub-categories of this theory offer an originally conceptualised rendering of the therapists' use of silence. The theory has therefore originality in purpose and output.

It also challenges some existing ideas as to how silence is used in psychotherapy, extending and refining current ideas, concepts, and practices. In doing so, it makes an original contribution to the theoretical and clinical knowledge base of psychotherapy.

10.2.3 Resonance

It is proposed that the theory *intersubjective–silence* portrays the fullness of the participants' experience. Whilst not included to validate the study, the samples from the data contained in the presentation of the findings (see Chapters 7 & 8) help evaluate resonance by reflecting the richness of the data in how it captures the participants' experience and the logical connectedness to the categories and sub-categories.

The utilisation of line-by-line-coding, memo writing, and continuous reflexivity reduced the potential bias of the researcher. The power and resonance of the data further challenged residue ideas and presuppositions. Resonance was inherent in the research process itself as theoretical sampling followed what was relevant for the participant and not the researcher. Further questions were asked of the data as emerging themes and categories were developed. When discussed as part of theoretical sampling, participants expressed a resonance with these categories and offered deeper insights about silence and how they worked with it.

The ultimate evaluation of resonance can be achieved by a presentation of the findings to psychotherapists. This has been achieved on an informal scale through presenting the findings to colleagues, who expressed a high level of resonance with *intersubjective–silence* and its associated categories and sub-categories.

10.2.4 Usefulness

The data analysis offers interpretations that have implications for psychotherapy and will be discussed in Section 10.4. The analytic categories suggest generic and specific processes in how the therapist uses silence. The grounded theory *intersubjective–silence* goes some way to predict and explain how the therapist resolves the use of effective silence.

The transferability of this research from the current setting to another is yet to be determined. The potential of this study is arguably enhanced due to clear reflexivity and the role and perspective of the researcher, and the clear audit trail of how data was captured and analysed. This transparency should ensure that a similar study can be repeated in a different setting. Given that the research is interpretive and not seeking positivistic validation, publishing the research may be the most efficient way to obtain feedback on the theory, categories, and sub-categories.

The theory has implications for when and how silence is used and can potentially enhance the process of training new and currently practising psychotherapists, discussed further in Section 10.5. As with all significant research, the study has usefulness in identifying areas for further study and consideration, which will be discussed in Section 10.7.

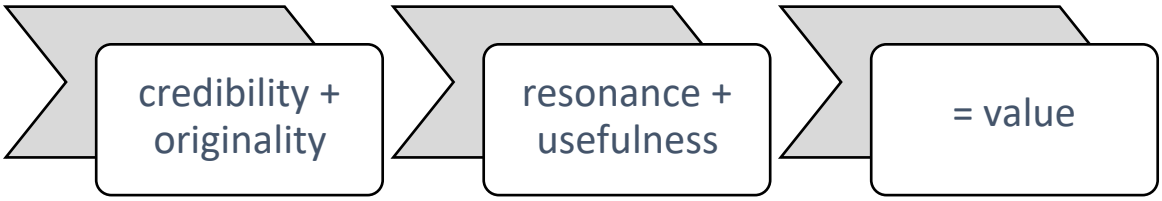
The findings in this study illustrate how silence can be used more effectively. This has the potential to improve the practice of psychotherapy and ultimately the experience of the client.

10.2.5 Value

Charmaz (2014) argues that a strong combination of credibility and originality increases resonance and usefulness, and ultimately the subsequent value of the theory, see Figure 25. She proposes that "when born from reasoned reflections and principled convictions, a grounded theory that conceptualises and conveys what is meaningful about a substantive area can make a valuable contribution" (p. 338).

Figure 25

Value of the research



10.3 Further Reflexivity

The previous chapters have contained instances of reflexivity throughout. In this section I will give further consideration to some of the most salient areas of reflexivity.

10.3.1 Preconceptions

The grounded theory method addresses the issue of preconceptions by applying line-by-line coding. I resisted the urge to merge codes prematurely, leaving over 600 of initial codes. On reflection, this was probably a case of over-coding, but I believe it ultimately led to a much more robust final theory.

The literature review did not generate any significant preconceptions that influenced the interview process. I was however aware that I retained some residue ideas and preconceptions as I commenced the first interview. I had a background interest in the use of silence and the relationship to negative transference. I was also specifically interested in whether therapists avoided negative transference by limiting the silence.

I was vigilant of avoiding nomenclature and only used jargon when first mentioned by the participants. Negative transference was mentioned in the data but mainly as it related to *evolving disparity*. The statement by several participants that it arises regardless of the use of intentional silence satisfied my initial interest in this area. It had the impact of changing how I saw the use of silence:

> "I think, there's no way to prove this, but my sense is that negative transference emerges and that I don't need to do anything on purpose to stimulate it. It will happen" (Melanie, INT3.7).

Several analysts described negative transference as being caused by silence rather than facilitating in its exposure. I thought that this was a deeply insightful hypothesis:

> "negative transferences are probably iatrogenic" (Sol, INT3.18).

I retained a belief that culturally, mid-West, Chicagoans had a greater propensity to chatter than people working and living in London, UK.

This was a reasonable assumption based on experience, but it was unsubstantiated in the data as most of the participants had no experience of the UK. The participants held some assumptions around Americans liking silence less than Europeans, but these were sporadic instances in the data. Cultural differences did not earn their way into the data. I did reflect on how freeing it was to conduct the field research in a different culture. It enabled me to embrace the interviews with a beginner's mind, having to understand from a phenomenological perspective how clinicians viewed their practice in the USA. I could not assume that I knew, and I believe this led to more open questions and an appreciation of learning more – the ideal attitude from which to conduct intensive interviews.

The research question in this study had its genesis in a previous study (Montgomery, 2018) that suggested therapists in the UK, due to fear of persecution as a consequence of audit culture and managerialism, were less likely to take a clinical risk than they had previously in their practice. I had questioned if clinicians felt pressured to reconsider taking risks, would they also feel under pressure to do something rather than nothing, and as a result use less silence (Hazanov, 2019)? The original plan for the study had targeted the UK for its core sample.

Following a family relocation, this was changed to the USA, where practitioners work in a private health care system with different pressures and considerations. There was only one explicit acknowledgement of external bodies potentially influencing the use of silence (see Section 9.5).

The therapists' preoccupation with clients' level of comfort presented itself as a more resilient influence on their use of silence. It earned its way into the data as a meaningful theme and eventual category. I was struck by the desire of the therapist to ensure the client was comfortable and reflected on how much this was related to the economic imperative of retention.

> "I think they're very burdened by the idea that they've got to respond in such a way that it's going to keep the patient there and that it's a terrible failure if they don't do that" (Freda, INT3.1).

The balancing of how much silence to use was a significant component of the theory *intersubjective–silence*. One therapist articulated how they tipped this balance in the favour of retention over discomfort:

> "If they're too comfortable they're not doing anything but if they leave they're definitely not doing anything. So, I use the harm reduction metaphor a lot you know, which comes from the substance abuse" (Peggy, INT3.14).

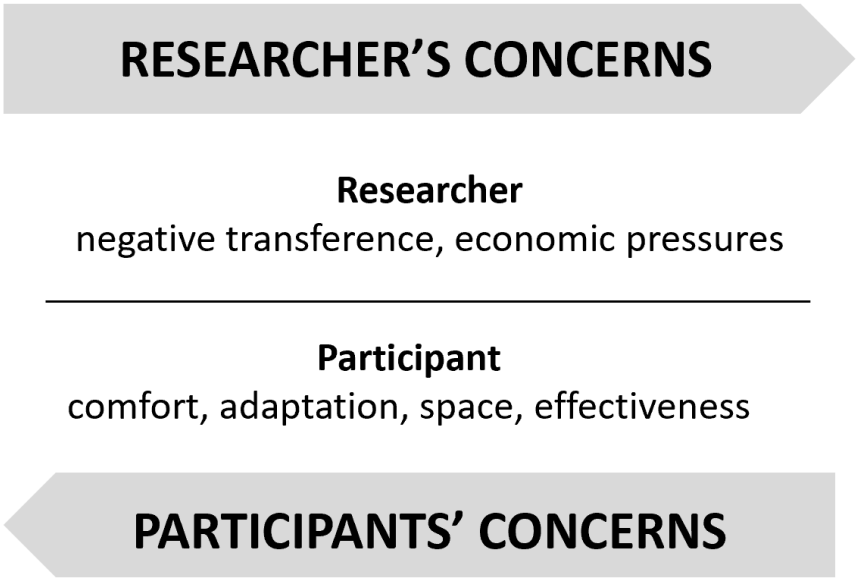
In addition to reflexivity, and memoing, my experience of conducting interviews and theoretical sampling acted as a failsafe to eradicate residue bias and assumptions. Ideas and concepts that were of interest for me would be quickly given less priority by the corrective nature of the interview exchange. It was curious to watch how I could get prematurely excited by striking anomalies in the participant experience.

For example, several participants had extreme childhood experiences with silence that were still impacting their relationship with silence in practice. Although striking, this was not a strong pattern in the data. Participants appeared to have no reservations in correcting a question or correcting an assumption. I reflected that this may have been a combination of cultural confidence and experience as senior therapists. It felt like we were engaging in *intersubjective* research practice.

As a final exposé of residue preconceptions and bias, I re-coded the interviews beginning at interview 4 and working *back* to interview 1. What I experienced was much more bias on my part in the first few interviews. My concerns were obvious from the questions. However, as the interview process proceeded, it was clear that I was letting go of my residue presuppositions and mini hypothesis, leaving more room for the participants' concerns. It also became clear that comfort was emerging as a significant category from the very first interviews. The shift from the researchers concerns to that of the participants is illustrated below:

Figure 26

Prioritising participants' concerns



10.3.2 Field notes

The field research afforded a unique opportunity to interview the participants in their clinical settings. All but one interview was conducted in one of their consulting rooms. There were many reflections on the settings but the most relevant to the study was around noise pollution. It was noted in many of the field notes that the noise pollution in the therapist's office was significant. These noises included: muffled but distracting voices from adjoining office, pets making noise, traffic on busy roads, and air-conditioning and standalone fans.

> "Sometimes the walls are not quite thick enough here" (Melanie, INT3.7).

The level of these noises was often initially distracting to me as an interviewer but were also objectively present and captured on the recording of the interview.

I reflected on the quality of the physical silence that the therapists could therefore offer the client, and I became aware of how relative and contextual that it is. There are levels of silence; noise pollution will impact on that.

10.3.3 Technology

I was cautious about the use of qualitative data analysis software (NVivo), specifically the potential to restrict the scope of the analysis by being constrained by the limitations of the programme. I reconciled these concerns by using the technology to support the analysis, as opposed to fitting the analysis into the functionality of NVivo. I reflected that this felt similar when using theory to support the therapeutic process rather than fitting the relationship into the theory. This resulted in using a combination of NVivo to support the analysis of data, and hosting a substantial amount of codes and references, and making use of multiple coloured index cards, pens and paper to develop concepts, and build theory.

I reflected on how the endless physical manipulation of the codes, concepts and categories on cards reflected the complexity of the therapist experience. It represented a more analogue flow of ideas and processes that could not be so readily replicated in NVivo. Early memos were also initially recorded in NVivo but later transposed to index cards for easier sorting.

10.3.4 Uncomfortable silences

I reflected that I had not foreseen the therapists' preoccupation with uncomfortable silences, despite it being common parlance – as captured so eloquently by Tarantino (1996):

> Uncomfortable silences. Why do we feel it's necessary to yak about bullshit in order to be comfortable? That's when you know you've found somebody special. When you can just shut the fuck up for a minute and comfortably enjoy the silence (p. 45).

I reflected further on what causes silence to be so uncomfortable at times. Several participants discussed the noise in society and how people are less familiar with experiencing periods of silence. In addition to the ambiguous nature of silence discussed in the findings, the silence between a therapist and client can seem to lack a structure or direction. Clients and therapists are left with their own thoughts about what each is thinking about the other. I reflected on how, with the ubiquitous use of smartphones, there is less and less learned behaviour of being in silence socially and emotionally. I also thought about silence as a metaphor of death, as Mitchell (2020) describes it: "we know our lives are going to end, we don't know when or how, but we know it silently and uncomfortably" (p. 75).

10.3.5 Personal impact of conducting the study

When I commenced this study, I had my own ideas on the use of silence, forged from a combination of training, theory, clinical and personal experience. I valued the use of silence in the clinical setting. There is often debate as to how closely psychotherapy represents a normal conversation.

It was clear for many of the participants that their practice was much closer to a normal conversation than that synonymous with classical analysis. Some commented that too much deliberate silence would detract from that normalcy.

My experience of a normal conversation is one where there is virtually no silence, people can interrupt and freely offer advice rather than be-with the pain of the other. The silence offered by psychotherapy is exactly why I believe psychotherapy is not a normal conversation. It is an enhanced conversation with significant skill and attention being bestowed upon the client.

I contemplated that true listening is being open to the possibility that it can change you. The therapists were overwhelming in their emphasis on the needs of the client being primary. They were categoric in their belief that the abstinence and withholding associated with more classic psychoanalytic therapy was not something they would now use. I think I had some residue attachment to this way of working and I now believe that meeting the needs of the client to feel safe, comfortable, and held, supersede any pre-notion of theory. It is what the majority of clinicians with hundreds of years of experience were arguing for. This did not contradict the participants' use of theory; it just became dependant on the client. Loewenthal (2017) suggests for example, that not wishing to start with psychoanalytic theories seems very different to allowing them to sometimes come to mind. He suggests:

> What emerges between therapists and patients can similarly be seen as calling for an open, engaged, phenomenological approach, rather than a scientific or psychological one with its claims for neutrality, impartiality or objectivity. Psychotherapy can be considered to be an attempt to carry out phenomenology à deux (p. 30).

At the commencement of the study, I would have described myself as an existential-phenomenologically informed psychoanalytic practitioner (Montgomery, 2020). I had avoided the term integrative because I viewed it as an attempt to fuse disparate theories. The study reframed how I viewed the whole concept of integrative from one that focused on theory to one that focused primarily on the therapeutic needs of the client, and what theory best meets those needs.

I have trained in a spectrum of psychological approaches beyond the psychoanalytic or existential, in a similar way to my American colleagues Hubble, Duncan, and Miller (1999): "The survival of mental health professionals, in other words, will be better ensured by identifying empirically validated treaters rather than empirically validated treatments" (p. 439). This view was more recently revised and made more specific by Miller, Hubble, Duncan and Wampold (2010): "A recovery-focused service requires a shift from professional interventions based on diagnostic labels and prescriptive treatments to individually tailored, consumer-directed planning" (p. 426).

10.3.6 Silence

I wanted to give the final reflection to silence. During the write-up of this study, I visited the remote area of the Fisher Towers, near Moab in Utah. I had no memory of ever being in such a remote place, so far away from society, just rocks and scorched landscapes, as far as the eye could see. It was early morning, there were no other visitors.

I became conscious of silence, dead silence, the deadest of silence. Not even the sound of an insect, a bird, electric pylons, or planes. I was overwhelmed with the feeling that one can only have when experiencing something completely new – absolute silence.

I sat in it and felt its awe, for it was not I experiencing silence, it was silence experiencing me. After some time and just as my mind started to struggle with processing the experience, I was saved by a growing awareness of the ringing of mild tinnitus. Just as the audacious explorers of silence before me discovered, I truly experienced what I had only previous read in the literature (Chapter 2 Introducing Silence): echoing the experience of serious explorers of silence before me.

10.4 Implications for Psychotherapy Practice

The main implication for psychotherapy practice is that the theory of *intersubjective–silence* endeavours to represent what constitutes the effective use of silence for this group of participants. The study proposes that these are the main implications for psychotherapy practice:

- silence in therapy can be powerful and ambiguous
- the use of effective silence is a skilled intervention
- most therapists seem to learn from experience
- silence is most productive when used after the formation of a strong therapeutic alliance
- the use of silence is most effective when tailored to the therapeutic needs of the client
- therapy is more effective when clients feel comfortable safe and trusting.

The study vividly highlighted the therapists' *sensitising silence* to the individual needs of the clients, highlighting that over time and experience therapists placed the focus of their intervention on the client over any theoretical orientation. This approach is perhaps accentuated by the collective length of clinical experience that participants hold. It urges the practitioner and or trainee, in the context of manualised treatment, to reconsider the therapeutic needs of the client.

Non-therapists may make the assumption that therapy always focuses on the client. However, therapists can be engaging in a range of activity rather than being-with the client and listening. This can manifest in the need to be doing something rather than nothing, including a range of activities seen as part of the process: taking notes, praying, formulating, interpreting. This study has brought into sharp focus the experienced therapist's focus on the client. Their practice could be described as client-centred and adaptive to their needs – *sensitising silence*. It could be argued that this may be true for all interventions. Over time the therapist learns that what is most important and effective is the focus on the client.

10.5 Implications for Education and Training

The art in psychotherapy became vividly clear whilst conducting this study. The focus on evidence-based, manualised treatment, can leave little or no time for the nuances and subtleties involved in clinical practice – none more so than when considering the effective use of silence. What also became clear was how little formal discussion there is about the therapist's use of silence. As a crude exercise, and to complement the background literature review (Chapter 3) I randomly selected 40 books from a collection spanning psychoanalytic thinking, existential, person-centred, to relational.

None of the books had a single reference to silence in the index. Silence, perhaps like death, is a topic to be avoided. When contrasted with how powerful, uncomfortable, and ambiguous therapists describe silence, it needs to receive the attention that it deserves in training and education.

There are three key recommendations for training and education: becoming aware of silence; being comfortable with silence; and the most effective use of silence. The theory *intersubjective–silence* has a contribution to make in all three areas.

Therapists in early training need to become more aware of the power and ambiguous nature of silence. Given what the participants said about pressures to be silent, the expectations around the therapeutic relationship need to be made more explicit. An effective method for achieving this is to allow the trainee to experience silence in control settings, an experience of being silent and experiencing what it is like for a client.

When considering training, Bohart and Tallman (2014) are specific in their recommendations: "Be comfortable with silence. Silence is critical when the client is thinking effectively, engaging in self-reflection, imagining new possibilities, and considering changes" (p. 99). This suggestion of a training experience and encounter with silence will hopefully contribute to the therapist becoming more comfortable with silence.

The importance of *free associating* has been discussed and conceptualised to promote its importance but also to distinguish it from the classical psychoanalytic concept.

There is an opportunity to position the importance of *free associating*, as the data supports – the therapeutic benefit of allowing time and space for what arises to arise.

I also concur with Geller and Porges (2014): psychotherapy training typically centres around intervention and techniques, with little attention to or discussion of how the therapists can cultivate presence to support client connection and safety. This could be addressed with more focused training on the use of silence in ways that best meet client needs.

There is a growing literature in what constitutes best practice in psychotherapy. The effective use of silence needs to be added to the list. This study has built on previous studies to offer further consideration to when is the best time to use silence. There is strong consensus that silence is most effective when used later in treatment and when there is a strong therapeutic alliance. These are key points that could be presented for further exploration and discussion within training and education environments.

10.6 Limitations of the study

The sample size of 20 participants yielded sufficient data, concepts, and categories to construct the beginnings of a grounded theory. As argued under Section 10.2, this was evaluated as fully adequate to meet the aims of the study. The sample size and the limited timeframe of the study placed restrictions in going deeper into individual concepts and categories. The theory offers what is arguably a general theory with signposts to key areas in the therapist's use of silence for further exploration and depth.

The geographical catchment area from which to conduct face-to-face interviews was within the city and suburbs of Chicago. This was arguably a limitation as the geography was specific and contained. However, it offers subsequent research a solid sample area from which to contrast and compare. Some participants referred to the dominance of a more formal psychoanalysis in New York and parts of California. Chicago provided a more "mid-west" alternative that may be more representative of America as a whole.

The focused geographical area may, however, offer future researchers a clearly defined position from where to commence. It may provide, for example a different distinct geographical area with which to contrast another. It is also worth noting, as highlighted in the study the lingering influence of key analysts and theorists from the predominant Chicago institution where some of the participants were trained.

Whilst in accordance with grounded theory data generation, interviews provide a statement on the therapist's use of silence – their own interpreted version, further explored and interpreted in the data analysis.

A limitation of the study is just that: an interpretation of what the therapist is doing conceptualised into a theory. This is an inherent limitation that is hopefully somewhat mitigated by the adherence to transparency and reflexivity throughout the study.

A major motivation for conducting the study was the lack of research. There was an abundance of research on client silence, but limited research on the therapist's use of silence.

Whilst the interviews remained focused on therapists, they often discussed what they perceived and believed to be happening for the client. It is fair to say that this has its limitations, in that the therapists are offering second-hand information and interpretation, as to what is alive for the client. Whilst a therapist's potential understanding of the client is arguably at the heart of psychotherapy, and therefore one would hope that the therapist does have a degree of insight, the study is only offering the therapist's interpretation of this collaboration, and therefore this is a limitation to the study.

The few previous studies conducted on silence captured a predominately white older male demographic. This study sample had some diversity in gender, sexuality, professional orientation, and stated modality. Despite direct appeals to individuals and organisations representing traditionally underrepresented groups, including people of colour, young people, and people of non-binary gender, and non-heteronormative sexuality, the sample was predominantly older white participants identifying as female (n=12) and male (n=8). This could be seen as a limitation to the study.

The use of critical realism was in part selected to address some limitations drawn out from a critique of social constructionism namely its inadequacy in addressing issues of embodiment, materiality, and power (Chapter 5, Section 5.2). A sustained effort was made to explore them with the sample achieved, a broader sample would have arguably offered more data in these. Embodiment was explored in terms of how and where in their 'body' the therapists were listening to, and intuiting, their own, and clients' responses. It would have been valuable to explore the variations between cultures in the use and meaning of silence, soft signalling, and intuiting.

The setting of the clinical work was never divorced from the cultural context, and the issues of power between structures, institutions, therapists, and clients were discussed. The richness of the interview conducted in a federally funded organisation offering services to LGBTQ populations was notable in this regard. These issues were prevalent and explored in much detail, the interview differentiated from the other interviews in this regard.

I would envisage that if I had obtained a broader sample then these issues would have had more opportunity to arise when engaging with traditionally more oppressed or silenced voices. I would propose that the limitations in the sample were countered somewhat by my commitment to reflexivity on these areas throughout the study.

The individual categories within the demographic data did not earn their way into the data. However, a key finding in the data was the influence of the therapist's experience – *silently experiencing* – as influencing their willingness to use silence. All participants were experienced therapists, with a total of 580 years in practice, 28 on average, and 6 years as the least experienced. Whilst participants did discuss the contrast between their early practice and provided significant detail from long careers, it would have been useful to explore the experience of younger and or newly trained therapists. Consideration may need to be given to incentivised participation in order to reach these groups which points to the potential for further research.

10.7 Further Research

It has been argued that this study has met the aims of the study outlined in Chapter 1. However, it is viewed as only the beginning. As Morse (2018) states: “excellent research, even seminal research, does not terminate inquiry; it stimulates, increases interest, and promotes further research” (p. 812).

As identified in the limitations of the study, it would be valuable to interview a younger and less experienced demographic. In contrast to the hindsight described in the current study, the focus of this future research could be, to try and elicit, what the barriers are to effective silence, closer to the beginning of clinical careers. This would include trainee and newly qualified therapists.

The client’s direct perspective would be invaluable in deepening and further enhancing the theory. Examining the client’s experience of what the therapist perceives is effective silence would be valuable data to capture and analyse. It would be useful to explore if the client agrees with the therapist, or if they have different insights. It would be interesting to bring more focus as to what the client’s needs may be at any given time, not to manualise silence but rather to give further insight into best clinical practice.

The study seems to suggest that there is value in conducting further research into the concept of *benign witnessing* and the concept of *presencing*. I retain the belief that these practices continue to be under threat from a technologically busy, and increasingly noisy society. It is arguably the practice of being-with a client that separates depth psychotherapy from the doing-with of more action orientated approaches.

Due to the prevalence of these concepts further research could explore each of them in more detail, focusing on the nuances between witnessing and presencing. It is believed that the more that can be understood about what is occurring for the therapist, and indeed the client, during these intersubjective events, then the more it would contribute to a deeper understanding of the therapeutic implications.

I want to avoid the whimsical arrogance of Žižek (2021), "If you have a good theory, forget about the reality" and I therefore view *intersubjective–silence* as merely the beginning of understanding and not the end.

10.8 Conclusion

The 20 psychotherapists who generously participated in this study have contributed to our understanding of the use of silence in the clinical setting. The study highlights the complexity of silence as an area of study in a field that is constantly evolving.

The study adds to the existing practice knowledge by attempting to theorise how therapists use silence effectively. It proposes a contemporary reframing of effective silence in the theory of *intersubjective–silence*. Whilst previous studies have touched upon aspects of some categories, *intersubjective–silence* is unique and ambitious in its attempt to capture the therapist's process in totality.

This study also addresses the gap identified in the background and primary literature regarding how the therapist uses silence. It proposes the theory *intersubjective–silence* that begins to explain the therapist's process when using silence in a contemporary way. It suggests that therapists, regardless of stated practice modality, are working in a more client-focused and integrative way.

The study reappropriates the concept of free associating from the original psychoanalytic term, proposing the importance of the therapist creating a welcoming space where material is free to arise.

Previous studies have suggested when the therapist may be more inclined to use silence. This study is original in its definitive proposal around the timing of silence. It also considers the experience and confidence of therapists as a significant influencing factor in their propensity to use silence.

In addition, the study offers an original contribution by capturing the *evolving disparity* in therapists' use of silence when contrasting how they practice now with how they were trained. It vividly highlights the shift from a one-person psychology to one that is collaborative and considered intersubjective.

The heart of the theory, and indeed the study, attempted to conceptualise the process the therapist goes through when *intersubjective-silence* is in effect. The four cornerstones of the theory offer new concepts and categories, providing for the first time a clear insight into what contributes to effective therapeutic silence. The theory also shows that silence is sensitised to individual client needs moment to moment, and challenges claims by previous studies that there are broad client categories as to the use of silence. It proposes the importance of comfort in *intersubjective-silence* and offers a more nuanced view of the positive experience of remaining with some potentially mutual, discomfort in silence.

The theory presents a new concept in *optimal specificity*, capturing the therapist adapting silence to the specific needs of the client. The study further argues that there is no set way to use silence with clients who have experienced trauma, but rather the effective use of silence demands a *sensitising silence* to the specific needs of the client.

Previous studies have suggested the potential benefits of silence but *intersubjective-silence* offers three detailed concepts (*room of their own, benign witnessing, taking stock*), that support the therapeutic process in *deepening the treatment*. Whilst theorists have been aware of some of these properties, the study argues that this is the first time they have been conceptualised and presented in a single cohesive theory. *intersubjective–silence* is unique in offering a vision of best practice that transcends any one specific modality, placing the emphasis on the needs of the client.

I remain optimistic and excited about the potential of the theory *intersubjective–silence,* the dissemination of the findings, the subsequent feedback, and what it may offer to the knowledge base of psychotherapy in the future.

CHAPTER 11: References

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CHAPTER 12: Appendices

Appendix 1 – Search Strategy

Flow of information during literature review

PROCESS	METHOD
Identification	• Search strategy using key words on electronic databases
Screening	• Duplicates would be removed using excel/citation software • Title and Abstract would be screened against Inclusion and Exclusion criteria
Eligibility	• Full text article would be screened using data extraction form • Primary research would use Hawker's Critical Appraisal • Citation chaining would be used to source additional relevant papers
Included	• Only papers meeting the final eligibility criteria would be included for further analysis
Analysis	• Meta-ethnography would be used to analyse the data, employing the lines-of-argument method to compare the data, cluster findings, then to develop a new-line-of-argument

Adapted from Moher, Liberati, Tetzlaff, Altman, and The PRISMA Group's (2009) flow of Information.

Scoping Exercise

There was a period of experimentation, trial and error as part of the initial scoping exercises. Due to 'silence' being a multifunctioning term publication were searched by title and abstract. The low volume of data and necessity for careful data mining meant that the use of Boolean searches was restricted, and search criteria given below in clear terms.

Other key words were explored like non-verbal and intentional.

Search strategy for PsychINFO

MAIN SEARCH AREAS	**SEARCH TERMS**
Silence	*Silence OR Non-verbal*
	AND
Discipline	*Psychoanalysis* OR *Psychotherapy OR Counselling OR Counseling* OR *Psychotherapeutic*
	NOT
Excluding	Career OR Education OR Educational

Additional databases searched:

PEP-Web (Psychoanalytic Electronic Publishing) Database

http://www.pep-web.org/

"The PEP-Web Archive is the quintessential website for psychoanalytic scholarship, with the full text of 59 journals dating back to 1918, cross-linked to each other and full bibliographic references to external sources, and where a multi-source psychoanalytic glossary is a click away for any technical term"

DATABASE	SEARCH TERMS	RESULTS
Pep-Web 07.03.18	Silence	126
	Total:	***126***

PscyNET Database

https://psycnet.apa.org/

PscyNET is an amalgamation of PsycInfo and PsycArticles.

PsychINFO Database

"The PsycINFO, database, American Psychological Association's (APA) renowned resource for abstracts of scholarly journal articles, book chapters, books, and dissertations, is the largest resource devoted to peer-reviewed literature in behavioural science and mental health. It contains over 3 million records and summaries dating as far back as the 1600s with one of the highest DOI matching rates in the publishing industry. Journal coverage, which spans from the 1800s to the present, includes international material selected from around 2,500 periodicals in dozens of languages".

PsycArticles

"PsycARTICLES is a database of full-text articles from 117 journals published by the American Psychological Association, the APA Educational Publishing Foundation, the Canadian Psychological Association, and Hogrefe & Huber. The database includes all material from the print journals".

DATABASE	SEARCH TERMS	RESULTS
PsycNET 16.01.18	Silence AND Psychotherapy	591
	Silence AND Counsel* NOT educat* [Counselling, counselling, education, educational]	28
	Total:	***619***

PubMed Central®

https://pubmed.ncbi.nlm.nih.gov/

"PubMed Central® (PMC) is a free full-text archive of biomedical and life sciences journal literature at the U.S. National Institutes of Health's National Library of Medicine (NIH/NLM)"

DATABASE	SEARCH TERMS	RESULTS
PubMed Central	Silence AND Psychotherapy OR Counsel* [counselling, counselling]	5
16.01.18	***Total:***	***5***

ProQuest

https://www.proquest.com/

Through active partnerships with more than 700 universities, ProQuest disseminates and archives of more than 90,000 new graduate works each year. These works are available through library subscription databases and for easy and convenient ordering. To see examples of quality research from our archive, visit ProQuest's most-accessed dissertations.

DATABASE	SEARCH TERMS	RESULTS
ProQuest	Silence AND Psychotherapy OR Counsel*	110
16.01.18	***Total:***	***110***

EthOS

https://ethos.bl.uk/

EThOS is the UK's national thesis service which aims to maximise the visibility and availability of the UK's doctoral research theses. There are approximately 475,000 records relating to theses awarded by over 120 institutions. Around 160,000 of these also provide access to the full text thesis, either via download from the EThOS database or via links to the institution's own repository. Of the remaining 240,000 records dating back to at least 1800, three quarters are available to be ordered for scanning through the EThOS digitisation-on-demand facility.

DATABASE	SEARCH TERMS	RESULTS
EthOS 08.03.18	Silence AND Psychotherapy	5
	Silence AND Counsel* [counselling, counselling]	9
	Total:	***14***

Inclusion and Exclusion Criteria

INCLUSION	**EXCLUSION**
Primary literature	
Articles published in peer-reviewed journals	book reviews
Published doctoral dissertations	
Focus on silence	
Silence within the clinical setting	group therapy family therapy silence that relates to confidentiality inter-professional communication career counselling educational counselling
Focus on silence from the perspective of the therapist	silence of the client only silence as power or control silence as it relates to confidentiality maternal silence silence as trauma political silence (oppression)

Appendix 2 – Interview Codes

CODE	INTERVIEW DATE	PSEUDONYM	LENGTH MINS
INT3.1	20.02.19	**Freda**	79
INT3.2	28.02.19	**Alison**	55
INT3.3	04.04.19	**Kerry**	51
INT3.4	24.04.19	**John**	75
INT3.5	30.04.19	**David**	57
INT3.6	08.05.19	**Maria**	78
INT3.7	10.05.19	**Melanie**	53
INT3.8	13.05.19	**Ester**	52
INT3.9	24.05.19	**Neil**	64
INT3.10	29.05.19	**Betty**	52
INT3.11	04.06.19	**Richard**	61
INT3.12	08.06.19	**Harvey**	94
INT3.13	11.07.19	**Jill**	83
INT3.14	12.07.19	**Peggy**	58
INT3.15	15.07.19	**Jenny**	54
INT3.16	17.07.19	**Ezra**	83
INT3.17	23.07.19	**Frankie**	78
INT3.18	23.07.19	**Sol**	52
INT3.19	29.07.19	**Clive**	64
INT3.20	30.07.19	**Anna**	63

Appendix 3 – Informed Consent

1 x Participant Information Sheet

1 x Participant Consent Form – researchers copy

1 x Participant Consent Form – participants copy

https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

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Appendix 4 – Demographic Information Sheet

Appendix 5 – Demographic Data

NO.	AGE	GENDER	RACE	SEXUALITY	QUAL.	ACADEMIC DESCRIPTION	LICENCE	PRIMARY MODALITY	FREQ.	AVERAGE LENGTH	YEARS EXP.
1	67	Female	White	Hetro	MA	MA in community counselling	LCPC	Integrative	1	28 sessions	15
2	62	Female	White	CIS	PhD	PhD in Clinical Psychology	LCP	Integrative	1	6 years	33
3	74	Female	Cauc.	Hetro	PhD	PhD in Clinical Social Work	LCSW	Psychoanalytic and Integrative	1 to 2	?	30
4	71	Male	White	Straight	PhD	PhD in Clinical Psychology	LCP	CBT	1	1 to 25 years	45
5	69	Male	Cauc.	Hetro	PhD	PhD in Clinical Psychology	LCP	3rd wave behaviour therapies	1	12 sessions	40
6	46	Female	Latina/ White	Hetro	PsyD	PsyD in Counselling	LCPC	Systems/Integrative	1	8 months	10
7	61	Female	Cauc.	Bi	PhD	PhD in Clinical Psychology	LCP	Interpersonal / analytical	1 to 2	variable	33
8	52	Female	Cauc.	Hetro	MA	MA in Clinical Mental Health	LCPC	ACT/CBT	1 to 2	variable	20
9	42	Male	White	Hetro	MA	MA in Counseling Psychology	LCPC	Psychodynamic (relational), DBT, somatic experiencing	1 to 2	3 years	6
10	47	Female	White	Straight	MA	MA in Psychoanalytic Psychotherapy	LCPC	Psychoanalysis/ Psychoanalytic Psychotherapy	1 to 3	3 years	10

NO.	AGE	GENDER	RACE	SEXUALITY	QUAL.	ACADEMIC DESCRIPTION	LICENCE	PRIMARY MODALITY	FREQ.	AVERAGE LENGTH	YEARS EXP.
11	73	Male	White	Hetro	MD	Medical Director	MD	Psychoanalytic orientated	1 to 2	years	40
12	58	Male	White	Gay	MA	Masters in Social Work	LCSW	Rogerian client centred	1	24 sessions	12
13	61	Female	White	Fluid	MA	Masters in Social Work	LCSW	Relational/self-psychology	1 to 2	5 years +	35
14	52	Female	White	not stated	PhD	PhD in Clinical Psychology	LCP	Integrative Relational Psychodynamic	1 to 2	2-4 years	29
15	60	Female	White	Hetro	MA	Masters in Social Work	LCSW	Integrative	1 to 2	1-2 years	30
16	64	Male	Jewish/Cauc.	Hetro	PhD	Social Welfare (advanced Practice)	LCSW	Contemporary Psychoanalyst	1 to 4	6 months - 10 years	41
17	72	Female	White	Hetro	PhD	Human Development	LCP	Psychodynamic, relational, developmental	1 to 4	5 years	45
18	68	Male	Jewish	Hetro	MD	Medical Doctor	MD	Psychoanalytic	1 to 4	5 years	35
19	71	Male	Cauc.	Hetro	PhD	Behavioural Sciences	LCP	Psychoanalytic	1 to 4	1 year	31
20	76	Female	Cauc.	Hetro	MS	Counseling Mental Health	LCPC	Psychodynamic	1 to 2	6 weeks to 10 years	20

**Participants were asked to voluntarily complete the demographics sheet using whichever language they felt represented how they viewed themselves.*

Appendix 6 – *Data Management Plan*

The Digital Curation Centre's (DCC) template for data management was used in the preparation of this plan.

Data Collection
Approximately 20 participants will be interviewed one-to-one by the researcher. The interview will be recorded using an Olympus digital voice recorder using MP3 file format. The MP3 file will be transferred to the main PC and then deleted off the recorder.

The interviews will be recorded and transcribed to a Microsoft Word document format (.doc).

Documentation and Metadata
The data will be anonymised, and client details redacted. Documentation and metadata will be supplied with the final data including a description of the study, time and date of the interview and broad demographic information. The data will be provided in transcribed text format.

The University of Northampton's Ethics committee reviewed and granted approval prior to the collation of the data. The American Psychology Association's (APA)ethical principles and code of conduct was also adhered to (see Section 8: www.apa.org/ethics/code/). The new General Data Protection Regulation (GDPR) guidelines were also consulted.

Storage and Backup
Data will be stored on a standalone, sole access, password protected PC.

A backup of the data will be made on a password protected WD Elements external drive.

Data will be transferred to a trusted transcribing company via an encrypted file transfer service. The company adheres to strict confidentiality and data protection policies and procedures. They delete all data 7 days after return to the and confirmation from the researcher.

In the instance of the supervision team requiring to review the data, the file will be sent using encrypted password protection.

The data will be stored for 10 years using the university's developing services enabling registration, deposit, storage, retention of and access to digital research data (via TUNDRA2).

Selection and Preservation
All of the interviews will be preserved in Rich Text Format (.rtf) format and stored on the university's servers for 10 years. The researcher will retain a compressed, password protected backup.

Data Sharing
It is not intended to share the data.

Responsibilities and Resources
The researcher, under supervision from the supervisor and director of studies will be responsible for the data management and security.

The resources to deliver the plan are:

- Dell Desktop PC – sole access and password protected
- Microsoft Word 2016
- WD Elements external hard drive – password protected
- Olympus digital recorders x 2
- Xfinity connection
- www.wetransfer.com (encrypted data transfer service)

Appendix 7 – Modality and Theory

MODALITY AND THEORY	INTERVIEWS	INCIDENTS
COGNITIVE BEHAVIOURAL RELATED		
Acceptance and Commitment Therapy (ACT)	2	2
Cognitive Behaviour Therapy (CBT)	8	25
David Barlow	1	1
Dialectical Behaviour Therapy (DBT)	4	4
EMDR (Eye Movement Desensitization and Reprocessing)	2	12
The Unified Protocol (UP)	1	3
EXISTENTIAL RELATED		
Irvin Yalom	1	1
INTEGRATIVE		
Integrative	4	9
Internal Family Systems	2	3
Paul Wachtel	1	2
PEOPLE-CENTRED		
Carl Rogers (Rogerian/client-centred)	4	11
PSYCHOANALYTIC RELATED		
Anna Freud (Ego Psychology)	4	11
Carl Jung (Jungian)	2	2
Donald Stern	2	4
Donald W. Winnicott	6	24
Harry Stack Sullivan	1	4

MODALITY AND THEORY	INTERVIEWS	INCIDENTS
PSYCHOANALYTIC RELATED (Continued)		
Herb Slazenger	1	1
Howard Bacal	2	4
Melanie Klein	7	17
Merton Gill	2	6
Object Relations	4	5
Psychoanalysis	12	27
Psychoanalytic	20	73
Psychodynamic	5	21
Ralph Greenson	1	1
Robert Langs	1	1
Sándor Ferenczi	2	2
Sarah Nettleton	1	1
Sigmund Freud	8	34
Thomas Ogden	1	2
Wilfred Bion	3	6
RELATIONAL RELATED		
Beatrice Bebe	1	1
Contemporary Analyst Relational	4	10
Lora Tessman	1	1
Relational	15	51
Stephen Mitchell	2	4
Tony Bass	1	1

MODALITY AND THEORY	INTERVIEWS	INCIDENTS
SELF-PSYCHOLOGY RELATED		
Heinz Kohut - self psychology	3	5
Self-Psychology	3	4
TRAUMA RELATED		
Laurie Khan	1	1
Polyvagal Theory	2	3
Tri-Phasic Model of Trauma Treatment	1	3
MISCELLANEOUS		
Body Centred (embodiment)	2	2
Constructivist	1	1
Jane S. Hall	1	1

The question "Primary Modality" was contained in the demographic sheet, but individual modality was not a separate category in the final theory.

Appendix 8 – *Sample Interview*

INTERVIEW CODE: INT3.7 [Melanie]

I: So, what comes to mind when I mention the topic?

P: Well, I think what comes to mind first is the disparity between the way I was trained which was primarily psychoanalytic or psychoanalytically informed and silence was very much identified as one of the therapist tools. The idea was that one doesn't necessarily try to make a patient comfortable, that would allow them to sit or in some cases, lie with silence, lie down with silence and that from their discomfort in some ways will emerge what needs to emerge. And while I'm still very comfortable with the use of silence I think I think about it in a different way now because I really try to tailor each treatment to the very specific needs of very different patients. So, for some people there is a kind of comfort for them in knowing that I'm patient. They can take time to sort of form their thoughts, articulate their thoughts and that won't be disruptive. For others, that could be agonising, they could feel abandoned, they could feel embarrassed. And I think of my primary task as creating alliance and so, for people who are either new to the process or really uncomfortable with any kind of silence are more likely to jump in and make some kind of bridge.

I: So, wow [laughs].

P: Sorry, is that too much?

I: It's great, it's great. So, going back then, what changed for you in your relationship with silence?

P: Well, I think it really is and I don't mean to just be theoretical with you but I think it really paralleled the shift in really my thinking about how to treat people because there is a lot in the psychoanalytic model

that I found foolish and just not very realistic and also I objected to the fact that it really limited the scope of type of patients we could treat.

So, people with a lot of severe personality disorders which my practice had many of for the first 10, 15 years, a lot of my patients were referred by the Eating Disorders Unit at [Redacted] which is one of the places I worked. Anyway, I became interested in self-psychology and one of the things I liked about it is again, the focus on providing a more understanding setting, a more understanding interpretation that speaks to the need for certain defences as opposed to just throwing lances at them and trying to pop them open. And so, that certainly influenced me. And then in the last maybe 10, 12 years I've read a lot more of the relational therapists who speak to the need of, or speak to the importance of the relationship as the curative medium and therefore, everything we do matters, and I suppose it always has. The relationship needs to be alive as opposed to setting oneself aside in the superior all-knowing position where one is impassive, quiet, very reserved, more like your experienced sort of people in the southern part of England – that sort of thing. So, I think some of my views about silence correspond with this evolution in my, I hope it's an evolution and not a devolution in my view of how I see myself as a therapeutic agent.

I: So, just out of interest, the relational people, is there anybody pops out or a particular influence?

P: Well there's a lot and I'm going to go blank on names right at the moment, but I'll come back to that.

I: I would be aware of a lot of that, but I don't want to feed it, but it just helps me position a little bit. So, you used the word 'comfort/discomfort' so where is the place then for discomfort in the session?

P: I think the place for it depends on the strength of the patient and what we're trying to do. So, for example, in seeing someone who was badly abused as a child and who is trying to figure out if some of that abuse included sexual abuse as well as the more ordinary kinds of

physical abuse, there are times when she's kind of just sitting on the couch and she's clearly uncomfortable but she's processing, she's kind of revisiting her past in her mind and I feel as though it's important for me just to be with her, I don't need to do anything. And if it goes on for a really long time and you may ask me how long that is, I'm not sure but maybe five minutes or something like that then I may say I'm curious about where you've been going in your mind, something like that.

I: So, in those five minutes what would you be doing?

P: I sit, I try not to fidget because I'm a fidgeter. I'm not usually staring right at her because I think that would be uncomfortable, so I'm kind of staring kind of like I am now a little one way or the other.

I: And would you be going through a process yourself?

P: Yeah. I feel as though I'm with her, I'm kind of hypothesising about what's going on and reviewing what she's been talking about.

I: So, it sounds like silence has a big place in the way you work but you're making a distinction between the more traditional psychoanalytic use of silence. Could you say a little bit more about that contrast?

P: Well, I think some of it has to do with intentionality. I think with the psychoanalytic model that we were taught and groomed into behaving there was a much more confrontational mindset, it was kind of like we were going to find the holes in their arguments, so to speak, almost like attorneys and all for the greater good but still, it was a bit of an adversarial stance. It feels very different to practice the way I do even if in terms of some of the silences they would look exactly the same, but I feel as though I have much more discretion about how I use silence now.

I: That's really interesting.

P: And my goal is never to make someone uncomfortable, I don't see a purpose in that. Someone may be uncomfortable and may need to be uncomfortable just to kind of sit with something and kind of get to a place where they can speak about it if they choose to but I'm not trying to make somebody uncomfortable or trying to be right, my goal is really to be an ally and a leader but a leader in a way that feels like I'm on their team.

I: It's quite subtle though isn't it because if a member of the public observed you in practice they would probably, I assume most therapists are more silent than a normal conversation.

P: I don't, I'm not sure that that would be true.

I: Would it be true of you?

P: I think that I am fairly interactive. Like it's interesting what people will say when they refer patients and like in my study group somebody will say oh, he really needs somebody who is going to be really interactive with him and so, they'll refer him to me.

I: So, how do they know you're interactive?

P: Because we've been talking together for 30 years [laughs] and sometimes we've shared cases like right now I see a woman in a couple, my colleague sees the man, my other colleague, Carla – do you want to do more interviews?

I: Yeah.

P: Okay because I know a lot, well I know mostly self-psychologists at this point, but I know people who are kind of at the top of their field.

I: I would love to because my experience is without an introduction I'm getting nowhere.

P: No, I understand that.

I: But once I get an introduction people are really keen and they seem to enjoy it and it's a dialogue and a wee bit of a culture exchange. So yeah, absolutely.

P: Well, [redacted] is the women that a friend and I hired to be our study group leader because she was the best teacher we'd ever had, so she's been doing it for 30 years and she is beautifully lucid. An then my friend, [readacted] has kind of, followed in [redacted] footsteps and has become kind of a bigwig in self psychological circles as [redacted] has been and [redacted] is also a very competent therapist. We're all a little different but I think they'd be interesting people to interview.

I: Yeah, that would be fantastic.

P: So, I'll give them your name if you want me to?

I: Yeah, that would be great, I'll send you through the sheet as well. Fantastic.

P: Alright, so you're asking about somebody looking at me and would I look all that different from the traditionally psychoanalytically trained therapist?

I: No, I mean two non-therapists having a conversation compared to a therapist having a conversation, do you not feel there is more silence by the fact that they're listening.

P: Yeah.

I: You know.

P: There is more silence in a therapy conversation.

I: Yeah.

P: Yeah.

I: So, then it's to what degree. So, for example, if somebody came into see you would you start in silence or would you okay…?

P: No, we were trained to do that when I worked at [Redacted] [giggles] and I thought that was awful, it was awful because we saw people, I don't know if you know the term 'catchment area' but it's basically the district that a mental health service services. So, our catchment area included people from [Redacted] which was a housing project or a council flat and people who earned, you know, in the top one tenth of one percent and particularly for the people who were poor they had no idea what this was suppose to be or how to comport themselves and I didn't think that was a fair thing to do so I would try to follow the rules as much as I could but I would also do things like introduce myself and ask people why they were here and all those sorts of things.

I: So, on the second session would you start it in silence or would you…?

P: I think at [Redacted] I often did start in silence and in the second session now I would not.

I: So, what would you say, for instance?

P: Well, it sounds so banal, but I would start with "Hi" and I would kind of gage what the person's affect was like. So, some people are kind of eager, you know, they're like eager puppies they want to get right into it and so, I do stay back and let them go. Other people look at me kind of like okay, now what and so then I will kind of lead the conversation to get it going, so I might say something like uhm are there things from last session that you'd like to start out with or any things that you have questions about or would like to make more comments about. Sometimes they will, sometimes they won't. If there are themes that are really evident to me that I think we should go back to or that I have more questions about uhm I'll enquire about that. And during my first session with people I take notes during the

session which is not something I do usually at any other time. Uhm so, I may pull out my notes and you know, refer to them and say I recall you saying something about issues with your husband, but we didn't have an opportunity to get to that, would you like to add to that today. Something like that.

I: That gives a real clear. You said evolution, I don't think in certainly in London that evolution has happened even with people who aren't psychoanalytic, they tend to start the session with silence, and I don't think that's a huge difference but it's very powerful as well just to be hit with the silence in a session. I'm going back to this word 'comfort', so those people in the catchment area you feel they were a bit uncomfortable with that silence?

P: I think they were, yeah. I think it lessened the likelihood that an alliance would be formed, that they would come back.

I: So, by not using silence you're more likely to foster the rapport?

P: I think so. I think it's different if somebody who had had an experience with psychoanalytic therapy had come in then their experience of the silence would have been familiar, it wouldn't have felt like a massive failure of good manners or something like that. And just to be clear with a lot of my established patients, I don't say much of anything but Hi, I do say Hi though, I think a form of meeting matters to me and it's kind of like an invitation to start the process and that process may start with somebody just sitting quietly for a few minutes.

I: So, your longer term people have been educated in silence, would that be fair to say?

P: Yeah, I don't know, educated just because, yeah, over time they've understood to use your word is maybe a powerful part of the process and gives them space to be how they need to be, to come up with whatever they need to come up with.

I: So, what has changed for them in that relationship with silence, is it just time?

P: Well, it's the relationship.

I: Okay. So, the stronger the relationship the more comfortable use of silence?

P: Hhmm. Every once in a while I'll actually speak about the use of silence but that's rare, it's just more something that I think is lived and so, people learn to get, learn to feel more comfortable with it.

I: What would you say about silence?

P: Well, I saw someone a couple of weeks ago who was extraordinarily self-conscious just about so many different parts of his being and so, I think we'd met three times and he came in and sat down and said, "So, how do other people start sessions", so I asked him if he felt a bit uncomfortable about how he was doing it and he said, "Well yeah, I'm not sure I'm doing it right". And because it's so early in our relationship I didn't really comment about the fact that he basically has this concern about everything. I felt as though it would be more useful just to give him a little intro about how we might do therapy and so, one of the things I told him is that people start in different kinds of ways, some people just plot right down on the couch and start talking about whatever is at the top of their minds, other people will just sit quietly for a few minutes and kind of transition from their busy, non-therapy world into the quiet space of my office and he said, that's fine. I said basically, there are multiple ways of doing this and I hope you find a way that feels right for you. And so, that was his introduction to the possibility that he could just be quiet.

I: Hmm. But then that would be not common for you to do that?

P: Hhmm no, not so common. I think it's usually an experiential process.

I: And time-related?

P: Yeah.

I: So, you said, so you can make a distinction between more traditional psychoanalytic ways or working, is there ever a time when you feel you are very intentionally being silent?

P: Hhm.

I: When you know it's causing discomfort?

P: Hhmm but it has to be in people with whom I have a strong alliance, so they feel held by the relationship and so, I think, I don't think I run the risk of people just being so uncomfortable and wondering what the hell they're doing here and that sort of thing. They'll understand that it's an opportunity to do something that's uncomfortable but makes a certain kind of sense to them.

I: Do you think there's ever incidents where the client might misinterpret the silence?

P: [long pause] Well, I think in my earlier days, yes and I don't know to what extent that had to do with my lack of experience or the theory I was using, I don't feel as though that's something that happens now.

I: Because one way you could say potentially evokes those reactions…so, I guess what I'm saying is you know, do you see any value in the way people worked before and how does that translate to your silence now? I'm thinking of silence being used to evoke a negative reaction to draw out, I think you used the word piercing or lancing.

P: I did [laughs]. So, do you think are you asking me if silence can be useful in stimulating negative transference from somebody?

I: Yeah. Now I can say it because you've said it but that's kind of the area.

P: You wouldn't.

I: No.

P: I think….well, first of all it may be that I'm less hardy than I should be about negative transference. Sometimes it does get to me when people are just vitriolic in their rage, other times not. So, I probably don't seek that out, but I also absolutely don't try to stimulate it. I think, there's no way to prove this but my sense is that negative transference emerges and that I don't need to do anything on purpose to stimulate it, it will happen.

I: So, when you say that rage, was that rage towards you? Towards you, okay. And was there a connection with silence?

P: [long pause] I don't think so. I'm laughing because I'm thinking about someone's rage about my poor choice of language, language that doesn't seem uhm attuned, that sort of thing which resulted in injury and then the rage.

I: And was the rage, how would you interpret the rage in relation to the relationship?

P: Uhm I think in general when that occurs, and it doesn't happen that often but when it does the disruption and then the repair process usually strengthens the relationship. I've had one case actually of a woman I had seen five days a week or five hours a week which was a very successful treatment initially, we actually floundered in the last part of the therapy because her rage because overwhelming and I was not able to help her with it so it's like one therapeutic failure that I've had in the last ten years.

I: I guess what I'm asking is was the rage, you know, a pure transfer, did you see it as a pure transference, negative transference.

P: No, I think in her case it was a mix, it was a lot, I knew that the rage would be coming because there was a lot, it made sense. So, that was the transference piece but I think unfortunately there was a confluence of events that made me less [pause] that made working with her more difficult for me and so, I became less effective with her and so, there was all of the history that contributed to her rage but then there was also what was going on between us which just wasn't satisfactory to her which I understood.

I: And uhm…

P: But not related to silence, maybe I would have done better if I'd just kept my mouth shut more.

I: Okay. So, why didn't you?

P: In her case I know that she often felt abandoned if I wasn't responsive, so I didn't. I'm not sure I could have, I'm not sure I could have pulled that treatment up again, it had been taking a beating and I think we finally got worn out.

I: So, you feel that it's not necessarily to use silence, if I heard you correctly, the negative transference just comes anyway eventually.

P: I'm going to say yes but I don't know that to be true because it's not provable so I could be wrong.

I: I'm thinking of instances where in that silence the client feels judged or criticised and it's categorically not the case so something emerges quite useful in that. Yeah.

P: I think that happens, yeah. I hope I'm not giving you an erroneous view of my use of silence because it's definitely part of the work I do, it' just not usually part of the very early work I do with people.

I: Yeah.

P: But I think it definitely plays a work with the work I do with most people, it's definitely not like a conversation at Starbucks.

I: No, I get that sense from you. I guess it's my own bias, I am comparing it to my experiences both in training and individually and it was extreme, There's incidents where it was extreme. I have given participants the example of, [laughs] I was doing a forensic training and you had to have psychanalysis twice a week on the couch and after my first month I went in and my cheque that I'd given for the first month was sitting on the couch so I picked it up, [laughs] I had no idea, she didn't say anything, it turned out it was maybe say, 15

dollars short but it was that level of, I didn't even lie down, I was just sitting there trying to work that out.

P: Kind of figuring out.

I: Yeah, so that's not how I would practice but I could also appreciate theoretically maybe what she was trying to use that for, the interpretation being it was under so am I committed, blah, blah, blah.

P: Of course.

I: She didn't actually go there too much but she was touching around those…

P: Are you devaluing here, that sort of thing [laughs] I did do the psychoanalytic bit for quite a while.

I: I think you can do both at once. So, you could say oh, you know, and I'm curious about. The other story was someone had analysis for weeks and the analysist hadn't said anything and as she was going into the room she tripped and went forward and the analyst was so overwhelmingly kind and lovely she was completely shocked because she hadn't got any of that, she was overwhelmed by how much this man obviously cared about her, but it hadn't been conveyed, you know. So, are there other, do you use silence for you? We can talk about from the client point of view in a minute but…

P: Well, I think my primary focus is on what's going to be helpful to the client or I think of them as patients. But I suppose as part of that every once and a while I might take a little bit more time to reflect on something before composing what I'm going to say next, but I don't do that a lot. So, that's a use of silence, to take care of myself to kind of give myself some thinking space. And I certainly do it more than I would again, than I would in ordinary conversation.

I: Sure. Then from the client point of view, you know, other reasons why you would use silence?

P: Uhm well, the overarching thing we've talked about which is basically to give people an opportunity to sift through their own experience to get past some of the ordinary maybe social niceties that might govern talking for a bit. To give space and time for something that's been a little below the surface or a lot below the surface time to emerge.

I: When you say below the surface would you be indicating unconscious, would you use that term still?

P: Hhm.. or like I've seen a fair number of people who have been traumatised fairly badly and silence is helpful because people need the time to get past the automatic shuttered door that they've been living with and allow themselves time to open that door and just take a quick look and see whether or not they can articulate that and maybe go further. And so, there is a fair enough of silence in that process in an ongoing way.

I: So, how does that manifest, are you conscious, do you bring the two together? This is someone who has experienced a lot of trauma so I'm going to consciously use silence more or how would that work?

P: I think it's so automatic for me that I don't think about it as being a conscious decision because it's just what I do at this point, maybe if you had been talking to me 10, 20 years ago, 20 maybe it would be more of a conscious thought process but it just is what feels natural at this point so I probably don't think about it that much.

I: When you're talking immediately the sense of therapy as an art but it's trying to bring some form to that art so we can share that knowledge.

P: Yes.

I: What would have changed between it being more conscious or it being more organic or natural for you?

P: [long pause] Well, I suppose some of the obvious things like doing more reading about trauma, learning more about trauma. Thinking carefully about what creates a very safe, welcoming environment for whatever thoughts and sometimes horrific things people have to say. I suppose to some extent dealing with trauma in my own life so I could be comfortable receiving traumatic information from other people and maybe earlier in my career I might have not been as receptive just in general.

I: So, your own personal experience is shaped by…?

P: I think so, yeah.

I: Could you say a bit more about that?

P: Uhm [pause] well I think the nature of trauma usually involves memories that are, to some extent, unintegrated. They can be fully dissociated, or they can just simply be someone that has a vague sense of like, over here some place but it's not part of one's integrated self. And I think whatever people have, those kind of not quite integrated experiences of trauma, that filters in and affects their ability to be a) completely present to themselves but certain as

therapists, I think it can get in the way of being or wanting to receive anybody else's truly traumatic experiences and those can be, obviously there are differences in the type of traumas people have experienced but some of the more truly horrific ones I think one can, or at least in my case, I'm fairly certain that I, maybe in some ways just didn't want to know and I'm sure that wasn't my conscious awareness but just reflecting back on the arch of my career I think that's probably right. And so, I think dealing with my own experiences settled me and so, I feel as though I can provide a level of comfort and safety and receptivity to someone else and that often includes my being silent but, this may sound very hokey, but I feel as though I'm silent in a welcoming kind of way, like I feel very much like I'm with the person. And I'll contrast that to the kind of silence that I was trained in and that's where that comment about my throwing lances at people's defences came in because I think there was a certain hostility to the silence I was trained in, even though I mean the ultimate goal is therapeutic and I get that but in terms of the relational piece, my experience of it was that it was often hostile and I'm not sure that….I don't really understand the need for that and I think it's hurtful and also keeps the range of people we can treat limited.

I: Can you say a little more about, define that hostile?

P: Well, I think it was sort of like creating, creating discomfort for the sake of it even though I understand what you're saying about that discomfort being productive sometimes, you know, that it leads to the emergence of what people need to work on – that sort of thing.

I: Yeah. I mean…

P: And you may have had that experience.

I: This process is changing the way I think about therapy [laughs]. The other thing that came to mind when you were talking was I found this lovely piece where the supervisor advised the analyst to be different in the silence and the patient said oh, your silence is different today which I thought was really powerful and it touched on what you were saying about hostile silence, so silence just isn't silence.

P: No, it's not.

I: So, you talked a lot about training an that influence, can you think about any other influences on your use of silence?

P: Other than training? Uhm…

I: So, I'm thinking of that, is there anything in your own relationship, maybe childhood or… One guy talked about listening through the wall at his father who was a therapist and he sat and never mentioned it right until the end but obviously that had an influence.

P: Huh, that's an interesting question. [outside noise] Sometimes the walls are not quite thick enough here. Uhm [pause] I think just in general I'm probably someone who is more comfortable than many are with conversational silence. That phrase companionable silence is one that probably applies to me and some of my relationships. [long pause] I love language, I grew up in a multicultural polyglot kind of family and I think that I did like the idea of just being sometimes and not having to converse, so actually, I'm kind of making a case for why I should use silence even more than the ordinary self-psychologist. I think basically though a lot of my use of silence and my comfort with it just has come out of simply practicing for as long as I have and for also continuing in my education through my study group, I mean, that's been a really powerful force in, I was about to use the word 'moulding me' but I don't think I like the idea of being moulded but just in furthering my education. The study group is 6 people and this leader, Jill Gardiner and so, we've been reading articles and presenting case for the last 30 years, we meet during the academic year – September through May and I think the kind of, we've gotten very comfortable with one another because it's mostly the same people except for a couple who move away.

So, I think getting very comfortable with sort of a support group really. I think that's helped me feel much more comfortable probably than I'm sure it would have had I not done that because I feel I have a supportive base that's kind of helped me grow and has carried me. So, I think I'm extraordinarily comfortable meeting with most people, it's rare for me to be uncomfortable and so, I'm comfortable with my use of silence, I'm comfortable with my use of interaction and in general, that's been very effective, people usually get a lot better so with the exception of that one case I told you about. I find as though I am, I'm able to include silence in the range of tools I have at my disposal and things are going well. I suppose if I slip into senesce, I'll continue to think that things are going well when they stop going well [laughs] but for now…

I: So, it sounds very much like there's a huge personal connection between your use of, as you've developed as an individual then your capacity to use silence has evolved.

P: I think so, yeah, yeah.

I: That's very powerful. Okay, I've just a few, I'm conscious of time. It was so rich I didn't even need to look at my interview schedule. Is there anything that I should have asked you, do you think, that I've not asked?

P: I don't think so but if something occurs to me I can email you. I don't know if that will work in your study or not?

I: Yeah, I'm using grounded theory.

P: Okay.

I: Yeah. Is there anything that you would like to ask me about the study or anything that's came up while we were talking ?

P: Well, I'd love to read it, your study because it's an interesting topic and it's not one that we've talked about much in my study group, in fact, I'm not sure that we've really talked about it at all, that may have been a few years ago. So yeah, I'd be interested in reading it once you've finished.

I: Absolutely, it will take ma few years.

P: I understand; took me a few years too.

I: Something came to mind, silence in general. Something I thought about was for some people 50 or 60 minutes might be the longest period where they're off their phone.

P: Hhm.

I: Are you finding any seepage?

P: Yeah.

I: Could you say something about that.

P: Yeah, when you say seepage you mean the phone bleeding into the session?

I: Yeah.

P: Yeah. That's a problem and it's been difficult, this is a new thing and so, it's been difficult for me to gage how to address it. Like some people self-police and if their phone goes off they'll say oh, sorry and they'll turn it off. Other people will leave it face up so the volume may be off, but they can still look. And I know some therapists whose rule is – no phones. Which I actually think make sense. There are a couple of people though for whom I don't think it would be a good idea for me to say that so, I haven't but I'm still kind of working that out. For

some people I feel very comfortable saying it would be better if you put your phone away for now.

I: Because I' been thinking about the tension that must be for people to, I'm going to go to therapy, and I would be able to check my phone for…

P: Yeah, it's awful.

I: Which actually puts therapy under pressure.

P: It does. It's a real change.

I: And have you had people using, coming in with say, an email that they want you to read?

P: A lot and that's actually been good, people have read texts, they've played messages for me and that's felt as though it's just been part of building our community and so that way, I get to hear the raw material rather than just their summary of it. I think there is a lot, that's very effective and I welcome that, and I've let people know that that's a fine way to use their phones in the session, but I think that's completely different from leaving a phone face up or obviously having the volume up.

I: It's impacting the silence, the relative silence.

P: It does! And I think actually, that's a really interesting point and one I think I will raise with my study group members because it does change the nature of the therapeutic environment, it's kind of like we all have this other world we could connect to if we turn over the phone and take a look or if the phone is face up which is really problematic.

I: Yeah.

P: So, that's messing with the frame in a major way.

I: Yeah, I mean it's kind of like a side interest, but I could see that actually being an area of research on its own.

P: Oh, I think so particularly as the dependents and what you spoke of earlier of people being a little panicked not being able to look at their phones for an hour.

I: There are definitely addiction problems and the phones are structured to be that way. Thank you.

P: You're welcome.

END

Appendix 9 – Code Book: *intersubjective–silence*

categories and subcategories (merged)

NVivo Codes\\FINAL CODING

Name	Description	Files	References
RENDERING RELATIONSHIP	**category**		
alliancing	*sub-category*	19	102
MINDING THE GAP	**category**		
free associating	*sub-category*	15	39
holding back	*sub-category*	13	52
EVOLVING DISPARITY	**category**		
evolution	*sub-category*	16	57
residue abstinence	*sub-category*	14	32
traditional abstinence	*sub-category*	15	57
SENSITIZING SILENCE	**category**		
increasing tolerance	*sub-category*	15	34
intentionally modulating	*sub-category*	20	96
optimal specificity	*sub-category*	16	48
traumatizing	*sub-category*	10	36
TEMPERATURE GAUGING	**category**		
intuiting	*sub-category*	11	17
soft signalling	*sub-category*	14	33
verbalising	*sub-category*	6	10
PRODUCTIVE COMFORTING	**category**		

Name	Description	Files	References
co-creating comfort	*sub-category*	19	85
influencing therapist	*sub-category*	20	104
PRODUCTIVE DISCOMFORTING	**category**		
co-creating positive discomfort	*sub-category*	14	30
DEEPENING TREATMENT	**category**	10	27
benign witnessing	*sub-category*	20	156
room of their own	*sub-category*	20	87
taking stock	*sub-category*	14	44
SILENTLY EXPERIENCING	**category**	15	49
TIMING	**category**	16	38
treatment timing	*sub-category*	11	14
treatment length	*sub-category*	2	9
treatment frequency	*sub-category*	3	5

Appendix 10 – Full Code Book

categories, sub-categories, and properties (pre-merge)

NVivo Codes\\FINAL CODING FULL

Name	Description	Files	References
RENDERING RELATIONSHIP	**category**		
alliancing	*sub-category*		
authenticity	properties	8	12
caring	properties	4	14
collaborating	properties	18	45
safely trusting	properties	13	31
MINDING THE GAP	**category**		
free associating	properties	15	39
holding back	properties	10	33
not filling	properties	7	18
not jumping in	properties	5	10
EVOLVING DISPARITY	**category**		
evolution	*sub-category*		
humanizing theory	properties	13	25
personally emerging	properties	5	7
practically experiencing	properties	9	14
transitioning training	properties	12	18
residue abstinence	*sub-category*		
absencing	properties	8	10

Name	Description	Files	References
techniqueing	properties	11	22
traditional abstinence	*sub-category*		
interpreting silence	properties	8	16
manipulative techniqueing	properties	8	12
neutrally posturing	properties	5	10
withholding responsiveness	properties	10	23
SENSITIZING SILENCE	**category**		
increasing tolerance	*sub-category*		
higher tolerance	dominant code	5	6
increasing tolerance	*sub-category*	11	23
lower tolerance	dominant code	6	7
intentionally modulating	*sub-category*		
avoiding discomfort	dominant code	13	25
balancing	dominant code	17	64
comforting	dominant code	6	13
optimal specificity	*sub-category*		
adapting depending	dominant code	15	40
responsiveness	dominant code	4	8
traumatizing	*sub-category*		
sensitivities to silence	dominant code	6	14
silence not helpful	dominant code	6	13
silence useful	dominant code	8	18
TEMPERATURE GAUGING	**category**		

Name	Description	Files	References
intuiting	properties	11	17
soft signalling	properties	14	33
verbalising	properties	6	10
PRODUCTIVE COMFORTING	**category**		
co-creating comfort	*sub-category*		
holding	properties	11	14
insight	properties	7	15
not pushing	properties	8	12
rapport	properties	10	16
welcoming silence	properties	18	39
influencing therapist	*sub-category*		
experience & confidence	properties	11	27
meditation & mindfulness	properties	7	14
positively viewing	properties	21	43
professionally influencing	properties	13	28
PRODUCTIVE DISCOMFORTING	**category**		
co-creating discomfort	*sub-category*		
abandoning	properties	8	11
anxiety	properties	13	22
attachment insecure	properties	3	6
dissociating	properties	6	10
negative transference	properties	16	37
persecutory	properties	11	24

Name	Description	Files	References
traumatizing	properties	8	14
unsafe	properties	8	12
withholding	properties	10	15
co-creating positive discomfort	*sub-category*		
collaborating	properties	5	8
leaning in	properties	10	16
positive emerging	properties	5	6
DEEPENING THE TREATMENT	**category**	10	27
benign witnessing	*sub-category*		
actively listening	properties	15	54
attentiveness	properties	12	29
calming presence	properties	10	28
empathy	properties	5	8
being-with	properties	18	48
validating & respecting	properties	11	21
room of their own	*sub-category*		
evoking responsibility	properties	6	11
introspecting client	properties	20	82
taking stock	*sub-category*		
introspecting therapist	properties	14	44
SILENTLY EXPERIENCING	**category**		
experience & confidence	properties	11	27
more silence with support	properties	8	12

Name	Description	Files	References
more with personal therapy	properties	6	10
TIMING	**category**		
less at the beginning	dominant code	11	14
less in short term therapy	dominant code	2	9
more in longer term	dominant code	3	5
more likely to use later	dominant code	9	11