



Beyond Words: The Experience of Silence in the Therapeutic Room

By

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Abstract

It has been widely accepted that psychotherapeutic work consists of both verbal and non-verbal processes. This study set out to explore the experience of silence in the therapeutic room. Five practicing therapists participated in semi-structured interviews that aimed to explore the factors that affect silence in therapy. The participants were invited to reflect on their clinical work, personal development and attitudes towards the use of silence as a therapeutic intervention. The study found that the clinical practice and personal therapy were the two main factors that impact the experience of silence in the therapeutic work. The study also found that the therapists base their use of silence on the strength of the therapeutic alliance and the usefulness of it as an intervention.

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Chapter 1 – Introduction

1.1 Background and Context

It is widely accepted that the phenomenon of silence is present in all human communication. Kenny (2011) suggests that silence manifests itself in many forms, and theoretical approaches to the functions of silence reflect such variety. Sabbadini wrote “Silence is an element of human language, not its opposite; it is a complement to words, in constant dialectical interaction with them, not their converse” (2004, p. 231).

It cannot be argued that silence plays an important part in psychotherapy. As Lehmann (2014) suggests, moments of silence with a wide spectrum of meanings will emerge in the development of any psychotherapeutic process. Knutson and Kristiansen (2015) suggest that while silence has the potential of creating an environment where the relationship between therapist and client is sensed, not spoken, it can also limit or block further communication in the therapeutic space. O’Toole (2015) further suggests that using and working with silence in the therapeutic space may give the therapist a unique access of the privacy of the self within the context of the therapeutic relationship.

As proposed by Knutson and Kristiansen (2015), silence in the therapeutic space can be loaded with a variety of possible interpretations, functions and meanings. All of these will have an influence on the communication process between the therapist and the client. They propose that research into the topic of silence can help to acquire a

better understanding of verbal statements, and can potentially lead to a wider range of possible interpretations of communications.

2.1 Research to Date

In-dept review of the previous research on the concept of silence in therapy will be presented in the next chapter. It is important to note a shortage of quantitative and qualitative research on the topic. The two most notable studies on the concept of silence in therapy were conducted by Hill, Thompson and Ladany (2003) and Ladany, Hill, Thompson and O'Brien (2004).

Hill et al (2003) conducted a survey among eighty-one therapists, which explored their use of silence during a specific event in therapy and general attitudes towards the use of silence in therapy. The research examined how the therapists use silence and what conditions would prompt them to introduce it to the therapeutic room. The study found that the therapists primarily used silence to facilitate reflection, encourage responsibility, facilitate expression of feelings and convey empathy. It was also found that clinical practice was the main source from which the therapists learned to use silence.

Ladany et al (2004) interviewed twelve experienced therapists on their perceptions of why they would chose to use silence in therapy. The study found that the interviewed therapists typically used silence to convey empathy, facilitate reflection, challenge the client, facilitate expression of feelings and to take time for themselves to figure out what to say next. The participants of this study stressed the importance of a good therapeutic alliance when silence is being used as an intervention. The participants

also determined the conditions in which they would not chose to use silence – for example with highly anxious, angry or psychotic clients. The participants also recognised that their use of silence changed when compared to the start of their careers – they became more flexible, comfortable and confident with the use of silence as a therapeutic intervention. In this study, the participants believed that they typically learned about the use of silence from supervision or their own experience as a client.

1.3 Aims and Objectives

The aim of this research is to provide an in-dept and nuanced understanding on the experience of silence in the therapeutic room. The researcher aims to explore how silence is used in therapy and when the therapists opt out from introducing silence into the therapeutic room. Furthermore, the researcher aims to explore the factors that affect the therapist’s experience of silence and determine how this experience changes over time.

The research has the following specific objectives:

- Are therapists comfortable with the presence of silence in the therapeutic setting?
- What are therapists’ perceptions in relation to silence being used as a therapeutic tool?
- Do therapists see a link between being able to tolerate silence and their personal development?

Chapter 2 – Literature Review

2.1 Introduction

The purpose of this literature review is to explore the existing literature that relates to the research question. When looking at silence in the therapeutic relationship, the researcher identified the need to look at both the phenomenon itself and how the occurrence of it is managed by the therapist. This will give a well-rounded background for this research and will allow a better understanding of the data collected.

This chapter is divided into two sections. The first section will look at silence as a phenomenon in psychotherapy. Firstly, it will explore silence from the perspective of different therapeutic orientations. Secondly, different types of silences occurring in the therapeutic setting will be examined. Finally, silence will be looked at as a therapeutic intervention that can be used by the therapist during the sessions. The second section of the literature review will concentrate on the person of the therapist. This section will firstly look at clinical experience and how it affects therapeutic process. It will follow an examination of how the therapist's personal development affects their work. To finish off, the researcher will explore the therapist's attunement to their client's individual needs.

2.2 Silence in therapy

Lehmann (2014) suggests that in the development of any psychotherapeutic process, moments of silence emerge with a wide spectrum of meanings. She suggests that the focus on silence faces the challenge of polysemy and polyphony when conceptualising its' functions and their role in affective regulation. O'Toole (2015) suggests that

working with silence gives a therapist a unique access to the privacy of the self within the context of the therapeutic relationship. This section will explore silence in the therapeutic encounter from different angles, aiming to capture the essence of it and the impact that it might have on both the therapist and the client.

2.2.1 Silence and the therapeutic orientation

In classical psychoanalytic theory, silence is viewed in terms of patient's resistance as well as patient's transference toward the analyst (Lane et al., 2002). Traditionally, psychoanalysis held more interest in verbal communication rather than the non-verbal. Silences during analysis were seen neither as random intermissions nor analytic rests. Instead, they are seen as richly over-determined states and "together with the allied processes of verbalization, thinking, remembering, and posturalization, provide an essential continuity to the psychoanalytic process" (Zelig, 1961, p. 14). Psychoanalysis sees silence as a potential barrier to the psychoanalytic method, and failure to analyse its meaning may undermine and disrupt the treatment. Silence may also impede the analytic process by prolonging it (Zelig, 1961). Psychoanalytic theory often sees silence as manifestation of the transference and the therapist's reaction to silence linked to the countertransference (Lane et al., 2002).

The concept of silence in humanistic psychotherapy relates to boundaries in person-centred work. In person-centred therapy, silence can be used creatively as a form of facilitation for clients – it can promote the opportunity for client self-disclosure and self-responsibility (Owen, 2007). However, this approach also recognised dangers of using too much silence, as it has the potential of promoting the processes of imagination and transference. Furthermore, it can de-skill the client and induce anxiety

(Owen, 2007). Rogers believed that therapist's silence can be interpreted in many different ways. He believed that it is neither ethical nor helpful to maintain silence if the therapist perceives that the client is struggling (Rogers, 1951). According to Rogers and person-centred theory, therapeutic relationship does not allow for an impartial, disinterested spectator (Owen, 2007).

A study on the use of silence conducted by Hill, Thompson and Ladany (2003) highlighted the difference in attitudes toward silence, which were based on the therapist's theoretical orientation. Psychodynamic therapists used silence to facilitate reflection, with the emphasis put on the insight. Humanistic therapists, on the other hand, used silence to convey empathy, respect and support. Furthermore, they believed that it was acceptable to use silence with a wider range of clients (Hill, Thompson and Ladany, 2003).

According to Denham-Vaughan and Edmond (2010), verbal dialogues are central to most forms of psychotherapy – words are often seeking a shared sense of meaning and the need to be 'understood'. However, they point out that Gestalt therapy recognises that verbal contact is only one of the modes of contact. They suggest that withdrawal from contact is a necessary and valuable polar opposite. They propose that within Gestalt therapy model, there is a place for the "non-verbal, inactive, quiet self to emerge" (2010, p. 5). Therefore, silence and stillness can be seen as a universal language, providing a sense of being most authentically in contact with ourselves and others.

2.2.2 Types of silence in the therapeutic space

Silence in therapeutic space can be loaded with a variety of possible interpretations, functions and meanings, which will have an influence on the communication process between the therapist and the client. Silence has the potential to create an environment where the relationship between therapist and client is sensed, not spoken. On the other hand, silence can also limit or block further communication in the therapeutic space (Knutson and Kristiansen, 2015). Silence can also be viewed as a form of non-verbal communication in therapy. Kurtz (1989) wrote “the experience of silence may reveal to the practitioner what even the best words cannot...the experience includes not merely wordlessness, but the active suppression of speech” (p. 178).

Langs (1977) proposed that silence conveys many important ego and superego-building communications. He suggested that silence can be seen as the therapist’s acceptance of their patient. It can be a way of giving the patient responsibility for the work being done in the therapeutic space. For Sabbadini, silence is meaningful as it originates from a psychic conflict – he proposed that “silence is not, or not just, an absence (of words) but an active presence” (Sabbadini, 1991, p. 232). He suggested that silence more than just an absence of verbal processes – it is an active process requiring mental energy. There is an unconscious fantasy behind each silence – concealing and expressing something at the same time (Sabbadini, 1991).

Levitt (2001) suggests that silences occurring in therapy fall into three higher order categories: productive, obstructive, or neutral. Three pausing processes were identified as emotional, expressive and reflective pauses. According to Levitt, these pausing processes “entailed the productive, or facilitative, experiences of profound

emotion, difficult symbolization, and reflexive analysis” (2001, p. 299). Other moments of silences are identified by Levitt as representations of obstructions that the clients face in their process of self-exploration. When an issue occurs that was considered too threatening, Levitt suggests that pauses result from unclear or disturbing reactions – either from therapists or attributed to therapists. Finally, mnemonic and associative pauses appear to be more neutral in their effects of the therapeutic process.

Knutson and Kristiansen (2015) point out that it is crucial to distinguish between conscious use of silence for power and the intended meaning in the psychotherapeutic process. They suggest that that unconscious influences can give a different significance and intention to silence. This would suggest that silence rooted in transference, resistance and countertransference would be experienced differently in comparison to silence used as a specific therapeutic intervention.

Studies have shown that silence can facilitate both engagement and disengagement in therapeutic relationship. Silence has been shown to be useful in reflective introspection, which contrast the emphasis in the existing literature on silence as an obstructive process (v. Stringer et al., 2010). Constructive silences can promote insight and emotional expression for the clients – this is associated with positive outcomes in therapy. On the other hand, obstructive silences can suggest disengagement from inner experiences – this can be attributed to underlying anger, withdrawal, depression, fear, loneliness and anxiety (v. Stringer et al., 2010).

Knutson and Kristiansen (2015) suggest that silence should be studied and understood in context – whether it's ethnic-cultural factors or past experiences. Merleau-Ponty wrote “We must consider speech before it's spoken, the background of silence which does not cease to surround it and without which it would say nothing” (Merleau-Ponty, 1960, as quoted in Knutson and Kristiansen, 2015, p. 5). A traumatic experience in the past can be seen as an example of that – in such case, silence might be imposed on the victim of abuse and it can make them unable to process the experience. Therefore, silence can be used as an expression of the person's powerlessness and shame (Knutson and Kristiansen, 2015).

Therapist's silence can be seen as also having a significant importance in the therapeutic relationship. Silence can be used as a therapeutic intervention (Owen, 2007; Ladany et al., 2004; Hill, Thompson and Ladany, 2003) and it is typically used with an intention of facilitating client reflection. However, silence in therapy can be also caused by overload of information, countertransference, enactment, personality traits, therapist's behavioural patterns or even their cultural and ethnic factors (Knutson and Kristiansen, 2015). While it can be helpful in the therapeutic process, the use of silence by the therapist must be understood by the client. Where there is a lack of understanding or negative perception on its use, silence can create a barrier to the therapeutic work (Knutson and Kristiansen, 2015).

In their study, Daniel et al (2016) found that it may be possible for therapists to use in-sessions silence as a source of information on client characteristics and the current quality of the therapeutic alliance. They suggest that increased frequency of silence, particularly obstructive silence, could indicate insecure client attachment. Similarly,

those characteristics may also indicate poorer treatment alliances. They propose that this could also work in reverse – since insecure client attachment is associated with poorer alliances, it may lead to the increased frequency of obstructive silence. However, Daniel et al (2016) also recognise that higher frequency of productive silence, when present in mid-treatment, may indicate good treatment prognosis.

2.2.3 Silence as a therapeutic intervention

Langs suggested that silence as a therapeutic intervention is “the most basic, the most undervalued, and the most misunderstood” (Langs, 1973, p. 367). Silence can be presumed as a powerful therapeutic intervention, as it allows the clients to reflect upon their thoughts and feelings (Ladany et al., 2004). Silence as part of the therapeutic process can be seen both as having a facilitating and inhibiting effect of the therapeutic work. The literature suggests that the use of silence as a therapeutic technique can have a positive effect on the work. The greater use of silence can be associated with higher client perceptions of success and insight (Ladany et al., 2004). On the other hand, it can also be suggested that the use of silence has a potential of leading to negative consequences in work. This can happen when clients experience silence as insulting, withholding or critical, which is in turn linked to a greater client dropout rates (Ladany et al., 2004).

Sharpley (1997) found that most effective instances of silence in therapy fell during the middle and end sections of therapeutic session. This suggests clients most value silence when they are at the ‘work’ and the ‘decisional’ stages of a therapeutic work. Sharpley proposes that this happens when the clients are confronting the discrepancies between their actual behaviour and the ways they want to behave, and also when they

are developing plans to change their behaviour. Sharpley suggests that these findings are particularly value to novice therapists, as they can help nervous trainees to allow their silent time during the central and final stages of the sessions. Sharpley suggests that clients may value time to think and reflect on issues arising in therapy, and counsellors should not judge silence as these times as a sign of weakness in their professional expertise.

A study conducted by Ladany et al. (2004) explored the therapist's perspectives on the use of silence in therapy. It set out to examine the factors associated with experienced therapists' perceptions of their use of silence. Furthermore, it set out to examine the extent of the participants' belief that silence can facilitate or inhibit therapeutic work. The study interviewed participants in the following areas: reasons for using silence; client variables considered prior to using silence; reasons for breaking silence; the influence that silence can have on the therapeutic relationship; what happens to the therapist during silence; examples of when silences did or did not work; and training in using silence as a therapeutic intervention.

The study has found that silence was used for both client-focused and therapist-focused reasons. The typical reason for use of silence as an intervention was the therapists' wish to convey empathy, respect and support. Silence was used to demonstrate understanding and provide conditions that facilitate therapeutic work. The participants suggested that silence can facilitate client reflection, challenge the client to take responsibility for therapeutic work and facilitate client expression feeling. The participants also proposed that silence invites the clients to take up a more active role in the therapeutic process (Ladany et al., 2004). The study also found that

the therapists used silence to give themselves time to reflect on the therapeutic process and decide how they want to respond to their clients. It was determined that therapist anxiety and level of distraction played a role in the use of silence. The study established that similar-looking silences could be motivated by a wide range of reasons – therefore, “silence cannot be conceptualised as a single entity in therapy with a single therapist intervention and single client perception” (Ladany et al., 2004, p. 83).

A study conducted by Hill, Thompson and Ladany (2003) referenced Ladany et al. (2004) study, pointing out the importance of exploring therapist perception regarding the use of silence; however it also highlighted its limitations – particularly regarding the small sample of participant. Hill et al. developed a survey based on the results for Ladany et al., aiming to explore the perceptions on the use of silence in a wider sample of participants. The survey focused on the intentional use of silence by the therapist. The results indicated that the use of silence in therapy enhanced the therapeutic relationship. Going through a ‘silence event’ was seen as factor enhancing the work in the session. The participants of the survey generally felt that silence was helpful in therapy (Hill, Thompson and Ladany, 2003). Similar to the previous study, the therapists primarily used silence to encourage clients to reflect and take responsibility in the therapeutic work. They were thoughtful in their use of silence – they did not use it to provoke client anxiety, which contrasts to what has been suggested by the psychoanalytic literature.

Both studies found that the therapists’ use of silence changed with the length of clinical experience (Ladany et al, 2004; Hill, Thompson and Ladany, 2003). Both sets of participants indicated that they learned most of what they knew about using silence

through clinical experience and supervision. The therapists indicated that they only “somehow” learned about the use of silence as an intervention in the course of their training (Hill, Thompson and Ladany, 2003). Both studies suggest that silence was rarely thought of as a formal intervention – instead, through a process of experimentation and trial and error, the participants explored what level of silence felt comfortable for both them and their clients. As they gained experience, the therapists believed they became more confident and comfortable in using silence as a therapeutic technique.

In the study conducted by Frankel et al (2006), silences were understood as markers of internal processes. They see that as significant, as it suggests that there are times in therapy when clients’ internal experiences are so compelling that they disrupt the therapeutic interaction. The findings of the study suggest the presence of internal experiences that unfold for clients within the discourse gaps. The authors suggest that the findings are consistent with client-centred psychotherapy’s theory of change – they propose that change results from the accessing of genuine feelings, thoughts and experiences, which sometimes can be anxiety-provoking. Frankel et al (2006) propose that avoiding emotional experiences can be negatively associated with psychotherapy outcomes, whereas bringing the focus on arising issues and seeking new ways of symbolising experience is positively associated with psychotherapy outcome. Overall, the study found that it can be helpful for a therapist to stimulate emotional, reflective and expressive silences. The study also found that therapists hesitate to intervene during a silent period unless the silence appears disengaged – they believe that such an intervention during a productive silence may interrupt clients’ introspective processes. The authors of the study also suggest that further research is required into expressive and emotional silence.

2.3 The person of the therapist

Lapworth, Sills and Fish (2001) propose that the most significant factor in therapeutic change is the relationship between the client and the counsellor. They point out that according to the available research, the therapist's interpersonal skills and the capacity for forming meaningful therapeutic relationships means more than their theoretical approach. Many factors will affect the effectiveness of the therapeutic work. Erskine (2015) further suggests that the unique interpersonal relationship between therapist and client remain as the central and significant factor in psychotherapy. This section will explore the role of the therapist from three different perspectives: therapist's clinical experience; therapist's own development; and therapist's attunement to the client's individual needs.

2.3.1 Therapist's clinical experience

Kolb (2014) states that experience is a core requirement of learning, and it serves as the basis for which all learning takes place. According to Overholser (2010), years of clinical experience has been deemed as a necessary but insufficient basis of the building of clinical expertise. An important question can be put forward – does the clinical experience of the therapist contribute to the therapist's ability to handle complex issues, such as silence, that may present themselves during therapeutic sessions?

Dawson (2018) considers the relevance of therapist's amount of clinical experience and how it can affect their work. According to Dawson, years of psychotherapist's clinical experience are related to qualitatively different therapist self-perceptions and mental states, both inside and outside of therapy sessions. Furthermore, since the

process of psychotherapy is centred around a therapeutic relationship, with the gained experience a psychotherapist may gain new perspectives on their role in the therapeutic relationship. Additionally, increasing years of experience may transform the way therapists perceive their own skills and the nature of their role in a therapeutic relationship.

A number of studies have been conducted to determine how clinical experience affects the work of psychotherapists. Orlinsky et al (1999) carried out a large-scale survey on practicing psychotherapists' perceived therapeutic mastery. The study found that years of clinical experience was positively and significantly related to perceived therapeutic mastery across all therapeutic orientations. Furthermore, using the same sample with more respondents, Orlinsky et al. (2001) examined what factors contributed to the therapists' development across a wide range of years of clinical experience. The top perceived influences were rated by the participants as experience in therapy with patients, formal supervision or consultation, and receiving personal therapy. Both of these studies suggest that the years of clinical experience affect how the therapist perceive their mastery and the factors that contribute to it.

A study conducted by Gildewell and Livert (1992) showed that years of clinical experience positively impacted the confidence in therapeutic practice. However, it also showed that this positive impact was not present with the clinicians above the age of 50 – the researchers contemplated whether this might be the case due to the clinicians becoming humbler about their abilities.

Rønnestad and Skovholt (2003) explored how years of clinical experience affected professional development among therapist with various levels of clinical experience. They found that increasing years of clinical experience corresponds with an increased integration of therapists' personal and professional identities. According to Rønnestad and Skovholt, as therapists increase their clinical experience, they increasingly rely on internal expertise as opposed to external expertise – they bring less rules into therapy about how sessions should be conducted, and they continue expanding their openness to other theoretical orientations. Overall, the therapists feel that they continue to improve their professional skill as they gain clinical experience (Rønnestad and Skovholt, 2003). The study found that active engagement in reflection and openness to new learning are key elements to growth as a therapist. The study concluded that increasing years of clinical experience directly and indirectly influence therapist professional development.

2.3.2 Therapist's personal development

The concept of personal therapy for psychotherapists have been present in the literature since the beginning. In "Analysis Terminable and Interminable", Freud (1937) wrote "But where and how is the poor wretch to acquire the ideal qualifications which he will need in his profession? The answer is, in an analysis of himself, with which his preparation for his future activity begins". Yalom (2000, p. 40) writes "To my mind, personal psychotherapy is by far the most important part of psychotherapy training". Beyond personal outcomes and development, the existing literature views the therapist's won therapy as desirable or even necessary as part of the development of clinical practice.

A study involving 4,000 therapists from a number of countries (Orlinsky, Botermans, & Rønnestad, 2001) determined that personal therapy was one of the top three sources of positive influence on therapist's development. Personal therapy was ranked ahead of taking courses or seminars and reading professional journals. The same study determined that for the most senior therapists, who have been practicing for 25 to 50 years, personal therapy became the second most highly rated influence on their development.

A study conducted by Daw and Joseph (2007) set out to explore qualified therapists' experience of personal therapy. The study concluded that the therapists who engagement with personal therapy found it useful and valuable among many areas of both their personal and professional life. Personal therapy was deemed a valuable way to provide self-care – the participants acknowledged the benefits of having their own therapeutic space to process and reflect upon the impact of their client practice and also to take care of themselves psychologically so that their clinical work is safe and effective. Furthermore, the participants recognised that the personal therapy impacted on their professional practice – it allowed them to learn experientially and helped them gain a deeper understanding of theories, models and therapeutic processes. Finally, their experience of being a client allowed them to gain deeper empathy and respect for their own clients (Daw and Joseph, 2007).

Orlinsky et al (2005) suggest that a personally beneficial experience in personal therapy should further develop therapist's interpersonal skills. According to them, the experience of personal therapy should help them become more sensitive, more skilful and more flexible in adjusting the impact of their behaviour to the individual and evolving needs of their clients. They suggest that personal therapy should reduce the

degree of pathogenic influence that a therapist, when under stress, might introduce into the therapeutic relationships. They further suggest that personal therapy should shield the clients from being influenced by their therapists' own unresolved personal issues (Orlinsky et al, 2005).

Another area that can provide the therapists with an opportunity for both personal and professional development is clinical supervision. Phillips (2001) proposes that regardless of theoretical orientation, supervision is intended to expand technique and interpersonal capacities. Phillips suggests that supervision space invites the supervisee to identify with the supervisor as a mentor as it “offers skills that foster autonomy” (2001, p. 155). She identifies that the area where supervision crosses with personal therapy is in the exploration of supervisee's countertransference – the supervisor may suggest personal therapy if the countertransference is viewed as an obstacle to clinical work. She writes “, it is valuable for the supervisor and supervisee to distinguish between those objective and subjective countertransference reactions that can be utilized in the service of the treatment and those that actually disrupt or compromise the care of the patient and the treatment goals” (2001, p. 155). When combined with the experience of supervision, personal therapy may provide a way to enhance personal and professional effectiveness.

2.3.3 Therapist's attunement to client's needs

Attunement is a term used to describe a relationship in which one person focuses on the internal world of the other, and the recipient feels felt, understood, and connected (Siegel, 2007; Stern, 1985). In his study of attunement between parents and infants, Stern (1985) noted that attunement requires the parent to be able to accurately read the feeling state of the infant, to then communicate this understanding to the infant through

their behaviours, and finally for the infant to recognise their feeling state in these behaviours. Siegel (2007) noted that attunement is needed in order for people to feel vibrant, alive, understood, and peaceful in relationships.

Bruce et al (2010) suggest that the psychotherapeutic process depends on a psychotherapist's sensitivity to the patient's signals, both verbal and nonverbal. This includes what the patient does and does not say, eye contact, voice quality, facial expression, and body posture. According to them, attunement goes beyond perceiving signals - it involves the psychotherapist actually feeling something of their patient's state of mind.

According to Erskine (2015), in a relationship-oriented psychotherapy, the therapist's self is used in "a directed, involved way to assist the client's process of developing and integrating full contact and the satisfaction of relational needs" (2015, p. 44). Erskine suggests that the effective attunement to the client's needs requires the therapist to be simultaneously aware of the client's experience, the boundary between the therapist and the client, and their own internal processes. It is through the process of attunement that the therapist can offer a holding space of the client – they can provide them a sense of validation, care, support and understanding.

Empathy seems appear alongside attunement in the available literature. It can be argued that the difference between these terms are based primary in language (Bruce et al, 2010). It can be noted that Siegel (2007) used the terms 'attuned relationship' and 'empathic relationship' interchangeably. Rogers defined empathy as the therapist's ability "to sense the client's private world as if it were your own, but

without losing the ‘as if’ quality“ (Rogers, 1961, p. 284). However, Stern (1985) recognised the difference between the concepts, as his description on empathy deemed it a more conscious process.

Bruce et al (2010) suggest that both empathy and attunement describe a “balanced state that resides between being emotionally withdrawn or cut off from another and being overwhelmed by another’s internal world” (p. 88). They propose that the empathic individual opens their mind to the influence of another but does not lose themselves in the process. Siegel (2007) suggests that empathy enhances the therapist’s ability to sense when the client may need space – an empathic psychotherapist will know when to allow space by reducing the intensity of the empathic connection. Sander (1962) also proposes that an empathic psychotherapist is sensitive to their client’s signals, most of which are nonverbal, that can indicate the need for closeness or distance – similar to an attuned mother who senses when her infant needs space.

Therapist’s ability to attune to the needs of their clients can be argued to be one of the core skills that are needed to be present for a successful therapeutic alliance. Siegel (2007) proposed that mindfulness can be seen as a form of self-attunement that can increase one’s capacity to attune with others. Bruce et al (2010) believe that the ability to be attuned to others can be learned – they state that this ability is at the heart of a healing, empathic relationship. Additionally, they further propose that a psychotherapist’s ability to form an attuned, empathic relationship with the patient can lead to improvement in the patient’s ability to self-attune. They suggest that

mindfulness practice will allow a psychotherapist to increasingly know themselves, fostering their ability to know the patient.

2.4 Summary

The existing literature suggests that silence can be a very powerful tool in the therapeutic encounter. Current research suggests that, when used in the most optimal and appropriate way, silence can allow the clients to reflect and process the thoughts and feelings that arise in the course of therapy. However, research also suggests that obstructive silence can disrupt the therapeutic process.

While reviewing the available literature, the researcher identified a number of gaps in research on the topic of silence in the therapeutic space. Firstly, most of the literature looked at the use of silence as a psychotherapeutic intervention from psychoanalytic and psychodynamic perspectives – there seems to be a lack of literature exploring the concept of silence from a humanistic perspective. Secondly, most of the literature explores silence from a theoretical point of view. The researcher was able to find one quantitative study and a few qualitative studies involving silence in therapy, however it's important to note that those were conducted a number of years ago and there seems to be a lack of contemporary research on this topic. Thirdly, there seems to be a gap in qualitative research which focuses on the experience of silence – most past studies concentrate on the use of silence as a therapeutic intervention. Finally, the researcher failed to find any research conducted among therapists practicing in Ireland. Therefore, the researcher believes that the current study can fill in the gaps listed above.

Chapter 3 – Methodology

3.1 Introduction

This study aims to explore the experience of silence from a perspective of a practicing therapist. It sets out to gain detailed descriptions of the participants' experience of silence, their attitudes towards it and their ability to cope with it when it arises in the therapeutic room. The aim of this chapter is to outline the methods used in this research project. The chapter explores research design, sample of participants, method of recruitment and the mode of enquiry. It further discusses the collection and analysis of the data are examined and any potential ethical issues of this study.

3.2 Methodological Approach

According to Knox and Burkard (2009), all research methods are founded on philosophical beliefs regarding the acquisition and interpretation of data, and they propose that these beliefs drive the researchers' interview approach toward study participants. However, in recent years they point out emerging emphasis on constructivist-interpretivist perspectives among qualitative researchers. They point out that researchers are more likely to work collaboratively with participants to understand the phenomenon of interest, and they use interviews as a way of exploration of the meaning of the participants' experiences.

According to McLeod (2003), qualitative research represents a number of approaches with a fundamental goal to uncover and illuminate what things mean to people. He uses a definition of qualitative research as "a process of systematic inquiry into the meanings which people employ to make sense of their experience and guide their

actions” (McLeod, 2003, p. 73). He highlights that the key idea of qualitative research is the search for meaning – the researcher must strive to describe understandings of the participants on the chosen topic. With this in mind, the researcher decided that qualitative method would be best suited for the exploration of this area, which sets out to explore the participants’ experience of silence in the therapeutic room.

3.3 Method of Data Analysis

The study chose to use thematic analysis as a method for identifying and analysis data collected during the semi-structured interviews. Braun and Clarke (2006) propose that thematic analysis should be seen as a foundational method for qualitative analysis.

According Braun and Clarke (2006), one of the benefits of thematic analysis is its flexibility of this approach. There are methods of analysis that tied to a particular theoretical or epistemological position and there are others that can be applied across a range of a particular theoretical or epistemological approach – according to Braun and Clarke (2006), thematic analysis firmly fits into the latter category. The method differs from other analytic methods in allowing the researcher to not subscribe to the implicit theoretical commitments of other methods. Therefore, Braun and Clarke propose that through its theoretical freedom, thematic analysis is a flexible research tool which can provide “a rich and detailed, yet complex, account of data” (Braun and Clarke, 2006, p. 78). They also propose that thematic analysis can offer a more accessible form of analysis, particularly for novice researchers.

According to Braun and Clarke (2006), thematic analysis is a method for identifying, analysing and reporting patterns within data. This method goes beyond organising and

describing the data collected – it can aid the interpretation of various aspects of the research topic. It can generate unanticipated insight through organisation of data into themes, and it allows for both social and psychological interpretation of data. Therefore, Braun and Clarke suggest that the thematic analysis can be a method that works both to reflect reality and to unravel its surface.

Thematic analysis sets out six steps of data analysis. In the process of data analysis for this research, the recommended steps were followed. Five semi-structured interviews were conducted as part of this study. All interviews were transcribed and the transcripts were then coded. This allowed for the deeper interpretation of the data collected and the identification of themes and patterns presented in the data. The coded were organised into possible themes, and the data from each interview was divided into each emerging theme.

Using a Microsoft Word document, the audio recorded interviews were transcribed verbatim by the researcher with an aid of software called Otter. Thematic analysis was used as a method of data analysis. The results were analysed to determine any repetitive descriptions and patterns. These patterns were categorised by the researcher and main themes were identified. Following the steps identified by Braun and Clarke (2006), the researcher has coded the data collected into potential emerging themes. These themes provided a framework for deeper data analysis

3.4 Sample and Recruitment

The study set out to recruit five to six experienced psychotherapist, working within a humanistic integrative model. Certain inclusion and exclusion criteria were identified

for the recruitment process. The therapists participating in this study was required to have at least five years post accreditation experience. The presence of clinical experience will allow a comparison of how silence was tolerated as a trainee therapist versus how it is tolerated as an experienced therapist. The therapists' experience will also allow for richer clinical examples, which in turn will allow the study to identify common themes across diverse sample of therapeutic encounters. The study set out to recruit therapist who work within the long-term psychotherapeutic model. The recruitment process excluded any therapists whose main way of working is CBT or other short-term therapies – the researcher deemed that those types of therapeutic work wouldn't allow for sufficient period of silences and therefore were deemed unsuitable for this research.

The recruitment of participants for this study was mostly conducted by word of mouth – details of the interested therapist were provided to the researcher by their colleagues and the interviewees who have already participated in the study. Advertisements for the study were displayed in three different centres (see Appendix 1), however only one interviewee was recruited through these advertisements. One interviewee was contacted directly by the researcher with an invitation to participate.

A brief description of the study was provided to each potential participant (see Appendix 2). If they agreed to take part of the study, they were provided with an information sheet, consent sheet and a demographic sheet. Each document was signed by the participant and returned to the researcher. The chosen participants were allocated pseudonyms to ensure anonymity.

3.5 Overview of Participants

Five participants were recruited to take part of this study. Each participant took part in a semi-structured interview. Participants are anonymised by pseudonyms in Table 1. below.

Table 1. Participant's Details

Pseudonym	Gender	Age Group	Training Level	Orientation of work	Years of experience
Margaret	Female	60+	H.Diploma	Humanistic Integrative	19
Barbara	Female	40-50	MA	Humanistic Integrative	8
Claire	Female	40-50	MSc	Humanistic Psychodynamic	13
Susan	Female	50-60	MSc	Humanistic Integrative	15
Niamh	Female	60+	BA	Humanistic Integrative	14

3.6 Data Collection – Semi-Structured Interviewing

Semi-structured interviews were deemed by the researcher to be the best way of gaining data for this research project. It is evident that personal interviews are widely used as a method of data collection in qualitative research. According to McLeod (2003), interviews allow the researcher on-going monitoring of the relevance of the information that is being collected, and they also enable the researcher to check out their understanding of what is being said by the participants. Personal interviews provide greater control and will allow greater depth of information to be collected. They also provide flexibility in a complex topic (Heppner, Kivlighan and Wampold, 1999). Considering that the topic chosen in this study can be considered complex, personal interviews will best suit this research topic.

Originally, the researcher aimed to conduct all interviews face-to-face. Face-to-face interviews would allow the observation not only of verbal but also nonverbal data (Hiller & DiLuzio, 2004). However due to a change of circumstances, video and phone interviews were set up instead, with the researcher acknowledging potential limitations to this mode of interviewing. The researcher prepared a number of open-ended questions, aiming to explore the participants' experiences and attitudes toward the occurrence of silence in the therapeutic space. Using semi-structured interviews allowed to keep the participants on subject of this research while also allowing flexibility and freedom of expression.

Each interview took an average 40 minutes. Three interviews were conducted over Zoom, one interview was conducted over Skype and one interview was conducted over the phone – this was the case because the participants were given a choice of their preferred method of communication. The interviews were recorded with an audio-recording application called Otter. The application recorded the audio and also provided a rough transcription, which was later adjusted by the researcher. The researcher took field notes immediately after the interview – this allowed to capture any first impressions and note any content of the interviews that were found by the researcher to be significantly impactful. Through the transcribing process, the researcher gained a deeper understanding of the data, which provided a good basis for the process of data analysis.

3.8 Ethical Issues

Prior to the commencement of this study, approval was granted by the ethics board of Dublin Business School. As part of the recruitment process, participants have been

furnished with an information sheet (Appendix 3) and a consent form (Appendix 4) to allow them to give informed consent to take part in this research. These forms contained an overview of the research topic and advised the participants of their right to withdraw from the present study at any point. At the start of each interview, the researcher gave a verbal explanation of the study. Each participant was assured of the safety and anonymity of their personal details and contributions. Participants were asked to sign a consent form, which outlined that they have been informed of the subject of this study, research design, rights as participants and potential risks. Each consent form, alongside a signed information sheet and a demographic sheet, was sent to the researcher via email prior to the interviews. Participants were also invited to contact the researcher or the module tutor should any queries arise at a later stage.

The personal details of the participants in this study are held by the researcher in line with the mandatory practice laid out in the General Data Protection Rights (GDPR) Act 2018. In line with the GDPR legislation and DBS requirements, any data collected as part of the interviews will be stored by the researcher for five years and will be deleted afterwards.

During the recruitment process and at the start of each interview, participants were made aware that the interviews were being audio recorded. These recordings, along with transcribed notes, were coded and securely kept in adherence with Dublin Business School's ethical procedures. Pseudonyms were used to de-identify participants. All collected data was stored on the researcher's computer and protected by a password, known only to the researcher. A software called Otter was used as an aid in the transcribing process. This software is compliant with GDPR regulations.

Chapter 4 – Results

4.1 Introduction

This chapter will explore the data collected from five semi-structured interviews conducted as part of this research. During the interviews, the participants were invited to reflect on their experience of silence in the therapeutic room.

The researcher identified the following three main themes that have emerged from the research:

- Theme One: Client’s experience of silence
- Theme Two: Therapist’s experience of silence
- Theme Three: How personal development affects the experience of silence

The above themes were further broken down into subordinate themes, as demonstrated in Table 2 below.

Table 2. Subordinate Themes

Theme One	Theme Two	Theme Three
Client’s experience of silence	Therapist’s experience of silence	How personal development affects the experience of silence
When silence is helpful When silence needs to be broken Therapist’s experience of silence in their own personal therapy	Finding comfort in silence Staying present Attunement to clients’ needs	Psychotherapeutic training Clinical experience Personal therapy Self-care

Each theme explored in this chapter is highlighted with extracts from the interviews which the researcher deemed as best representations of the issues explored in the theme. Each participant is identified by a pseudonym and the extracts are written verbatim.

4.2 Theme One: The client's experience of silence

The first theme that emerged from the interviews focused on the client's experience of silence in the therapeutic work. All of the participants agreed that the use of silence in therapy can be a powerful tool. Margaret proposed:

***Margaret:** I think some of the best pieces happen in the silence.*

Barbara reflected on the presence of silence in therapy:

***Barbara:** It's quite a paradox – that there are no words, it looks like nothing's happening but actually beyond that there's so much going on.*

All of the participants seem to use silence in a similar way – to facilitate reflection for the clients and allow their clients to slow down when work begins to get overwhelming. However, the participants also stressed that using too much silence may not be optimal for the therapeutic work.

***Barbara:** When silence is used, it can be very powerful. I also think that it has to be used carefully, because if somebody is not ready for it, they can be overwhelmed too early.*

Susan further reflected on the role of silence:

***Susan:** A bit of silence is really good to help things connect, but then when you go to the too much side of it, that becomes a problem as well. It can feel like it's been used as a weapon against you as opposed to something that facilitates.*

The further exploration of this theme will be divided into three subordinate themes: when silence is helpful; when silence needs to be broken; and the therapist's experience of silence in their own personal therapy.

4.2.1 When silence is helpful

The participants recalled some instances when they would see the use of silence as a helpful therapeutic technique. The most common instance would be allowing the client to reflect on their work. All of the participants stressed that they would be hesitant to jump in when the client is processing. They believe it's more beneficial to allow the client to make the connections for themselves.

***Margaret:** It's about allowing reflection for the client. It's all about allowing the person to make the connection for themselves. You might have some insights, but allow them to come to it themselves.*

Niamh suggested that she would introduce silence when she believed the client needs to be challenged. By staying silent, she would allow the client an opportunity to challenge themselves.

***Niamh:** If I feel the client needs to be challenged on something, I might just stay quiet and let them hear themselves rather than challenge too quickly, and risking being interpreted as colluding.*

The participants agreed that silence can be used as a way of slowing the client down. In the instances of the client becoming too overwhelmed or too upset, introducing silence allows the client sufficient amount of space without overwhelming the client further.

***Claire:** If somebody is unable to slow down, I probably use silence a lot more because I'm trying to let them dump it all out but I would eventually interject to try and push it out and slow them down.*

Barbara: *If someone is massively overwhelmed, you need to give them space. You're not looking for them to re-live the pain. Instead, you bear the pain with them in silence.*

Some participants linked the presence of silence to grief. They recalled working with clients, who were able to use silence as a way of containing and processing their grief

Barbara: *Silence can allow containment of situations like grief - creating a space for the grief to be present in the silence, giving the pain space.*

Susan: *Just giving her space in silence and allowing her to connect with what was present for her seemed to bring up unresolved grief.*

Niamh: *A client that was experiencing grief found comfort in silence. I knew the client was comfortable – she was even answering her own questions without me asking them. Work was being done, without the words.*

4.2.2 When silence needs to be broken

While silence can be a useful technique in psychotherapy, the participants agreed that it may not always be helpful to the therapeutic work. In some instances, the use of silence may cause the clients more distress and overwhelm.

Barbara: *When somebody is dreadfully silent because they're scared is just an overwhelming experience... I want to create something to ease them and I think silence won't bring that to somebody who is quiet.*

Susan: *I think if you hold in the silence too long, the clients won't come back, because they might find the therapy too uncomfortable. You need to go back to that attunement piece.*

The participants agreed that silence should be avoided when the client begins to dissociate. The therapist should then step into a more directive role and stay connected to their client. Barbara proposed the following question:

Barbara: *Let's say I'm working with a deeply traumatised client who dissociates. If I leave them in the silence and I can see them dissociate... Do I run the risk of them going into a state that I can't reach, or that they can't reach me?*

Margaret reflected on her work with a client who had a tendency to dissociate:

Margaret: *When she was beginning to talk on the difficult stuff I would notice the silence, and she would begin to dissociate... I would have to intervene and stay connected. I think with dissociation there could be the danger of allowing the silence but then allowing dissociation at the same time.*

Some of the participants also pointed out that client with certain mental health issues or psychiatric diagnosis may not be able to tolerate silence in the therapeutic work.

Claire: *With psychiatric patients, or people with personality disorders... I don't think they do well with too much silence. Certainly some people who need a much more directive approach, and containing approach. It's actually very risky and unethical to work in a way, in kind of tug-of-war to open somebody, rather than actually closing them and containing them.*

Margaret: *She had a bipolar diagnosis so there would have been so many instances when silence wouldn't have been helpful. Sometimes with mental health issues there isn't the same tolerance for silence.*

4.2.3 Therapist's experience of silence in their own personal therapy

The participants were invited to reflect on their own experience of personal therapy. The researcher enquired whether they experience silence in therapy themselves, and how were they able to manage such experience. All of the participants recognised the presence of silence at various stages of their personal therapy. Their reflections on this would suggest that silence may be uncomfortable in the early stages of the therapeutic relationship, but this discomfort eased with time. Niamh recalled:

Niamh: *When I was years younger I was squirming – thinking “why isn't she speaking”. Now, I'm very comfortable if a therapist is silent. It's a space in itself for me, for reflection.*

Most of the participants agreed that the level of comfort with silence in therapy is strongly linked to the therapeutic relationship itself. They stressed the need for the therapist to be attuned to the client's experience.

Claire: *For me, it was always tied up in how comfortable I was with a therapist. With some therapists, I've felt entirely comfortable. But then there were other times when I wasn't comfortable, it just didn't work at all. And that experience was awful.*

Niamh further added:

***Niamh:** If I have a sense that the therapist is not attuned to me, I might even be irritated with her silence. If I have a sense she's just allowing me to hear myself, it's useful.*

Barbara concluded:

***Barbara:** In my own therapy, silence allowed me to sit back and allow myself the therapeutic space. But it all depends on what headspace I'm in. I think my therapist reads it well.*

4.3 Theme Two: Therapist's experience of silence

The second theme that emerged from the interviews was the therapist's experience of silence. The participants were invited on how they feel when silence is introduced to the therapeutic space. Their experience was divided into three subordinate themes: finding comfort in silence; staying present; and attunement to clients' needs.

4.3.1 Finding comfort in silence

The participants reflected in length about their comfort levels, and what factors might add to the level of comfort or discomfort in the silence. Their responses seemed to suggest a link between their level of comfort and their own process.

***Niamh:** I think the more comfortable we are in our own selves, the less we find ourselves as lost or overwhelmed or disempowered. We don't know what a client is going to bring until they walk in the door and maybe it could be tapping into something that we haven't even checked out in ourselves.*

***Susan:** Sometimes we are much more connected in ourselves when we're in session, and sometimes we're not. That's where staying with your own work and your own process is so important. I think the more experienced you are, the more aware you are of this.*

Some of the participants recognised that sometimes they find themselves lost for words. It can be suggested that the main reason that can cause this can be the depth of the client's experience. Barbara recalled:

Barbara: *There has been situations where I have been lost for words, because of the depth of somebody's experience. And this is where I always feel that language fails. I might just put my hand on my chest and I might go "that sounds horrendous" and then just sit there and be there for the client.*

Niamh further added:

Niamh: *I have had that experience, where I felt... Maybe overwhelmed by the energy of the client... Or maybe I felt the balance of power in the room was inaccurate... And it's an uncomfortable place. It's more a loss for words, and losing your own power.*

4.3.2 Staying present

All of the participants stressed the importance of staying actively present when during silence in therapy. They suggested that by staying present, they are able to track the clients and notice if the silence becomes too distressing for them.

Barbara: *I'm quite present in the room, so people are able to feel that I am there for them. It's like saying "I am here". I'm not necessarily thinking of the next intervention. I'm just staying with the moment, the issue at present. Listening to the client.*

Susan further added:

Susan: *I do feel it's important to observe in a way that doesn't feel too intense on the clients. It's very non-verbal process and hard enough to describe. But it's about staying really present with them and picking up those non-verbal cues – they will help you get a sense of what the clients are processing.*

Niamh recalled instances when she might have not been fully present in the therapeutic encounter, however she stressed the importance of bringing yourself back to the awareness.

Niamh: *I think it depends on is the process going on. I can sometimes slip away, but my intention is always to be present. And if I do go somewhere I bring myself back, because I want my awareness to be in the room, with the client.*

4.3.3 Attunement to clients' needs

All of the participants agreed that attunement of clients' needs is extremely important, particularly when introducing a technique such as silence. With the risk of causing the client more distress, the participants recognised the importance of tracking where the client is in the therapeutic space.

***Susan:** You need to stay attuned to where the client is at. You will see the people who feel the pressure to come in and just speak for the sake speaking, versus people who are comfortable being silent, allowing it to unfold and coming in when they feel it's right for them to come in.*

***Niamh:** I think that's an energy thing that you pick up, isn't it? You get a sense that some people are perfectly comfortable and working in silence, whereas other people are just waiting in silence.*

The participants also recognised that each client is different, and therefore the attunement of their individual needs is extremely important. Margaret suggested:

***Margaret:** It's about creating the space for every client's needs. You never get two times the same, you might get themes that are the same, but the experience is never the same.*

The participants agreed that they would be cautious when breaking the silence in the therapeutic room. Some of the participants highlighted the fact many therapist might have a tendency to jump in and save the client in a silent period.

***Niamh:** I think a lot of us have this tendency – "it's up to me", "I must do something here", where it's not necessary to do anything. It's about realising "this is not about me, this is about the client".*

Claire further added:

***Claire:** We want to be so engaged and involved and you know your mind might be jumping all over the place in terms of what you might do with a client.*

Some participants suggested that they would be reluctant to break the silence, as they recognise that a certain level of discomfort can be beneficial to therapeutic work.

Susan suggested:

Susan: I might hold back and really be with that pressure, as it might be necessary for the therapy space.

Barbara added:

Barbara: Leaving the silence longer has tested me hugely, but also let me see what could eventually come out of it.

The participants seemed to agree that they would only break the silence if they would see something in that process that might need to be interrupted. This awareness of the destructive side of the process closely links with the attunement to client's needs.

Susan reflected on this as follows:

Susan: I would be reluctant to intrude the silence, until there was a sign that there was something that needs to be interrupted. It's very much about using your countertransference and seeing what the client's needs are. When your client becomes too uncomfortable with it, I know that it's not going to aid the therapy work.

4.4 Theme Three: How personal development affects the experience of silence

The third theme that emerged from the data collected covered the question on how personal development affects the therapist's experience of silence. The participants were invited on their personal development in the following four areas: psychotherapeutic training; clinical experience; and personal therapy. One further area – that of self-care – was identified by some of the participants which prompted the researcher to include in the subordinate themes, as it provided further understanding how this can affect the experience of silence in the therapeutic room.

4.4.1. Psychotherapeutic training

All of the participants recognised that silence in therapy was first introduced to them during their psychotherapeutic training. The overall feeling that the researcher got from the interviews was that the experience of silence in training caused some discomfort and frustration among the participants. Margaret reflected on her experience as follows:

***Margaret:** I think it's something that takes a while to settle into, it depends on the person.*

Claire added:

***Claire:** I remember learning the skill of it, and being really frustrated because I wanted to jump in and I wanted to do so much, you know, be the therapist. But actually, I remember distinctly the value of it, despite the discomfort.*

Barbara reflected on the main learning she took away from the experience of silence in training.

***Barbara:** We were told we didn't have to keep jumping in to save the client, so that's stuck with me.*

For Susan, the most memorable experience of silence in training was through participation in process groups. As she reflected on the discomfort of silence, she noted:

***Susan:** I remember the chief trainer's response was "now isn't that interesting, and you're finding it difficult, I wonder what does that say about you". And it was like the penny just dropped. And this was profound.*

Some participants believed that there was enough emphasis on silence in training and they didn't believe that the silence piece was missed out.

***Susan:** There's so much to training in groups and process groups, I think we were in a great place for learning to be with silence.*

However, other participants believed that silence could have been given a bigger part in psychotherapeutic training. They suggested that introducing more emphasis on silence could be beneficial to the initial development of a psychotherapist,

Niamh: I remember it being alluded to, but I didn't come away from my training thinking about the necessity of it.

Barbara: I think it would be beneficial to push for silence in training courses. It was the most uncomfortable thing to do, but there was something in that. Yeah... I think there's something lacking in the training to bring in more silence.

4.4.2 Clinical experience

The length of clinical experience seemed to a factor that all participants recognised as something that helped them get more comfortable with silence. They all recognised that in the beginning of their clinical practice, silence in the therapeutic room was something that felt quite uncomfortable. Some participants recalled jumping in and breaking the silence to reduce that level of discomfort.

Barbara: As a therapist at the beginning, I had to work really hard to be in the silence. I now know that when I wasn't able to stay with it, I jumped in to reduce the stress.

Niamh: It's not something that I was comfortable with when I first started seeing clients. I would have rushed in to fill the space.

The participants were in an agreement that the longer they practiced psychotherapy, the more they were able to bare the silence in the room. They all recognised that the length of clinical practice transformed their initial discomfort with silence.

Claire: The massive difference between then and now. It's like two different people, absolutely huge difference. The journey is to trust yourself and allow time.

Margaret: The more experience you've had of this therapist, the easier it is to cope with silence and be more in tune to where to use it, where to step in and where to step out.

***Susan:** I think the longer you're working, you certainly are able to separate out when you come into the therapy space. It's like you're you step into a very different space so you can leave your own personal stuff outside the door.*

They attributed this shift in better integration of their skills and life experience. They deemed expose to silence and reflection on their work as key factors in reducing discomfort with silence.

***Claire:** It's in the experience – experience of every part of this work and being able to integrate all them, put them all together.*

***Niamh:** When I started seeing clients, I started reflecting on the importance of the silence. I think it's something that I developed myself as I became more comfortable in my work as a therapist. And also, like exposure to silence is key, it's really where we do our most of our learning.*

4.4.3 Personal therapy

Some of the participants recognised that the experience of personal therapy helped them to bare the silence better in their own therapeutic work. They pointed out that personal therapy helped them to explore the concept of silence as therapeutic intervention, which helped bring this skill into their own work.

***Barbara:** My training impacted the idea of the usefulness of silence. Personal therapy helped me explore it.*

***Niamh:** I suppose through our own growth and personal therapy as well, it brings us to those places without any actively planning to go there. It happens organically. Any work that you do on it, any inner work or any personal growth, that changes you.*

***Margaret:** Early on I would have struggled with silences in myself and therapy. But now, I actually welcome it.*

As Niamh reflected on the lack of silence in her current personal therapy, she made a striking link to the continuity of personal therapy. She pointed out that she attends therapy every couple of weeks, and with that she brings a “backlog” of things. The

researcher found it interesting consider the continuity of therapy as a factor which influences the presence of silence.

Niamh: I feel, because it's not weekly, you don't have that continuity. When you go to therapy every week, you have more space to reflect [...] I want to get maximum benefit from this hour. I'm not going to be sitting in silence, but maybe that shows an impatience... So I'd say maybe I'm not giving myself even enough space for silence.

4.4.4 Self-care

Two of the participants mentioned self-care as an important factor that is allowing them to sit better in silence. Claire reflected on the practice of mindfulness and meditation.

Claire: The preparations that we do when getting ourselves ready for clients are important. I think of my training, when I did loads of mindfulness and meditation. That gave me a really good grounding in how to prepare myself in terms of life skills, my inner kind of stillness and my inner kind of sanctity, and calmness, which I would equate all of that with silence.

Barbara recalled attending a silent retreat earlier this year. She believed the experience of the silent retreat gave her an extra insight into silence and allowed her to find more comfort in silence.

Barbara: I think the silence piece has made me stronger, and having been at silent retreat has made me stronger as an individual. Thanks to that, and meditation every morning, I can sit easier with clients.

Chapter 5 – Discussion and Conclusion

5.1 Introduction

This chapter will discuss the results obtained as part of this study, as outlined in Chapter 4. The overall aim of the research was to explore the experience of silence in a therapeutic training. The researcher hoped to gain a better understanding of, when silence is typically used in therapy and what factors affect the level of comfort around silence.

As discussed in Chapter 3, Thematic Analysis was selected as a method of data analysis. Three main themes were identified in the process of analysis of five semi-structured interviews. This chapter will look at those themes and in-depth discussion will be provided, keeping in line with the relevant literature presented in Chapter 2.

The three themes identified in the results of this study were: client's experience of silence; therapist's experience of silence; and how personal development affects the experience of silence. The findings suggest that the experience of silence in therapy is affected by many factors and it changes over time. Personal growth seemed to be acknowledged by all the participants as the most important element that influences how they are able to manage silence in the therapeutic room. The experiences gained in both training courses and personal therapy allowed the participants to explore the concept of silence and improve their comfort levels during their a silent period in the therapeutic room. The participants concurred that clinical experience positively impacts their ability to cope with silence – the longer they have been practicing, the easier it was for them to manage it. Furthermore, the participants stressed the

importance of being actively present during the silent period in therapy. They also reflected on their attitudes towards the use of silence as a therapeutic intervention. They identified a number of factors that would encourage them to use silence with their clients, and the conditions where silence could be potentially damaging to the therapeutic work.

5.2 Theme One: Client's experience of silence

Theme one explored the role of silence in the room. It looked at when silence is useful for therapeutic work and when the silence needs to be broken. Furthermore, it explored the participant's experience in their own personal therapy. The results of this study provided a descriptive picture of what happens for the client in a silent period during therapeutic work.

Langs (1973) saw silence as the most undervalued and misunderstood therapeutic intervention. O'Toole (2015) suggests that working with silence give a therapist a unique access to the privacy of the self within the context of the therapeutic relationship. The results of the current study echo a similar attitude among the participants. The participants agreed that, when used in an optimal setting, silence can be a very useful technique, allowing the client sufficient space for the deep work to be done. Some suggested that some of the best and most difficult pieces of work can happen in silence. The participants suggested that using silence can provide a non-verbal challenge to the client's process. It allows the client to make the connections for themselves without the therapist interrupting the process.

In the survey conducted by Hill, Thompson and Ladany (2003), the results showed that the reason why the highest number of participants used silence in the therapeutic space was to facilitate reflection. Other high agreement reasons included: to encourage responsibility; to facilitate experiencing of feelings; to not interrupt the flow; and to convey empathy, respects and support. Similar findings were identified by the current study. When looking at both their clinical work and their own experience of personal therapy, the participants agreed that silence first and foremost facilitates reflection in the therapeutic room. The participants also linked silence to allowing their client to process difficult emotions, such as grief.

The participants of this study have emphasised the distinction between productive and unproductive periods of silence in the therapeutic work. According to Levitt (2001), silences occurring in therapy can be categorised as productive, obstructive or neutral. V. Stringer et al (2010) suggested that constructive silences can promote insight and emotional expression for the clients, which is associated with positive outcomes in therapy. On the other hand, obstructive silences can reflect disengagement from inner experiences. The participants of this study agreed that a productive silence can facilitate reflection and can allow the client to make connection and insight into their own experience. When silence becomes obstructive, it can potentially disrupt the therapeutic work if not caught in time. The participants stressed that when the client becomes disengaged, whether through overwhelm or dissociation, the silence can potentially cause harm and it needs to be broken.

Hill, Thompson and Ladany (2003) have found that the therapists were thoughtful in their use of silence – they would not use silence as means to provoke anxiety. This

finding matches the findings of this study. The participants all agreed that they would not introduce silence if the clients seemed overly anxious. It seems that all participants concurred with the fact that one of the most important factors in therapy was the containment of the client and the creation of safe space. The results suggest that the participants would interrupt the silence if they believed that it was not promoting a productive and safe environment for their clients.

There has been some stark differences between the results of Hill, Thompson and Ladany (2003) study and the current study surrounding the reasons why therapists may choose to use silence in therapy. Hill et al found that the therapists were moderately likely to use silence with clients who were manic or had a personality disorder. Furthermore, they found that humanistic therapists thought it was acceptable to use silence with a wider range of clients, including those who are psychotic and with whom they have a poor therapeutic alliance. These findings directly contradict the finding of this study. While some participants did not touch on the use of silence with clients who hold a psychiatric diagnosis, others stated that they would be cautious in using silence with those clients. They believe that some mental health disorders, particularly personality disorders, affect the client's ability to tolerate silence. The current findings would correlate more with a study conducted by Ladany, Hill, Thompson and O'Brien (2004), which found that while some therapists would use silence with clients with a personality disorder diagnosis, others would see that as factor for the silence to be avoided.

Another contradiction found between the current study and the study conducted by Hill et al (2003) concerned the use of silence and the therapeutic orientation. Hill et al

found that humanistic therapists thought it was acceptable to use silence with a wider range of clients, including those with whom they have a poor therapeutic alliance. However, the participants, who all had a core humanistic orientation, agreed that their use of silence would depend on the depth and strength of the therapeutic relationship. The results further suggest that silence is perceived as more comfortable when the therapeutic alliance between therapist and client is strong. While reflecting on their own experience of personal therapy, the participants concurred that their level of comfort with silent periods in therapy is strongly linked to the relationship with their therapist. All of the participants stressed the need for the therapist to be attuned to the client's experience. This finding fits with the belief of Erskine (2015), who suggested that the relationship between the therapist and the client is a central and significant factor in psychotherapeutic work.

5.3 Theme Two: Therapist's experience of silence

Theme two focused on the therapist's experience when silence is present in the room. The theme explored concepts such as finding comfort in silence, staying present and attunement to client's needs when silence is introduced to the therapeutic room.

Sharpley (1997) suggests that clients may value time to think and reflect on issues arising in therapy, and counsellors should not judge silence as these times as a sign of weakness in their professional expertise. This statement was somewhat reflected in the results of this study. The participants agreed on the value of silence in the therapeutic room, however they did acknowledge anxiety around having to bear with the silence in the room. Most of the participants acknowledged a tendency to jump in and "save" the client during longer periods of silence. They stipulated that this tendency might be

common among psychotherapists. They suggested that bringing this tendency to their awareness helped them to cope better with the anxiety of a silent period in therapy. Acknowledging the value of silence as a psychotherapeutic intervention and the necessity of its presence at times seems to influence the comfort levels of the therapist in the room.

Staying present during a silent period in therapy seemed to be important to all of the participants in this study. It became evident from the results that most of the silence is a very active place for a therapist. The participants suggested that staying actively present allowed them to develop a better attunement to their clients' needs. Ladany et al (2004) found that therapist reported doing a number of things during silences. These included observing clients, examining their thought and feelings and conveying empathy. They concluded that although silence might appear as uneventful, it's actually an active time for the therapist. It certainly seems to be the same for the participants of this study, as they spoke at length about the importance of staying active in a silent period.

According to Bruce et al (2010), the psychotherapeutic process depends on a psychotherapist's sensitivity to the patient's signals, both verbal and nonverbal. The participants all agreed that staying actively present during silence in a session allows them to track the clients and pick up on those non-verbal cues that are so important for the assessment of the client's emotional state. This would suggest that active presence in a silent period is key to a better attunement to client's needs.

Siegel (2007) suggests that empathy enhances the therapist's ability to sense when the client may need space – an empathic psychotherapist will know when to allow space by reducing the intensity of the empathic connection. This further suggests the importance of therapist's attunement to the client's needs, which is in line with the results of this study. The participants all agreed that working on their attunement to the needs of each individual client allowed them to use silence in therapy in the most optimal way. They concurred that through this attunement they are able to sense their client's comfort levels around silence, which then allows them to assess when silence is helpful and when perhaps it is not serving its purpose. It can be suggested that this is of significant importance when using a therapeutic intervention such as silence, as it has the potential of provoking anxiety and overwhelming the client.

All of the participants agreed that when it came to breaking the silence, they preferred to wait for the client to break it. They would only step in if they perceived the silence as being either unproductive or overwhelming for the client. Otherwise, their preference was to allow the client enough space to make their own connections. This falls in line with the results of Ladany et al (2004) study, which found that therapist typically broke the silence if they believed that the clients were not using the silence productively. They recognised that sometimes uninterrupted silence can lead to harmful effects on their clients.

5.4 Theme Three: How personal development affects the experience of silence

The third and final theme looked at factors that affect the experience of silence in the therapeutic room. The literature shows that many factors affect the professional and

personal development of a therapist. The current study invited the participants to reflect on their development over the course of their training and psychotherapeutic careers. The researcher hoped to gain a deeper understanding of what factors contribute to personal and professional development of a psychotherapist. With that in mind, the study hoped to explore how these factors affect the participants' experience of silence in therapeutic work. The participants were invited to reflect on their experience of psychotherapeutic training, clinical practice, personal therapy and self-care.

In their 2004 study, Ladany et al found that silence was rarely thought as a form of intervention throughout psychotherapeutic training. The participants of that study suggested that they were more likely to learn about silence through supervision and clinical experience. An interesting comparison can be made between these results and the current research. The findings of this study established that the concept of silence as a therapeutic intervention was first introduced to the participants during psychotherapeutic training. The participants highlighted the impotence of training in shaping their ability to manage silence in therapy. However, some participants acknowledged that although silence was present in their training, there potentially could have been more emphasis put on it. They suggested that more exposure to silence during training could have positively contributed to their ability to manage silence early on in their careers.

According to Dawson (2018), the length of clinical experience relates to qualitatively different therapist self-perceptions and mental states, both inside and outside of therapy sessions. Additionally, it can transform the way therapists perceive their own

skills and the nature of their role in a therapeutic relationship. Rønnestad and Skovholt (2003) suggest that as therapists increase their clinical experience, they increasingly rely on internal expertise, bringing less rules into therapy and continuing to expand their openness to other theoretical orientations and therapeutic interventions. Furthermore, Ladany et al (2004) found that with experience, therapists found themselves becoming more flexible, comfortable and confident about using silence. They began trusting themselves and the therapeutic process more when silence occurred, and they found themselves using silence more judiciously. All of these statements seemed to be echoed in the results of the current study. On reflection of their clinical practice, the participants concurred that clinical experience positively impacted their comfort level around the presence of silence in the therapeutic room. They suggested that the more experience they had, the easier it was for them to cope with silence. Clinical experience allowed to be more in tune with their clients' needs and the ability to gage when using silence would prove to be helpful to the therapeutic work.

According to Daw and Joseph (2007), personal therapy has a huge impact on therapist in many different areas of their lives. They found that personal therapy is seen as a valuable way to provide self-care, as it gives the therapists a space for reflection on both client practice and personal issues. Furthermore, Daw and Joseph found that personal therapy impacts the professional practice (2007). The therapists are able to use personal therapy as an opportunity for experiential learning and the deepening of their understanding of different theories and therapeutic processes. It also allowed them to develop deeper empathy and respect for their clients. A similar finding was discovered as part of this study. The participants acknowledged that personal therapy

had a significant positive impact on their personal and professional development. Personal therapy allowed them to experience how it feels to sit in silence in therapeutic room, which provided them with a better understanding of their clients' experiences. While they might have struggled with silence in the beginning, having the experience of it allowed them to develop comfort around it.

Orlinsky et al (2005) further suggest that the experience of personal therapy can therapists become more sensitive, more skilful and more flexible in adjusting the impact of their behaviour to the individual and evolving needs of their clients. They also suggest that personal therapy should shield the clients from being influenced by their therapists' own unresolved personal issues. This attitude towards personal therapy seemed evident through the interviews in this study. The participants concurred that personal therapy allowed them to work through their own stuff, and thanks to that they were able to stay some actively present in the therapeutic room. Furthermore, personal therapy allowed to grow both as human beings and practitioners. All of the participants agreed that any personal development changes you as a person and helps you to evolve your clinical practice.

5.5 Strengths and limitations of the study

The choice of semi-structured interviews as a method of data collection and Thematic Analysis as a method of data analysis corresponded well with the nature of this study and allowed for an in-depth insight into the participants' experiences. The data collected filled the existing gap in literature on the experience of silence among therapists practising in Ireland. The participants suggested that the issues raised in the interviews made them reflect on the areas of their work that perhaps they would not

otherwise. All of the participants agreed that going forward they will reflect more on the topic of silence in both their therapeutic practice and personal life.

The study had a number of limitations. Firstly, the small sample size can be seen as the most significant limitation of the research. It provided a limited insight into the experience of silence in therapy as it relied on the reflections of five participants. As the outcomes of the study needed to be generalised, some nuanced differences among the experiences of the participants could have been potentially missed. Secondly, all participants of this study were Caucasian cis females, with English as their native language. This could suggest a gender, ethnic and cultural imbalance in the results of the study. Thirdly, the participants of this study were all accredited therapists with an average of 14 years of experience. The study excluded trainee and notice therapists, which could have provided further insight of the experience of silence at different stage of the therapeutic career. Finally, all participants had a core humanistic orientation, which excluded the experiences of therapists that choose to practice in different modalities.

5.7 Suggestions for further research

The researcher believes that further enquire into the experience of silence in the therapeutic room would be beneficial for both trainee and practising psychotherapists. The interviews conducted as part of this study suggested that the experience of silence in the early years of psychotherapy practice differs significantly when compared to the experience further into the career. A better understanding of those different experiences can potentially provide valuable information to the training courses and

professional bodies as an influence to shape the content of psychotherapeutic training and further professional development courses.

As mentioned earlier in this chapter, this study had a number of limitations, most significant being a number of participants. The participation of five practicing therapists provided a limited insight into the experience of silence in the therapeutic room. Knutson and Kristiansen (2015) suggest that silence should be studied and understood in context, whether it's past experiences or ethnic-cultural factors. The researcher believes that it is important to conduct further research among Irish therapists, as it can be suggested that experience of silence might have a strong root in the cultural background of both the therapist and the client. The researcher feels that a study conducted on a bigger scale could fill in the current void in the literature available, particularly on the experience of a therapist who practices in Ireland.

It is important to note the similarity among the participants of this study. Perhaps further research among therapists of different genders, cultural backgrounds and therapeutic orientations could expand the understanding of what affects the experience of silence. Further research with a more diverse sample could provide a better overall understanding of the experiences of silence in therapy. It could explore whether different genders have a similar or contrasting experience of silence. Furthermore, it could explore the differences, of any, in the experience of silence among therapists practicing from different therapeutic frameworks. Finally, it could also provide an insight of what the experience of silence is like for a therapist whose native language isn't English.

5.6 Implications for psychotherapy

While silence was acknowledged by the participants as being part of their psychotherapeutic training, some suggested that a bigger emphasis on silence could benefit the development of a therapist in the early years of their journey. Participation in group situations where silence is present seems to be a strong and positive influence on the comfort levels of the participants.

Perhaps a stronger introduction of silence into the training courses could benefit the personal and professional growth of a therapist and allow them to establish their comfort levels with silence early in their careers. Some participants also suggested further emphasis on mindfulness and meditation as a way of developing a better understanding and insight into what silence can offer as a therapeutic intervention.

5.8 Conclusion

This study has identified a number of factors that affect the experience of silence in the therapeutic room. Through the exploration of both the client's and the therapist's experience of silence in therapy, the researcher was able to gain a deeper understanding of what affects the comfort level during a silent period in therapy.

By exploring the participants' attitudes towards the use of silence as a therapeutic intervention, the researcher was able to identify the conditions that affect the usefulness of silence as intervention. The reflection on their own clinical work allowed the participants to determine what prompts them to introduce silence into the therapeutic space. Productive silence seemed to promote deeper reflection and allows the clients to make connections for themselves without the therapist needing to step

in. Silence also allows the client to process difficult emotions in a safe space. On the other hand, obstructive silences can potentially cause harm and overwhelm to the client. The participants stressed the importance of being attuned to the client's needs in order to determine when silence can potentially become threatening and unsafe. The participants agreed that the depth of the therapeutic alliance influence their use of silence as a therapeutic intervention.

The study has identified a number of factors that affect the experience of silence in the therapeutic room. It has found that personal development has a significant impact on the therapist's ability to manage silence in therapy. The participants agreed that therapeutic training, clinical experience and personal therapy all contribute to their ability to hold silence. It can be suggested that personal growth contributes to the therapist's ability to attune to their clients' needs and stay actively present in the therapeutic space.

As proposed by one of the participants, some of the best therapeutic work happens in silence. Keeping this in mind, the research concludes that some of the most important therapeutic work can happen beyond the words.

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Appendices

Appendix. 1 – Centre Advertisement

LOOKING FOR RESEARCH VOLUNTEERS FOR MA THESIS

My name is Katie Dobosz and I am a final year student, studying MA in
Psychotherapy at Dublin Business School.

As part of my Masters thesis, I am conducting research on

THE EXPERIENCE OF SILENCE IN THE THERAPEUTIC ROOM

I am inviting interested psychotherapists to participate in a qualitative interview
that will take approx. 45mins.

The interview can take place at a mutually agreed location. Alternatively, it can
take place online through Skype or Zoom.

I am seeking to interview humanistic integrative psychotherapists with at least
three years post qualification experience.

I would very much appreciate your participation in this research. I can be
contacted by email:

katiedobosz@gmail.com

Appendix. 2 – Email Invitation

Dear ...,

My name is Katie Dobosz and I am a final year student, studying MA in Psychotherapy at Dublin Business School.

I am currently conducting research as part of my final year thesis. I am looking to explore **the experience of silence in the therapeutic room**.

As stated above, the focus of my research is the exploration of the experience of silence in the therapeutic room. During the interview, I would be focusing on your experience of silence during psychotherapeutic training and clinical practice. I would also be looking at your experience of silence in personal therapy (as a client).

I am wondering whether you would be interested in taking part in an interview for my research project. The interview should take approx. 45mins. Considering the current situation with the virus outbreak, I am inviting participants to meet either over Skype/Zoom or we can set up a phone interview.

If you are not interested in participating in my research, I would be extremely grateful if you could pass on this invite to any colleagues of yours that might be willing to take part.

I can be contacted by email: katiedobosz@gmail.com

Kind regards,

Katie Dobosz

Appendix. 3 – Information Sheet



INFORMATION SHEET

My name is Katie Dobosz and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which sets out to explore

THE EXPERIENCE OF SILENCE IN THE THERAPEUTIC ROOM

What is Involved?

If you agree to participate in this research, you will be invited to attend an audio recorded interview with myself in a setting of your convenience, which should take approx. 45mins to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage. Should you need clarification, you can contact me on my email: **katiedobosz@gmail.com**

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.

I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant:

Date:

Appendix. 4 – Consent Form



CONSENT FORM

The experience of silence in the therapeutic room

Please put X beside the appropriate answer.

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.

Yes No

I understand that my participation in this study is entirely voluntary and that I may withdraw at any time, without giving reason.

Yes No

I understand that my identity will remain confidential at all times.

Yes No

I am aware of the potential risks of this research study.

Yes No

I am aware that audio recordings will be made of sessions

Yes No

I have been given a copy of the Information Leaflet and this Consent form for my records.

Yes No

Participant _____
Name Date

To be completed by the Principal Investigator or his nominee.

I the undersigned, have taken the time to fully explained to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved and have invited him/her to ask questions on any aspect of the study that concerned them. In line with GDPR regulations, data will be retained for no longer than is necessary. All records where you can be identified (e.g. recordings, etc) will be destroyed after all phases of data collection are complete and the data have been fully anonymised. At this point, your data can no longer be withdrawn from the study as it is no longer identifiable.

Signature

Name in Block Capitals

Date

Appendix. 5 – Demographic Sheet



DEMOGRAPHIC SHEET

GENDER (please put X beside the appropriate answer)

Male

Female

Other

AGE GROUP (please put X beside the appropriate answer)

<30

30-40

40-50

50-60

60+

TRAINING LEVEL (please put X beside the appropriate answer)

BA

HDip

MA/MSc

PhD

Post-doctoral

ORIENTATION OF WORK:

YEARS OF EXPERIENCE POST QUALIFICATION:

FREQUENCY OF SUPERVISION (please put X beside the appropriate answer)

Weekly

Fortnightly

Monthly

Other:

CURRENTLY IN PERSONAL THERAPY? (please put X beside the appropriate answer)

Yes

No

Appendix. 6 – Interview Schedule

1. What does silence mean to you (therapeutic space, personal life)? How comfortable do you feel around silence?
2. When did you first learn about silence as a therapeutic intervention? Training, supervision, own clinical practice?
3. Can you tell me about your experience of silence in psychotherapy training? Was silence explored as part of your training?
 - If yes, how was it introduced and to what extent was it explored?
 - If not, do you think it would have been useful?
4. Have you ever worked with a client who was silent?
 - Length of silence, types of silence, remaining engaged
5. Do you tend to break the silence/check in during a silent period with your client?
 - Can you think of an example of this (prompt)
6. Do you look at your client during a silent period?
 - What do you find is the impact of this (prompt)
7. Have you ever used silence as a therapeutic intervention? Can you give me an example?
8. What would make you use silence as a therapeutic intervention?
9. Can you give me an example of when silence was helpful in therapeutic work?
10. Can you give me an example of when silence was unhelpful to therapeutic work?
11. Have you ever been lost for words? Can you tell me about a time when you didn't know what to say next?
12. Have you ever experienced silence in your own personal therapy? How has this shaped your ability to hold silence in your own practice?
13. Is there anything else relevant to this discussion that you feel is important to add?

Appendix. 7 – Transcript Excerpt with Codes

Abbreviations: R = researcher

<p>R: Do you still tend to break the silence first, or do you wait for the clients to do it?</p>	<p>Factors that influence the use of silence</p>
<p>Niamh: Once again, I think it depends on the individual circumstances, the individual person, relationship, the time, even whether it's close to the end or beginning of the session, or whether there's process going on or there's just a void. So it's dependant on so many factors. As I take my cue from, from all those things.</p>	<p>Attunement to client's needs</p>
<p>R: It sounds like it's a very attuned process to what the client needs in that moment.</p>	
<p>Niamh: Yeah, exactly.</p>	
<p>R: If you reflect on your client work to date, can you recall any client that you worked with, that would have been particularly silent or struggled with talking and you were left sitting in silence with them?</p>	
<p>Niamh: I think I actually recall two very different experiences. One of the early experiences in my work as a therapist, when I was quite uncomfortable with just silence, and I think I might have done an awful lot of inner work at that time. And bring those issues to supervision as well, to learn from the silences.</p>	<p>Experience as a novice therapist Personal development Learning from experience</p>
<p><i>(pause)</i></p>	
<p>Niamh: And I think then later, not recently but a few years ago, a client that was experiencing grief found comfort in silence. I knew the client was comfortable, and I knew the client was even answering her own questions without me asking them. Generally, I could see the work being done. Yeah. For me without, without words to say something.</p>	<p>The usefulness of silence Attunement to client's process</p>
<p>R: I am wondering in the experiences you described, did silence arose organically or was it something that you consciously introduced as an intervention?</p>	
<p>Niamh: No, it was very it was totally organic, it was the nature of, I think. Throughout the relationship I thought it was comfortable for us to just sit quietly. You know, it was soothing, I think for both of our souls, or whatever aspect of it, you know, it was just soothing our hearts. Yeah... It felt comfortable for both of us.</p>	<p>Shared experience of silence Comfort in silence</p>

Clients experience of silence Therapist's experience of silence Personal Development