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The shifting sound of silence: A constructivist grounded theory

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Abstract

Data on the use of silence from a therapist's perspective remain limited. This study aimed to develop an understanding of psychotherapists' use of silence in clinical settings. Practising psychotherapists were interviewed about their experiences of silence, and a constructivist grounded theory approach was adopted to arrive at a substantive theoretical understanding of psychotherapists' silence. A grounded theory analysis supported the construction of a theory conceptualised into four main categories: conditions (evolving disparity, rendering relationships and minding the gap), cornerstones (sensitising silence, productive comforting, productive discomforting and temperature gauging), consequences (deepening the treatment) and considerations (timing and silently experiencing). Silence is intersubjective and effective in clinical settings, and the results of the current study indicate that silence is powerful and ambiguous and is best used later in treatment when a strong therapeutic alliance is in place. Individual comfort and the needs of the client were found to be more significant than any single modality or theory. Silence is used to create a space in which treatment can be deepened through the presence of a therapist and mutual introspection. This study recommends a greater focus on a contemporary use of silence during the training and education of psychotherapists, and the importance of free association should be addressed earlier in clinician training. This theory requires further exploration of patients' experiences to establish their correspondence.

KEYWORDS
grounded theory, intersubjectivity, presence, psychotherapy, silence

1 | INTRODUCTION AND BACKGROUND

Fuelled by people and technology, the world is experiencing an increase in noise. By contrast, psychotherapy has long been associated with the concept of silence. When viewed as a cultural setting, clinical practice acts as a social regulator of speech and silence (Lehmann, 2014). Defining silence poses a challenge as it is a complex, ambiguous and multifaceted concept (Nakane, 2012). In a milieu where evidence-based practice remains focussed on "doing," a question arises: do therapists now view silence as doing nothing (Gnaulati, 2018)?

1.1 | Primary research

Secondary research follows the evolution of the understanding of silence from that of a "meaningful phenomenon," with early theorists conceptualising silence in therapy as primarily an indication of the

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client's resistance (Acheson et al., 2020). Later theorists considered silence in terms of its communicative function, placing emphasis on the therapist's response to silence and how this develops as treatment progresses (Ladany et al., 2004).

The phenomenon of silence in psychotherapy has not elicited much primary research in the past 50 years (Ferber, 2004); however, psychotherapy researchers have always treated silence as an active process. Five primary research studies focussed on therapists' use of silence. These publications were by Hill et al. (2003, 2019), Ladany et al. (2004), Regev et al. (2016) and Cuttler et al. (2019), and all reported empirical or field research conducted in the United States.

Meta-ethnography, as proposed by Noblit and Hare (1988), was used to systematically interpret the studies. 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). Four themes, or points, of focus were constructed to facilitate the exploration of the findings: the concept of silence, motivation for silence, appropriate use and learning silence. Table 1 summarises the main points of this argument. Each of these four points of focus is discussed in further detail.

Implications for practice

- This study developed a set of categories indicating how silence is employed by therapists in a clinical setting. Silence can be viewed as intersubjective, creating a space where treatment can be deepened by the presence of the therapist and mutual introspection.
- When considering the use of silence, the individual comfort and needs of the client were found to be more significant than any single modality or theory.
- The use of intentional silence in therapy is best utilised later in treatment when a strong therapeutic alliance has been established.
- This study also highlights the need for training institutes to address the contemporary use of silence in therapy so that students can begin to experience and explore what silence may mean for them and their clients.

1.2 | The concept of silence

Silence is an active event, and Hill et al. (2003) suggest that it generally has positive outcomes. Ladany et al. (2004) proposed that silence is a multifunctional intervention with multiple concepts used for different interests. All the primary studies suggest that the use of silence in practice can have both positive and negative effects on clients. Although the positive aspects of silence are described as generative, the destructive aspects of silence and its capacity to rupture the therapeutic relationship can leave it in need of repair. Regev et al. (2016) showed that clients can experience silence not only as positive but also as abandoning and anxiety-provoking.

Hill et al. (2019) proposed that silence changes across the course of therapy, reflecting shifts in the therapeutic relationship. Their study was more specific than others in relating feelings of abandonment to anxiously attached clients. They found that silence reflected different processes at different times during psychotherapy. They argue that the therapist 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 et al. (2019), Cuttler et al. (2019) suggested that silence can be a helpful intervention for some clients, especially when there is engagement during silence.

1.3 | Motivation for silence

Ladany et al. (2004) suggested that therapists use silence to convey empathy, respect or support. Silence was used by all the therapists to demonstrate their understanding and create conditions that would facilitate therapeutic work. Silence was also used to provide therapists with time for their own reflections and analyses before responding to clients. Therapists also used silence to encourage clients to take responsibility and control. Assuming that silence, when used skillfully, which is highly subjective, challenges the client to play a more active role in finding their own answers, it is possible to hypothesise that this would lead to less dependency on the therapist and greater self-efficacy for the client. Therapists generally indicated that a sound therapeutic alliance was a prerequisite for using silence and that they typically educated their clients on how they used silence.

Therapists were asked to choose a recent silence event based on Hill et al. (2003). A variety of reasons for the silence were given, including facilitating reflection, encouraging responsibility, facilitating feelings of experience, and not interrupting flow; and conveying empathy, respect and support. The therapists generally felt that silence was helpful. The results demonstrate that the therapists were active during silence, thinking about clients, therapy and how to help them make the best use of the process. Despite differences in their methodology, Ladany et al. (2004) and Hill et al. (2003) reported similar findings. Both studies found that therapists used silence to help clients reflect, take responsibility, support the expression of feelings and avoid interrupting session flow. The therapists in Regev et al.'s (2016) study stated that silence offered clients a space for deeper awareness, recognition of creative work and reflective capabilities. They collectively framed it as a unique space for processing content related to transferences and countertransferences. Being silent and present is considered to be a conduit between intimacy and closeness. Cuttler et al. (2019) and Hill et al. (2019) agree that, for psychodynamic psychotherapists, silence is a valuable tool for encouraging deep client exploration, and client silence may indicate that important material has been identified.

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TABLE 1 Summary of line of argument I.

Study	Focus 1: conception of silence	Focus 2: motivation for silence	Focus 3: appropriate use	Focus 4: negative impact
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 is a prerequisite. Use of silence selective to client presentation	Increase anxiety, feelings of abandonment and negative transference
Regev et al. (2016)	Silence creates space for the 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 countertransference	Silence is 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 nonrushed, 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 a client's emotional and expressive processing	Productive silences were especially effective with lower attachment anxiety	Collaboration decreases if therapist or client not engaged

1.4 | Negative impact of silence on clients

Ladany et al. (2004) found that when not used skillfully, respondents believed that the use of silence could increase clients' anxiety, feelings of abandonment and negative transferences (feelings of being insulted, criticised or devalued), which are often related to perceived early childhood trauma. Regev et al. (2016) found that silence could create feelings of anxiety in clients owing to a sense of helplessness and lack of control, and both parties could experience silence as unpleasant if they were unfamiliar with it. The therapists intervened if they believed that silence was unpleasant for the client. Hill et al. (2019) explored attachment styles and how they predicted the outcomes of 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. Cuttler et al. (2019) argued that if the client or therapist were disengaged during silence, client collaboration would decrease. They prioritised the importance of the therapist's intentions and behaviour during silence.

1.5 | Appropriate use

Ladany et al. (2004) indicated that following the formation of a strong therapeutic alliance, therapeutic silence should only be used primarily with clients who exhibit greater ego strength and coping capacity. Some participants indicated that they would not use silence with clients who had features of personality disorder; were highly disturbed or psychotic, highly anxious, paranoid and highly suspicious; or felt persecuted, angry, dangerous to themselves or others and overwhelmed; or were new to therapy. Despite the perceived benefits, there have been some discussions on the reduced likelihood of using silence in brief therapies because of time pressure. These results indicate that no specific recommendations can be made regarding the use of silence during the course of therapy.

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

Regev et al. (2016) found that silence at the beginning of a session could provoke anxiety in clients and should be avoided. Changes in the use of silence over time were observed, with silence being more likely to be used when the therapeutic relationship was stronger and

deeper. When the client and therapist were deemed present and attentive, the likelihood of collaboration was greater. Hill et al. (2019) agreed with Ladany et al. (2004) in that therapists who utilised silence as an intervention reported using it only after a strong relationship had been established. Providing time for clients to reflect on and connect with their feelings is considered an important aspect of productive silence. Cuttler et al. (2019) reiterated that not all silences are equal. They are prescriptive in concluding what they believe the therapist should do during productive silence: being attentive to working hard internally, being curious about what is going on with the client, behaving invitationally during silence by adopting an encouraging and facilitative attitude towards the client and attuning to how clients handle silence by noting nonverbal behaviours.

1.6 | Learning silence

Although not included as a main line of argument, these studies provide interesting insights into how therapists learn to use silence. Ladany et al. (2004) and Hill et al. (2003) found that therapists had received minimal education on using silence during their graduate training. Participants stated that they subsequently learned to use silence through their clinical experience and supervision. The challenge in this aspect of learning is that the therapist's countertransference to silence may only be explored in the presence of a client. I have reflected on the ethical implications of this and how dangerously unprepared therapists appear in the face of client silence. Regev et al. (2016) stated that experience with diverse populations throughout training contributed to the use and understanding of silence.

1.7 | Purpose

Most studies have highlighted the need for further research. Ladany et al. (2004) concluded that the reasons for therapists' use of silence were more important than whether silence occurred. Although silence has been identified as important in psychotherapy, in the most recent study, Cuttler et al. (2019) argued that research on the use of silence in psychotherapy remains limited. This study aimed to address this gap in the literature and understand how psychotherapists use silence in clinical settings.

2 | METHODS

2.1 | Research design

Grounded theory is an appropriate method when little is known about a topic; when there are no grand theories that adequately explain the area of interest; or when there is a desire to elicit participants' understandings, perceptions and experiences of their world (Lyons & Coyle, 2016). Constructivist grounded theory (CGT; Charmaz, 2014) was selected for this study because it addresses many epistemological criticisms and concerns regarding first-generation grounded theory (Morse et al., 2009). CGT retains the inductive, comparative, emergent and open-ended elements of the earlier version of grounded theory (Glaser & Strauss, 1967) but offers more flexibility and resists a more mechanical application. CGT is used not only to create themes and concepts but also to understand the differences and variations between research participants and to co-construct meaning with them. It provides the opportunity to conceptualise and theorise participants' experiences while retaining a place for their voices. It also reflects the researcher's constructivist and interpretivist epistemological outlook.

Themes and concepts were constructed from the data and grounded in lived experiences, as disclosed in the interviews. Codes and categories were constructed from the analysis of the interview data using the constant comparative method. Mirroring psychoanalytic practice, CGT creates a space for the data to speak while acknowledging that the researcher and participants have constructed the data.

2.2 | Reflexivity

A carefully examined reflection on the researcher's part is essential to support the grounded nature of CGT, as the subjective position of the researcher is acknowledged as part of the research context. Rather than seeing the researcher's presence as a source of bias, CGT includes the epistemological and theoretical outlook, values of the researcher and their starting points. The aim of reflexivity is not to eradicate the researcher's subjectivity from the subsequent theory but to allow the data (core concerns) to be prioritised over the researcher's assumptions and previously acquired knowledge and experience, including any literature that has been reviewed.

2.3 | Participants

Data collection was initiated through purposive sampling of information-rich participants who satisfied the following inclusion criteria: licensed and practising psychotherapists in America who were seeing adult patients one-on-one in weekly, or more frequent, sessions. Participants were recruited through authorised communication channels of professional associations. As the data were coded, it appeared appropriate to seek specific participants from diverse demographics through theoretical sampling. Data collection was halted upon the saturation of the theoretical codes and categories (Charmaz, 2015).

A total of 20 participants took part in this study (12 women and eight men, with ages ranging from 42 to 74 years). The participants had the following credentials: a postgraduate degree (50%) and a doctorate (50%). The group had a mean of 28 years of experience (*Mdn* = 35) and reported their primary modalities as psychoanalytic/psychodynamic (50%), integrative (30%), cognitive and behavioural

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(15%) and Rogerian client-centred (5%). The authors had no prior relationship with the participants.

2.4 | Data collection

Intensive in-person interviews were conducted by the first author using open-ended questions to facilitate the exploration of participants' concerns, with the objective of obtaining detailed responses on their perspectives, meanings and experiences. The interviews lasted between 51 and 94 min, with an average duration of 65 min. After transcription, the audio recordings of the interviews were reviewed by the first author and the transcription accuracy was validated. The data from the transcriptions and answers to the emailed follow-up questions were uploaded to the qualitative data analytical software NVivo.

2.5 | Data analysis

The data were initially coded line by line and incident by incident and included analytic questions consistent with CGT, such as "What is the participant's main concern?" "What process(es) are an issue here?" "How can I define it?" "How does this process develop?" and "What do the data suggest? Pronounce? Leave unsaid?" In the data analysis at this preliminary level, patterns of stable regularities and varying forms emerged, including similarities, differences, frequencies, sequences, correspondences and cornerstones. Memoing (active process of taking and managing notes on data collection, coding and elements of the developing theory) and reflexivity were the core elements throughout the analytic process. Focussed coding (Charmaz, 2015) resulted in further exploration and constant comparisons between codes to construct tentative categories and preliminary themes that addressed the research aims. The coding was presented to and reviewed by the second and third authors, and was deemed as successful before proceeding.

2.6 | Ethical procedures

The first author obtained informed consent from the participants by providing them with an information sheet, informed consent document and demographic form. The participants signed the consent form if they wished to continue in the study. Informed consent was also verbally obtained prior to the interviews. Ethics approval was granted by the University of Northampton (15 April 2019). All participants agreed to the recording and transcribing of their interviews. During data collection, names were replaced with pseudonyms and any identifying data were removed from the transcripts. The participants had the right to withdraw from this study at any time without penalty, and all participants consented to their data being used as part of any publication. No incentives or compensation were offered.

3 | RESULTS

Categories and themes were constructed directly from the data. A four-part coding structure was created, which included conditions, cornerstones, consequences and considerations. This structure supported the structuring and development of categories into a theory. This structure contained 10 main categories, 13 subcategories and 19 main properties or dominant codes (Table 2).

3.1 | Silence revisited

When considering the participants' general conceptualisations, there was a range of complex and potentially conflicting properties associated with silence: *active*, *powerful*, *persecutory*, *ambiguous*, *uncomfortable* and *welcoming*. Strong themes of core concern were identified, including *comfort*, *adaptation* and *space*. The participants' overall concern was to connect the main themes and categories. There was a clinical concern that intentional silence is effective and therapeutic.

TABLE 2 Grounded theory of intersubjective silence categories and subcategories.

Coding category	Categories and subcategories
Conditions	Evolving disparity
	Rendering relationship
	Minding the gap
Cornerstones	Sensitising silence^{+}
	Intentionally modulating
	Optimal specificity
	Increasing tolerance
	Traumatising
	Productive comforting^{+}
	Cocreating comfort
	Influencing therapist
	Productive discomforting^{+}
	Cocreating discomfort
	Temperature gauging^{+}
	Soft signalling
	Verbalising
	Intuiting
Considerations	Timing
	Silently experiencing
Consequences	Deepening the treatment^{+}
	Room of their own
	Benign witnessing
	Taking stock

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> It made me stop and think, ‘Okay, am I being too silent in this situation, and is it being effective?’
>
> (Maria)

The core category was conceptualised as *intersubjective silence* and presented under the generated coding categories of *conditions*, *cornerstones*, *consequences* and *considerations*.

3.2 | Conditions

Three main interrelated conditions were identified as existing when *intersubjective silence* was reported or intimated: *evolving disparity*, *rendering relationship* and *minding the gap*.

3.2.1 | Evolving disparity

The participants described the evolution in the way they thought about and used silence from when they were first trained. They described how a combination of their own practical experiences and personal values affected their use of silence over the course of their careers. The participants' responses were thoughtful and revealing, with therapists being open about their own vulnerabilities and learning processes. The participants described how they valued a theory that was more humanising, with qualities of care, kindness and sensitivity. Humanising theory was a dominant code in the evolving disparity category.

Another important finding was that the participants no longer believed in the neutrality of the therapist, the blank slate or traditional abstinence. This finding offers clear implications regarding how therapists see themselves in practice and the shift in relation to silence. The category *evolving disparity* is unique in that it is grounded in the data and appears to capture a sense of unlearning. However, it goes much further in making a distinction in the evolution away from traditional abstinence while 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–residual abstinence. Silence continues to evolve towards a collaborative way of working.

Evolving disparity captures the process of evolution in participants' thinking and practices away from a more traditional and formal use of silence to one that is more fluid and intersubjective.

This study found that all therapists experienced a shift in their relationship with silence in clinical practice. They reflected on what had changed since they were first trained and began to practise how they currently use silence. They elaborated on this *evolving disparity* as an active and continuous 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 was more fluid and focussed on the needs of the client rather than any theoretical or training experience:

> 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)

> 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)

3.2.2 | Rendering relationship

The significance of the therapeutic relationship was evident throughout this study. This study proposes an alliance based on an authentic and caring relationship that is collaborative in orientation and creates a sense of safety and trust. All the participants described a collaborative way of working. Although some participants referenced key relational theorists, the collaborative aspect of the relationship was conceptualised as more of an orientation. The significance of this finding is that it appears to have arrived organically. The participants suggested that through trial and error, a more collaborative way of working would be more effective.

The centrality of alliancing—cocreating a strong therapeutic alliance before using silence—was the dominant property of *rendering relationship*. In terms of the conditions for using silence, therapists typically reported that alliancing was a prerequisite. Some participants cited the use of silence as both a conduit and hindrance to building an alliance, highlighting that the effective use of silence was tailored to the individual needs of a client from moment to moment:

> I think of my primary task as creating an alliance, and so 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)

3.2.3 | Minding the gap

The third condition identified as existing when *intersubjective silence* was present was the therapist's intentional silence. The active process of the therapist's use of silence was conceptualised as *minding the gap*. A dominant code or property within this condition is free association, which is considered an important finding. Although some participants used the term free association with its intended psychoanalytic meaning, through further data analysis, it was conceptualised as something broader: a space where the therapist and client allowed feelings, thoughts and associations to freely arise intersubjectively—*free association*. This study proposes the evolution

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of the therapist's use and understanding of silence but reappropriates the concept of free association with a contemporary and intersubjective meaning:

> So, I consider letting myself just think and feel what comes up naturally – which is free association in some ways, right?
>
> (Jill)

3.3 | Cornerstones

These four cornerstones represent the heart of the theory: *sensitising silence*, *productive comforting*, *productive discomforting* and *temperature gauging*. They represent the active intersubjective process between the therapist and client, which participants believed made silence therapeutically effective.

3.3.1 | Sensitising silence+

Participants' concerns about being able to balance the right amount of silence were conceptualised as sensitising silence.

> I think again there's a balance of how much to talk, how much to allow the silence to happen.
>
> (David)

Therapists varied the amount of silence used (intentionally modulating), adapting to the specific needs of the client (optimal specificity), and worked to increase both the client's and their own tolerance to silence (increasing tolerance). They remained cognizant of the connection between silence and trauma (traumatising). Participants' general approach to silence was thoughtful and judicious:

> It's not that I've become more silent, I've been more comfortable with whatever the person kind of needs.
>
> (John)

This study suggests a multifaceted, complex, contextual and personalised use of silence by therapists. The data captured the process of adaptation that was prevalent throughout this study. The therapeutic needs of the client at any given moment were uniquely conceptualised in terms of *optimal specificity*. Some therapists were aware of client attachment patterns related to silence and therapeutic relationships. The participants were sensitive to the power of silence for someone who had experienced trauma, stating that silence could be supportive or detrimental, depending on the client. They unanimously demonstrated the need for sensitivity to trauma. The participants demonstrated a high level of skill in distinguishing between instances when silence supported a client in processing trauma or exacerbated the client's emotional intensity. While most trauma theories that were referenced value explicit emotional connections and actual dialogue, many participants discussed the importance of silence in working with clients with a history of trauma.

3.3.2 | Productive comforting+

There was a consistent pattern in the data, indicating that a level of comfort was necessary for the therapist and client for *intersubjective silence* to occur. *Productive comforting* has two major subcategories: *cocreating comfort* and *influencing therapists*. For productive comfort to be present, both the therapist and the client must have the capacity to be comfortable in silence. Core factors influence the therapist's capacity or desire to employ intentional silence.

> I think the more confident I have become as a therapist, the more I'm able to tolerate silence, appreciate it and use it.
>
> (Kerry)

Productive comforting versus productive discomforting

The therapists' focus on client comfort was a key finding of this study. The participants were precise about their need to make clients feel comfortable engaging with them. This finding offers unique insights into how comfort is achieved, captures the process of *productive comforting*, describes how such comfort is cocreated and offers properties that define this intersubjective process. The therapist needs to build rapport with the client to develop an awareness of the client's level of insight and offer a welcoming silence regarding the client's emotional material. Silence can sometimes be uncomfortable even for highly experienced therapists. The theory of *intersubjective silence* proposes that, at times, some degree of discomfort can be therapeutically productive—*productive discomforting*. This can manifest the tension between the therapist and the client and how much discomfort each can tolerate. This study offers an important finding on the importance of both the client and therapist being able to tolerate silence and how the therapist works actively to increase this tolerance.

3.3.3 | Productive discomforting+

A pervasive view among therapists was that they would not intentionally use silence as a technique or method to make clients feel uncomfortable. As part of *evolving disparity*, people recognised that they had moved away, in theory and practice, from this more one-sided 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)

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Many therapists stated that when supportive conditions were in place, such as a strong sense of collaboration and comfort, some discomfort could be experienced and tolerated by the therapist and the client (co-creation) with a positive outcome. The therapists described the act of leaning into discomfort with the client. Sometimes, it was their own discomfort that they had to tolerate:

> I've had quite a few clients who say, 'This is uncomfortable', and I just kind of raise an eyebrow and see what happens next.
>
> (Neil)

> What's the level of discomfort? Because sometimes it's really productive.
>
> (Alison)

In a sense, this leaning in could lead to something positive emerging and a deepening of understanding between the client and the therapist.

> 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 a growing edge.
>
> (Jenny)

> Deliberate silence that feels sort of provocative on the one hand and intentionally therapeutic on the other hand.
>
> (Kerry)

3.3.4 | Temperature gauging+

The concept of temperature gauging was an essential finding, offering a detailed explanation of the therapist's process as they remained aware of what was going on in the room during times of silence. The participants sought moment-to-moment communication from the client regarding their states of comfort. Often, this communication was subtle and nuanced (soft signalling), received intuitively (intuiting) or was verbally discussed (verbalising). Therapists highlighted the importance of noting nonverbal behaviours as a way to be attuned to how clients handle silence. Although theorists (Cuttler et al., 2019) have referenced the importance of nonverbal communication, this is the first time that the significance of temperature gauging has been directly related to the use of silence.

3.4 | Considerations

This study suggests that there are at least two significant considerations regarding the use of intentional silence: *timing* and *silently experiencing*.

3.4.1 | Timing

This study strongly indicates that therapists are more likely to use silence later in the treatment process when a strong therapeutic alliance is present. The initiation of therapy was considered the least appropriate time to use prolonged silence. Therapists appear to use silence later in treatment; however, it is difficult to separate this variable from the importance of the therapeutic alliance. Even with the best therapeutic connections, a therapeutic alliance requires time for cocreation and building.

> 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)

Therapists stated that they were more likely to use silence when the treatment duration was longer. They suggested that a longer treatment period would mean more space and time to use the silence.

3.4.2 | Silently experiencing

Therapists learned most of what they knew about using silence from clinical experience, supervision and experimentation in gauging the level of silence with which clients were comfortable. Participants typically thought that they currently used silence more flexibly, comfortably and confidently than they had at the beginning of their careers as therapists:

> 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)

3.5 | Consequences

The intended 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 (benign witnessing):

> Silence can be a very powerful means of deepening the treatment.
>
> (Neil)

The ability to use silence to offer a client space allows the client to take more responsibility for generating answers and reduces dependency

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on the therapist to do the work. The participants believed that the space for the client helped facilitate their ability to find and experience their emotions and the supportive freedom from which they could express themselves. In addition to creating space for the client to take responsibility, participants championed the use of silence to support the client in becoming more introspective, giving them space to feel, process, reflect and think.

3.5.1 | Deepening the treatment⁺

The interplay among these three subcategories constitutes *deepening the treatment*. While some individual properties of these categories have been touched upon in previous studies, this is the first time that the use of silence has been conceptualised in this comprehensive way, providing an explanation of what constitutes the effective use of silence and the deepening of treatment.

One effective consequence of *intersubjective silence* is benign witnessing. The theory, grounded in data, defines this as the therapist's capacity to be present and actively listen, offering a calm, empathetic and inviting space in which the client can feel safe, validated and respected. The participants often referred to the process of "listening to silence." The therapist listened to the client and spaces between them. Additional properties of benign witnessing (attentiveness, calming presence and validation and respect) were shared among the participants.

Benign witnessing goes beyond a state of being, to evoke a relationship. When present, clients experienced benign witnessing as feelings of being met, felt or understood. The participants described how they would communicate their presence while engaging in benign witnessing using expressions and body language.

The importance of the therapist behaving invitationally during silence was reiterated by the participants; the therapist needs to create a welcoming silence. All properties of benign witnessing suggest an intersubjective experience for the client and therapist: moments of connection between the therapist and client when each is aware of the other.

The theory of *intersubjective silence* suggests that silence also provides space for therapists to take stock. They introspect about feeling, processing, reflecting and thinking about what is going on for them, the client and the therapy process. In addition to conceptualising what leads to *deepening the treatment*, the theory is unique in that it transcends any other theory and offers an integrative language from which to appraise best practice.

3.6 | Evaluation

The three ethical principles of rigour (disciplined by honesty and integrity), respect and responsibility were applied to all aspects of this research. Respect and responsibility were demonstrated in how the interviews were conducted and how the data were subsequently handled. Rigour was the foundation of credibility when evaluating this study. This is demonstrated by the commitment to transparency at all stages of this study, with evidence provided throughout each stage of the research process. 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. The second and third authors reviewed the data and coding decisions at regular intervals throughout this study.

4 | DISCUSSION

The theory of *intersubjective silence* proposes a contemporary rendering of what constitutes the effective use of silence in clinical practice (Figure 1). The main considerations for the practice of psychotherapy are as follows: silence in therapy can be powerful and ambiguous; the effective use of 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; and therapy is more effective when clients feel comfortable, safe and trusting. The importance of the therapist–client relationship, as defined by a strong therapeutic alliance, has been widely recognised in the assessment of effective practice (Fonagy, 2015; Prochaska & Norcross, 2018; Wampold & Imel, 2015). *Intersubjective silence* can create space where embodied attunement and presencing can occur. It has been proposed that the experience of presence activates a neurobiological experience of safety that strengthens the relationship, is trauma attuned and, in turn, supports deeper therapy (Geller & Porges, 2014).

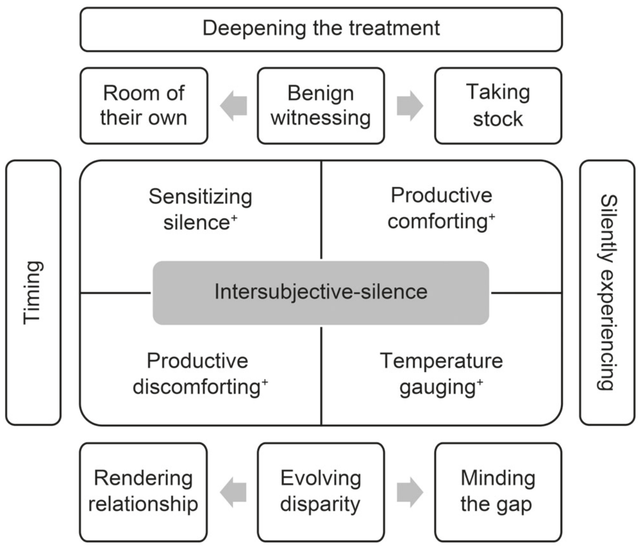

FIGURE 1 Model of the grounded theory intersubjective silence.

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These data add to the argument that care can significantly affect treatment outcomes (Tessman, 2013; Trzeciak & Mazzerelli, 2017). There was a notable shift in how therapists viewed silence in contemporary practice compared with how they were trained. The propensity to use silence in a dehumanising manner was avoided, and a more flexible way of engaging was recognised. As Orange (2009, p. 9) proposed, and as is highlighted in this study, when considering the use of silence "from a clinical point of view, intersubjectivity is not so much a theory as it is a sensibility."

All the participants described sensitising silence to the individual needs of the patient. Strikingly, this study emphasised that, over time and through experience, therapists seemed to focus their intervention on the therapeutic needs of the client, superseding any protocol inherent in the associated modalities. This was true for overtly psychoanalytic practitioners as well as for those who had moved to a more integrative theoretical identification. This study supports the prediction of Prochaska and Norcross (2018) that "the future we foresee for psychoanalysis can be summed up by the terms interpersonal and integrative" (p. 46).

4.1 | Implications

The main implication of this study is that greater focus needs to be placed on silence during the training and education of psychotherapists. The recommendations can be organised into three main themes: becoming aware of silence, being comfortable with silence and effectively using silence. The proposed theory addresses all three themes. Based on the data, this study proposes that the concept of *free association*, which allows time and space for what arises, can have therapeutic benefits. The importance of free associations can be addressed in the earlier stages of clinician training.

4.2 | Limitations

While it is acknowledged that these considerations are borne out of this study, based on extensive analysis and grounded in data, they are constructed from this unique constellation of participants and researcher reflexivity. Therefore, transferability and applicability must be carefully considered.

The patient's voice must be included in this theory for it to be considered truly intersubjective. Therefore, a recommendation for further research is to explore patients' experiences of *intersubjective silence* to establish how this corresponds to the proposed theory. There are many appropriate methods to support the understanding of patients' experiences, but in keeping with the design of the original study, we would recommend using CGT as it can investigate the different angles of the theory, scrutinise and provide further insights that might challenge and/or support the further development of the theory. Rather than attempting to verify any of the categories supporting the theory, we would suggest commencing with no presuppositions of the participants' experiences but rather exploring what the patients' presenting concerns are when experiencing silence in the clinical setting. Patients' experiences of silence need to be researched to provide an understanding not only of therapists' use of silence but also of patients' experiences of it.

5 | CONCLUSION

The theory of *intersubjective silence* proposes an effective use of silence in clinical practice. This study emphasises that silence can be powerful and ambiguous, and its effective use requires skill tailored to the therapeutic needs of the client after forming a strong therapeutic alliance. The therapist–client relationship is crucial for effective practice, and the use of silence can create space for embodied attunement and presencing, activating a neurobiological experience of safety that supports deeper therapy. This study recommends a greater focus on silence during the training and education of psychotherapists, and the importance of free association should be addressed earlier in clinician training. This theory requires further exploration of patients' experiences to establish their correspondence.

CONFLICT OF INTEREST STATEMENT

No potential conflict of interest was reported by the author(s).

ETHICAL APPROVAL

Ethics approval for this study was granted by the University of Northampton (15 April 2019).

INFORMED CONSENT

All participants gave written consent to be interviewed, recorded, transcribed and analysed with the knowledge that their anonymised words may be included for publication.

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