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Newly qualified counsellors'
experience of silence within
the therapeutic setting.

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Abstract

The aim of this study was to explore how participants experience silence within the therapeutic setting, as well as their past and training experiences of silence. Data was collected via the participants' discourse, during semi-structured interviews. Seven participants took part in the study. The data was analysed using Thematic Analysis (TA). Five themes were identified in the analysis: felt experience; the cognitive experience; silence as a control mechanism in childhood; silence taught as a therapeutic skill and silence seen as adding to the therapeutic process. The theme of cognitive experience contained the sub themes of power and control and internal dialogue. Therapists typically believed that silence was a useful phenomenon, which they became more comfortable with as they gained more experience. The findings further showed that their past experiences and training played a part in their use of silence.

Introduction

In my fourteen year career, firstly as a hypno-psychotherapist and then additionally as a counsellor, I have been exploring in supervision, within myself and with colleagues, just what makes therapy work. What is the ingredient that has allowed some of my clients to be rid of lifelong phobias, to move from suicide attempts to enjoying life, for people in crises to work their way towards the changes they desire? In my reading and personal explorations of what felt like effective and ineffective therapy sessions, I became aware that it was not just the skills used, but also something about how they were used that formed a relationship with my clients that made a difference.

It was about 'being' with the client and wanting to know more about their experiences. I noticed at times that when the pace of a session was slow, with pauses and silences, a greater intensity of connection was felt. There appeared to be something about the deeper meaning of communication that involved saying nothing, the silence holding and capturing the essence of the said and unsaid. I was further drawn into the realms of silence on reading Ladany *et al* (2004), details of which are included later, which took me to exploring specifically my own use of silence in therapy. I found that when silence between my client and I occurred, change in the relationship ensued. This was not always a measurable phenomenon, as each person reacted differently to silence, but these times illustrated aptly the multiple levels of communication taking place in the therapeutic setting. I found a distinct lack of literature on the specific subject of *therapeutic* silence which led me to ask other counsellors' about their use of silence and it was during these conversations that I unearthed a lack in the acknowledgement of silence within these counsellors' training.

In my own teaching of students and the observation of their practice sessions, I found myself giving feedback about the lack of moments of stillness in the session. This

was aimed at helping students work towards more silences, to allow themselves and their clients to both think and feel to a deeper level. I give much emphasis to the importance of silence, teaching it as a skill, with practice sessions to illustrate this in an experiential way and also to teach when, specifically, the use of silence can be effective, for example after offering a question or statement for consideration, in order to allow the client the space and time to access their thoughts and feelings. Often this can be hard for trainees to do, as there is a desire for one or other of those present to 'speak'. I believe that in, or after therapeutic interventions, little enlightenment can be gained without a silence. As Elson (2001) writes, "The silence that may follow offers an opportunity for the patient to reflect and begin to transform previously distorted self structure into the capacity for self observation and choice." (p.2).

Additionally, it is during these training sessions that I have seen the damaging impact of silence in a therapeutic session when it is used without awareness on the part of the therapist as to its purpose. When a trainee therapist is, for example, affected by their client's story, silence can be used to distance themselves away from the client, which I have seen happen on a number of occasions when observing sessions. This is echoed in the words of Holmes (1998) who wrote, "Protracted silences from the therapist may also be a tactic employed as a defence against the patient's messages ... and may therefore be used as a means of keeping the patient at an appropriate distance." (p.37). From this there seemed to be a need for greater understanding of what silence in therapeutic communication means.

The focus of attention in communication is generally centred on the spoken word. It is what is verbalised that is often seen as the interaction and yet inextricably linked to what, when and how the words are being spoken, are the pauses or silences in between. Silence happens in just about every human social interaction and most distinctly, in therapeutic counselling.

In the field of linguistics silence receives as much attention as speech and is seen often as the definer of contexts in many different communicative arenas. As Jaworski (1993) concludes, "It (silence) cuts across different levels of linguistic usage bearing relevance to the social, political, and emotional aspects governing the lives of individuals and whole communities." (p.1). It adds meaning to speech, allowing spaces to experience the words. As Tupper (1849) writes, "Well timed silence hath more eloquence than speech." (p.75). These statements appear to describe a large amount of processing occurring in silence. Indeed, as Sperber and Wilson (1986) identify, the processing effort necessary for the interpretation of silence is greater than in the case of most forms of speech.

Silence is often described as 'deafening' or 'golden', with most recently van Deurzan (2009) penning a chapter entitled 'Speech is silver and silence golden'. Silence is both used and experienced and can undoubtedly be a natural and an unnatural part of human interaction. Jaworski (1993) writes, "Silence has many faces ... it is probably the most ambiguous of all linguistic forms. It is also ambiguous *axio-logically*; it does both good and bad in communication." (p.24).

In discourse analysis, *implicature* describes the additional conveyed meaning that so often occurs in silence and enables exploration of the absences as well as the presences. It contextualises something often used to concrete the meaning in the absence of words. In essence silence allows for a context to be born and for the hidden to be made explicit. Johnstone (2008) writes, "Foregrounds are only possible in the context of backgrounds; what is not said or cannot be said is the background without which what is said could not be heard." (p.70).

Historically, as early as Descartes, silence has been discussed within the realms of communication. "Neither the presocratics nor classical philosophy seems ever to

explicitly accentuated silence as the ground of language” (Smith and Taylor, 2005, p.158). Philosophers such as Nietzsche described silence as an aid to the ‘helping’ process of both internal and external communication and further asserted that silence transcends words and everydayness. “Nietzsche holds that silence may be the only proper reaction to the superficial ‘chatter’ of everyday life – Every word is a prejudice.” (Angier, 2006, p.121). Sartre (1948) also commented upon silence as a part of language with blank spaces controlling the revealed speech. “Silence itself is defined in relationship to words, as the pause in music receives its meaning from the group of notes round it. The silence is a moment of language.” (p.14).

From a religious perspective silence has long been used as a method of worship. Silence forms part of the mantras of orthodox Christian worship and also plays a part in Hindu meditation and Buddhism, allowing space for connection with a higher divine. Furthermore, Leach (1976) refers to Bauman’s (1974) point that “... it is a fundamental tenet of Quaker theology that God communicates directly with each devout individual who is prepared to sit in silence and await divine inspiration.” (p.63). Silence in religion can be seen as transcendence from speech.

Culturally silence can be seen as passive or restrictive, as it is in many western societies (Jaworksi, 1993), to where ‘something’ is happening, as Inkinen (1999) writes about in Finnish culture. “To consciously permit periods of silence within a conversation demonstrates wisdom and reflection on the topic. In Finland one “comprehends” silence as a linguistic “act”.” (p.178). Conversely, in the west, silence is often used as a form of punishment via the concept of solitary confinement or by giving somebody the ‘silent treatment’.

In literature silence has been written about in various ways. Poetically:-
Silence can be a plan rigorously executed,
the blueprint to a life,
It is a presence it has a history a form,
Do not confuse it with any kind of absence.
Adrienne Rich (1975).

In Shakespeare's play 'Hamlet' - Act 5 scene 2, we hear the final words, "The rest is *silence*", the meaning of which has held much debate. Is this simply stating the end of the story or a reference to the silence found in the rest or sleep Hamlet is now to experience? Or is it a reference to his endurance of no more pain? Whatever the answer, *silence* is the poignant word.

Fictionally, Potok (1983) told the tale of a young boy in 'The Promise', where silence was the major obstacle to overcome in the character's treatment.

This brief historical research into silence shows that when words are absent, the phenomenon of silence notably adds depth and to engage in an understanding of the quality of silence, is to open up to experiencing how powerful abstinence from speech is. Whether it is planned, as in meditation or through elective muteness, or whether it descends upon us in conversation, silence creates a powerful unearthing of our experiencing of the moment and an opening up to ourselves and others. As Hauser and Rankin (1997) describe, "... complex psychological processes occur even when words are not present. In communication therefore, when a period of silence occurs, much is happening." (p.167).

In exploring silence within a communicative context we can see that silence itself requires a complex and almost separate level of interpretation in relation to speech, as Jaworski (1993) suggests:

Of course, the nature of communication structured through talk is different for the nature of communication structured through silence (Philips, 1976, 1.6.3).

Different senses are involved in decoding the signals present in both types of communication, and this creates inevitable qualitative differences in the interpretation of the intended messages. (p.46).

This is not to say that words *per se* are inadequate at relaying our message, but, as Jaworski further suggests, "... it is important to note that in communication talk is simply not always necessary, sufficient, or easy to use". (p.50). I have found in my own therapeutic practice some of the most connected moments I have experienced with my clients (and they with me) have been in moments of silence, where a look, a slight facial expression or just simply a 'moment of stillness' (Spinelli, 2007, p.123) seems to say more than words could ever express. In the therapeutic encounter, silence can hold as much importance in the communication that ensues as do the words that fill the space.

Silences and Counselling Approaches

The importance of the qualitative differences in communication that are so present in therapeutic counselling is for me of much interest. In psychotherapeutic counselling, interactions within the relationship between therapist and client involve communication that explores the client's experiences, and subsequent meanings. As it is primarily a talking based approach, silences will naturally be present as a communicative phenomenon. Silence here will not be explored precisely, nor will it be specifically defined, as it has been in previous quantitative research in relation to its impact on therapy. Sharpley (1997), for example, described that a *pause* for more than 5 seconds became a silence, whereas Tindall and Robinson (1947) referred to silence as "any

noticeable pause.” (p.136). More so silence here is to be explored in terms of its experiential qualities.

In seeing silence as a form of therapeutic communication we are reminded that there is something to be listened to. Casement (1985) stressed “... when the therapy hour begins with the patient’s silence, there is already a communication.” (p.206).

Historically, therapeutic silence has been examined from a plethora of different paradigms. Freud, at the turn of this century, abandoned hypnosis as a way of overcoming silence, which was seen as a form of resistance, “According to certain authors, silence is to be interpreted as a resistance (Karl Abraham, Sándor Ferenczi, Sigmund Freud, Wilhelm Reich, Otto Fenichel, Anna Freud, Stephen Weissman).” (<http://www.answers.com/topic/silence>, 2008).

In the psychodynamic approach, the therapist needs the client to talk to make interpretations of the material presented, as the underpinning philosophy is that in talking, unconscious material is being revealed. Silence, in this sense, may be seen as resistance and will be used to further explore the anxieties that are present, or interpret the communication that is occurring in silence. “Silence is "a state of restoration of primary narcissism, it is the realization of desire" enabling one to "re-experience narcissistic omnipotence." (<http://www.answers.com/topic/silence>, 2008).

Casement (1991) describes the many different experiences that occur within silence, including silence as being ‘with’, silence as resistance, and silence as a mode of communication. From the above it is clear that during silence ‘something’ is happening, hence the position of this study is to explore what that something is. “It (silence) is not only a resistance but also a communication.” (Pressman, 1961, p.582).

Egan's (2002) 'skilled helper' model states communication skills, of which silence is included, are vital for an effective helper. These skills "... are integrated under the rubric of the therapeutic dialogue", "... dialogue is at the heart of the communication between helper and client." (p.63).

The CBT and Existential models rely heavily on therapeutic conversation as the primary vehicle for change and so the use of silence as a specific therapeutic skill is less relevant. In the Person Centred approach however, the specific art of silence is an effective vehicle for healing and change, as simply talking at length about situations brings little change. As van Servellen (1997) suggested, if the use of silence brings depth to the experience of their situations, then healing and change can occur. From the person centred perspective we may see a silence as a communicative *clue* by the client, inviting the therapist to move to a deeper level. Mearns and Thorne (2003a) suggest, "The clue might be an unnaturally long pause, a change in the tone of voice, or a shift in eye contact." (p.120).

More recently, current methods of understanding communication, such as Neuro Linguistic Programming's *presupposition* that somebody 'cannot *not* communicate' (Bodenhammer and Hall, 2002), suggest that silence within communication is a phenomenon that requires exploration.

Current Research on Silence in Therapy

There is an ample body of current research on silence in the context of communication and linguistics. Much of this research states that silence has two values: positive and negative. In particular Jenson (1973) describes these positive and negative aspects in relation to five functions of silence.

1. A linkage function: Silence can bond or separate people.
2. An effecting function: Silence can heal or wound.
3. A revelation function: Silence can make explicit or hide information.
4. A judgemental function: Silence can signal agreement or disagreement.
5. An activating function. Silence can signal mental activity or mental inactivity.

In the context of therapy we can see here some of the most important functions of the therapeutic process and with such a variety of affective outcomes, understanding silence as a therapist therefore seems vital.

Currently a small sample of literature explores silence and its use in therapy. In research by Tindall and Robinson (1947), therapeutic transcripts were analysed and a classification system devised regarding the use of silence as a technique in counselling. Two general headings were identified, 'Counselee-initiated' pauses and 'Counsellor-initiated' pauses, with further subgroups being identified within each.

For the counselee initiated pauses the subgroups were described as:

1. Counselee Initiated.
2. Counselee Indecision (*emotional involvement*).
3. Normal (*natural ending of the conversation*).
4. Organizational (*to organise what is going to be verbalised*).
5. Solicitation (*awaiting a response from the counsellor*).

For the Counsellor the subgroups were:

1. Counsellor Initiated.
2. Deliberate (*to encourage client to carry on*).
3. Organizational (*to organise what is going to be verbalised*).
4. Normal (*natural termination of what has been discussed*).

The results suggested that counsellors used silence more than their clients, with a tendency to be in the organisational category, that is, to formulate what they were going to say. The clients' use of silence was more towards the normal category, where a natural ending came to their communication.

It was noted that each silence tended to have more than one effect and that there were different types of silence involved in the therapeutic setting, each of which will affect the client and the session, which echoes Jenson's (1973) five functions of silence. The research concludes that therapists' awareness of the frequency and the nature of different types of silence can forecast the possible effect on the immediate session experience, and allow greater control over the progress of the therapy. Blos (1972) also identifies different types of silence. "We speak of silence as pregnant, cold, warm, stony, ominous, empty, tense, and so on. Again we can say that these figures of speech reflect the affective quality of the unspoken content of the particular silence." (p.351).

It could be said that silence holds a number of psychological *activities*, leading to the notion that silence indeed can be conceptualised and is something of substance. Samarin (1965) wrote that "silence is not just the absence of a significant piece of behaviour. It is not just emptiness." (p.115). As Lakoff and Johnson (1980) wrote, "We use ontological metaphors to comprehend events, actions, activities and states. Events and actions are conceptualized metaphorically as objects, *activities as substances*, states as containers." (p.30).

Studies show silence as being of therapeutic benefit within a session. In terms of the amount of silences used in a session Hill, Charles and Reed (1981) identified silences typically used across orientations as less than 5% of the time. Cook (1964) researched the duration of silence in therapy as a possible factor in 'therapeutic movement'. Tapes

and transcripts were analysed from sessions that therapists rated as more or less successful. Continuous speech was associated with the less successful therapy cases and silences associated with more successful cases, although this research has some shortcomings in its validity, such as the limit of the therapy to the person centred approach, the small range of silences and the lack of exploration of individual differences in relation to the silences.

Cook's research does however agree with Sharpley (1997) and Sharpley and Harris (1995) who researched the influence of silence upon client-perceived rapport and found that silence "... is associated with increased client-perceived rapport." (p.149). Furthermore, Hill, Carter and O'Farrell (1983) described the impact of silence on the greater enabling of richer description, experience and insight.

Importantly, research has also explored the effect of silence on possibly more unwanted aspects of client experience, such as the clients negative view of the therapist's empathy (Matarrazzo and Wiens, 1977) and ultimately the clients drop out from therapy (Davis, 1977), showing that richer understanding of the effects of silence are necessary in the therapeutic encounter.

Research into silence and rapport during initial interviews, (Sharpley, Munro, Elly, 2005) looked in particular at the perceptions of twelve experienced therapists as to why they used silence, how they used it and how experience changed the way they used silence. The researchers initially aimed to find out the different factors associated with experienced therapists' use of silence and how using silence could possibly help or hinder the therapeutic process. Clients could experience silence in a number of different ways which could be dependant on their experiences of silence outside of the therapy room. Further it was hypothesised that certain groups of clients would not benefit from the use of silence in therapy, namely the excessively anxious, suicidal or psychotic.

Consensual qualitative research (CQR) methodology was used in this study to analyse the data. The results inform us of a number of points.

1. The manner in which silence is delivered is critical.
2. Therapists believe they use silence to convey empathy, respect or support.
3. Silence is a multifunctional intervention and should be used judiciously.
4. No specific recommendations can be made in terms of when to use silence.
5. Clients may perceive silence to be anything from benevolent to intimidating.

Additionally Elson (2001) explores the use and abuse of silence in the therapeutic process. Elson describes the actual amount of communication that occurs in silence during a therapeutic session, including silence as a response, as a defence and in achieving attunement. Elson goes further, describing the process of working with silence, again attesting that something needs to be 'worked' with.

The main piece of research that has been used as a benchmark for this study was by Ladany et al (2004). Ladany et al interviewed twelve experienced therapists about their 'perceptions of why they used silence in therapy'. Eight psychodynamic therapists, three integrative therapists and one CBT therapist were questioned on areas such as; reasons for using silence, reasons for breaking silence, influence of silence on the therapeutic relationship, what happens with the therapist during silence, examples of when silence did and did not work and training in silence. The data was analysed using consensual qualitative research methodology. The results identified that all therapists used silence to show understanding and provide "therapist conditions that would facilitate the work" (p.83). Reflection, for example, allows client responsibility to facilitate expression of feelings. It was noted that silence was also used when the therapist didn't know what to do or was anxious or distracted. It showed that there were different uses of silence and

different perceptions of it, further agreeing with the findings of Tindall and Robinson (1947), Jenson (1973) and Blos (1972). Therapists believed that silence enhanced the therapy relationship and process when used appropriately.

During the silence in Ladany et al's study (2004), therapists observed what was happening with the client, thought about what was going on in the therapeutic process and focused on what was going on within themselves in relation to the therapy. It was noted that it was during supervision and postgraduate training that silence was learnt about and seldom through undergraduate training was silence taught as an intervention. The research identifies limitations about the findings. For example it was completed with all white American therapists and no specific example in which silence was used was asked for. However it does show that experienced therapists are aware of the value of silence in the therapeutic process.

From this research it can be seen that therapeutic silence is valued, that there are different kinds of silence and that silence is often experienced differently by the client and therapist. The research also shows that the use of silence is influenced by past experiences and that this appears to have an effect on the therapeutic relationship.

Aims of Research

The aim of this research is to explore newly qualified counsellors' experience of silence within the therapeutic setting. I aim to investigate the impact that silence has in the therapeutic setting and how this affects counsellors' use of silence as a therapeutic tool, as well as the counsellors' past experiences of silence, their training in silence and the usefulness of silence in their subsequent practice.

The specific aims of this research are:

1. To explore the meaning of silence for newly qualified counsellors.
2. To explore the value that counsellors place on silence in the therapeutic setting.
3. To explore the links between pre-training experiences of silence and the subsequent perception of silence as a therapeutic intervention.
4. To explore the counsellors experience of therapeutic silence during training.

Reference to 'silence' for the purpose of this study is defined as follows:

1. The condition or quality of being or keeping still and silent.
2. The absence of sound; stillness.
3. A period of time without speech or noise.
4. Refusal or failure to speak out.

(<http://www.thefreedictionary.com/silence>, 2008)

This research is not about participant's perceptions of how long a gap between speaking constitutes silence, more so, it is about the experience of 'therapeutic silence' and hence silence *is* as the participant *describes* it.

Newly Qualified Counsellors

This research aims to explore the experience of silence with a specific group of individuals, who have chosen the career of therapeutic counselling. In the context of this study 'therapeutic counselling' will include the roles of 'Counsellor', 'Therapist' and 'Psychotherapist'. In this sense 'therapists' are people who have trained to become professional counsellors, where one person helps another using a variety of skills and techniques, within a process, and around a theoretical framework. "Therapeutic, from the Greek *therapeutikos*, concerns, *one who administers, to serve, or to administer treatment.*" (www.thefreedictionary.com/therapeutic, 2008).

In studying newly qualified counsellors, the intention is to gain insight into how silence is used, experienced and valued by somebody fresh from training and embarking on being a therapist, as compared to those considered 'experienced' therapists. It is anticipated that the knowledge gained will inform the training of new therapists in the subject of silence. The question to be explored here is, 'what is the newly qualified therapist's position in relation to therapeutic silence?' In gaining such a body of knowledge, training and supervision can be more informed for the developing counsellor in the use of therapeutic silence. 'Newly qualified', for this piece of research, was seen to be up to eighteen months post diploma qualification.

Newly qualified counsellors of course are no strangers to the phenomenon of silence. Most, having been engaged in 100-150 hours of client contact time, will have inevitably experienced silences, whether it be enforced by not knowing what to say, or practiced as a definite skill, taught to them during their training.

Current research appears to centre on the use of silence with experienced therapists, somewhat overlooking the issue of new counsellors experiences of actually managing silences. However, a few texts do cover the specific areas of training in the use of silence. Levenson (1995) in Vanmeter et al (2001) speaks of 'beginning therapists' tending to speak, when silence is the best response. Vanmeter et al's research looked at discrete silence (at least 2.5 seconds in length) and its use in a simulated therapy session. These sessions were at the beginning of specific training and then repeated after certain phases of training with the behavioural differences being observed. The research seems inconclusive, likely due to the limitations of the study, such as its small sample size, duration of intervention and that the sessions were simulated. The study suggests an area of possible exploration as the personality of the therapist and their propensity towards solitude and silence. Additionally, questions arose from the study looking to further explore the way silence is taught, the effect it has on the

personality of the therapist and consequently the possible altering of their therapeutic interventions.

Wilberg (2004) in “Therapist as Listener” suggests that the newly qualified therapist tends to hear only what they are trained to hear within their immediate therapeutic framework, suggesting that, at first, the new therapist will be concerned at using their set of skills correctly to the detriment of ‘listening’ to the client. Also, that if the trainee is not made aware of their own listening process, then ‘deep listening’ will be limited. This learning *is* possible within the training; however Wilberg infers that this is a weakness in the learning of listening.

This Research

For this research I aim to explore the counsellor’s cognitive and emotional ‘experience’ during silence, to get as rich a description of the experience as possible and explore the phenomenology of the participant’s experience:

Phenomenology is the study of structures of consciousness as experienced from the first-person point of view. Basically, phenomenology studies the structure of various types of experience ranging from perception, thought, memory, imagination, emotion, desire, and volition to bodily awareness, embodied action, and social activity, including linguistic activity.

(Smith, 2008, <http://plato.stanford.edu/entries/phenomenology/#1>).

A qualitative research perspective, and in particular, thematic analysis, was chosen for this study to elicit the participant’s ‘felt’ experiences and explore possible strains of information from these experiences that have not as yet been organised. Thematic analysis, as described by Boyatzis (1998), allows for the divergent organisation of themes within qualitative information. “A theme is a pattern found in the information that at the minimum describes and organises possible observations or at the

maximum interprets aspects of the phenomenon.” (p.vii). The research looks to elicit information via interviews, in relation to a number of questions about newly qualified counsellors’ experiences of silences. In particular, attitudes to and understanding of, therapeutic silence, including how an individuals training programme covers the concept and what, if anything, could enhance learning in the use of silence.

A qualitative research method was deemed essential, as the study was concerned with the naturalistic description of the phenomenon of silence, and a rich description of the felt experience of silence would be necessary for possible commonalities to be seen and an analysis to be made.

Qualitative research uses a number of different methods, such as Grounded theory, Interpretative phenomenological analysis (IPA), Conversation analysis (CA), Discourse analysis and Narrative analysis. Thematic analysis was chosen as the method of studying this research because of its flexibility in finding rich meaning, especially in something as diverse as ‘experience’. It was chosen because this richness does not preclude the advantage of providing detailed data, the purpose of this study. As Braun and Clarke (2006) state, “Through its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data.” (p.78).

Due to the vast nature of such a topic and the fact that the description was of a notion where dialogue is non-existent (hence itself possibly being a complex and intricate experience to describe), as well as the expectation of the data being gathered and the desire to produce research of some substance accessible to a variety of fields of study, combined with the limited experience of the researcher in carrying out qualitative research, thematic analysis as a research method was deemed most effective. Braun and Clarke (2006) highlighted some advantages of thematic analysis, describing how it

“can usefully summarize key features of a large body of data .. can highlight similarities and differences across the data .. results are generally accessible to educated general public.” (p.97).

Boyatzis (1998) further states thematic analysis as being a “...process for encoding qualitative information.” (p.vi), and goes on to say that it is a “way of seeing.” He described the process of inquiry as first of all ‘seeing’, then ‘seeing it as something’ and finally ‘interpretation’. It was deemed that it is a process that would take the raw text (information) and through encoding, formulate qualitative data from which enrichment into the understanding of therapeutic silence would occur. The value of this approach, regarding the semi-structured interview data gathering method, is that the themes can be identified by “bringing together components or fragments of ideas and experiences.” (Leininger, 1985, p.60).

It is well documented that thematic analysis transcends different fields of study (Denzine and Lincoln, 1994; Miller and Crabtree, 1992) and hence such a study on the phenomenon of silence may be easily viewed by others deemed interested (nursing, social work, etc.) Although this exploration specifically focuses on counsellors and counselling, it is possible that these findings would be of use to others, where communication is an essential element in effective working.

As this study aims to explore initially the felt ‘experiences’ of the participants, thematic analysis was chosen over a quantitative research method, to lead to a ‘rich’ enquiry into the results and information gained from the interviews, opening up further considerations around silence as a therapeutic phenomenon. In exploring the experiences of silence it is anticipated that many subjective views will be explored. To glean further information, the interviewer will benefit from *sensing* what other information via the interview questions will be gained to elicit a clearer view of the participants’

experience, thus opening the study up. This 'sensing' will play a valuable role later on, when the thematic analysis is undertaken, as a sensing of the possible themes will play an essential part. As Boyatzis (1998) states "Many researchers already have developed the ability to sense themes. Their ability should help them understand how sensing themes is the first step in using a systematic, disciplined way of analysing (i.e., encoding) information ..." (p.viii).

Furthermore the information gained and subsequent themes explored from the interviews will rely heavily on 'description', via the interviewees' words, as opposed to a more structured method, such as questionnaires or surveys that may be used within quantitative methods. This is designed to gather more 'experience' based raw data with which to highlight possible domains to be studied further.

It is with awareness however, that in choosing this qualitative method of research, areas of the interviewees' experiences will *not* be addressed. In the subjective meaning applied to words, used in the description of experience, there may be some misunderstanding of what was actually meant by the interviewee and what the researcher clustered together within a 'theme', due to their own assumed meanings. McLeod (2006) writes, "The principal source of knowing in qualitative inquiry is the researcher's engagement in a search for meaning and truth in relation to the topic of inquiry." (p.54).

In addition, it requires a transparent approach and an ongoing reflexivity within the research. As the intention is to delve into the experience of silence in therapy and the researcher is a practicing therapist, his own assumptions would need to be constantly checked so as to retain balance and as much of an objective view as is possible. This opens the possibility of researcher bias and could lead to limitations within the study.

However, the attractiveness of the chosen method over some of the other methods that could have been employed in this research, such as grounded theory or IPA, is that thematic analysis is not attached to any one theoretical framework and thus allows for use within different theoretical frameworks, possibly overcoming any (theoretical) bias that could affect the results:

Thematic Analysis can be an essentialist or realist method, which reports experiences, meanings and the reality of participants, or it can be a constructionist method, which examines the ways in which events, realities, meaning, experiences and so on are the effects of a range of discourses operating in society. (Braun and Clarke, 2006, p.81).

Method

Design

Semi-structured face-to-face interviews were used in this research as it was felt to be the best way to gain detailed descriptions of the 'felt' experience of silence. The research questions would allow consistent information across participants to be collected, provide a framework to gather a depth of detail required for thematic analysis to occur and allow the researcher a chance to examine and expand upon individual experiences for further clarification.

Participants

Posters were placed in several counselling training establishments asking for assistance in completing the research (Appendix 2). Upon reading the research outline, seven newly qualified counsellors (five women and two men) agreed to participate in this study. In studying specifically newly qualified counsellors, the intention is to gain insight into how silence is used, experienced and valued by someone fresh from training and embarking on being a therapist, as compared to those considered an 'experienced therapist' (as other research has explored; Ladany et al, 2004), and explore the significance of training and past experiences within this. 'Newly qualified' for this piece of research was seen to be up to 18 months post Diploma training.

All participants had completed a Diploma in Counselling. Three had completed a Post Graduate Diploma, two of which were in the process of completing their MA's and one had completed an MA in Psychotherapy and Counselling. The remaining four had completed a Diploma at an undergraduate level and were now working towards accredited status with BACP. All had completed a minimum of 3 years of counselling training, which had included a supervised counselling placement of at least 100 face-to-

face client hours. All were actively engaged in seeing clients at the time the interviews took place.

Four described the therapeutic approach to their training as Integrative, one as Existential, one as Psychodynamic and one as Person Centred. The ages of the participants ranged from between 35 - 50 years.

Table 1: Participants.

Participant	Age	Gender	Therapeutic Orientation	Qualification
1.	41	Female	Existential	MA
2.	50	Female	Integrative	Diploma
3.	36	Male	Integrative	Post Graduate Diploma
4.	38	Male	Integrative	Post Graduate Diploma
5.	49	Female	Integrative	Diploma
6.	47	Female	Psychodynamic	Post Graduate Diploma
7.	37	Female	Person Centred	Diploma

Materials

Having examined the literature on silence, researched materials about newly qualified counsellors and considered personal experiences of training and therapeutic silence, an interview protocol was developed. The areas of interest would be the 'felt experience' of therapeutic silence both in the context of a client and a therapist. This would give information on how (if any) their personal experience as a client affects their understanding and responses to, and value of, using silence as a therapist. Childhood experiences and therapeutic training were also deemed as providing valuable data in the individuals understanding and use of therapeutic silence.

A pilot interview was conducted prior to embarking on the interviews that would make up the main body of the research. This was to ensure that the questioning for both researcher and participant were clear and were going to produce material that was useful for the researcher. The feedback was then used to revise the protocol, which then consisted of questions relating to the following areas:

- The experience of silence as a client.
- The experience of silence from the therapist perspective.
- The response to silence.
- Childhood meaning and experiences of silence.
- Training in silence.
- The value of therapeutic silence.

Questions were designed to elicit information for the aims of the study to be met, which were concerned with the meaning and value of silence for newly qualified counsellors, possible links between past experiences of silence and the counsellors' use of silence therapeutically, as well as their experiences of silence in their training.

Procedure

A research proposal and application was submitted to the MA Ethics Subcommittee at Roehampton University and approval to proceed was given subject to a small number of changes and additional information (Appendix 1).

From the initial postings, a total of 12 people expressed an interest and agreed to receive the Recruitment Information Sheet (Appendix 2) for further clarification of the research and the Informed Consent Form (Appendix 3). This explained that potential participants would be agreeing to undertake a short 45-minute semi-structured taped

interview, describing their experience of therapeutic silence. The nature of confidentiality was clearly explained as was the fact that they could withdraw at any time. It was explained that there would be a debriefing at the end of the interview and post interview. The people approached were counsellors who worked at different counselling establishments, which regularly took students for placements whom continued to practice there once qualified. None were known to the researcher.

Seven agreed to participate and returned their consent forms, following which a phone call took place setting up an interview day and time. Each attended a taped, semi-structured interview that was in a quiet, undisturbed area, convenient to the participant. At the end of the interview a debriefing sheet was given to participants (Appendix 4).

In line with ethical guidelines in relation to research and as a safeguard against possible issues raised by the nature of the research questions, approximately one week after the interview participants were contacted for further debriefing. This was considered important so as to give them a period of time for reflection, bearing in mind the possibility that the interview could have elicited emotional concerns for the participants. Following this, the interviews were then transcribed and served as the raw data.

Analysis

A step-by-step thematic analysis, as described by Braun and Clarke (2006), was used with the specific creation of the code being drawn from Boyatzis (1998), as it was felt that the specific guidelines would give greater clarity to the creation of themes.

There are 3 approaches to thematic analysis that Boyatzis (1998) identifies, Theory Driven, Research Driven and Data Driven (inductive). For this research, a data driven approach would be used, focusing only on the data collected. It was noted that this would be challenging for the researcher as a practicing therapist, but by using clear

criterion referencing, possible bias influencing variables that the researchers theoretical perspective may give, would be kept to a minimum.

The raw data for each participant was put into a column and the researcher read and re-read the data, making initial comments along side the specific material (Appendix 5). This was in line with Phase 1 of Braun and Clarke's (2006) 6 phase process of Thematic Analysis, that being *Familiarising oneself with the raw data*.

In Phase 2 – *Generating initial codes*; codes were drawn up. Here for each question, similar descriptions of the experience of silence were noted and bullet points under each heading for each participant was recorded (Appendix 6).

In Phase 3 – *Searching for themes*; the data was read and re-read again alongside the initial coding for each question and there was a collation/combination of the themes explored and formed with brief descriptions, so that identification could be made within the text. Sub-themes were also added (Appendix 7).

In Phase 4 – *Reviewing Themes*; the themes and sub-themes were then all positioned together, extracts from the raw data were considered for accuracy and there was a general checking (stepping back) to see if it was felt that the themes had captured the coded data.

In Phase 5 – *Defining and naming themes*; the themes were then written in the format described by Boyatzis (1998):

1. A Label.
2. A Description or definition.
3. Indicators and
4. Examples.

The results were then reported with the use of evidence from the text and an observation and analysis was undertaken in narrative format (Phase 6) drawing from relevant research and theoretical perspectives.

Results

In accordance with the criteria of thematic analysis (Boyatzis, 1998; Braun and Clarke, 2006) the raw data from the interview discourse was analysed and then coded into a number of themes, each being qualified with a label, definition and indicator to inform how the information was classified into themes, with examples taken from the data itself. This was considered important when aiming to keep the results data driven rather than theory driven. The information was then analysed with a view to finding common themes amongst the coded themes, thus allowing the data to be split into 5 themes. One of these themes was further classified into 2 subthemes. The following description of the themes will also contain narrative examples of the descriptions that enabled classification into a theme.

Each participant, whilst describing similar experiences of silence, had their own way of recounting these experiences. Participants 1 and 2 provided a large amount of content about their experiences of silence, while participants 5 and 7 provided less content and description. All could clearly recollect silence within their experiences both when they were a therapist and a client. All described silence as playing a highly valuable role within counselling which they recognised was becoming more comfortable as they gained more experience, e.g., silence “Becomes more comfortable with experience” (Participant 4).

The 5 themes identified within the data were the 1) Felt experience as client, 2) Cognitive experience, 3) Silence as a control mechanism in childhood, 4) Silence taught as a therapeutic skill and finally 5) Silence seen as adding to the therapeutic process. The theme of Cognitive experience contains further sub themes, Power and Control and Internal dialogue (Table 2).

Table 2: Themes.

Theme 1:		
<i>Label:</i>	Felt experience as client.	
<i>Definition:</i>	The person describes the felt experience via emotional or physical words and mechanisms, which contain a dynamic sense of movement within the experience.	
<i>Indicators:</i>	Coded when the person uses a description of an <i>emotional</i> response in silence.	
<i>Example:</i>	Emotional response might be “Shutting down / going mute” as opposed to cognitive process (2a) “Forced to reveal”.	
Theme 2a:		
<i>Label:</i>	Cognitive experience.	Power and control.
<i>Definition:</i>	The person describes the experience through a belief structure / interpretation and then assigns power.	
<i>Indicators:</i>	Coded when a person describes their thoughts in response to a silence.	
<i>Example:</i>	A <i>thought</i> may be “I was left in silence” as opposed to an emotional description (1) such as “It was gut wrenching and painful”.	
Theme 2b:		
<i>Label:</i>	Cognitive experience.	Internal dialogue.
<i>Definition:</i>	The person implies what silence creates in the therapeutic session.	
<i>Indicators:</i>	Coded when the person describes their thoughts during a silence.	
<i>Example:</i>	“Sense something be expected of them” as opposed to emotional response (1) “Comfortable in silence”.	

Theme 3:		
<i>Label:</i>	Silence as a control mechanism in childhood.	
<i>Definition:</i>	Coded when the person describes a familiar 'saying' heard in childhood related to either being quiet or speaking up.	
<i>Indicators:</i>	The person describes hearing another person tell them directly to speak or be silent.	
<i>Example:</i>	"Be seen and not heard".	
Theme 4:		
<i>Label:</i>	Silence taught as a therapeutic skill.	
<i>Definition:</i>	Coded when the person describes silence as being included explicitly within their training programme experience.	
<i>Indicators:</i>	The person describes 'silence' in the context of being taught about it directly within their training.	
<i>Example:</i>	"Training concentrated on using silences".	
Theme 5:		
<i>Label:</i>	Silence seen as adding value to the therapeutic process.	
<i>Definition:</i>	Coded when the person describes the observed value of silences and how they progress therapy.	
<i>Indicators:</i>	The person describes what they perceive silence offers the therapeutic process through experiencing and observing its impact with clients.	
<i>Example:</i>	"It allows the therapy process to slow down".	

Felt experience

The felt experience was made up of the physical and emotional responses described by the participants from both therapist and client positions, which they had personally been exposed to. Emotive feeling words and physical sensations described were evident in all of the participants discourse.

As a Therapist: Participants 3 and 4 used the word “comfortable” with being in silence; For 2 participants, the felt experience of silence was described using dynamic, emotive language with an experience of internal events occurring; Participant 2: “Stomach will churn” and “Will be paralysed; Participant 5: “Overwhelmed with questions”, which was further associated with discomfort and a distraction.

The lack of description by these 2 participants, along with the absence of any description of physical and emotional responses by the remaining 5 participants, led to this data not being classified as a particular theme, as it was deemed the weight of the data was not at a similar level as the rest of the themes.

As a client: The experience of silence, as well as the absence of silence, was a powerful dynamic experience. Participant 1 recognised that silence allowed them to go to a ‘more emotional depth’ but also described being in silence as “Gut wrenching”. Participant 2 described feeling “watched”. Participant 3 described feeling “uncomfortable” and “On edge”. Participant 5 “didn’t feel safe” when silence was present in the session, and participant 6 described, “waiting anxiously”.

It was clear that participants used a greater quantity of physical and emotional language when describing silence in their client position than their therapist position, where the language was, on the whole, taking a more neutral stance.

Cognitive experience

The discourse of the experiences of silence contained specific thought patterns. All participants described 'considering, reckoning, judging and contemplating' during a silence whether client or therapist, however it was noted that this cognitive activity was more prominent when the participants illustrated their experience as therapist. Two subthemes were recognised and classified to further distinguish the findings.

The sub theme of 'power and control' emerged. This being the thoughts and the responses to the thoughts, in terms of being influenced, dominated or managed by the other involved in the silence. As a *client*, participant 1 described experiencing being "Left in silence". Participant 2 used descriptions such as "Intrusive" and "Forced to reveal" during moments of silence, or from the therapist's *use* of silence. Participant 3 thought that something was expected of them. Participant 5 described in definite terms (that helped largely to create the naming of this sub theme) experiencing "Bullying", a "Power struggle" and used the word "Damaging" in their dialogue. Additionally participant 6 described their experience of silence as "Threatening". Thus, silence was translated as an expectation to do or say something that was uncomfortable.

The sub theme 'Internal Dialogue' also emerged when analysing the cognitive experience occurring in silence in relation to the participants' role as *therapist*. Prominent, in particular, was the internal questioning the therapist engaged in, which pointed towards considerable thought being given to what the therapist should 'do' next with the silence.

Participant 1 described engaging in a great deal of internal questioning of what they should be 'doing' in the silences of the session, including "Checking my reaction and deciding what to do with that", "Checking where the client is", and further considering whose turn it is to speak and what is deemed 'polite'. Participant 2 was

aware of their temptation to speak during a silence and also considered what to do with the silence, whilst in it. Participant 3's thoughts were about maintaining the silence and the length of the silences, as was Participant 4's. Participant 4 was also aware of considering their clients' perception of the purpose of the silence as well as being "Aware of own projections". Participant 5 considers what to do in the silence, what the client expects and "Considers breaking silence". It was noted that in the role of therapist, *internal dialogue* was a prominent part of the experience of therapeutic silence.

Silence as a 'control mechanism' in childhood

The participants all used descriptions they remembered from childhood and their formative years of silence, involving adult carers who either controlled their silence or made them speak up if in silence, thus seen as controlling behaviour. "Being seen and not heard", "What do you have to say for yourself?" and "I don't want to hear another sound" were all expectations which were comparable to the cognitive experiences described previously by the participant as both a therapist and a client (Power and control).

By far the most common aphorism described by participants (1, 3 and 5) was "Be seen and not heard". In the felt experience of participant 1 it can be seen that in the client role they began to experience 'shutting down' and 'becoming mute' (they were seen and not heard). In their cognitive responses it can be seen that silence created thoughts such as "something expected of them" along with their internal dialogue of checking their reaction to the silence and "deciding what to do with that", suggesting expectations of actions.

Participant 3 described feeling "cut off" as a therapist when the client wouldn't allow for silence to be present. This conflicted with their childhood experience, where the other was being seen *and* heard. Cognitively they experienced this as a "pretence" and

“unreal”, not normal within their frame of reference. Conversely as a *client* they “switched off”, became “blank” and “on edge” as well as thinking that something was expected of them.

Participants 2 and 4 shared the experience in their childhood of hearing “Speak up” or “What do you have to say for yourself?”, so believing that “silence means disapproval”. Participant 2 described being aware of types of silence, identifying how a “safe” silence can be chosen and for participant 4 the “purpose” of the silence is relevant. For participant 2, speaking back, if spoken to, was seen as being ‘good manners’, so with the expectation of not being silent as a child, the participant was able to identify that there were types of silence with different purposes and meanings.

Participant 3 recalled being told, “I don’t want to hear another sound” and interestingly describes as a client in silence “Switching off”, “going blank” and “falling asleep” as well as thinking that something was expected of them, that being ‘no’ sound. Participant 4 described hearing “Quiet, I can’t hear myself think” and also describes definite cognitive processes such as checking out their own projections, the purpose of the silence and additionally how long it has lasted. Participants 1 to 5 show evidence of likeness between childhood experiences of silence and the frame of reference of silence in their therapy.

Moving to participant 6, their descriptions from childhood and the meaning they have attached to silence in therapy are in contrast; “Silence is calm, peaceful, quiet” and “Solitude, poise”, which shows little resemblance to their felt experience of silence as a client where they described “waiting anxiously” and being “bored waiting”. Their cognitive experience however seems to be in line with their previous description, where it allows them to reassess their values and ‘acknowledge’ the silence.

Silence taught in training as a therapeutic skill

Overall, silence is mentioned by the majority of participants as being a part of their training experience. The only 2 participants that describe silence as not being specifically included within their training are participants 1 and 3. Participant 1, despite not being taught silence as an explicit therapeutic skill however, still described silence as being “Used for different purposes” including allowing “time to think”, a “time for stillness” and further says that silences are “essential and valuable”. Additionally, in the same vein, participant 3 describes silence as “conveying respect” and stopping “pointless talk”, describing a belief in silence as therapeutically valuable, without having been taught this specific viewpoint.

In considering participants 1 and 3’s cognitive responses to silence, it can be seen that both consider the area of ‘expectation’. Participant 1 “Something expected of them” and participant 3 “No expectations”. Participant 1 describes a large degree of questioning and checking in their internal dialogue, “checking my reaction ...”, “... who goes after who?” and “checking where the client is at”. Participant 3 describes how they maintain the silence, as they appear to believe it “gives space”. Participant 3 describes feeling “cut off if silence not present” and “agitated if silence not allowed by the client”. Participant 1 describes going to a more ‘emotional depth’. It was noted that the language in the discourse was not considered theoretical terminology and seemed to be a personal subjective perspective.

Progressing onto the remaining participants, it can be seen that in being trained in silence to some degree, a more theoretical or tangible understanding is apparent. For example, participant 2 described “silence taught as a skill” and at the same time, describes silence as having an impact on ‘avoidance’. Additionally they describe an awareness of how silence can delve into ‘meaning’, “open up dialogue” and are aware of

the 'different reasons for silence' (within their cognitive responses). Furthermore they describe how silence encourages them to think before offering a therapeutic intervention.

Another example of a theoretical perspective being taught in silence may be found with participant 4, who describes silence as being taught 'in its own right, as an exercise' meaning that silence was explored explicitly as a skill. The awareness of the impact of silence for the client may be seen in the comments, "Silence may be rare or a new experience to clients" and "Is extremely powerful for those that put the needs of others first". Furthermore, within their internal dialogue they describe considering the clients perception of the purpose of the silence, as well as being aware of their 'own projections' and the 'length of silences', recounting a more conjectural awareness within the silence itself.

Participant 5 shows an awareness of a 'therapeutic' slant on silence, as does Participant 3. Participant 5 describes silence as being "highly valued as a therapeutic skill" and also has the notion that it allows the client to 'own the session', in addition to enhancing and adding to 'rapport and empathy'. They see it clearly as a skill, in the context of it being 'used along with other *skills*'. They further define silence 'therapeutically' in their portrayal that silence "Can be abusive and leave a client unsafe if not used carefully" and clarify their stance on silence as a therapeutic skill as "one of the hardest skills".

These responses appear to have a more objective view of therapeutic silence. In retrospect it can be seen that in the role of client, the participants' 'experienced' silence as opposed to 'using' silence, as they did in the role of therapist. It is worth noting that participant 7, as the most newly qualified counsellor (within weeks of finishing their training course) was the only participant in the 'silence taught' group that showed little awareness of the impact of silence for the client, but appeared to be more aware of the

'value' of silence for themselves, e.g., "Space to think" and "Stop me missing something".

Silence seen as adding value to the therapeutic process

Overall silence was seen as a valuable and important part of the therapeutic process for both client and therapist. Participant 1 included, "a time for stillness", participant 2 said "Silence is helpful" and "Takes to deeper meaning", "Opens up dialogue" and "Causes a reaction". Participant 3 had no expectations of silence and saw it is a "Natural" occurrence. Indeed they saw it as "Pretence / unreal if silence if not present" and had a *need* for silence to be present. Participant 4 thought that silence "Gives time to client and therapist". Participant 6 experienced silences as giving them time to reassess their values, and for participant 7, silence allowed them to get in touch with their feelings as well as stopping them missing something that could be overlooked if silence was not present.

A number of experiences within silence were described, in an affirmative way, in terms of silence being an effective addition to the therapeutic process. Only 2 participants warned of the use of silence, both using vocabulary such as 'careful' and 'cautious'. An overall appreciation for the inclusion of silence in therapy was shown by the following comments.

Participant 1: "Silence allows both the client and therapist to experience themselves experiencing each other."

Participant 2: "It allows the therapy process to slow down."

Participant 3: "Silence conveys a respect."

Participant 4: "(Silence) gives time to client and therapist."

Participant 5: "A lot about a client can be found out in silence."

Participant 6: "It is a vital part of building the relationship."

Participant 7: "Explores feelings in the moment."

Discussion

From the results of this research it can be seen that silence, whether present or absent within a session, holds an important place within the communication that takes place in counselling and psychotherapy. In reflecting on the dialogue of the participants across the research sample, all describe silence as holding a dynamic element within their human interaction, whether that be related to past experiences or linked to the more immediate needs of the client or therapist to engage in therapy. In this section I will further explore the findings of this research with a view to opening up the observations in relation to previous research.

The felt experience of silence

It was found across the majority of participants that there was a perceived high level of therapeutic engagement for the therapist when silence was present. It was noted that the participants 'felt experience' as *therapist* appeared not to be presented in terms of emotional content but with more emphasis on their cognitive processes and what they could or should be 'doing', or what the silence was 'doing' for the therapeutic experience. Participant 7 for example described 'stopping' themselves feeling anxiety in order to *allow* for a silence, perhaps indicating that for a silence to be present they thought they needed to become engaged with the client, devoid of anxiety.

Considering the new role of the therapist and the expectation of both they and the client that the therapist is the one that 'helps' them, it is not surprising that their cognitive processes and 'doing' mentality are dominant in these periods of silence. Aldred (1999) cited in (Bor and Watts 1999) describes the attitude of the trainee, " ... she is likely to be keen to prove her ability, that she 'can do it' and be helpful to the client ..." (p.263).

Silence in itself then, may be felt by the newly qualified therapist as not offering this 'help' to the client, thus not living up to the expectations that either they or the client place on them. However, as van Servellen (1997) states, "While it would appear that the provider (therapist) is doing nothing in these moments of silence, in actuality much is going on" (p.126). Much of this relates to observation, listening, feeling and sensing on the part of the therapist. It is also worth noting Mearns and Cooper's (2005) position, "It is no surprise that many therapists experience their deepest moments of relational depth with clients in silence." (p.119).

For these newly qualified therapists the concept of 'relational depth' was not mentioned and was certainly not linked to the use of silence when a therapist. For them, this may well be a hard concept to grasp. The therapists were aware of the impact of silence at some level, however, awareness that silence can offer as much therapeutically for the client as when they are talking and 'doing' therapy seemed to be lacking.

Interestingly, the felt experience of the participants as client was recalled with a markedly more emotional and internally dynamic description, to the point where the emotional reaction seemingly overcame their cognitive processes in the actual moment of silence itself. Many of the descriptions they used as to their feelings led to some 'movement' happening inside them. It could be said that there was clearly an emotional 'relational depth' within them being achieved in therapeutic silence. Words used included shutting, using, being, switching, going, falling and waiting. This 'shutting down' appears to echo van Servellen's (1997) explanation, "The defensive use of silence demonstrated patient's beliefs that if they are silent and withhold thoughts and feelings, they will not be hurt." (p.127). The results demonstrate that silence is a 'felt' experience that goes to depth within the client and creates a felt experience within the relationship.

The cognitive experience

The participants' experience of silence showed a high level of cognitive processing occurring within the therapist during silence, in contrast to them as clients, where there was a high level of emotional experiencing. From these newly qualified therapists' point of view this appears to be somewhat of a struggle, which may well echo the observations of Casement (1985) who reminds us that "A therapist has to discover how to be psychologically intimate with a patient and yet separate, separate and still intimate." (p.30).

Power and Control

The sub theme of 'power and control' was observed with the high level of 'threatening' descriptions gained from participants in the role of client. Descriptions, such as "Bullying", "Power struggle" and "Damaging" appeared to leave the client vulnerable and aware of the power held by the counsellor. This highlights the power of silence in therapy and the importance of it being managed by the therapist sensitively; taking into consideration how each client reacts, individually. This research suggests that as therapists, the participants were more preoccupied with 'making' therapy work or 'doing' what they thought would bring about the same result, inferring they believed they held a level of power over the outcome of therapy.

The issue of the power differential in therapy is well documented (Mearns and Thorne 2003a; McLeod 2003). It can be said that for newly qualified therapists, the balance of remaining in control, holding power over their therapeutic interventions, making sure they use the theoretical concepts and skills they have been taught, whilst at the same time fostering a relationship where both present can relate as equals with the issue of power temporarily suspended, can be somewhat of a melee. Power for many clients has been experienced in a destructive way, many feeling *powerless* in their angst.

As Mearns and Thorne (2003b) write, “As therapists we are concerned at all costs not to add to this destructiveness.” (p.217).

Therapy is widely seen as a coming together of two people with the aim of working through a problem or problems. Recent evidence suggests the *relationship* in therapy is what is seen to make the biggest difference to the outcome. Evidence suggests that generic features, such as the capacity of the therapist to form an empathic relationship, is one of the most significant indicators of therapeutic success (Norcross 2002; Cooper 2004). For the relationship to be a healing factor in therapy, there also appears to be the need for that relationship to have the presence of depth. Cooper’s research (2005) described relational depth as “Neither they nor their clients were wearing masks. Just 2 very naked people, a touching of souls.” (p.92).

It can be seen in this study that indicators to relational depth were lacking or absent in most, if not all cases when experiencing or using silence, as the cognitive process theme suggests a feeling of responsibility and control over the events occurring in the therapy. As newly qualified therapists it is possible that the participants’ experiences of silence were driven by their desire to give their clients as much as they could or be competent and in control, instead of simply ‘being with’ the client. This is not uncommon for trainees or new therapists. As Mearns and Cooper (2005) suggest, “This is something that we all experience, to some extent, but the problem is, the more we are focussed on how proficient our therapeutic work is, the less we may be focussed on the actual human being in front of us.” (p.114). This may also be why there appears to be a lack of relational depth being mentioned as present for the client, as there is a need for both to experience each other at the same level. Mearns and Cooper (2005) further described relational depth as “... fundamentally dyadic.” (p.113).

Internal Dialogue

All participants, when describing their experiences of silence as a therapist, became aware of their internal dialogue in relationship to what was happening 'in' the silence and the questions this ignited within them. This showed the beginnings of a process of 'internal' supervision, whereby the therapist begins to look at their own internal processes, as well as those of the client. The importance of this dualistic experience, this internal supervisor, is described by Casement (1999) as "This capacity to be in two places at once, in the patient's shoes and in one's own simultaneously ..." (p.35). Nelson-Jones (2000) reminds us also that, "In any therapeutic relationship there are at least four kinds of communication going on: namely, therapist and client inner and outer speech." (p.8). Casement (1999) further states, "... therapists have to learn how to remain close enough to what the patient is experiencing for this to have a feeling impact upon himself while preserving a sufficient distance still to function as therapist." (p.30).

As the participants in this study were all newly qualified, it may be seen that the development of this internal supervisor has not yet sufficiently matured and is still in the early stages of growth as the descriptions seemed to lack the feeling impact that Casement describes. We can see from the research of Ladany *et al* (2004) that therapists with more experience tend to be more aware of their internal dialogue and allow that to *inform* the therapeutic work. "For the most part, therapists believed that they were actively engaged in the therapeutic work during silences." (p.85).

Furthermore Ladany *et al* (2004) reported these therapists, "... observing clients, conceptualising clients and therapeutic interactions, examining their feelings and thoughts in relation to the client and therapy work, conveying empathy and remaining relatively still ..." (p.85). This shows a difference from the participants in this study, who remained mostly pensive within their own experience and wondering what to do and when to do it.

It can be seen from Ladany et al's study that in the development of the internal supervisor in *this* study's participants and with further learning of the ability to 'bracket' parts of their experience that more of a connection between their cognitive and felt experience can occur. Casement (1999) further wrote of an ability to be internally together with another and at the same time 'split' from the experience. "The therapist also has to be able to maintain this benign split within himself, whereby his experiencing ego is free to move between himself and the patient." (p.34).

From this research it is possible to see that this ability to hold separate experiences of thinking and feeling is what was absent from the descriptions of the participants as therapists and may well be what is needed to create the moments of depth in the relationship, that enable moments of silence to be a meaningful and useful process. It might be said that in gaining experience the therapist becomes more able to hold multiple experiences, or, as Casement (2002) describes, 'contain' another, as they themselves begin to integrate their own inner and outer experiences and further develop from their past way of 'being'.

Childhood experiences of silence

In existential terms, the past can be seen as a 'given'. It has already happened, we cannot consciously deny it and it informs our present and our future. As Jacobs (1998) writes, "Past, present and future are linked inseparably in the way we think and act." (p.1).

Within the interviews, the issue of the participants past experiences with silence was explored, with a view to discovering if and how past experiences affected silences in the therapeutic encounter.

As all the participants were newly qualified therapists with limited encounters of silences in therapy, it was deemed possible that their previous historical experiences of silence would be informing them during their sessions. Current research (Ladany et al, 2004) explores 'experienced' therapists' perspectives of silence in therapy; however these therapists had the benefit of experiencing silences with clients over prolonged periods of time (10 to 25 years) with regular supervision and hence had many experiences to base their working knowledge of silences upon, unlike the participants in this research.

On the whole, the majority of participants in the client role (5 in total) showed evidence of a similarity between their childhood experiences of silence and their frame of reference to therapeutic silence. How silence was used as a 'control' mechanism in childhood appeared parallel to the participants' client experiences, with phrases such as being 'left in silence', 'switching off', 'going blank', being 'on edge', being 'forced to reveal' present. Additionally it was believed that silence was unsafe and a "power struggle" and the concept of "Be seen and not heard" were present.

It is not uncommon for clients to re-experience past thoughts and feelings during therapy and indeed much has been written about how the past becomes part of the therapeutic encounter and the relationship. Clarkson (2003) in her description of *transference* explains how the transference relationship, "... is the experience of unconscious wishes and fears transferred onto or into the therapeutic partnership." (p.67). It can be said that these wishes and fears can only come from past experience.

Furthermore, it can be seen that the participants as clients were displaying behaviours similar to their past experiences and learning's. It is possible the same was also true for them in the role of therapist, where the large degree of 'expectations' they became aware of, or 'owned', were not exclusively those of the client, but related to their

own earlier experiences, thus raising the concept of *countertransference*, or the therapist's reaction to the client or situation. The subject of 'expectation' is explained in this sense further by Clarkson (2003), "In this way it describes primarily a response elicited and in answer to the patient's expressed or unconscious needs." (p.94).

It is possible that the degree of 'checking' the client, along with their choosing "what to do with the silence", considering "what client expects" and considering "breaking silence" as well as feeling "cut off" if silence wasn't allowed by the clients, "waiting anxiously" and being "bored waiting" indicated thoughts and behaviours informed by their past experiences. Furthermore it may be seen that powerful internalised statements such as "Speak up", "What do you have to say for yourself?", "Quiet, I can't hear myself think" and beliefs such as "silence means disapproval" could have an impact on how the therapists dealt with silences, therapeutically.

In the sense of moments of silence therefore, past messages appear to play a role, along with what was explicitly said or conveyed. Clarkson (2003) reminds us of the importance of recognising that internalised relationships (and the messages learnt from those) are present even when no explicit communication is taking place, "It is vital to remember that transference and countertransference phenomena are carried across not only in verbal content, but also in non verbal ways through body language, smells or atmospheric and contextual cues." (p.94).

From the participants' descriptions of their therapeutic use of silence it can be seen that their responses were more so linked to their present experiencing of the silence and what they should 'do' with it, as apposed to being aware of what may have been happening on a deeper relational level. This poses the question as to *how* the phenomenon of silence was taught in the participants' training courses.

Silence taught in training as a therapeutic skill

The participants in this research were taken from a variety of theoretical approaches. These included person centred, existential, psychodynamic and integrative models. The subject of silence appears to be included, on the whole, into the training courses attended by most of the participants and most appear to have an understanding of how silence can impact them and/or the therapeutic process, regardless of their theoretical orientation.

From the study it can be seen that the participants fall into one of two groups; those that were taught the use silence as a specific therapeutic skill and those that were not. From those that were taught silence in their training there appears to be a more objective awareness of silence as well as some level of theoretical understanding. Many of the descriptions appear to show a theoretical perspective to the work they were engaged in and some appreciation as to the relevance of this perspective within a silence, an important factor in helping the therapist understand what is going on. As McLeod (2003) suggests, "It is widely accepted that counsellors need to be equipped with a theoretical perspective through which to understand their work with clients." (p.498).

In the group that were not taught how to manage silences within their training, there appears to be a more subjective description as to the impact of silences, such as it being "Used for different purposes", allowing "time to think", a "time for stillness", and being "essential and valuable". Further, they described silence as 'conveying respect' and stopping 'pointless talk'. These statements still describe understanding that silences initiate some possible therapeutic movement, but show less of a theoretical perspective of the process of silence in the relationship.

However, this is not suggesting that any one perspective is correct. In Existential therapy for example, experiencing the moment, without relating specifically to therapeutic 'skills', may serve the client just as well. Theories, therefore, differ in their viewpoint upon certain ideas and it can be said that no one theoretical perspective has the answer. As Hall and Lindzey (1970) write, "A theory is an unsubstantiated hypothesis or speculation concerning reality which is not yet definitely known to be so." (p.10).

Silence seen as adding value to the therapeutic process

It can be seen that throughout these two groups; those that were taught silence as a therapeutic skill and those that were not, a value, worth and importance was placed on silence within the therapeutic process. This appears to agree with the research of Tindall and Robinson (1947) who described amongst other things how clients tend to introduce important material to their session if the therapist waits for them to break a silence and that in moments of silence the therapist was able to organise their thoughts and decide on what intervention may be useful. Furthermore Cook (1964) found in his study of one to one cases of psychotherapy, that successful cases were those that included more silences than not.

However, as the results gained from Cook's study were only from the perspective of the counsellor and did not include the client's impressions, it is likely that important aspects were left out. Adding to the fact that the counsellors' perspective of success was taken at the end of each individual session, it is hard to see how each individual moment of silence could be measured as successful or not. The importance of the client's perspective is noted in Sharpley (1997) who describes that "Clients are the only reliable source when evaluating counselling effectiveness, since it is for them that the process is maintained." (p.244).

Sharpley's research also concluded that when silence is present in a session clients report experiencing higher rapport with the counsellor. The study not only confirms Cook (1964) but also goes further to measure the client's perspective of the therapeutic success of silence.

This current research, which explored the perspectives of the participants from both their roles as client and therapist and also added into the equation the matter of historical perspectives and training experiences, allowed the participants' to describe freely any differences in their experiences of silence from many of the perspectives that are vital within any therapy session, namely their own experiences, the past and their training.

The influence of length of client / training experience on the therapeutic use of silence

Previous studies (Ladany *et al*, 2004) have focussed on experienced therapists' use of silence including 'why' they used it and what impacted and affected their use of silence. From the participants' dialogue in *this* study it can be seen that the experience of the newly qualified therapist in terms of the length of time engaged with clients and as a client, had an impact on how they used silences and the outcome of its use.

This suggests a link to the importance of therapists undergoing/experiencing their own 'training' therapy, as most appear to agree that the use of silence becomes easier (possibly suggesting a belief in it being more effective) with the more experience that is gained. There also appears a need for trainees to be aware of and explore the meaning of relational depth, which additionally appears to become easier with experience.

Limitations of Study

It should be noted that this research holds challenges with the participants' describing their experience of silence itself; a process where finding meaning was being

attempted of a period of time where no explicit communication was taking place. As Churchill (2000) questioned, in gaining descriptions of experience we are dealing with the "Subjective reflective consciousness of the experience." (p.54).

The question of how language is used to re-experience our experiences is raised here also. Willig (2001) writes, "... language can never simply give expression to experience. Instead, it adds meanings which reside **in** the words themselves and, therefore, makes direct access to someone else's experience impossible." (p.64). In such circumstances it could be seen that the participants were describing their experience both for themselves and for the researcher and could do so only as they were able to understand it. Furthermore it is possible these experiences were contaminated by what they, as newly qualified therapists, *thought* was occurring, that is, what they thought about silence and what it means and creates, as well as the experience and theoretical standpoint of the researcher, they also being a practising therapist.

These points raise the issue of validity, a point within thematic analysis that was considered throughout the developmental stages of this study. In the process of design, development and validation, openness to the subjective experience of the researcher in the interviews and the subsequent reporting of the data was vital in the delivery of the information. However, as the study of linguistics has shown us, words are but a vehicle for expression of experience and can be deconstructed in any number of contexts.

Future possible research

In exploring the experiences of silence of those newly qualified in counselling and psychotherapy a number of possible areas for further investigation arise. Firstly the research can be carried out with a larger sample of participants to increase its reliability. Additionally it may be beneficial for observations of triads to be carried out and the individual silences that occurred explored, in the moment, to determine the content of the

silence that made it therapeutic or not. The use of video data gathering would further enrich the study of the unique moment of 'silence', as it was experienced and then described.

As this research was carried out with newly qualified therapists it may be beneficial to repeat the study at a later date when the participants have gained more experience to see any differences in 1) their use of silence and 2) their perception of the value of the silence.

The participants represented a range of theoretical perspectives as previously described. The study elicited questions about the type of training received in the subject of silences in therapy from different theoretical perspectives. Notably absent from this sample were participants trained in cognitive behavioural therapy. Further research into the experiences of silence within a wider variety of different psychological models could give a deeper understanding of the theoretical purpose and proposed outcomes of using silence within each of these approaches.

Also worth exploring in greater depth is the therapist's past experience of silence and how that plays a part in the use of silence in therapy, as it is usually the therapist that initiates the silence (Tindall and Robinson, 1947).

Furthermore, this study seems to have highlighted the lack of inclusion in counselling training of the vast body of research in linguistics and discourse analysis, including the types and *functions* of silence, which would appear to have much to offer those engaged in such an advanced form of communication as therapy requires. Future research may offer useful insights in linking silence as a linguistic phenomenon to the use of silence in the therapeutic arena.

Conclusion

This study has illuminated the experiences of the participants in relation to silences occurring in therapy. It has shown differences in an individual's experience of silence when as a client and when a therapist. It has also highlighted the factor of past experiences of silence manifesting in therapy as well as how training courses approach the subject of therapeutic silence. It suggests that past ways of relating to another surfaced during therapy, whether as a client or therapist.

The discrepancies between how the therapist and client experienced silence in this study appears to indicate a lack of awareness of the therapeutic relationship, which silence, as an intricate form of communication, is a part of. It is not enough for the therapist simply to 'use' silence with a client. There appears a need for it to be *experienced* by both.

I am reminded that the 'core conditions', proposed by Rogers (1959) as being the healing quality of the relationship, included six necessary conditions in total, not three as is often portrayed within counselling training (as the conditions of the therapist to work towards). As Mearns and Thorne (2003b) described, in addition to the conditions of empathy, unconditional positive regard and congruence there is, "... the need for psychological contact between therapist and client, the incongruence or anxiety of the client, and the experience of at least a minimal level of the therapist acceptance and empathy by the client." (p.88).

Scott (1972) reminds us of just how important it is to be aware of the impact of our choice of communication. "Every decision to say something is a decision not to say something else, that is, if the utterance is a *choice*. In speaking we remain silent. And in remaining silent, we speak." (p.146).

Considering the work of Jenson (1973) it would appear that it is not enough for therapists to be aware of their own processes within silence. More so, it appears that an appreciation of the dualistic *functions* and *outcomes* of silence is what could be of most use to the communication between therapist and client and hence, the therapeutic encounter. Jenson's work reminds us that silence can have both positive and negative effects, which this study highlights. It is what these outcomes *are* that may be of most benefit. With awareness of this knowledge it may become possible to be more open to the undeniable mistake of the therapist's assumption that simply *using* silence is enough. Here, possibly, we have a road into the world of 'relational depth' that the therapeutic community now appears to acknowledge as a determining factor of therapeutic success.

This research has highlighted that a moment of silence between a client and therapist can touch the deepest of emotions. It can transcend the immediate experience and enable a connection between two people at a deeper human level to emerge. It is within this depth that an exploration of the *degree* of this connection can occur, which can thus delve further into the experience. In discovering that a connection *is* or is *not* present we can perhaps communicate at a more profound level and maybe serve the client's needs in a truer sense. As Laing (1967) reminds us, "We hope to share the experience of a relationship, but the only honest beginning, or even end, may be to share the experience of its absence." (p.48).

References

- Aldred, G. (1999) cited in Bor, R. & Watts, M. (1999) *The Trainee Handbook: a guide for counselling and psychotherapy trainees*. London: Sage.
- Angier, T. (2006) *Either Kierkegaard/or Nietzsche: Moral philosophy in a new key*. Aldershot: Ashgate Publishing.
- Beck, A. T., Freeman, A., & Associates. (1990) *Cognitive therapy of personality disorders*. New York: Guilford Press.
- Blos, P., Jr. (1972). Silence: A Clinical Exploration. *The Psychoanalytic Quarterly* 41:348-363.
- Bodenhamer, B. & Hall, L. (2002) *The User's Manual for the Brain, Volume 1*. Carmarthen: Crown House Publishing.
- Boyatzis, R. (1998) *Transforming Qualitative Information*. London: Sage.
- Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*. 3:77-101
- Casement, P. (1985) *On Learning from the Patient*. Hove: Brunner-Routledge.
- Churchill, S. (2000) Seeing through "self deception" in narrative reports: Finding psychological truth in problematic data. *Journal of Phenomenological Psychology* 31, 1:44-62.
- Clarkson, P. (2003) *The Therapeutic Relationship*. London: Whurr Publishers.
- Cook, J. (1964) Silence in Psychotherapy. *Journal of Counseling Psychology* 11.1:42-46.
- Cooper, M. (2005) Therapists' experiences of relational depth: A qualitative interview study. *Counselling and Psychotherapy Research* 5(2): 87-95.
- Cooper, M. (2004) 'Encountering self-otherness: "I-I and I-Me" modes of self relating'. In Hermans, H. J. M. and Dimaggio, G. (Eds.). *Dialogical Self in Psychotherapy*. Hove: Brunner Routledge.
- Davis, (1977) An Empirical study of the meanings of silence occurring early in psychotherapy. 51:1484B (University Microfilms 77-19). In Ladany, N., Hill, C., Thompson, B., and Obrien, K. (2004) Therapist perspectives on using silence in therapy: a qualitative study. *Counselling and Psychotherapy Research*. 4.1:80.
- Denzine, N. K. & Lincoln, Y. S. (1994) *Handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Elson, M. (2001) Silence, Its Use and Abuse: A View from Self Psychology. *Clinical Social Work Journal*. 29.4:1.
- Egan, G. (2002) *The Skilled Helper: A problem-management and opportunity development approach to helping* (7th ed.). CA: Brooks/Cole.

- Hall, C. & Lindzey, G. (1970). *Theories of Personality*. New York: Wiley & Sons.
- Hauser, M & Rankin, C. (1997) Math without words. *Natural History*. Retrieved May 14, 2008 from http://findarticles.com/p/articles/mi_m1134/is_n8_v106/ai_20147999
- Hill, C. E., Carter, J. A. & O'Farrell, M. K. (1983) A case study of the process and outcome of time limited counseling. *Journal of Counseling Psychology*. 30:3-18.
- Hill, C. E., Charles, D. & Reed, K. G. (1981) *Manual for counselor and client verbal response category systems*. Columbus, Ohio: Marathon Consulting Press.
- Holmes, C. (1998) *There is no such thing as a therapist*. London: Karnac Books.
- Inkinen, S. (1999) *Mediapolis: Aspects of Texts, Hypertexts, and Multimedial Communication*. Berlin: Walter de Gruyter.
- Jacobs, M. (1998) *The Presenting Past*. Buckingham: Open University Press.
- Jenson, V. (1973) Communicative functions of silence. *ETC*. 30: 249-257.
- Ladany, N., Hill, C., Thompson, B., & Obrien, K. (2004) Therapist perspectives on using silence in therapy: A qualitative study. *Counselling and Psychotherapy Research*. 4.1:80-89.
- Laing, R. D. (1967) *The Politics of Experience*. London: Penguin Books.
- Lakoff, G. & Johnson, M. (1980) *Metaphors we live by*. Chicago: University of Chicago Press.
- Leach, E. R. (1976) *Culture and communication: The logic by which symbols are connected. An introduction to the use of structuralist analysis in social anthropology*. Cambridge, UK: Cambridge University Press.
- Leininger, M. M. (1985). Ethnography and ethnonursing: Models and modes of qualitative data analysis. In M. M. Leininger (Ed.), *Qualitative research methods in nursing* (pp. 33-72). Orlando, FL: Grune & Stratton.
- Levenson, H. (1995) Time limited dynamic psychotherapy. New York: Basic Books. In Vanmeter et al. (2001) Solitude, silence, and the training of psychotherapists: A preliminary study. *Journal of Psychology and Theology*. 29.1:22-28
- Lombard, P. (2008) *Psychoanalysis: Silence*. Retrieved May 14, 2008, from <http://www.answers.com/topic/silence>
- Matarrazzo, J. & Wiens, A. (1977) Speech Behaviour as an objective correlate of empathy and outcome in interview and psychotherapy research. *Behavior Modification* 1:453-480. In Ladany, N., Hill, C., Thompson, B., & Obrien, K. (2004) Therapist perspectives on using silence in therapy: a qualitative study. *Counselling and Psychotherapy Research*. 4.1:80.
- McLeod, J. (2003) *An Introduction to Counselling*. Buckingham: Open University Press.
- McLeod, J. (2006) *Qualitative Research in Counselling and Psychotherapy*. London: Sage.

- Mearns, D. & Cooper, M. (2005) *Working at Relational Depth in Counselling and Psychotherapy*. London: Sage.
- Mearns, D. & Thorne, B. (2003a) *Person Centred Counselling in Action*. London: Sage.
- Mearns, D. & Thorne, B. (2003b) *Person Centred Therapy Today*. London: Sage.
- Miller, W. & Crabtree, B. F. (1992) Primary care research: A multimethod typology and qualitative road map. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research: Research methods for primary care* (Vol. 3). Newbury Park, CA: Sage.
- Nelson-Jones, R. (2000) *Six Key Approaches to Counselling and Therapy*. London: Continuum.
- Norcross, J. (Ed.). (2002) *Psychotherapy Relationships that Work*. Oxford: Oxford University Press.
- Potok, C. (1983) *The Promise*. London: Penguin.
- Pressman, M. (1961) Silence in Analysis: Bulletin of the Philadelphia Association for Psychoanalysis XI. *The Psychoanalytic Quarterly* 31:582.
- Rich, A. (1975) *Cartographies of Silence*. Retrieved August 28, 2008, from http://www.americanpoems.com/poets/adrienne_rich/14288
- Rogers, C. (1959) A theory of therapy, personality, and interpersonal relationships, as developed in the client centred framework. In S. Koch (Ed.), *Psychology: A study of a science: Volume 3. Formulations of the person and the social context*. (pp. 184-256). New York: McGraw-Hill.
- Samarin, W. J. (1965) Language of silence. *Practical Anthropology*. 12(3):115-119.
- Sartre, J. P. & Frechtman, B. (1948) *What is Literature?* London: Methuen and Co.
- Scott, R. L. (1972) Rhetoric and silence. *Western Speech*. 36:146-158.
- Sharpley, C. F. (1997) The influence of silence upon client-perceived rapport. *Counselling Psychology Quarterly*. 10:237-246.
- Sharpley, C. F. & Harris, M.A. (1995) Antecedents, consequences, and effects of silence during cognitive-behavioral therapy interviews. *Scandinavian Journal of Behavior Therapy*. In Ladany, N., Hill, C., Thompson, B., & O'Brien, K. (2004) Therapist perspectives on using silence in therapy: a qualitative study. *Counselling and Psychotherapy Research*. 4.1:80.
- Sharpley, C. F., Munro, D. M. & Elly, M. J. (2005) Silence and rapport during initial interviews. *Counselling Psychology Quarterly*. 18.2:149-159.
- Silence*. (2008) Retrieved August 28, 2008, from <http://www.thefreedictionary.com/silence>
- Smith, D. (2008) Phenomenology. *Stanford Encyclopedia of Philosophy*. Retrieved August 28, 2008, from <http://plato.stanford.edu/entries/phenomenology/#1>

- Smith, N. D. & Taylor, J. P. (2005) *Descartes and Cartesianism*. Newcastle upon Tyne: Cambridge Scholars Publishing.
- Sperber, D. & Wilson, D. (1986) *Relevance: Communication and cognition*. Oxford: Basil Blackwell.
- Spinelli, E. (2007) *Practising Existential Psychotherapy: The Relational World*. London: Sage.
- Therapeutic* (2008). Retrieved August 28, 2008, from <http://www.thefreedictionary.com/therapeutic>
- Tindall, R. & Robinson, F. (1947) The Use of Silence as a Technique in Counselling. *Journal of Clinical Psychology*. New York: Wiley & Sons, Inc.
- Tupper, M. F. (1849) *Proverbial philosophy: A book of thought and argument. "Of discretion"*. New York: John Wiley.
- van Deurzan, E. (2009) *Psychotherapy and the quest for happiness*. London: Sage.
- van Servellen, G. (1997) *Communication skills for the health care professional: concepts and techniques*. Maryland: Aspen Publishers.
- Wilberg, P. (2004) *The Therapist as Listener: Martin Heidegger and the Missing Dimension of Counselling and Psychotherapy Training*. Eastbourne: New Gnosis Publications.
- Willig, C (2001) *Introducing qualitative research in psychology*. Maidenhead: Open University Press.
- Jaworski, A. (1993) *The power of silence*. CA: Sage.
- Johnstone, B. (2008) *Discourse Analysis*. Oxford: Blackwell Publishing.
- Young, J. E. (1990) *Cognitive therapy for personality disorders: A schema focused approach*. Sarasota, FL: Professional Resources Exchange.