Assessing the Therapist's Use of Silence as an Intervention in the Therapeutic Setting

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Abstract

The use of silence in psychotherapy has received limited attention in counsellor training and academia. Although clinicians report learning about it through personal therapy, clinical supervision, and practice, research on this topic is scarce. Despite silence being recognized as a powerful tool in psychotherapy, there is a lack of research investigating its use as an intervention in therapeutic settings. Factors such as cultural identity, pre- and post-silence interactions, attachment style, and type of silence have been identified as important considerations, but existing research does not adequately assess these factors. This paper aims to review the literature on the impact of therapists' use of silence in therapy and proposes a research framework for counsellors to assess the use of silence as an intervention in the therapeutic setting.

Keywords: silence, therapeutic relationship, psychotherapy, therapeutic intervention, psychodynamic psychotherapy, attachment, and culture

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Chapter 1: Introduction

Silence has always been an inherent part of human experience and existence (Valle, 2019). Theoretically, silence is a potentially powerful therapeutic intervention to encourage client introspection that helps or hinders therapeutic work (Greenson, 1967, as cited in Ladany et al., 2004). Though silence occurs often in psychotherapy, little is known about its effectiveness (Cuttler et al., 2019).

This capstone project aims to examine the literature on the therapist-client relationship when the therapist uses silence as an intervention in the therapeutic setting. Furthermore, the project explores the therapist's reasons for using silence and the outcome and function of silence. The first chapter provides an overview of the topic, the purpose of the topic, my motivation for completing the chosen project, and an explanation of key terms. In chapter two, I review the literature on the phenomenology of silence, silence and the therapeutic relationship, and silence as an intervention. In chapter three, I propose a framework for counsellors to determine when and how to use silence and to understand their client's context, and indeed their own, in understanding silence as communication.

Overview

Philosopher John Gray asks—is human silence possible (Harris & Harris, 2018)? Gray's work identifies how humans understand and make sense of the world around them through the use of language. Though we use language to create narratives of our lives, Gray has suggested that humans gravitate towards silence to move inwards and connect with our sense of self: retreating from conversation, thought, and distress. Similarly, Blaise Pascal wrote that man's [*sic*] inability to sit in quiet is the reason for his unhappiness (Harris & Harris, 2018). Silence has always been part of the human experience; according to Bindeman (2017) silence is implicit

communication and has the power to expose us to inaccessible aspects of human experience. Silence operates by reflecting and mirroring what is around us because it cannot address us directly.

Research on silence appears in different areas of interest that are not directly connected to one another, such as medicine and musical arts. Silence has been explored across multiple dimensions, including politics, music, law, art, nature, comedy, mental health, and violence (Valle, 2019). This list highlights that silence is of great significance across disciplines and therefore, deserves further in-depth exploration (Valle, 2019). Silence deserves further exploration because it offers valuable insight into the thought process, emotions, attitude, and perception of others during conversation (Chowdhury et al., 2017). Another reason silence has been studied is that it serves as a vehicle for transcendence—not only revealing meaning but creating meaning. At the same time, silence evokes fears of mortality and madness (Bindeman, 2017). Thus, the role of silence in psychotherapy has gained importance because of its potential to facilitate several therapeutically beneficial processes within the client's inner dynamics (Knol et al., 2020).

Using silence in therapy has the advantage of integrating thoughts and emotions. This is possible because silence creates an atmosphere where words can disclose their complete meaning and purpose through nonverbal cues, and where the connection between the client and therapist can be sensed even in silence (Knutson & Kristiansen, 2015). According to Gale and Sánchez (2005), there are benefits of silence in psychotherapy. Silence gives meaning to words, enables reflection, promotes thinking about experiences, supports interpretation, encourages the client to have the capacity to be alone, and supports the client to gain self-esteem. All of these benefits enable the client to gain insight.

There is growing interest in researching silence. For example, the role of silence was listed as one of the newly developing main research topics in music therapy (Oberegelsbacher & Timmermann, 2012, as cited in Pfeifer & Wittmanm, 2020). Silence is important to understand because it can lead to alterations to the sense of self (Thönes & Wittmann, 2016). Spending time in silence with our thoughts may increase our overall sense of well-being and life satisfaction (Pfeifer & Wittmann, 2020). Hence, silence is a powerful tool in psychotherapy (Cuttler, 2019).

Purpose of the Paper

The following capstone study examines the therapist's use of silence as an intervention in the therapeutic setting. As well, this paper investigates the therapist's intentional cognitive and psychological processes when using silence as an intervention. Silence is an expected part of the therapeutic conversation (Valle, 2019)—yet while studying to be a counsellor at university, I have learned very little about silence as an intervention. The purpose of this paper is to provide practising clinicians and student counsellors with an exploratory analysis of the impact of the phenomenology of silence in the therapeutic setting. In the final chapter of this project, I introduce a framework for therapists to gain a better understanding of silence as an intervention in the therapeutic setting.

Theoretical Framework

Psychodynamic theory guides the current project as it considers the client's previous experience with silence and how this informs the client's present experience. This project also considers and discusses the attachment style of the client when using silence in the therapy setting. John Bowlby is the scholar behind the creation of attachment theory, the majority of his work was published from 1960-1990. Bowlby's work is grounded in understanding the role the caregiver plays in shaping the psychological well-being of the child, setting the trajectory for

how the child, across the lifespan, approaches relationships with others. In the 50 years since its birth, attachment theory has become a uniquely influential developmental theory, with views extending to adult romantic relationships, developmental psychopathology, and clinical intervention (Thompson, 2017, as cited in Laible et al., 2019).

Attachment styles are a developmentally formed means of regulating affect and processing knowledge concerning close interpersonal relationships (Mikulincer & Shaver, 2007, as cited in Daniel, 2011). Bowlby (1969, 1988) theorized that the attachment patterns infants establish with caregivers transfer over to all adult relationships, including the therapeutic relationship. When experiencing stress, clients with anxious attachments tend to feel more emotional distress and depend on others for emotional regulation, whereas clients with avoidant attachments tend to shut down and disregard emotional distress (Brennan et al., 1998). Adult attachment styles are related to attitudes about seeking and receiving support and specific ways of engaging in emotionally significant relationships (Daniel, 2011). Within the context of the psychotherapeutic process, client attachment styles are likely to affect the therapeutic relationship and client outcomes (Daniel, 2011). It seems likely that clients with different attachment styles would respond differently to silence in psychotherapy, given that silence can evoke intense emotions (Cuttler et al, 2019).

Knowledge about how client attachment is expressed in the therapeutic relationship is important because it may help therapists in considering attachment when creating their treatment approach to specific clients (Daniel, 2014). The methods that clients use to regulate the possibility of therapeutic attunement through their language related to attachment can significantly impact the therapeutic relationship. Therefore, the frequency and quality of in-session silences may play a role in determining the strength of the attachment alliance

relationship (Daniel et al., 2018). Studies by Daniel (2011) and Daniel et al. (2018) examine clients' attachment styles and in-session silences, and their findings suggest therapists may be able to use in-session silences as an indicator of attachment insecurity and treatment outcome (Daniel et al., 2018). In-session silences may indicate problems in the client-therapist relationship, one source of which can be client interpersonal problems such as attachment insecurity. In contrast, a study examining the use of silence in therapy revealed that sessions with higher levels of client-perceived rapport had significantly more instances and greater overall duration of silence (Sharpley, 2005).

Studies have investigated the relationship between attachment style and various aspects of the psychotherapy process. For instance, client attachment style has been associated with the working alliance, therapist immediacy, client crying, client laughter, and therapist exploration skills (Anvari et al., in press; Gupta et al., 2018; Hill et al., 2014; Marmarosh et al., 2014; Robinson et al., 2015). A growing body of literature now supports the relevance of adult attachment to the psychotherapy process and outcome (Diener & Monroe, 2011; Levy et al., 2011; Taylor et al., 2015), but there are still relatively few studies of observable in-session correlates of client attachment styles (Daniel et al., 2018).

Significance of the Study

Due to minimal qualitative research studies exploring the use of silence as an intervention in the therapeutic setting, there is a lack of qualitative evidence exploring how silence impacts the therapeutic relationship and client outcomes. Therapists use silence in sessions for a variety of reasons: to express empathy and support, allow clients to reflect, provide space to integrate, induce affect, and encourage the client to accept responsibility. Yet there is little formal training in counselling academia on silence as an intervention. I hope this project adds to the research by

supporting the development of a framework to support counsellors in understanding the client's internal process when using silence as an intervention in the therapeutic setting. The proposed framework is significant as it will address a gap in current literature by drawing attention to factors therapists should be assessing when using silence with a client in therapy. Therapists need to explore what is going on with the client during times of silence. The framework will allow therapists to study different types of silence with different types of clients.

Silence is a form of communication and communication styles differ among cultures. In individualistic cultures, direct and explicit language is commonly used, while in collectivist cultures, indirect and implicit expressions are more prevalent (Kawabata & Gastaldo, 2015). Not surprisingly, therapists need to consider the attachment style and culture of the client when deciding to bring silence into the therapy room. However, research on silence has predominantly focused on Western nations, including North America and Europe (Heldner & Edlund, 2010, as cited in Soma et al., 2022). Hill et al. (2019) identify the lack of diversity as a limitation in their study; most of their participants were middle-aged White males. Similarly, Ladany et al. (2004) identify their lack of diversity, stating all participants were White, and the study did not attend to cultural variables. In Frankel et al.'s (2006) study, participants were all White. Both Levitt's (2001a and 2001b) and Daniel's (2018) studies were conducted in Western contexts and did not identify participant ethnicity. Likewise, studies by Dobosz (2021), Brandsaeter and Hauge (2021) and Barbor (2009) did not identify the ethnicity of the participants, and all three studies were carried out in Western contexts. Future research would benefit from including participants with diverse backgrounds, therapeutic process variables, and therapy outcomes (Soma et al., 2022). Furthermore, I believe counselling professors and training institutions will benefit from the information provided from this project, as they will be able to educate trainees on the

different types of silences, facilitate role plays, support student counsellors to engage with silences, and provide feedback to students on their competency with the use of silence as an intervention.

Positionality Statement

I remember being in my psychotherapist's office and experiencing a mix of feelings when sitting in silence together. There were powerful moments where I cried out years of pain, moments when I gained awareness or when I felt deeply responsible for my emotions, and moments where I felt paranoid, and I wondered what he was thinking, wondered if I should be talking. As a young child, I was told I should be seen and not heard. I associate my introversion and struggle to have a voice with the silencing I experienced in my childhood. It feels familiar to me to sit in silence. And then there is silence as punishment; when I was growing up, my parents would spend weeks not talking. Silence became the sound of separation and pain.

In more recent years, I have experienced several friends breaking the silence within seconds, friends who seem uncomfortable being in the presence of others without words. Observing different responses to silence has made me curious to understand silence in the therapeutic setting. Six years ago, I participated in 10 days of silent *vipassana* in India, where I challenged my mind, body, and spirit. Although not a therapeutic setting, this experience of being silent for such an extended period had a profound therapeutic effect on me. I hope this capstone project provides therapists with a deep understanding of silence in the therapeutic relationship. I also hope the knowledge provided equips therapists with the considerations and skills to engage with productive silences and navigate obstructive silences, fostering a strong therapeutic relationship and producing positive client outcomes.

Definition of Terms

Attachment

Psychological lasting connectedness between human beings (Fletcher et al., 2014).

Culture

A set of shared and enduring meaning, values, and beliefs that characterize national, ethnic, or other groups and orient their behaviour (Mulholland, 1991).

Psychodynamic psychotherapy

"Treatments that can be applied for chronic and disabling psychiatric disorders, symptoms, and recurrent interpersonal or personality problems, that are driven by thoughts, feelings and reactions that remain outside conscious awareness because they are distressing" (Doidge & Freebury, 1998, as cited in Abbass et al., 2020, p. 3).

Psychotherapy

"The incremental pursuit of exploring the client's past and its impact on the present" (Knol et al., 2020, p. 1).

Silence

"The temporary absence of any overt verbal or para verbal communication between therapist and client" (Feltham & Dryden, 2004, p. 177).

Therapeutic interventions

"Developed and tested for specific problem areas that fit the needs of the client based on the process of change. Therapeutic interventions are used in the hopes that they bring about positive change for the client" (Hoffman & Hayes, 2019, p. 37).

Therapeutic relationship

The feelings and attitudes felt and exchanged between the therapist and client (Norcross & Lambert, 2019).

Outline of Capstone Chapters

In chapter two, I review the previous literature about the therapist-client relationship and the therapist's use of silence as an intervention in the therapeutic setting. In chapter three, I summarize the research findings of the previous chapter as well as discuss the strengths, limitations, and gaps within the current literature. Furthermore, chapter three includes my hope for future researchers to explore the phenomenon of silence more closely as well as other considerations deserving of exploration. Lastly, I discuss a proposal for a framework that caters to both practising and student therapists as well as counsellor training institutions, supporting them with the knowledge and skills to use silence as an intervention in the therapeutic setting.

Chapter Two: Literature Review

The purpose of this study is to examine the therapist-client therapeutic relationship and the therapist's use of silence as an intervention in therapy. The following section highlights various themes discovered about silence as an intervention in the therapeutic setting, including both the positive and negative impacts of silence in therapy. It is clear from the research that silence is a powerful therapy tool (Cuttler, 2019), so I begin with an exploration of silence and psychodynamic psychotherapy. I provide an overview of the phenomenology of silence and the therapeutic meaning of silence, followed by an exploration of silence and the therapeutic relationship. I then examine silence as an intervention in therapy as well as research on the outcome of silence. Lastly, I discuss psychotherapy training and supervision.

I found it difficult to find research published in the last five years on silence as an intervention; thus, I rely on seminal research and dissertations with small participant sizes. I also intend to address this research gap by examining the methodologies and generalizability of the existing research as well as highlighting areas of agreement and disagreement.

Silence and Psychodynamic Psychotherapy

In psychoanalysis, Freud considered silence as the client's concern about what the therapist is thinking and a way to freeze the connection (Levitt, 2001a). Silence was viewed as counterproductive to therapy, and clients were encouraged to resist silence and speak freely about whatever thoughts came to mind. The conceptualization of the client's silence as a defence continues to be salient in literature (Yalom, 1985, as cited in Levitt, 2001a). Often, silence as resistance transpires together with varying regressive processes. This is comparable to research by Lane et al. (2002), who found that in psychoanalysis, silence is interpreted to mean the client is resisting and engaged in transference toward the therapist. Thus, the therapist's response to

that silence is connected to the transference from the client. According to Levitt (2001a), regression to silence has been viewed as a return to a time before words, the infancy stage. The two interpretations for this regression are that silence symbolizes early childhood, where the mother and infant's core being is merged, and that silence is a signal for control.

Hill et al. (2003) found that psychodynamic therapists use silence to promote reflection, which aligns with their attention to promoting insight. Psychodynamic therapists learned the skill of silence from their own personal therapy, suggesting that because of psychodynamic therapists' experience as a client, they commit to using silence in their therapeutic practice (Basch, 1980, as cited in Hill et al., 2003). Research by Denham-Vaughan and Edmond (2010) mentions that gestalt therapy values non-verbal communication; they propose that there is a place for a quiet and voiceless client.

Daniel et al. (2018) examined the use of silence in both cognitive behaviour therapy and psychoanalysis. In both orientations, the therapist and client engaged in silence more often at the middle and end stages of treatment and less often in the early stage of treatment (the therapist and client focus on forming a therapeutic relationship in the early stages of therapy). There was four to five times more silence in psychoanalytic psychotherapy compared to CBT—a finding that is not surprising, as CBT is more directed and structured in its approach. Barbor (2009) states that CBT and Existential theory rely on verbal communication as the driver of change; therefore, the use of silence is not an important area of skill development. This approach supports research by Daniel et al. (2018), where CBT was found to engage less in silence due to its structured and directional approach.

Attachment Styles

Daniel (2011) examined silence and attachment style. Findings indicated that clients with dismissing attachment engage in silence more often than those with preoccupied attachment, who rarely engage with silence. In later research, Daniel et al. (2018) used PICS to measure attachment and silence in clients receiving CBT and psychoanalytic psychotherapy. As in the earlier study, Daniel et al. found that clients with dismissing attachments engage in more pauses than clients with preoccupied attachments. A higher number of pauses was connected to a poor therapeutic alliance, whereas a lower number of pauses in the session was connected to positive client outcomes. The research found more obstructive pauses with dismissing and preoccupied clients than with securely attached clients. Secure and preoccupied clients had the same amount of silence in session, but the number of obstructive pauses was more significant with preoccupied clients than with secure clients (Daniel et al., 2018).

Research by Cuttler et al. (2019) found that for clients who had an insecure attachment, it was essential for therapists to engage in productive behaviour during silence. The therapist's productive behaviour is described as connected, encouraging, and invitational. For clients who were high in attachment anxiety, during silence it was essential for the client's behaviour to be productive. The client's productive behaviour is described as emotional, expressive, or reflective. When Cuttler et al. analyzed clients' productive pauses, they found that emotional and expressive pauses were linked to an increase in the alliance whereas reflective silences were not. The therapist's productive silence was helpful for clients with low attachment anxiety, and it is suggested that clients with low anxiety can tolerate silence better than highly anxious clients. In contrast, client productivity during times of silence was helpful for clients who were high in anxious attachment. Perhaps they needed space to process their feelings. The results of this research align with previous research by Daniel et al. (2018), who found that clients with

different attachment styles will respond differently to the therapist's interventions (Cuttler et al., 2019).

Cultural Considerations

Kawabata and Gastaldo (2015) highlight the importance of cultural considerations when interpreting silence, as failure to do so leads to challenges in constructing meaning and negatively impacts outcomes. Research by Tisljár & Pléh (2014) found that silence is not a universal phenomenon. Silence can be seen as a positive or negative effect depending on the cultural framework of the person interpreting the pause. According to DeVito (2016), silence is interpreted differently across cultures. In the US, some people perceive silence unfavourably: in social settings, the silent individual may be perceived as uninterested, a poor listener, or lacking understanding of the discussed topic. In Japan, silence is a response considered more appropriate than speech (Haga, 1988, as cited in DeVito, 2016). Ethnic Norwegians view silence as consent, yet for the Sami culture in the north of Norway, silence is understood to mean disagreement (Amundsen, 2012). Among the Apache, friends do not introduce strangers to friends; the strangers are silent in each other's company for days; they observe each other and form opinions based on observing without engaging in verbal exchange. Early in romantic relationships, couples stay silent for hours; if they converse, it is minimal. Several months after dating, the couple has a long conversation (DeVito, 2016).

Phenomenology of Silence

Thomas Mann wrote that silence isolates humans and prevents contact; therefore, to engage in verbal communication is to engage with the world. However, philosopher Karl Jaspers wrote that silence creates thoughts, enabling us to verbally communicate. Philosopher Max Picard believed that silence should not be viewed as a lack of communication; silence by itself is

communication (as cited in DeVito, 2016). For Nietzsche, silence is a natural response to listening every day to the opinions of others. According to Satre (1948), the meaning of silence depends on the words before and after silence appears, just as a pause in music gets its meaning from the musical notes that surround it. Thus, silence is as important as words (Barbor, 2009). Collectively these philosophers agree that silence is communication (DeVito, 2016).

According to Levitt (2001b), “silence has been described as an indicator of such varied processes as the communication of a transferential struggle, emotional atonement, demands of cognitive processing, regression, expression of rage, trust and intimacy with a therapist as well as therapeutic resistance” (p. 295). The phenomenology of silence is captured in the writing of Sabbadini (1991, as cited in Warin, 2007), who notes that in certain situations, silence is a wise and appropriate response; silence serves to connect and contain. Yet silence is associated with anxiety and fear of morality. Silence communicates a variety of feelings, including appreciation and delight; silence is also preverbal and communicates regression (Lane et al., 2002). Silence can provide time to reflect, attend to feelings of anxiety, stop words from being expressed, prevent someone from speaking out of turn, express emotions, communicate that someone has nothing to contribute, or can cause harm (DeVito, 2007, as cited in Guitiérrez Menendez, 2019).

As therapists in the therapeutic setting, one must understand what the client is communicating to us when using silence. To support therapists with this task, Levitt (2001b) created an assessment to categorize clients’ silence in therapy. Levitt’s categories of silence include productive, obstructive, and neutral. Productive silences support the client in connecting to emotions, gaining insight, and making connections. Obstructive silences involve protecting the therapeutic relationship, the client avoids and withdraws from the therapist. Frankel et al. (2006), using Levitt’s assessment, found that therapeutic relationships with positive results had more

productive silences than dyads with negative results. Daniel et al. (2018) found similar results. Research on silence phenomena indicates silence is complex, with the potential to have positive or negative outcomes. Thus, silence has several meanings and functions in therapy (Brandsaeter & Hauge, 2021). Since silence is viewed differently across cultures, future research on silence would benefit from examining the phenomenology of silence across cultures (Levitt, 2001b).

Therapeutic Meaning of Silence

There are conflicting findings on the meaning of silence in the therapeutic relationship. As cited in Levitt (2001b), Becker et al. (1968) believed silence indicated the client's discomfort, while research by Hargrove (1974) found silence resulted from the therapist's experiences of empathy. Levitt's research highlighted the importance of context in understanding pauses. Inquiring with clients, after a tense pause, about what is happening for them internally provides the therapist with helpful information and insight into the client's internal process during times of disengagement or detachment (Levitt, 2001b). To understand the meaning of silence, one must examine the context in which it occurs, with the therapist's understanding of the context also being considered. Similarly, Kawabata and Gastaldo (2015) suggest researchers take context into account when interpreting silence. Asking curious questions allows us to demonstrate respect, interest, and compassion toward the silent client. Understanding the client's silence as a form of communication allows us to enter the conversation as an empathic and caring therapist (Knutson & Kristiansen, 2015). Mazzei (2007) also highlights the importance of understanding silence as a salient part of expression rather than as less important than spoken words. According to Hill et al. (2003), silence is received differently, depending on timing and the client's need.

As well, one's theoretical orientation determines how silence is understood. Silence can communicate care or punishment. Robert Lane and colleagues provided two perspectives on

silence: when the therapist uses the silence to hold the client's emotional processing, nourishing a healthy collaborative space, and when the therapist does not engage with the silence (Lane et al., 2002). For Lane et al., silence is used appropriately as an intervention in listening and communicating a wide range of meanings to the client. Silence conveys acceptance of parts of the client others have found disagreeable, which allows the client to safely explore these undesirable aspects of the self while gaining insight. Silence can communicate acceptance of a maladaptive response and demonstrate that it is the client's responsibility to make change. Lane et al. also believed responding to a client's queries with silence enhances their tolerance for frustration. All these silent intervention responses must be delivered with warmth and genuineness (Lane et al., 2002); otherwise, as Aull and Strean (1967) found, long silences by the therapist may feel punitive for the client (as cited in Lane et al., 2002).

Silence and the Therapeutic Relationship

In the late 1960s, Gordon (1969) asked a research question: "What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?" (p. 111). Empirical and clinical literature has examined how treatments work. Debate exists on whether the therapeutic relationship alone is responsible for creating change or whether the relationship alongside techniques creates client change (Vilkin et al., 2022). In a large-scale study, findings indicate that for clients with a strong therapeutic relationship, the application of the treatment manual was not relevant to treatment outcome; however, for clients with a poor therapeutic relationship, the therapist must apply treatment interventions for the client to have better outcomes (Barber et al., 2006). The therapeutic relationship does not exist in isolation from therapeutic intervention, and all interventions have a relational impact (Norcross & Lambert, 2011). According to Knol et al. (2020), silence in

psychotherapy might be what provides the therapist with access to the client's emotional awareness and insight.

The therapeutic relationship is defined as the feelings and attitudes felt and exchanged between the therapist and client (Norcross & Lambert, 2019). Researchers agree that both the client and therapist must contribute while communicating to form the foundations of a positive therapeutic alliance (Lingiardi et al., 2016, as cited in Del Giacco et al., 2020).

The client or counsellor may experience silence as challenging or disturbing (Lehmann et al., 2019). Research conducted by Sharpley et al. (2005) examined the relationship between building rapport and silence during intake sessions. They found a notable increase in silence during high rapport times in contrast to low rapport times. A counsellor filling silences doesn't necessarily help to build the rapport which, in turn, contributes to setting up the therapeutic alliance. Rather, research has found that it is during the work stage, around the 20-minute mark of a therapeutic meeting, when rapport building is associated with the use of silence (Valle, 2019). Silences started by the counsellor and terminated by the client were found to contribute to rapport more than silences that were started and ended by the counsellor only (Valle, 2019). While silence in the counselling session can mean emotional and motivational disengagement, negatively impacting both the therapeutic alliance and client outcomes, it is important to note that not all silences hinder treatment (Daniel et al., 2018). In a research study by Brandsaeter and Hauge (2021), participants believed silence to be threatening as it evokes difficult emotions and a negative evaluation of self. Yet participants believed a positive therapeutic relationship could correct this and that clients are less likely to interpret the silence negatively when there is a strong alliance. Participants believed silence can increase or decrease the feeling of trust and safety, and they perceived silence in a secure therapeutic relationship as proof of the strong

alliance between therapist and client (Brandsaeter & Hauge, 2021, pp. 21–22). The meaning participants made of silence depended on the therapeutic relationship (Brandsaeter & Hauge, 2021).

Numerous large-scale analyses (Baier et al., 2020; Fluckiger et al., 2020; Norcross & Lambert, 2018) have reviewed the different aspects of this relationship and its role in therapeutic change. The analyses show limitations in the conceptualization of the relationship. Notably, the theoretical orientation of a therapist can be a determining factor in how the relationship as an intervention is considered. For example, in relational psychotherapies the therapeutic alliance is of much more importance than, say, in exposure therapy. Therapists should determine the role of the therapeutic relationship by case conceptualization and not by their theoretical orientation (Vilkin et al., 2022). When a therapist integrates treatment approaches for a client from a variety of theoretical orientations, the therapist is demonstrating flexibility in using the therapeutic relationship when operating across orientations. A therapeutic relationship based purely on the theoretical orientation is limiting for addressing client needs; factors related to their needs—such as attachment style and learning history are connected to the client's concerns being addressed in therapy (Vilkin et al., 2022).

Non-Verbal Communication

According to Schore (2014), non-verbal communication in the therapist-client relationship and attachment impacts the therapeutic process. The therapist tracks the non-verbal internal processes of the client, and the therapist modifies their behaviour to attune to the client, thereby co-creating an environment where the client can grow. When the therapist and client's right brains are activated, change can occur. As Schore (2014) writes,

> right brain interactions nonverbally communicate essential nonconscious bodily based affective, relational information about the inner world of the client. Rapid communications between the right-lateralized "emotional brain" of each member of the therapeutic alliance allow for moment-to-moment "self-state sharing," a cocreated, organized, dynamically changing dialogue of mutual influence. (p. 390)

In therapy, the client and counsellor engage in verbal and non-verbal transactions to share information and emotionally regulate based on what is conveyed. This communication is foundational to establishing a therapeutic alliance. Several published works prove that the therapeutic alliance is an agent of change in therapy (Del Giacco et al., 2020). The therapeutic alliance is defined as the collaboration between the therapist's and client's agreement on goals and how to achieve the goals as well as a positive emotional connection (Norcross & Lambert, 2019). Most research examines verbal communication, however, with little research on nonverbal communications and their interactions with verbal components in forming the therapeutic alliance. More research is needed on the relationship between communication and therapeutic alliance by focusing on verbal and non-verbal dimensions; such research will provide therapists with helpful knowledge in building a working relationship with clients and therapy effectiveness (Del Giacco et al., 2020).

Transference and Countertransference

The therapist's behaviour, such as managing countertransference and empathy, supports the client in creating change (Vilkin et al., 2022). According to Levitt (2001b), when therapists use silence, clients can feel anxious and decompensate. Langs (1973) writes that the therapist's inappropriate use of silence might be to punish the client or to express hostile feelings towards the client; it may be an attempt to stop the client's maladaptive behaviour or a defence against

the therapist's sexual desires towards the client. For Lane et al. (2002), such a countertransference response starves the client of contact. This signals the therapist's inability to be client-centred and a failure to support the client to make positive changes. When this happens, the client's mental health may decline and the client may relapse (Lane et al., 2002).

Research by Barbor (2009) examining silence and countertransference found that most clients demonstrated a connection between their childhood experiences of silence and their understanding of silence in therapy. Participants in the study identified similarities in how silence was used to exert power over them in childhood and their experience as a client, with expressions such as "switching off," "going blank," being "on edge," or being "forced to reveal." Participants believed silence was a power struggle, and the idea of "being seen and not heard" was present (Barbor, 2009, p. 47). The client's behaviour mimicked that of their past. The same could be true for therapists, introducing the idea of countertransference (Barbor, 2009). In Dobosz's (2020) study, therapists said they are careful when breaking the silence in therapy; they mentioned the desire to rescue the client. A desire to break the silence is a normal response from therapists; Brandsaeter and Hauge (2021) found that several therapists felt anxious that the client might feel abandoned, which led the therapist to want to break the silence. Therapists felt that their anxiety toward silence decreased as they gained more experience. As the therapist's ability to regulate improved, they felt better skilled at not projecting their affect onto clients (Brandsaeter & Hauge, 2021).

Ruptures in Psychotherapy

Ruptures in counselling happen when collaboration is poor between the therapist and client; repairs occur when they collaborate and cooperate (Colli et al., 2017). The therapist's ability to recognize and handle these moments as they happen can lead to positive or negative

changes. Therefore, cooperation in the therapeutic relationship involves regulation on the part of the therapist and client, which can be an agent of change (Del Giacco et al., 2020).

Research by Baier et al. (2020) found that "trustworthiness, experience, exploration, confidence, empathy and accurate interpretation by the therapist contributed to a good therapeutic alliance" (p. 5). The use of silence is a skill the therapist must learn. The danger of using silence without consideration of its consequences is that it can signal to the client that the therapist is not interested or is distant. This can be a barrier to developing a solid therapeutic relationship (Lane et al., 2002). Research by Eubanks et al. (2019) examined the therapeutic relationship and concluded that silence is a significant indicator of ruptures. Likewise, research by O'Keefe et al. (2020), who explored the reasons adolescents drop out of therapy, suggested that therapist silence may adversely affect the therapeutic alliance.

Silence as an Intervention in Psychotherapy

Silence differs from an intersubjective perspective of psychotherapy: Seen as part of communication within a relationship and as encompassing layers of thought and affect (Sabbadini, 1991, as cited in Warin, 2007). Therapeutic interventions are used in the hopes that they bring about positive change for the client. Therapeutic interventions are developed and tested for specific problem areas that fit the needs of the client based on the process of change (Hoffman & Hayes, 2019).

In the 1960s, psychology researchers (Arlow, 1961; Blos, 1972; Bollas, 1996; Brockbank, 1970; Greenson, 1961; Khan, 1963; Langs, 1976; Leigner, 1971; Loomie, 1961; Shafii, 1973; Zeligs, 1961) began to view silence as a form of communication in the therapeutic relationship. Four leading theorists studied therapists' silence. Pressman (1961) identified the client's silence as resistance and the therapist's silence as creating the perfect setting for

psychoanalysis. Zeligs (1961) highlighted the role silence has on the development of transference and countertransference and how this impacts the therapeutic relationship. Zelig also believed silence was resistance; his work added that the client's attitude towards silence depended on the attitude of the therapist's use of silence. In 1969, Strean's work mentions that although most interventions require a verbal exchange, some clients do not engage with verbal interventions, while others are stuck in the non-verbal phase of development and thus require nonverbal interventions (Lane et al., 2002). Brockbank (1970) concluded the therapist's countertransference unveiled what the client was experiencing and what the therapist was experiencing internally. Brockbank found that for the therapist to understand the meaning of the client's use of silence, the therapist and the client's psychological differences and transference experiences must be explored (as cited in Lane et al., 2002). Brockbank identified silence as a powerful tool in therapy (Warin, 2007) as did Lang (1978), who understood silence to be the most fundamentally underestimated and misconstrued intervention (Warin, 2007).

Therapists' Cognitive Process

For the counsellor at the beginning of their career, one of the most challenging therapeutic responses to interpret is silence. Silence can cause the experienced counsellor anxiety, and the client may interpret the silence as disagreement, apathy, or acceptance (Walen et al., 1980, as cited in Sharpley et al., 2010).

In one study, 81 therapists (most identifying as White and male) completed a survey. Hill et al. (2003) found that therapists were active in their thought processes during times of silence; they reported observing the clients and attuning to what was happening in the therapy room and with themselves. Therapists supported clients to engage in the work of therapy, reported being active in thinking about their clients and the therapy, and reported that silence had a positive

outcome with clients. A limitation of this study is that some terms were left open to interpretation by the participants. In another study by Barbor (2009), seven therapists, with the majority identifying as female from a variety of theoretical orientations, were interviewed face to face. Participants' answers were analyzed using thematic analysis to allow for pattern identification about their experience with silence as newly qualified counsellors. Like Hill et al., Barbor (2009) found therapists were cognitively active during silence compared to emotionally active clients. Participants described being aware of their internal processes and those of their clients during silence. According to Cologon et al. (2017), an effective therapist can monitor the cognitive processes of both themselves and the client and can identify countertransference experiences towards the client.

Some participants felt that silence conveyed to the client that they were not competent therapists (Brandsaeter & Hauge, 2021). Silence can mean the counsellor lacks the skill, and this has the potential to damage the counsellor's self-esteem (Sharpley et al., 2010).

Therapists' Emotional Process

In one study, five participants were interviewed on their experience of silence in therapy; answers were analyzed using thematic analysis. Three themes emerged when the therapist was asked how they feel when silence is used in session: "finding comfort in silence, staying present and attunement to clients' needs" (Dobosz, 2020, p. 33). Therapists who participated in this study expressed a reluctance to interrupt a client who is processing. Participants recognized that a certain level of discomfort can be beneficial to therapeutic work and agreed they would break the silence only if they see that something in the client's processing needs to be interrupted (Dobosz, 2020, p. 37). Some therapists described using silence with clients to process grief; silence allows the client to slow down and process the emotions of grief. All therapists in this

study stated it is crucial to be present during silence in therapy; this allows therapists to observe the client's emotions to help determine if they are becoming dysregulated. Therapists discussed the importance of being attuned to the client's needs, especially when bringing silence into the session. Therapists also discussed the benefit of some silences in the therapeutic process and the importance of breaking the silence when there is a benefit to interrupting the client process (Dobosz, 2020).

Reasons for Using Silence

Therapists use silence to think about their responses and reflect on the work occurring in the session. In a study by Ladany et al. (2004), 12 participants in the US all identifying as White were interviewed using consensual qualitative research on their reasons for using silence in therapy. The study found that silence can be used for a variety of reasons; therefore, silence cannot be understood as having one meaning in the therapeutic encounter with a single therapist intervention and client perception (Ladany et al., 2004).

One study interviewed 14 participants, the majority of whom identified as female, on their perception of silence phenomena. The participants' answers were analyzed using thematic analysis to allow for pattern identification. Brandsaeter and Hauge (2021) found that therapists use silence for five main reasons: "to convey empathy, to facilitate exploration and reflection, to give room to integrate, to induce affect and a sense of responsibility in the client" (p. 18). Using silence to convey empathy is described as sitting with the client and feeling their pain; as the therapist you are not trying to take the pain away, but you are present with the client in the fact that sometimes life is painful. Participants identified silence as facilitating exploration and reflection in both the therapist and the client. Participants said they ask questions to explore and understand the client's experiences. Silence gives space for the client to think; participants

tended to use silence more if the client needs more time to process thoughts and feelings, or if the client uses speech as avoidance. Silence is used to integrate new ideas: one participant described how a client made a realization, and filling the silence with words would have taken away from the client's recognition. Another participant described how she uses silence to increase affect, which she believes helps the therapeutic process. When you start talking to a client you invite them to think; if you want the client to feel, you must learn to say nothing (Brandsaeter and Hauge, 2021, p. 18). Similarly, in Dobosz's (2020) study, therapists agreed that silence is mainly used to allow clients to reflect and slow down when feeling overwhelmed.

Likewise, Ladany et al. (2004) found that the therapist used silence primarily to express empathy and support and to show respect. Therapists state that silence allows clients to reflect, accept responsibility, and express emotions. Strong correlations were revealed by Hill et al. (2003), who found therapists primarily use silence to facilitate client reflection and for clients to take responsibility. Silence helps clients turn inwards to engage in deeper reflection of their thoughts and feelings. Clients describe reflective silences as searching for answers, experiencing a greater understanding of the importance of an event, making connections between different life experiences, or realizing a new idea. Clients gain insight and understanding during reflective silences (Hill et al., 2019, p. 578). Silence, as described by the participants, also carries a transformative dimension as a means of reflection in collective thinking, facilitating room for the accumulation of reflexive skills such as deep listening and reflection on experiences (Vu & Fan, 2021).

Brandsaeter and Hauge (2021) found four themes in examining the therapist's use of silence: "silence as a therapeutic tool, silence as amplifying ambiguity, ambivalence, and affect, silence and the therapeutic relationship and meeting without words" (p. 18). Therapists reported

that their interpretation of silence depended on the words expressed by the client before and after the silence. The findings in this study support research that silence gives meaning to speech (Chowdhury et al., 2017). Some participants believed it is essential to talk to the client about the different meanings of silence in therapy as well as discuss silence verbally afterwards. The therapists used silence more often if the client used words excessively as avoidance or needed space to integrate emotions. Some participants used silence to slow down the pace of the sessions (Brandsaeter & Hauge, 2021). However, some participants felt that silence conveyed to the client that they were not competent therapists (Brandsaeter & Hauge, 2021).

Silence and Discomfort

In research by Brandsaeter and Hauge (2021), therapists described silence as uncomfortable when used with someone they do not know and as triggering negative self-examination. Dobosz (2020) found silence is uncomfortable early in therapy, but comfort levels with silence improved as the relationship evolved. Therapists described how comfort and silence are directly connected to the therapeutic relationship. Ladany et al. (2004) found that a strong therapeutic relationship is essential when using silence in therapy. These findings demonstrate the importance of establishing a solid therapeutic relationship when using silence.

The Danger of Silence

Both seminal and recent research found similar findings related to the therapist's use of silence and the client's mental health. Hill et al. (2003) found silence was unlikely to be used by therapists on clients who historically experienced silence as punishment, clients who experience paranoia and psychosis or who may be harmful to themselves and others, or when there is a poor therapeutic relationship. Ladany et al. (2004) suggest therapists do not use silence unplanned; for example, therapists reported avoiding the use of silence with clients who experience psychosis,

paranoia, anger, anxiety, overwhelm, have a personality disorder, present as a danger to self or others, or when the client is new to therapy. For these clients, silence could harm the relationship or be experienced as cruel; it may make a client angry and feel frightened and overwhelmed. Brandsaeter and Hauge (2021) mention that therapists intentionally used silence depending on client factors; for example, silence was not used much if the client was a youth, presented with anxiety, or experienced psychosis. In Dobosz's (2020) research, participants agreed that silence is not appropriate for clients who dissociate or have a mental illness where silence is intolerable for them. Hill et al. (2003) found that therapists often use silence when problem-solving with clients. Silence was moderately used by therapists with clients who were experiencing mania, or were highly anxious and depressed and required support.

Silence may be helpful or may serve as a barrier in therapy, depending on how silence is handled interpersonally. When a client pauses, this may serve as a barrier, but if the therapist explores the pause and interprets the silence, this may be useful to the sessions overall (Levitt, 2001b). Research published by Hill et al. (2003) found that some counsellors use silence when they do not know what to say or fear saying the wrong thing, and some counsellors feel awkward with silence. Lane et al. (2002) warned that if a client becomes silent after a therapist's silence, this suggests that silence is dangerous for this client and the client is afraid, angry, or distrusting of the therapist. Specific to the categories of silence, Dobosz (2020) found that if a therapist interrupts a client during a productive silence, this interferes with the client's processing. In Barbor's (2009) study, clients used words such as "bullying," "power struggle," and "damaging" to highlight how powerful silence is in therapy. In Brandsaeter & Hauge's (2021) study, several participants described silence as having the ability to increase the positive and negative effects, depending on how silence is interpreted. Therapists described silence as having the ability to shut

down a client. Therefore, therapists must be intentional when using silence and consider each client's subjective experience (Barbor, 2009).

Outcomes of the Use of Silence

Frankel et al. (2006) suggest that when emotional experiences are not discussed in therapy, this leads to poor outcomes. When the therapist attends to the emotions and behaviours of the client in therapy, this leads to good outcomes. It is beneficial for therapists to evoke emotional, reflective, and expressive silences. Frankel et al. (2006) also suggest there are times when the client's internal process is so powerful, they have to pause the therapeutic work. Researchers suggest these findings are compatible with psychotherapy's theory of change; change occurs when clients make contact with thoughts and feelings that can cause the client discomfort (Dobosz, 2021). Several therapists felt words were not beneficial in some situations with clients, and genuine moments where they felt a deep understanding with the client were shared during silence. Therapists felt more attuned and connected to the client in these moments (Brandsaeter & Hauge, 2021) and described clients as experiencing a revelation before these shared moments. Therapists described the benefits of being present during silence with clients as this allows the client to integrate the therapeutic encounter, and the relationship is stronger as a result (Brandsaeter & Hauge).

Hill et al. (2019) found that a solid therapeutic alliance was a prerequisite for silence. This means the therapist should focus on establishing a strong therapeutic relationship with clients before using silence as an intervention. This research aligns with Ladany et al. (2004), who found that therapists generally used silence only when a solid therapeutic alliance had been formed (Hill et al., 2019). Lane et al. (2002) found that a therapist using silence with a client in search of an emotional connection may rupture the therapeutic relationship. Thus, therapists

should be aware of how silence will impact the therapeutic relationship. The client's silence is a message to be understood; the therapist's silence is a skill to be learned that communicates commitment and collaboration.

According to Lane et al. (2002), a client's silence can communicate regression to the infancy stage and the relationship between mother and child. The client's silence can also communicate adaptive patterns the client has learned throughout life. Research by Levitt (2001a) found that clients did not make a connection between experiences of silence in the early stages of life and transference toward the therapist or parent. It is suggested clients do not have the awareness to make this connection, or that this hypothesis cannot be applied to all clients. In Ladany et al.'s (2004) study, therapists found that silence allows the client to occupy space and be active in therapy.

The Function of Silence

Levitt (1998) developed the pausing inventory categorization system, a tool to measure silence phenomena—specifically, the categories of a client's silence. Levitt conducted research in 2001 with seven clients and four therapists, where the categories of pauses listed include productive, obstructive, and neutral (Cuttler et al., 2019). Categorization is based on what happens before and after the pause. Levitt (2001a) used consensual qualitative research, specifically grounded theory analysis, to examine clients' obstructive silences and found clients' obstructive silence falls into two categories: disengaged pauses and interactional pauses. Disengaged pauses are when clients move away from overwhelming emotions; interactional pauses are when clients attend to the emotions during communication. Clients who experienced disengaged pauses stated they avoided negative emotions or felt distant from the therapeutic encounter. Clients described feeling uncomfortable with the conversation and wanting to move

away from the emotions. Those who experienced interactional pauses described these pauses in three ways: wanting to protect the therapeutic relationship, not understanding what the therapist said, and the demands of interpersonal communication (Levitt, 2001b). Levitt found that both types of silences amount to 22% of pauses in session, supporting the view of psychodynamic theorists (Sabbadini, 1991, as cited in Warin, 2007) who believe silence has a variety of meanings and that not all silences are negative. This belief is supported by Frankel et al.'s (2006) research that suggests silence has a variety of meanings in therapy.

Different silences are connected to positive and negative client outcomes (Hill et al., 2019). During emotional silences, clients said they were accessing intense, powerful, profound emotional experiences with their therapist. During expressive silences, clients said they felt the therapy was progressing and had a more profound knowledge of themselves. During reflective silences, clients said they were making connections between past life events or understanding the event from a different perspective. Clients gained insight, knowledge, and awareness during these silences but felt uncomfortable while the therapist waited for them. Clients often ended the silence early to converse with the therapist (Hill et al., 2019). Levitt's research also demonstrates the heterogenous phenomena of silence within therapy and the impact of the use of silence on the client and the therapeutic relationship.

Hill et al. (2019) found that most of the silences occurred during the client's verbal communication, using silence to pause and reflect. Silence was used productively by both the client and therapist later in treatment; for example, the alliance strengthened when the client broke the silence and the therapist remained connected to the client during the silence. Similar results were found by Cuttler et al. (2019): when therapists connected with clients during silence, the client engaged in therapeutic work and the alliance increased. If either the therapist or client

was disengaged during silences, the alliance decreased. These findings support those of Frankel et al. (2006)—that the therapist and client processes during silences were productive and associated with positive outcomes. Similarly, Bartels et al. (2016) examined silence in doctor-patient communication and found that connective silences were productive. Using a pausing inventory categorization system measuring silence treatment outcomes with 70 participants, Daniel et al. (2018) found that a higher number of obstructive silences was connected to poor outcomes: findings that support Levitt's research that therapeutic work occurs during reflective silences. Silence allows for change to occur (Hill et al., 2019). These findings demonstrate the importance of therapists being connected and engaged with the client's therapeutic process during and after moments of silence.

However, Hill et al.'s (2019) findings that emotional silences increase across the course of therapy do not align with those of Frankel et al. (2006), and Soma et al. (2022) who found a weak link between the length of the silence and the feelings expressed. This research found no evidence to suggest silence generates emotional processing and expression.

Psychotherapy Training and Supervision

Silence is communication. Despite this, clinicians are not trained in or do not understand the importance and meaning of silence (Bartels et al., 2016). Psychotherapy is fragmented even though there is evidence of similarities that exist across orientations with the role of client, therapists, and contextual considerations. Consensus must be reached in the psychotherapy community (Gaines et al., 2020). Psychotherapists are requested to have academic qualifications and personal competencies such as communication skills, empathy, mentalization skills, and emotion regulation skills that are essential for successful therapy. Therefore, a competence-oriented framework can provide a different theory of psychotherapy that helps to integrate not

only existing approaches but common tools and competencies with psychotherapy (Rief, 2021). According to Wu and Levitt (2020), the response of the therapist should be a salient focus of therapist training. Several process measures can be used by therapists in training to increase their sensitivity to specific dynamics, such as changes in the client's ability to make meaning from their emotions, transference patterns, client silences, or client vocal cues.

Counselling professors and their students should also study the types of silence that help the therapeutic relationship and those that hinder it (Sharpley et al., 2010). Hill et al.'s (2003) research shows therapists learned how to use silence in supervision and clinical practice. Therapists reported experimenting with silence and what felt right, depending on the client. The research proposes that graduate universities need to teach student therapists how to use silence, or that silence is a skill that can be learned only in clinical settings. Dobosz (2020) reported similar findings; therapists felt silence needed to be discussed more in their therapy training. Therapists reported feeling uncomfortable when using silence in training. These therapists believed that emphasizing silence in training would benefit their professional development. All the therapists agreed that experience led to comfort with silence, specifically being exposed to silence and engaging in professional self-reflection. Some therapists discussed how exposure to silence in their own personal therapy helped them use it as a tool with clients. Two therapists mentioned how mindfulness and meditation supported their comfort with silence (Dobosz, 2020).

Summary

From synthesizing the findings of the literature, several considerations are apparent in the therapist's use of silence as a tool in psychotherapy. The theoretical orientation of the therapist determines the therapist's use of silence as a tool; for example, cognitive behaviour therapy and

exposure therapy consider the therapeutic relationship less important than person-centred and psychodynamic therapy. The attachment style and cultural context of the client should also be considered. Clients with different attachment styles will respond differently to the therapist's interventions, and it is challenging to understand the meaning of silence without understanding the cultural context of the client.

The literature suggests a clear connection between the strength of the therapeutic relationship and the client's experience of silence as positive or negative. A positive therapeutic relationship is one of the strongest predictors of client change (Vilkin et al., 2022). The therapist's inappropriate use of silence can cause ruptures in the relationship, impacting client outcomes and the change process (Del Giacco et al., 2020).

In general, it appears counsellors are active in considering the use of silence as an intervention (Hill et al., 2003). In all the studies, therapists agreed that a strong therapeutic relationship was required before using silence as an intervention (Ladany et al., 2004). The words used before and after silence determine the therapist's perception of silence. Research highlights the importance of the therapist remaining connected and co-regulating with a client, asking questions to understand what the client is experiencing during times of silence.

Research identifies the limited understanding of the therapeutic relationship in psychotherapy. Supporting student counsellors to develop competency skills may be a less isolating framework for the future of psychotherapy rather than theoretical orientation. Therapists are active in their cognitive processes during times of silence, using silence as a tool to support the client to integrate, reflect, take responsibility, process feelings and thoughts, induce affect, express empathy, care and respect, gain insight, and take space.

Limitations

As stated earlier, a gap in research exists on the use of silence as an intervention in psychotherapy. In psychotherapy, most empirical research studies the effectiveness of specific tools and techniques of varying theoretical orientations, but there are limited empirical research studies on silence as an intervention. To mitigate this limitation, I have used up-to-date research on the theory referenced throughout the literature review, and I have compared the findings of seminal research with more recently published dissertations with small sample sizes. I identify the methodology used across these studies as valid; researchers used consensual qualitative research, specifically thematic analysis. However, all the sample sizes were small, so the results may not generalize across all populations. In studies measuring clients' silence, the pausing inventory categorization system (PICS) was used to measure the types of silence. The future of psychotherapy would benefit from consensus on aspects of the therapeutic relationship that create change for clients, such as the therapist's competency with using silence (Rief, 2020). I believe this would encourage researchers to conduct large-scale cross-cultural studies on the use of silence as an intervention in psychotherapy.

He who does not understand your silence will probably not understand your words –

--Elbert Hubbard (as cited in Valle, 2019, p. 219)

Chapter Three: Discussion and Application

The purpose of this paper is to provide practicing clinicians and student counsellors with an exploratory analysis of the impact of the phenomenology of silence in the therapeutic setting. As mentioned many times throughout this capstone project, silence is a powerful tool in psychotherapy (Cuttler, 2019). As the research outlined in chapter two identifies, a client's attachment style is associated with the number of times silence is used in a session, and the type of silence influences the therapeutic relationship. Therefore, the attachment style of the client is an important consideration when using silence as an intervention. However, there is limited empirical research on silence and attachment style. In studies by Daniel (2011) and Daniel et al. (2018), the participants presented with bulimia nervosa and engaged with specific modalities for treatment, namely psychoanalytic and cognitive behavioural therapy, but the results make the findings hard to generalize. Other variables such as the client's culture were not considered. Both studies used the Adult Attachment Interview (AAI), a reliable method to assess attachment style (Daniel et al, 2018).

Researchers state there are conflicting understandings of the meaning of silence and suggest silence can be understood only by examining what occurs before and after silence is used. Yet none of the research identified in this capstone project assessed what occurs before and after silence is used.

The research in Chapter Two identifies the functions of silence in the therapeutic setting. Several research studies (Brandsaeter & Hauge, 2021; Dobosz, 2020; Hill et al., 2003; Ladany et al., 2004) found similar reasons therapists use silence as an intervention: to express empathy and support, encourage reflection, encourage the client to take responsibility, to take time to think about what to say, and to increase affect. Across these studies, the researchers did not identify

the ethnicity and cultural contexts of the participants, and the sample sizes were small. Some research (Kawabata & Gastaldo, 2015; Tisljár & Pléh, 2014) identifies the lack of cultural consideration in understanding the function of silence.

Therapists are active during silence, focusing on establishing rapport in the earlier sessions and bringing in silence as an intervention later in the process. Therapists report avoiding the use of silence with clients where silence may be punitive, specifically clients who experience psychosis and have high levels of anxiety. Research shows the therapeutic relationship is impacted by silence; if a strong relationship has not been established, silence can be negatively perceived. According to Schore's (2014) summary, the right brain's non-verbal communication co-creates regulation, positively impacting the therapeutic relationship. Studies examining silence and the therapeutic relationship show a positive impact of using silence as an intervention once a solid therapeutic relationship has been established. More research is needed on silence and the development of the therapeutic relationship.

According to Creswell and Creswell (2018), grounded theory is a design of inquiry where the researcher derives a general, abstract theory of an interaction grounded in the views of the participants. According to Frankel and Levitt (2009), grounded theory allows for rigorous inquiry into the subjective experience and facilitates the development of empirically grounded theory. A strength of several of the research studies (Barbor, 2009; Brandsaeter & Hauge, 2021; Dobosz, 2020; Frankel & Levitt, 2009; Levitt, 2001a) is their use of grounded theory to analyze their findings.

Considering silence is a powerful tool, it is surprising that most therapists learn the skill of silence through trial and error, mentioning how little attention is given to it in therapist

training and academia. Therapists report learning about silence in their own personal therapy, in supervision, and in practice in the therapeutic setting.

In examining the impact of the phenomenology of silence in the therapeutic setting, this capstone project encountered limitations in the research. These limitations included small sample sizes in existing empirical research studies and a lack of diversity among participants: therefore, a lack of consideration of participant culture and how this impacts their experience of silence. As well, the existing research studies are conducted in Western contexts; hence, there is a lack of research on silence as an intervention across cultures. Strengths of the research identified include findings across numerous studies that therapists use silence to express empathy and support, encourage reflection, enable the client to take responsibility, take time to think about what to say, and to increase affect. Another strength of the studies is the use of sound methodologies, such as the AAI and grounded theory analysis.

Research Proposal

Based on these research studies and the limitations identified, this capstone proposes that future research is needed to better understand the impact of silence as a phenomenological experience in the therapeutic setting. The proposed framework for this research includes a large sample size of diverse clients to assess for factors such as culture and attachment style. The framework also proposes an assessment of what occurs just before and directly after the use of silence. According to Valle (2019), qualitative research is the appropriate approach to interpreting the impact of silence, especially phenomenological research that seeks to identify the essence of the experience. Very few phenomenological research studies have examined the impact of silence, making this an area open to exploration, and understanding.

Study Aims

The purpose of the proposed study is to gain a better understanding of the impact of silence as a phenomenological experience in the therapeutic setting. For this study, silence will continue to be defined as "the temporary absence of any overt verbal or para-verbal communication between therapist and client" (Feltham & Dryden, 2004, p. 177). Attachment will continue to be defined as the psychological lasting connectedness between human beings (Fletcher et al., 2014). Culture will be defined as a set of shared and enduring meanings, values, and beliefs that characterize national, ethnic, or other groups and orient their behaviour (Mulholland, 1991). Continued research on silence in psychotherapy has the potential to enhance therapists' skills of being more attuned and responsive during moments of silence and to provide insights into clients' inner experiences (Frankel et al., 2006).

Theoretical Orientation

The proposed study will continue to utilize attachment theory while applying a multicultural lens. As identified in previous research, the attachment style of clients will impact their subjective experience of silence. Applying a multicultural lens to this study acknowledges the impact of culture on the client's experience of silence—a gap in previous research.

Methods

Sample Selection. The proposed study will recruit 70 adult clients actively engaged in psychotherapy across British Columbia. To recruit a culturally diverse sample of participants, multiple psychotherapy agencies—private practice, community agency, and university settings—will be contacted. The demographic data of the therapist participants will be shared with readers: including ethnicity and other cultural identities, age, gender, theoretical orientation, and years of experience. No identifiable information of the participants will be shared, the information provided in the data will be presented as whole numbers and percentages.

The psychotherapists will be from a variety of theoretical orientations with varied years of psychotherapy experience. The intent is to have diversity in the sample of client participants to assess how culture impacts the experience of silence in the therapeutic setting. Diversity among psychotherapists' approaches will enable findings that identify similarities and differences in silence across theoretical orientations.

Procedures. To be considered for the study, client participants must agree to take part in a semi-structured AAI with trained AAI coders to determine the attachment style of each participant (Daniel, 2011). Once the AAI has been completed and the results have been categorized by attachment style, the proposed study will introduce a qualitative grounded theory approach to develop a framework that assesses the impact of the phenomenology of silence in the therapeutic setting. This study will conduct individual interviews with participants to ensure responses are not distorted by others' perspectives. Participants will be asked to reflect on their cognitive and emotional process of three psychotherapy sessions by reviewing video recordings through Interpersonal Process Recall Interviews (Frankel & Levitt, 2009). The silence in each of these sessions will be explored with the participant by replaying the in-session pause and asking what was happening for the participant at that moment to determine the impact of the psychotherapist's use of silence. The interviewer will ask a question such as—can you describe your experience during this moment? As it won't be possible to review all the in-session silences, priority should be given to silences that appear particularly perplexing, aiming to capture a diverse range of silent experiences. This approach aligns with a hermeneutic methodology (Rennie, 2000), enabling the investigator to interpret the phenomena under investigation (Levitt, 2001b). The study will identify what occurred immediately before and after silence was used to identify themes or patterns in the meaning of silence. Finally, client

participants will be asked how their cultural identities impact their response to silence. Questions will be open-ended and as non-leading as possible.

Psychotherapists will be asked to identify their reason for using each moment of silence, and their responses will be categorized. This data will allow researchers to examine the similarities to and differences from findings in previous research studies.

Data Analysis. The proposed study will use a thematic design to identify themes that emerge from the information gathered. The participants' responses will be transcribed verbatim into text, and a select group of coders will assign codes to the transcribed data. The text will be divided into segments, each containing a single main idea. These segments will be organized into categories based on their similarities (Frankel & Levitt, 2009). Coders will work together to determine codes, code the textual data, integrate the coded data into themes, and consult with one another as needed (Creswell & Creswell, 2018). The main variables measured will be the client's attachment style and culture, what occurs before and after silence, the client's internal process, and the therapist's reason for using silence.

It is anticipated that themes will arise around the categories outlined in Chapter Two, specifically a participant's experience of silence and attachment style, the impact of silence as an intervention, and the meaning the participant makes of silence. It is also anticipated that the unaddressed themes of culture and silence and what occurs before and after silence will emerge.

Data presentation. The themes from the data will be presented in a narrative passage and the social location of the participants will be presented in a table of data within a journal article to share the proposed framework with academic peers and the wider community. The results will identify themes that emerged from the participant interviews, including diversity in the

participant perspective, what occurred before and after silence was used, the client's attachment style and culture, and the therapist's reason for using silence.

Implications for Clinicians

The findings from the research study will outline suggestions and implications for clinicians using silence as an intervention in the therapeutic setting. The research will identify how clients' attachment style and cultural identity impact their phenomenological experience of silence and, in turn, the client-therapist relationship. Examining what occurs before and after silence will reveal patterns enabling practising clinicians to have a better understanding of the effects of using silence as a tool.

Conclusion

This capstone project set out to assess the phenomenology of silence and the therapist's use of silence as an intervention. As outlined in this chapter, this capstone was able to identify variables that are necessary to include in such an assessment. As discussed, the existing research has limitations, and this is the reason why this chapter proposes a research study to better understand the variables that should be considered in such an assessment. The proposed study hopes to address research gaps and provide practising clinicians with knowledge about the implications of using silence as an intervention.

This capstone has personal significance. As a student counsellor, I have sat in silence across from clients and wondered what was happening for them at that moment. As a client sitting in silence across from my psychotherapist I have, as the research states, reflected deeply, accepted responsibility, and experienced an increase in emotions—and there were times when silence felt like punishment. I will take the knowledge from this capstone project with me as I move forward in my career.

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