Graduate thesis

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A Time to Speak and a Time to Keep Silent: Psychotherapists' Perceptions of Silence-phenomena

Graduate thesis in Clinical Psychology
Supervisor: S. Hroar Klempe & Olga V. Lehmann
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Preface

Through clinical practice during the course of our education to become psychologists, we found the topic of silence-phenomena in psychotherapy particularly interesting. The idea behind this project was inspired by our own personal experiences with silence-phenomena and the therapeutic relationship. How is it that silence-phenomena can induce tremendous anxieties in us as therapists, and later be a delightful and memorable experience? We wanted to pursue psychotherapists' meanings and experiences related to silence-phenomena and the therapeutic relationship in a therapeutic context. As novice researchers we have gained valuable knowledge and capabilities in conducting and analysing qualitative research. We want to thank our supervisors, Olga and Hroar, for thorough support, fruitful conversations and feedback, and for encouraging us to trust ourselves throughout the entire process. We would also like to thank our participants for sharing their valuable time and interesting insights and experiences with us.

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Abstract

Silence-phenomena are not merely empty spaces in between words, but are infused with meaning-making and filled with tension, affect and ambiguity. Due to the complex and dynamic nature of silence-phenomena, they can be difficult to navigate and make sense of in the context of psychotherapy. This study focused on psychotherapists' perceptions and experiences of silence-phenomena and the therapeutic relationship in psychotherapy. Semi-structured interviews were conducted on 14 Norwegian clinical psychologists and psychiatrists. The interviews were transcribed, coded and analysed using a theoretically driven latent thematic analysis (TA). The analysis yielded that silence-phenomena in therapy are perceived and made sense of by therapists in various ways. The participants use silence-phenomena as an intuitive tool in order to serve a diversity of functions in a therapeutic process (e.g. affective processing). Silence-phenomena were found to amplify ambiguity, ambivalence and affect in the participants, highlighting the importance of therapists' self-regulation. The interpretations and meanings ascribed to silence-phenomena were found to be highly dependent on contextual factors, especially the therapeutic relationship. In cases where the therapeutic relationship was perceived as strong, the therapists interpreted silence-phenomena as having greater potential to be facilitatory to the therapeutic relationship and process. Conversely, if the therapeutic relationship was perceived as weak, silence-phenomena were interpreted as having more detrimental effects. Silence-phenomena were found to have the potential to induce and encompass moments of meeting at relational depth.

Keywords: silence-phenomena, psychotherapy, the therapeutic relationship, relational depth

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A Time to Speak and a Time to Keep Silent: Psychotherapists' Perceptions of Silence-phenomena

Silent experiences are unavoidable everyday phenomena and are perceived and made sense of in various ways. The term *silence-phenomena* was coined in order to emphasise the plurality of meanings and experiences the word silence represents (Lehmann, 2015). Silence-phenomena are complex, ambiguous, and filled with tension (Lehmann, 2018). Since silence-phenomena can capture a variety of affective processes, they can be potent in the process of meaning-making, where affective processes are at the centre (Lehmann, 2018; Lehmann et al., 2019; Salvatore & Zittoun, 2011). An arena that is filled with both silence-phenomena and meaning-making is psychotherapy. This article investigates how therapists perceive and relate to silence-phenomena in a therapeutic setting.

Despite silence-phenomena occurring in practically all psychotherapies, there is sparse literature on how psychotherapists view and relate to silence-phenomena (although a few have studied this, e.g. Hill et al., 2003; Knutson & Kristiansen, 2015; Ladany et al., 2004; Lane et al., 2002). Overall, the literature indicates that silence-phenomena are perceived differently based on diverse factors, and that therapists do or do not use silence-phenomena for a variety of reasons (e.g. Barber, 2009; Hill et al., 2003; Ladany et al., 2004; Lane et al., 2002). One of the factors that affect therapists' perceptions and uses of silence-phenomena is the quality of the therapeutic relationship/alliance (Ladany et al., 2004). Since therapist-client interaction has been found to predict alliance ratings (Price & Jones, 1998), and a good alliance is connected to positive outcomes in psychotherapy (e.g. Krupnick et al., 1996; Lambert & Barley, 2001; Norcross & Lambert, 2011; Price & Jones, 1998), elements contributing to the quality of the interaction, such as silence-phenomena, are important in broadening the understanding of the therapeutic relationship.

Research on the therapeutic alliance is broad, exploring and taking into account many different aspects of the working relationship between therapist and client. Due to the ambiguous, tension- and affect-filled nature of silence-phenomena, we wanted to look at the most emotionally potent parts of the therapeutic relationship. The notion of *relational depth* attempts to capture these. Relational depth is an expansion of Roger's (1957, 1959) work on therapeutic alliance. The deep and intimate ongoing relationship between the client and the therapist, as well as relationally deep moments occurring in therapy, are at the core of relational depth (Cooper, 2013, p. 63). Since silence-phenomena have the ability to host numerous affective processes and experiences and can induce processes both inwards (self-exploration) and outwards (framing relationships with others) (Lehmann, 2018, p. 84), it is plausible that silence-phenomena have the potential to promote and encompass relational depth (Lehmann, 2018, p. 209).

Because silence-phenomena have relational content (Lehmann, 2018, p. 84), and the therapeutic relationship is important for therapy outcome (e.g. Norcross & Lambert, 2011), gaining further insight into how psychotherapists perceive and relate to silence-phenomena in relation to the therapeutic relationship may increase our understanding of how these phenomena unfold in therapy, and what implications they may have for clinical practice. Through increased knowledge of the meanings and functions of silence-phenomena and the therapeutic relationship, therapists may be better equipped to handle and use them in a way that is beneficial for the therapeutic process and relationship. Thus, our research, using qualitative methods, examines the following: What are the meanings that psychotherapists give to their experiences of silence-phenomena in a therapeutic setting? And in specific: How do their perceptions of the therapeutic relationship influence their experiences of silence-phenomena?

Theoretical Framework

Silence-phenomena

Both silence-phenomena and language play a central role in the ways we make sense of our everyday experiences. The function of language has traditionally been studied without considering the functions and powers that silence-phenomena might have (Bruneau, 1973; Valsiner, 2011). Silence-phenomena are commonly mistaken as corresponding to the complete opposite of speech. This is not the case; the significations of speech signs are possible due to their interconnection with silence-phenomena and vice versa (Bruneau, 1973; Kurzon, 2009).

What is spoken, what is kept silent and what is being silenced is crucial to the way we cope with uncertainty (Lehmann, 2015). In understanding affective processes, psychology recognizes that language has both possibilities and limitations with regard to capturing the richness of these experiences (Lehmann, 2018, p. 13). Since silence-phenomena can capture a variety of affective processes, they can also be a source of uncertainty, tension and anxiety (Lehmann et al., 2019). The uncertainty associated with plausible consequences of different decisions can evoke tension (Lehmann, 2018, p. 35). Affective processes may shape the relationship the individual has with themselves and others, through motivating the individual to take specific actions (Salgado, 2007). The spoken and unspoken, the expressible and inexpressible, often induce strong tensions and impulses in dialogues and interchanges.

Silence-phenomena can be explained by a theoretical distinction between different conceptualizations of silent experiences. One meta-categorization has resulted in the concepts of *silences*, *silence* and *silencing* (Bruneau & Ishii, 1988). Silences are described as being causal, conscious, social and secular, and deal with e.g. pauses in communication or turn-taking in conversations (Bruneau & Ishii, 1988). Silencing concerns rhetorical strategies of demonstrating power by restricting someone else's utterance (e.g. reflecting power dynamics)

and silence reflects aesthetic lived-experiences with the absence of borders between the subject and object of involvement (Bruneau & Ishii, 1988; Orlandi, 1995). All three notions of silence-phenomena are interconnected.

Silences

Silences are particularly significant in conversations. Bruneau (1973) differentiates between sociocultural, psycholinguistic and interactive silences. Sociocultural silences regard communicative patterns in different cultures and communities (Bruneau, 1973). Psycholinguistic silences can e.g. involve the experience of anxiety, decision-making on what to say next and changes in attitude (Bruneau, 1973). Interactive silences can be described as longer pauses or interruptions in conversations involving affective and relational content in interaction (Bruneau, 1973). Within these, cognitive judgments, decisions and conclusions appear (Bruneau, 1973). If these interruptions become too long, uncertainty can arise and the relationship between the people involved may be threatened (Lehmann, 2018, p. 89). In a therapeutic setting, it is plausible to assume that interactive silences may have consequences for the therapeutic relationship between therapist and client.

Silencing

Silencing concerns power dynamics and how the presence of an authority or perceived authority can function as a mechanism controlling speech (Bruneau, 1973). In interpersonal communication, silences can make people question the relationship with the other. In authority-subordinate relations this is apparent. The burden of maintaining communication often falls as the burden of the subordinate (Bruneau, 1973). A silencing strategy (whether intended by the authority or imagined by the subordinate) can often result in respectful silences (Bruneau, 1973). Communicating with an authority, such as a therapist, can be challenging. Therapists are in a dominant position relative to their clients, and this can affect the degree of freedom that the client feels to express themselves. Perceptions of uncertainty

seem to be relevant with regard to silencing (Lehmann, 2018, p. 96). Such uncertainty may be related to the perception of the power or powerlessness inhabited by the individuals involved in the interaction (Lehmann, 2018, p. 96).

Silence

Silence can be described as the borderless aesthetic lived-experiences between two individuals or between the object and subject involved (Bruneau and Ishii, 1988; Orlandi, 1995). Contemplative, meditative and other aesthetic experiences are associated with silence. Such experiences can be described as relational processes that connect individuals with e.g. others, themselves, nature and spiritual realms (Lehmann, 2018, p. 85). Silence can thus serve as a room for the inexpressible parts of existence (Lehmann, 2018, p. 77).

Psychotherapy as a Context

Silence-phenomena do not occur in a vacuum; rather, the context in which they occur may contribute to how individuals make sense of them. In this article, silence-phenomena are investigated within the context and dynamics of a psychotherapeutic process. Although there are a variety of approaches to individual psychotherapy, and therefore different understandings of what a therapeutic process *is*, therapies usually always involve a client expressing thematic material in the context of a supportive relationship (Shirk, 1988, p. 4). Furthermore, therapists attempt to use this supportive relationship systematically in order to produce lasting changes in the client (Shirk, 1988, p. 4).

This article treats psychotherapy as a process of co-construction of meaning in context. Meaning can be understood as a social construction that occurs by and within the social exchange (Salvatore et al., 2009). In a psychotherapeutic process, this underlines that meaning-making is not an autonomous process, but one that unfolds as a function of the therapeutic setting, and with the interaction between therapist and client as its main tool. The context entails not only the physical surroundings, the therapeutic setting, and the relationship

between the therapist and client, but also the contexts within both the therapist and the client. According to Dialogical Self Theory (DST), the self is not only being influenced by an external society, but also by an internal society of mind (Hermans, 2012). Individuals possess multiple I-positions that are activated according to the context, shaping their relational dynamics and the ways in which they bond with others (Hermans, 2012; Puchalska-Wasyl, 2010). Silent experiences can increase awareness of the tensions that form the dynamics between I-positions in the stream of consciousness (Lehmann & Valsiner, 2017, p. 100).

According to DST, the positions people are placed in within social exchanges are not neutral, and can be affected both by what the individual thinks from a multiplicity of I-positions, their internalized constructs of how they think others might think, and how the other individual(s) *actually* thinks and interacts with them (Hermans, 2001). The I-positions in the context of psychotherapy are affected by an uneven power dynamic between therapist and client and depend on the relationship and bond that is created, as well as the trajectory the relationship takes through the course of the therapy (Lehmann, 2014). Psychotherapy can thus be viewed as a complex, dynamic arena to navigate for both therapist and client, and making sense of both the self, the other, and the meanings of silence-phenomena is likewise a complex process.

Silence-phenomena in the Context of Psychotherapy

Scholars have argued that silence-phenomena in theory may both facilitate and inhibit the therapeutic process. They have suggested that silence-phenomena may be *facilitative* through the therapist conveying empathy, creating space for the client to reflect and gain insight, and through motivating clients to communicate (e.g. Back et al., 2009; Cook, 1964; Ladany et al., 2004; Macdonald, 2005; Stringer et al., 2010), or *inhibitory* through the client experiencing silence-phenomena as something unpleasant, e.g. as the therapist being cold,

judgemental, angry, insulting or withholding, or in increasing the client's stress levels and fears of abandonment (e.g. Daniel et al, 2018; Ladany et al., 2004).

Empirical research on silence-phenomena in psychotherapy is limited but supports theoretical assumptions about silence-phenomena having mixed effects on the therapeutic process. Silences can be used by the therapist to convey empathy, create space for the client to think or feel, and/or to invite the client to participate (Back et al., 2009; Ladany et al., 2004). Clients have reported higher perceptions of rapport with their therapist when the therapy has a higher frequency and greater overall amount of silences (Sharpley & Harris, 1995; Sharpley et al., 2005). Furthermore, therapies characterised by a lack of silences and a higher percentage of speech have been found to be less successful (Cook, 1964). Conversely, more frequent use of silence-phenomena on behalf of the therapist has also been associated with higher incidence of client dropout (Davis, 1977), been offered as an explanation by clients for dropping out of therapy (O'Keeffe et al., 2019), and has been associated with the therapist being perceived as unempathetic (Matarazzo & Wiens, 1977).

One explanation for the conflicting empirical findings on silence-phenomena in psychotherapy may be that researchers have a tendency to categorize silence-phenomena as a homogenous event, coding and analysing silences based on time elapsed, without necessarily factoring in the intention, meaning and context(s) in which they take place (Levitt, 2001a). In order to operationalize and study which types of silence-phenomena may facilitate or inhibit the therapeutic process, Levitt (2001b) created a typology where silence-phenomena occurring in psychotherapy are categorized as productive, obstructive, or neutral. Productive silences may facilitate - amongst other things - emotional experiencing, connection making, insights and realizations, whereas obstructive silences may involve disengagement, avoiding emotions, withdrawing, and safeguarding the alliance (Levitt, 2001b). Using Levitt's (2001b) typology (obstructive/productive/neutral), Frankel et al. (2006) found that therapist-client

dyads with good outcomes indeed had significantly more productive silences than dyads with poor outcomes. This finding was also replicated by Daniel et al. (2018).

Research also suggests that therapists do not use silence indiscriminately; for instance, in one study they avoided using silence-phenomena when the clients were psychotic, paranoid, angry, highly anxious, overwhelmed, a danger to themselves or others, had features of a personality disorder, or when the client was new to therapy (Ladany et al., 2004). Furthermore, they believed that a good therapeutic alliance was a prerequisite for using silence-phenomena effectively (Ladany et al., 2004).

The prevailing understanding in the literature is that silence-phenomena are complex to navigate, as they have the potential to be both facilitatory and inhibitory (e.g. Barber, 2009; Knutson & Kristiansen, 2015; Ladany et al., 2004; Lane et al., 2002). Taken together, the theoretical and empirical literature indicates that silence-phenomena in psychotherapy have several meanings and functions.

The Therapeutic Relationship

Therapeutic Alliance

Psychotherapy is carried out in the context of the relationship between those providing help and those seeking help (Knox et al., 2013, p. 1). The therapist and client will strive for the creation of a bond: A therapeutic relationship/alliance. The therapeutic alliance can be defined as "the collaborative, positive relationship between therapist and patient" (Price & Jones, 1998, p. 392). Rogers (1957) defined active components in the therapeutic relationship as unconditional positive regard, congruence and empathy on behalf of the therapist. The term therapeutic alliance has received a great amount of attention in the field of psychotherapy research and has been shown to be of critical importance. Empirical research has found that therapeutic relationships of high quality are connected to positive outcomes in psychotherapy (Horvath & Symonds, 1991; Krupnick et al., 1996; Lambert & Barley, 2001; Norcross &

Lambert, 2011; Price & Jones, 1998). In one study, the therapeutic alliance stood for more of the variance in outcome than treatment modality (Krupnick et al., 1996). Evidence has also been found for a causal link between the therapeutic alliance and therapy outcome, suggesting that the therapeutic relationship in itself might be healing (Zilcha-Mano, 2017).

Attempts have been made to understand which characteristics and elements contribute to a healing therapeutic alliance. A meta-analysis by Baier et al. (2020) found that contributions to a good therapeutic alliance on behalf of the therapist were e.g. trustworthiness, experience, exploration, confidence, empathy and accurate interpretation. However, a good therapeutic alliance cannot be explained by therapist factors alone. A study by Price & Jones (1998) found that the quality of the interaction itself between therapist and client predicted alliance ratings. One finding was that the quality of therapist-client interaction was dependent on successful communication (Price & Jones, 1998). In this study, successful communication was described as whether the client understood interventions made by the therapist. This indicates that use of silence-phenomena in a therapeutic setting have the potential to be problematic, especially if patients do not understand the purpose of and/or what is being communicated through silence-phenomena.

Relational Depth

Rogers (1959) noted that not only prominent characteristics, but also specific moments in the therapeutic relationship are important in leading to change. The potential role and value of the depth of relating in psychotherapy was termed relational depth by Mearns in 1996. As a meaningful therapeutic construct, relational depth is something that is part of the therapeutic alliance or present within the therapeutic relationship (Cooper, 2013, p. 63). Relational depth is defined as:

> A feeling of profound contact and engagement with a client, in which one simultaneously experiences high and consistent levels of empathy and acceptance

> towards the other, and relates to them in a highly transparent way. In this relationship, the client is experienced as acknowledging one's empathy, acceptance and congruence – either explicitly or implicitly – and is experienced as fully congruent in that moment (Mearns & Cooper, 2005, p. 36)

The term relational depth applies to both identifiable moments of relating at depth and an ongoing deep relationship between therapist and client. The specific and identifiable moments of connectedness have been the primary focus of research on relational depth in recent years (Knox et al., 2013, p. 3). A memorable and profound experience or incident between therapist and client has the potential to affect the therapeutic relationship deeply (Brown et al., 2013, p. 13).

Experiences of the relationship during moments at relational depth have been found to capture powerful feelings of intimacy, connection, closeness, mutuality and trust with the other in the moment of deep connection (Cooper, 2013, p. 69; Knox, 2008, Macleod, 2009). The therapist gives high levels of congruence, unconditional regard and empathy and the client accepts receiving this (Mearns & Cooper, 2005, p. 36). Research has shown certain asymmetries in how the therapist and the client experience relational depth (Cooper, 2013, p. 71). Therapists are more likely to describe emotions of acceptance and empathy towards the other, while clients more often experience self-enquiry and vulnerability (Cooper, 2013, p. 71). Descriptions of the experiences of the moment itself present a moment of deep encounter as rare, unique, strange, meaningful and something that is challenging to describe with words, to mention some (Cooper, 2013, p. 69-70). Such moments have been found to often take place without words (Mearns & Cooper, 2005, p. 47).

In terms of the therapeutic value of relational depth, Mearns & Cooper (2005) suggest that the moment itself can serve as a corrective relational experience (p. 48). Through such encounters, clients can begin to form hope of establishing more meaningful relationships with

others (Mearns & Cooper, 2005, p. 48). A meeting at relational depth can also be of value to therapy in terms of the therapists' experiences (Mearns & Cooper, 2005, p. 50). This can in turn benefit the clients, as it may give therapists more hope toward the therapeutic process and an increased willingness to relate in-depth with their clients.

Therapist Factors Associated with Relational Depth. A meeting at relational depth is impossible to describe in terms of the therapist alone. Both the experiences of the client and the therapist are involved in a so-called interpenetration of perceptions, feelings and experiences (Mearns & Cooper, 2005, p. 37). Certain characteristics have been associated with a relationally deep meeting from the viewpoint of the therapist. It is emphasised that the therapist is integrated and congruent in the relationship, that the therapist experiences and expresses unconditional affirmation toward the client and that the therapist experiences empathy towards the client and is able to convey this (Mearns & Cooper, 2005, p. 35).

Realness. A fundamental aspect of a meeting at relational depth is that the therapist is fully transparent and genuine in the meeting. Mearns & Cooper (2005, p. 38) referred to this as realness. Realness involves a willingness to be spontaneous, take risks and trust that being human and real can help the client (Mearns & Cooper, 2005, p. 38). In relation to realness, Geller and Greenberg (2002) emphasised that therapeutic presence is about being fully in the moment in the therapeutic setting on several levels. The presence of the therapist involves presence on both a physical, visceral, cognitive and emotional level (Geller & Greenberg, 2002). The inner receptive state of the therapist is considered an essential tool, and it is therefore important that therapists are aware of their own uncertainties and how these may affect the therapeutic relationship (Mearns & Cooper, 2005, p. 38).

Empathy. Empathy is considered crucial in moments of relational depth. Mearns & Cooper (2005, p. 39) describe an embodied empathy where the therapist is tuned in to both the client's thoughts, emotions and physicality. In this mode, the therapist will have the

experience of being highly involved or focused on their client and the therapeutic work. Distractions, external noise and invading thoughts are not present to a large extent (Mearns & Cooper, 2005, p. 40). Ferenczi (1928) stated early that empathy serves as a precondition for tact and that a suitable empathic comprehension dictates when the therapist should keep silent and when silence-phenomena are harmful and could potentially cause the client unnecessary suffering. Other researchers suggest that an exchange of words can contain wordless layers of empathy, especially with regard to honoring and appreciating others' traumatic experiences (Jackson, 2004; Kridon, 2009).

Affirmation. Affirmation can be compared to Rogers (1957) expression unconditional positive regard. The term positive affirmation goes beyond refraining from judgement and accepting who the client is; the therapist is actively prizing the client (Rogers, 1957). The positive affirmation should include a profound acknowledgement and valuing of the client's individuality and uniqueness as a human being (Mearns & Cooper, 2005, p. 43). The therapist should also have a real sense of and a curiosity towards the client's core (Mearns & Cooper, 2005, p. 43).

Aim of the Study

The study uses the terms, theoretical concepts and previous empirical research presented in the theoretical framework as a basis for exploration of psychotherapists' perceptions of silence-phenomena. The purpose of the study was to document and analyse the meanings psychotherapists ascribe to their experiences of silence-phenomena in a therapeutic setting, with special attention given to the therapeutic relationship and moments of meeting at relational depth. Gaining knowledge on meanings and functions of silence-phenomena and the therapeutic relationship may aid psychotherapists in perceiving and handling silence-phenomena in a way that is beneficial for both the therapeutic relationship and the therapeutic process as whole.

Methodology

Considering the subjective, complex and dynamic nature of silence-phenomena in psychotherapy, capturing a high level of detail and reflection surrounding the topic was key. We sought to find the therapists' subjective meanings and experiences, and not static generalisations or numerical facts. Consequently, we utilised a qualitative approach, using semi-structured interviews and thematic analysis (TA).

Study Participants

Clinical psychologists and psychiatrists with a license to practice psychotherapy in Norway were included in this study. To capture vivid experiences of silence-phenomena and relational depth with clients, we recruited participants currently practicing clinical psychotherapy. In order to obtain a variety of experiences and perspectives, we welcomed participants regardless of their clientele and preferred psychotherapy approach. A total of 14 participants (10 psychologists and 4 psychiatrists; 11 women and 3 men) were included in the study. The participants had between 2 and 40 years of clinical experience.

We utilised a combination of convenience sampling and self-recruitment through social media. For the convenience sampling, potential participants (known to the project) were contacted by email, and were sent an attachment with information and a consent form (Appendix A). 8 participants were recruited this way. A Facebook post (Appendix B) posted in internal private Facebook groups for psychologists and psychiatrists in Norway yielded the remaining 6 participants. All 14 participants gave written, informed consent. No compensation was offered for participation.

Data Collection

The participants were interviewed individually by the study authors, using a semi-structured interview guide (Appendix C). The interviews lasted between 45 minutes and 1 hour and 30 minutes, were audio-recorded, and subsequently transcribed, yielding 250 pages

of data. Of the 14 participants, 12 were interviewed digitally, and 2 were interviewed over the phone. No video was recorded. In the interviews conducted digitally, both authors were present. One took the role of the interviewer, and the other the role of the observer.

In the beginning of the interview, the participants were informed that we were interested in learning about their own perspectives and experiences. In order to encourage the participants to talk freely about these, we emphasised asking neutral questions, responded to their answers in a curious manner and occasionally asked open-ended follow-up questions. The purpose of this approach was to avoid introducing specific ideas to the participants.

Interview Protocol

We developed an interview protocol (Appendix C) with the purpose of investigating psychotherapists' perceptions of silence-phenomena and the therapeutic relationship. In order to capture aspects of relational depth, we took inspiration from Price's (2012) questionnaire on therapists' experiences of relational depth (RDI-2 Therapist), as well as Mearns & Cooper's (2005) descriptions of therapist factors associated with relational depth. Potential questions were analysed with regard to whether they captured aspects of cognition, emotion and/or behaviour. This was done in order to ensure that the protocol was well-balanced and suitable to encourage detailed, full descriptions of perceptions and experiences. In an effort to avoid priming the participants into providing certain answers, we paid special attention to the order and phrasing of the questions. To capture reflections we might otherwise miss out on, we inquired if the participants had any further thoughts they would like to share. This enabled us to apply constructive feedback to the remaining interviews.

A pilot interview was conducted, and based on the interviewee's responses as well as a discussion with the interviewee afterwards, we updated and improved the protocol by removing some questions and modifying others to make them clearer. Since we were interested in therapist factors, and the pilot interviewee answered one question by primarily

talking about client factors, we added optional follow-up questions to refocus on therapist factors (See Appendix C). We also added a description of what kind of relationship one might have with an acquaintance to point 3, question 1 based on a reply we got during an interview with one study participant.

Thematic Analysis

The transcripts were coded and analysed using thematic analysis (TA). This method was chosen due to its flexibility, the number of study participants and TA's potential to find overarching patterns in the data. The analysis was both deductive and inductive. The deductive aspects allowed existing theoretical concepts to contribute to the development of themes (Braun & Clarke, 2006). The use of inductive codes enabled us to stay closer and more truthful to the data. The themes were identified at a latent rather than semantic level, which allowed us to make some interpretations of the participants' meanings beyond the semantic content of their replies. During the process of analysis, we followed the six phases suggested by Braun and Clarke (2006). This process was not linear, moving from one phase to the next; instead it was recursive, and we moved back and forth between phases throughout (Braun & Clarke, 2006). The first phase (familiarising yourself with the data) involved transcribing the interviews verbatim, and both study authors immersing themselves in the data, reading and re-reading the transcripts, as well as writing down initial thoughts separately. For phase two (generating initial codes), we used a mix of deductive and inductive codes. Each author coded the 14 transcripts individually at first. For phase three (searching for themes), we analysed which codes might fit together in overarching themes. We did this by discussing the relationships between the codes and the themes, as well as organising them visually through lists. This yielded five initial themes.

Table 1.

Example of coding process

Transcript excerpt (Participant 4, p. 78, line 20-24)	Initial codes	Overarching themes
In moments where there are no words, I can probably show that I am moved after people tell me something really important, whether it's positive or negative. And I can allow myself to have tears in my eyes, without crying.	Interdependence with language Silence-phenomena as a way to convey empathy Empathy Realness	Meeting without words Silence-phenomena as a therapeutic tool
When I understand that "we're really at the core of something", in a way.	Meeting without words	

In phase four (reviewing themes), these themes were further refined. This was accomplished by reviewing the themes against the codes, and reading all the data extracts associated with each code. We also reviewed all the data against the themes in order to ensure that the themes were as close to being an accurate representation of the data as possible (Braun & Clarke, 2006). One of the initial five themes did not have enough data to stand on its own and was removed. In phase five (defining and naming themes), the essence of the themes were defined, data extracts representative of each theme were identified, and the final names of the themes were decided. The sixth and final phase (producing the report) is presented here and in the results section. In the following presentation of the themes, all quotations have been translated from Norwegian to English.

Ethical Considerations

The study was conducted in accordance with the guidelines of the Norwegian Centre for Research Data (NSD). Our application to NSD was accepted on the 20th of march 2020 (reference number 656268). All participants either sent us a signed consent form to participate or wrote that they consented in an email. In addition to written consent, the participants

reaffirmed their consent verbally before audio recording commenced. The recordings were kept on a password-protected hard drive. Personal data was removed from the transcripts, and no information can be linked to a specific person. Furthermore, each participant was assigned a random number as an alias, and this number is used in the following results section.

Results

Four themes were identified: (1) Silence-phenomena as a therapeutic tool, (2) Silence-phenomena as amplifying ambiguity, ambivalence and affect, (3) Silence-phenomena and the therapeutic relationship, and (4) Meeting without words. The corresponding codes can be found in Table 2 (Appendix D). These themes reflect the diversity in how psychotherapists perceive and make sense of silence-phenomena in psychotherapy. The first theme highlights how therapists perceive silence-phenomena in psychotherapy as an intuitive tool that can be used in order to serve a variety of functions in the therapeutic process. The second theme represents how therapists perceive silence-phenomena in therapy as filled with ambiguity, ambivalence and affect. This affects how the therapists make sense of both silence-phenomena themselves and the emotions that arise in both therapist and client, highlighting the importance of the therapist being well-regulated. The third theme examines perceptions of how silence-phenomena may affect and be affected by the therapeutic relationship, whereas the fourth theme explores how silence-phenomena can create room for moments of meeting.

Silence-phenomena as a Therapeutic Tool

When asked about silence-phenomena, most participants described them - either explicitly or implicitly - as a therapeutic tool, which they utilise intuitively and for diverse purposes. They emphasised that they did not pre-plan the use of silence-phenomena. Many participants noted that their perceptions of silence-phenomena are interdependent with language, and that language prior to or after a silent event contributes to the meanings they make of silence-phenomena. Some believed a prerequisite for using silence-phenomena

effectively as a tool was to inform the client of what silent experiences can mean in the context of psychotherapy, as well as exploring the silences verbally afterwards. The participants described five main things they used silence-phenomena for: to convey empathy (for instance, participant 2 (p. 31, line 2-4) remarked "but also just sitting with them and feeling their pain. Not to leave it [the pain], or attempt to do something about it, but being present in the fact that sometimes, life is painful"), to facilitate exploration and reflection (in both client and therapist), to give room for integration (of affect, new ideas, and relational experiences), to induce affect, and to induce a sense of responsibility in the client.

Participant 4 described one instance where silence-phenomena gave room for processing a recognition, whereas speaking would have been counterproductive:

> Then she said something that was so true, and we both understood it was so true. And filling the silence with words would only have taken away from that recognition. It was important to let it sink in. (4, p. 78, line 14-16).

Participant 13 described how s/he utilises silence-phenomena as a way to increase affect in the client (due to a belief that affective processing could be helpful to the therapeutic process):

> Especially in situations where the person you're talking to has a rise in affect, you need to be cautious. Because it's very easy to use - that words dampen affect. Because you invite people to think, when what you want is for them to *feel.* So once you start talking to them, they switch into a listening mode and don't really focus on their emotions. And I think it's very important to learn to shut up. Learn to be patient. And listen actively, and with- so that you signalise that you're on board. You're engaged and interested, and you're not necessarily saying anything. (13, p. 226, line 11-17).

The above quote is illustrative of how many of the participants try to signal to the client that they are engaged and present during silences. Mirroring the client and showing empathy non-verbally or through simple verbalisations such as "mhm" are examples of how they do this.

The therapists did not use silences indiscriminately; instead, they made judgements based on client factors. For example, they tended to not use silences as much if the client was a child or teenager, had high levels of anxiety, or was psychotic. Conversely, they tended to use silences more if the client needed more time to process thoughts and feelings, or if the client was hectic and used speech as avoidance. One participant described how s/he signalled clearly to the client that s/he was disengaging by not mirroring the client or responding, in order for the therapist to regain control over the therapeutic process. Some reported using silences as a means to slow down the overall tempo. In sum, silence-phenomena were either used or avoided as a tool by the participants in our study for a variety of purposes.

Silence-phenomena as Amplifying Ambiguity, Ambivalence and Affect

Several participants described silence-phenomena as having the potential to increase affect, within a therapeutic setting as well as in private spaces. This increase can involve either pleasant or unpleasant affect, depending on different factors and how the silences are interpreted. A few participants also described silence-phenomena as having the potential to decrease affect, or shut clients off. Several participants described experiencing a feeling of exhaustion and a sense of working for two in instances where they perceive silences to be uncomfortable. On the other hand, most participants described that when they perceive silences to be positive, they experience feelings of curiosity, warmth and an eagerness to work. Common for all the participants is that they described ambiguity and subsequent ambivalence and uncertainty when attempting to make sense of silence-phenomena. Participant 12 remarked how the ambiguity of silence-phenomena leaves room for interpretation:

> I do have experience with silence in the therapy room, and the silence can be good, but it can also be difficult, precisely because it leaves room for interpretation. And I guess we use previous experiences as a frame of reference, whether we are conscious of it or not. The same goes for social contexts. I think I face my own issues when meeting other people, and I think we all interpret the situation based on our own fears, in a way. (12, p. 206, line 11-15)

Participant 12's statement highlights how the ambiguity and affect present in silence-phenomena often is interpreted through the lens of one's previous experiences, which can create room for misunderstandings in the communication between the client and the therapist. Silences with someone you are not close to were described by most participants as uncomfortable, and as frequently activating intense self-examination, primarily of negative valence (e.g. not being interesting or competent enough). Several participants experienced this kind of self-scrutiny during silence-phenomena in psychotherapy, and believed the client felt the same way. Some were anxious that not having anything to say to the client during silences could be interpreted as a sign of them not being competent therapists. Some described feeling a strong impulse to prove that they were theoretically and technically competent as psychotherapists (e.g. by breaking the silences to write a case formulation on a blackboard), or rushing to speak ("galloping" away from the silences, as one participant put it). Several participants worried that the client may feel abandoned due to them being in a subordinate position compared to the therapist and this could create an impulse to break silences. Many participants also reported feeling responsible for how clients experience silence-phenomena in therapy. However, they said that increased experience - as a therapist generally and with regard to silence-phenomena specifically - helped reduce anxieties. Having a theoretical basis for using silence-phenomena also helped alleviate anxieties.

Participant 13 (p. 223, line 27 - p. 224, line 2) remarked that ambivalence could cause the therapist to mix up their own emotions and impulses with those of the client: "I think it's very common (...) that we kind of confuse our own need to not face unpleasant feelings in others, or strong feelings in others, with their urge to not face them." This highlights the tension and ambivalence that can arise during silence-phenomena, and the subsequent uncertainty of who (client/therapist) and what (tensions in the relationship, personal issues of the client/therapist, etc.) the impulses and emotions that arise belong to. In the face of such ambiguity, ambivalence and tension, several participants believed self-regulation was important in order for the silence to be constructive. By being well-regulated, many participants believed they were better equipped to not infuse their own affects and impulses into the silence-phenomena. Instead, they were able to meet and respond appropriately to the client's affect and impulses. Many participants claimed clients will notice if the therapist feels uncomfortable during silent events.

> You have to self-regulate. It's exactly the same, your only responsibility is to be well-regulated. If you feel safe in the silence, the patient will notice. If you're struggling [with the silence], it will be painful. Put on your own mask first, before assisting others. (5, p. 99, line 26-28)

Some participants implied that the ability to endure silence-phenomena is synonymous with the ability to endure affect.

Silence-phenomena and the Therapeutic Relationship

Most participants described experiences and interpretations of silence-phenomena as dependent on the therapeutic relationship. Our data indicate that the quality of the therapeutic relationship can affect how silence-phenomena in therapy are perceived, and silence-phenomena can likewise affect the therapeutic relationship. Participant 9 reflected on how silence-phenomena may impact the therapeutic relationship in diverse ways:

> It can go both ways. It is also very dependent on the situation. Because if the way I handle the silence actually increases reflections that are useful for the clients, it will be good for the therapeutic relationship. But in cases where it doesn't, it can sort of reduce- impact the relationship negatively. (9, p. 159, line 4-8)

As described in greater detail in the second theme, many participants viewed silence-phenomena as being potentially threatening, as they may give rise to unpleasant affect and negative self-evaluation. Most participants believed that a good relationship may counteract this, because there is less likelihood of interpreting silence-phenomena in a way that reflects negatively on the individual(s) or the relationship. This is due to there being a fundamental presence of safety and trust in the relationship. Many participants described the importance of feelings of trust and safety in the therapeutic relationship, and how silence-phenomena could either increase or decrease these feelings. For instance, participant 2 reflected on how silence-phenomena could lead her/him either to become closer to or more distant from the client:

> The thing is, you have to make sure they don't feel alone. By being silent *together*, and not separately. So if you are in it together, it will be an intimate experience. A beautiful experience. But if you've said something that doesn't resonate with the client [prior to the silence], you grow further apart. (2, p. 39, line 16-19)

Most participants perceived silence-phenomena as qualitatively different when a good therapeutic relationship is present - rather than being a potential threat, silence-phenomena in a secure therapeutic relationship may instead be understood as a confirmation of the strong bond between the therapist and the client:

> My hope and goal is that silence in therapy is experienced in the same way silence is experienced in a close relationship, so that it is perceived as safe and natural. So I believe that silence is a sign of quality in the therapeutic relationship or in the therapeutic setting. (5, p. 95, line 2-5)

It is noteworthy that participant 5 aims for silence-phenomena in the context of a therapeutic relationship to be experienced as similar to in a close relationship. Most participants described silence-phenomena with people who they are in a close relationship with as comfortable, and as less filled with ambiguity, ambivalence and self-scrutiny as compared to experiences of silence-phenomena with strangers.

Meeting Without Words

Many participants described moments where they felt as though they met the client during silence-phenomena in psychotherapy. Several participants said that words would have been interfering in these moments. They also expressed having difficulties describing exactly what happened with words. For example, participant 3 (p. 59, line 32 - p. 60, line 1) said: "There were emotions there, but I didn't have a very good grasp of what they were about. But I felt something. But what, exactly? I don't know." In general, such moments were characterised by feeling genuine, as well as the therapist experiencing a feeling of mutual understanding with the client. Furthermore, the therapists were filled with positive emotions both toward the client (e.g. warmth) and toward the therapeutic process itself (e.g. excitement, eagerness to work). Some noted how it was easier to feel and show empathy in such moments (by using e.g. physical gestures, facial expressions, eye contact, a tear in the corner of the eye and positioning of the body), as they experienced a sense of being on the same page, having a common understanding and feeling connected to and present with the client. Some participants emphasised that these moments of silence often occur intuitively: "On my part, I probably don't consciously use silence in therapy. It's a spontaneous reaction when I experience that we have met one another in a way." (12 p. 209, line 16-18). Several participants emphasised that it was difficult to describe what exactly happened prior to these moments, but a few mentioned that they experienced the client as having some sort of

revelation with regard to something the therapist had said, or that they perceived that the client understood that the therapist was there to help.

Participant 14 described how being with the client during silence-phenomena can be a way to affirm the client and their experiences:

> And also recognising and acknowledging the silence, because if she just sat alone thinking about it, no one would be there to affirm what she felt. But she could also see what was happening in me - and even though we were both silent, I could in a way mirror her experience so that she- I reflected her reality, which she had felt, but never put into words. And no one else had ever affirmed it. (14, p. 242, line 13-17)

Such moments can enable therapists to affirm the client nonverbally. Many participants described that being together in the silence can have a value in itself, as it allows the client to feel seen, to feel and explore the emotions that arise in the silence, and to integrate the relational experience of being with the therapist. Several participants described how the therapeutic relationship was strengthened after such moments of meeting without words, and noted that these moments may also have therapeutic value (through e.g. strengthening the therapeutic relationship, providing room for integrating insights and processing affective experiences).

Discussion

Our project yielded rich data highlighting the complexity of silence-phenomena and the therapeutic relationship in the context of psychotherapy. The participants described using silence-phenomena as an intuitive tool in order to serve a variety of functions in a therapeutic process. Silence-phenomena were found to amplify ambiguity, ambivalence and affect. The interpretations and meanings ascribed to silence-phenomena were found to be highly dependent on the therapeutic relationship and to have the potential to induce and encompass moments of meeting. The focus of this discussion is directed toward how both internal cues

(perceptions of own contributions to the meanings ascribed to silence-phenomena, conflicting and evolving I-positions), and contextual cues (the quality of the therapeutic relationship and speech prior to or after the occurrence of silence-phenomena) affect psychotherapists' perceptions of silence-phenomena. How silence-phenomena create room for affective processes and can induce and encompass meetings at relational depth will also be discussed. Finally, implications and limitations are presented.

The participants were aware that their own experiences, affect, expectations and theoretical reasoning influenced how they perceived silence-phenomena in the context of psychotherapy. According to DST, therapists will bring their own multiplicities of alternating and sometimes conflicting I-positions into the therapeutic context (Hermans, 2014). These I-positions will influence the meanings therapists make of silence-phenomena in various ways. For example, several participants noted that silence-phenomena could be uncomfortable, which could induce an impulse to avoid them (which can be one I-position). At the same time, they believed that silence-phenomena could be beneficial and wanted to maintain them (which can be a contrasting I-position). Some of the participants' I-positions seemed to have a tendency of evolving concurrently with gaining clinical experience and with gaining knowledge of the potential functions of silence-phenomena in therapy (similar to the findings of Ladany et al., 2004).

One of the I-positions mentioned by the participants was one of being an authority in the therapeutic context. This involved an experience of being perceived by their clients as powerful and knowledgeable due to their title. If considering Bruneau & Ishii's (1988) notion of silencing, in a therapist-client relationship the burden of speech is likely to fall as the burden of the client. In certain circumstances some of the participants believed this burden could be beneficial, as it has the potential to induce a sense of responsibility in the client. At the same time, many participants were focused on the client not experiencing silence-

phenomena as a burden. In cases where the therapists perceived their client to feel excessively uncomfortable during silent events, they reported feeling responsible for the situation. Most participants reported a concern that the client would feel left alone in the silences, and that this concern frequently induced impulses in the therapists to break the silences.

Given that meaning is a social construction (Wertsch, 1991), both the therapist and the client will bring in their own dynamic I-positions and create meaning partly based on their existing I-positions and partly based on how they perceive the other to experience silence-phenomena (Hermans, 2012). Most participants believed that their clients would be affected by how the therapists themselves perceive and relate to silence-phenomena. According to research by Schore (2014), nonverbal right brain interactions communicate bodily-based affective relational information about the inner world of both client and therapist. When the participants in our study experience silence-phenomena as uncomfortable, they believe that their clients are likely to notice on some level (conscious or unconscious). In a relational matrix like the therapist-client dyad, both partners simultaneously adjust their accelerating/decelerating arousal in response to the signals of the other (Schore, 2014). This highlights the importance of therapists being aware of their own discomforts and uncertainties regarding silence-phenomena in therapy.

Our findings show that not only internal cues, but external contextual cues are important when making sense of silence-phenomena. The participants' interpretations and perceptions of silence-phenomena seemed highly dependent on the quality of the therapeutic relationship. Similar to findings by Ladany et al. (2004), if the participants perceived the therapeutic relationship to be difficult or not secure, silence-phenomena were perceived as a detriment to the therapeutic process and were described as having the potential to weaken the therapeutic relationship and/or -process further. When many of the participants in our study considered the therapeutic relationship to be secure, they reported that they were more likely

to perceive silence-phenomena as having the potential to facilitate the therapeutic process. This finding supports previous research that found that therapists believe having a sound therapeutic alliance is a requirement for using silence-phenomena effectively in psychotherapy (Ladany et al., 2004).

The participants in our study described a hope that silence-phenomena could be experienced the same way in a therapeutic relationship as in a close private relationship. This aspiration makes sense, as Koudenburg et al. (2014) found that once solid bonds are created, people are less likely to believe that words are needed in order to understand each other. The participants in that study described it as a sense of shared reality, where smooth communication is not necessary to experience shared cognition and social validation (Koudenburg et al., 2014). Similarly, the participants in our study reported that when they perceive a relationship as close, silence-phenomena are experienced as less threatening and instead as having the potential to strengthen the relationship further due to a perceived mutual understanding of the security of the relationship. Furthermore, a strong therapeutic relationship was perceived by the participants as contributing to processes relevant in leading to change (e.g. integration of insights and the relationship, conveying of empathy, affective processing, exploration, reflection etc.). Considering the importance of the therapeutic relationship for psychotherapy outcome (Horvath & Symonds, 1991; Krupnick et al., 1996; Lambert & Barley, 2001; Norcross & Lambert, 2011; Price & Jones, 1998), it is noteworthy that silence-phenomena in the context of a good (secure) relationship are perceived by the participants as contributing to processes which are relevant to the outcome of therapy (e.g. expression of empathy (Elliott et al., 2018) and affective processing (Diener et al., 2007; Watson & Bedard, 2006)).

Another contextual aspect that shapes how silence-phenomena are perceived and interpreted by the participants is silence-phenomena's interdependence with language. This

interdependence is fundamental, as dialogue requires both language and silence, and silence-phenomena gain their qualities through interdependence with speech (Bruneau, 1973; Kurzon, 1998; Lehmann, 2018, p. 103). Research indicates that labelling emotions verbally can aid in emotion regulation (Lieberman, 2011; Matejka et al., 2013) which suggests that language has the potential to shape experiences. Likewise, the meanings and experiences of silence-phenomena can be shaped through the interdependence with speech. Framing silence-phenomena through speech (by talking about silence-phenomena in therapy) seemed to be a way the participants attempted to affect their own and their clients' interpretations of the meanings of silent events.

Lehmann (2018) highlights that language and linguistic systems alone are not sufficient when it comes to embracing the affective qualities of experience (p. 197). In line with this, the participants in our study described silence-phenomena serving as a room for affective processes in both the client and therapist. Considering the fact that silence-phenomena can be a source of uncertainty, tension and anxiety (Lehmann et al., 2019), a therapist might experience uncertainty associated with the plausible consequences of different decisions (Lehmann, 2018, p. 35). Furthermore, silence-phenomena may trigger anxiety concerning whether or not the therapist is competent (Hill et al., 2018; Sharpley & Harris, 1995). Most participants believed the reason silence-phenomena can be perceived as uncomfortable is because the focus can shift inwards and therefore one can become uncertain of oneself and the relationship in question (in line with Koudenburg et al., 2013). Several participants described feeling an urge to escape silence-phenomena in therapy, as these could induce too much tension and uncertainty regarding e.g. their competence as therapists and whether the client was feeling uncomfortable or not. At the same time, several participants highlighted the importance of enduring the tensions of silence-phenomena, because the

emotional content that can be induced in the client can be of high importance to the therapeutic process and/or outcome in itself.

Given that affective processing has been found to be associated with better therapy outcomes (Diener et al., 2007; Watson & Bedard, 2006), the tensions and rise in affect associated with silence-phenomena can potentially be beneficial to the therapeutic process and outcome, as they create opportunities for emotional processing. When several of the therapists in this study experienced unpleasant affective content during a silent event in therapy, they believed that self-regulation was a necessity in order for them not to charge the silence with their own unpleasant affective content. In this way, the therapist's ability to self-regulate unpleasant affective content was viewed as an important aspect of silence-phenomena having the potential to serve a facilitatory function in the therapeutic process. Conversely, they believed that the client processing *both* unpleasant and pleasant emotions could serve facilitatory functions to the outcome of therapy.

Our findings were in line with research demonstrating silence-phenomena as being a way for both therapist and client to share emotions (Lane et al., 2002), but extrapolates on this finding by highlighting the perceived importance of not charging silence-phenomena with the therapist's own unpleasant emotions. In a therapeutic setting, the different experiences of a therapist and a client in meetings at relational depth reflect this; in such moments, a therapist is more likely to experience pleasant emotions such as empathy and acceptance towards their client while clients more often experience feelings that could be both pleasant and unpleasant, such as self-enquiry and vulnerability (Cooper, 2013, p. 71).

Our data show that silence-phenomena can serve as an avenue to express factors associated with the occurrence of relational depth from the position of the therapist, namely empathy, realness and affirmation (Mearns & Cooper, 2005, p. 38-43). An affective process, e.g. the expression of empathy by the therapist, could in turn promote the occurrence of

relational depth (Mearns & Cooper, 2005, p. 39-43; Lehmann, 2018, p. 195). In our study, the participants described that they used silence-phenomena as a way to convey empathy. Several participants believed being silent together in itself was a way of showing empathy and affirmation, as it acknowledged that the client's emotions are valid and not something to run away from, and that the client is not alone with their emotions. Even though therapists use silence-phenomena with the intent to convey empathy, clients may experience it differently (e.g. as unempathetic, as found by Matarazzo & Wiens, 1977). However, most participants used silence-phenomena intuitively and not in an instrumental or pre-planned manner, but where they felt it was appropriate, natural or important. This could support the potential of therapists being real and therefore the occurrence of relational depth (Mearns & Cooper, 2005, p. 38-39).

Several participants stated that silence-phenomena frequently occurred when they felt as if they had met their clients. When the participants identified moments characterized by silence-phenomena and a sense of meeting the other, they found it hard to describe their experience with words. This supports findings by Knox (2013, p. 23), who found that most participants in her study had difficulties describing moments of relational depth in a way that would reflect their actual experience. This could imply that encounters at relational depth often transcend mere linguistic exchange and are something that have the potential to occur during silence-phenomena. Silence-phenomena in a therapeutic context can have the ability to host numerous affective processes and experiences (e.g. the expression of empathy), and these experiences have the potential to promote relational depth (Lehmann, 2018, p. 209). Through the affect, ambiguity and ambivalence associated with silence-phenomena being interpreted as an opportunity rather than a threat, silence-phenomena can promote moments of meeting at relational depth in therapy (Lehmann, 2018, p. 195; Mearns & Cooper, 2005). Based on our findings, we argue that this is more likely to happen when the therapeutic relationship is

characterised by a sense of security prior to the silent event and/or if the therapist practices self-regulation and is able to not charge silence-phenomena with their own unpleasant affect.

Implications

An implication of the findings in this study is that it might be beneficial for psychotherapists to work on their own relationship with silence-phenomena in order to not charge silent events in psychotherapy with their own uncertainties and unpleasant affects. Our research thus highlights the importance of therapists' self-regulation in a therapeutic process. We hope to contribute to an increased awareness of the potential beneficial functions silence-phenomena can have for a therapeutic relationship and process provided that the therapeutic relationship is secure. Conversely, if the relationship is not secure, therapists should be cautious of the potential detrimental effects silence-phenomena can have on the therapeutic relationship and consequently the therapeutic process.

When considering the fact that most participants felt less comfortable with silence-phenomena in the beginning of their careers as therapists, more focus on silence-phenomena during formal psychotherapy education could be beneficial. Expanding the knowledge regarding different functions silence-phenomena may have in a therapeutic process could potentially increase the effectiveness of therapy. These functions can include processing/conveying affect, inducing exploration/reflection, integrating relational experiences and insights and the occurrence of relational depth. If therapists are more comfortable with silence-phenomena, they may create more room for silence-phenomena to unfold. Furthermore, psychoeducation and dialogue with clients about silence-phenomena and their functions may be useful. Validation and normalisation of silence-phenomena as having the potential to be beneficial could contribute to reducing ambivalence, ambiguity and anxiety in both therapist and client.

Limitations

Several methodological considerations are relevant to this study. With regard to the collection of data, the authors had limited experience conducting semi-structured interviews in a research setting as well as analysing research data. Differences in tone, phrasing and follow-up questions may have affected the answers we received. Furthermore, the possibility that participants may have interpreted the questions differently has to be taken into account. We obtained the study participants by presenting the project through the lens of silence-phenomena, which may potentially have influenced their answers when talking about the therapeutic relationship more generally, as they could have been primed on silence-phenomena as a topic. This was noted by one participant, who gave us feedback that s/he had the topic of silence-phenomena in the back of her/his head when replying to the first half of the interview. The participants had not seen or heard the questions prior to the interviews. Not having the opportunity to prepare their answers may have added a layer of honesty to their replies, but could also have led to losing more detailed, thought out descriptions. Several participants were seemingly engaging in the process of meaning-making during the interviews. This could reflect that participants do not necessarily think about silence-phenomena in therapy on a regular basis.

It is possible that the participants' descriptions have been overextended based on our own theoretical biases. Due to the thematic analysis being latent, rather than semantic, our own ideas and interests may have affected our focus during the analysis of the transcripts. Attempts at counteracting these biases included repeatedly going back and forth between codes, themes and data extracts, and engaging in discussions on how to interpret the data as faithfully as possible to the replies given by the participants.

Conclusion

This study examined therapists' perceptions of and experiences with silence-phenomena in relation to the therapeutic relationship. The interpretations and meanings ascribed to silence-phenomena by psychotherapists were found to be highly dependent on both internal (e.g. the therapist's expectations and experiences with silence-phenomena) and contextual factors (e.g. the therapeutic relationship). The therapeutic relationship was found to contribute greatly to the participants' interpretation of silence-phenomena. In cases where the therapeutic relationship was perceived to be strong, the therapists interpreted silence-phenomena as having greater potential to be facilitatory to the therapeutic process and outcome (e.g. through affective processing and/or expression of empathy). Conversely, if the therapeutic relationship was perceived as weak, silence-phenomena were believed to potentially have detrimental effects. Silence-phenomena have the ability to host numerous affective processes and experiences (e.g. the expression of empathy), and these experiences have the potential to promote moments of meeting at relational depth. A secure therapeutic relationship can lay the foundation for interpreting the ambiguity, affect and ambivalence associated with silence-phenomena in a way that promotes moments of meeting at relational depth. In sum, the study findings indicate that therapists should seek to be aware of their own contributions to silence-phenomena. If a therapist is well-regulated and has a resolved relationship with silence-phenomena, silence-phenomena can serve a productive function for the therapeutic process. Special attention should be paid to the therapeutic relationship when facing or seeking to use silence-phenomena in psychotherapy.

The findings of this study can contribute to psychology by examining how silence-phenomena, which are relatively under-examined in research despite happening in practically every single therapy, may interact with, affect and be affected by the therapeutic relationship. The hope is to inspire further research on this topic, as it has the potential to give insights into

how therapists can better navigate the complex relationship between silence-phenomena and the therapeutic relationship in their clinical practices. The focus of this study was how therapists perceived and experienced silence-phenomena in therapy. Some attention was given to how they believed the clients to perceive and experience silence-phenomena. However, their perceptions may be inadequate in capturing the clients' actual perceptions and experiences. Further research examining the perceptions of both therapists and clients in therapist-client dyads could be particularly interesting, as it would illuminate where therapists and clients converge and diverge in their perceptions of silence-phenomena in relation to the therapeutic relationship.

References

Back, A. L., Bauer-Wu, S. M., Rushton, C. H., & Halifax, J. (2009). Compassionate silence in the patient–clinician encounter: a contemplative approach. *Journal of palliative medicine*, *12*(12), 1113-1117. https://doi.org/10.1089/jpm.2009.0175

Baier, A. L., Kline, A. C., & Feeny, N. C. (2020). Therapeutic alliance as a mediator of change: A systematic review and evaluation of research. *Clinical Psychology Review*, *82*, 1-14. https://doi.org/10.1016/j.cpr.2020.101921

Barber, T. (2009). *Newly qualified counsellors' experience of silence within the therapeutic setting.* [Unpublished master's thesis, Roehampton University]. Academia. https://www.academia.edu/362080/Silence_in_Psychotherapy_Newly_qualified_counsellors_experience_of_silence_within_the_therapeutic_setting

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Brown, C., Deacon, A., Kerr, J., Ralph, K. (2013). Meeting at relational depth in therapy: the lived encounter. In R. Knox, D. Murphy, S. Wiggins & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (p. 13-20). Palgrave Macmillan. https://doi.org/10.1007/978-1-137-29831-7_2

Bruneau, T. J. (1973). Communicative Silences: Forms and Functions. *The Journal of Communication, 23(1),* 17-46. https://doi.org/10.1111/j.1460-2466.1973.tb00929.x

Bruneau, T. J., & Ishii, S. (1988). Communicative silence: East and West. *World Communication*, *17*(1), 1-33. https://doi.org/10.4324/9781315080918-23

Cook, J. J. (1964). Silence in psychotherapy. *Journal of Counseling Psychology, 11*(1), 42-46. https://doi.org/10.1037/h004917

Cooper, M. (2013). Experiencing relational depth in therapy: what we know so far. In R.

Knox, D. Murphy, S. Wiggins & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (p. 62-76). Palgrave Macmillan.

Daniel, S. I., Folke, S., Lunn, S., Gondan, M., & Poulsen, S. (2018). Mind the gap: In-session silences are associated with client attachment insecurity, therapeutic alliance, and treatment outcome. *Psychotherapy Research*, *28*(2), 203-216. https://doi.org/10.1080/10503307.2016.1177673

Davis, H. S. (1977). An empirical study of the meanings of silence occurring early in psychotherapy. *Dissertation Abstracts International*, *38*(3-B), 1396-1397.

Diener, M. J., Hilsenroth, M. J., & Weinberger, J. (2007). Therapist affect focus and patient outcomes in psychodynamic psychotherapy: A meta-analysis. A*merican Journal of Psychiatry*, *164*(6), 936-941. https://doi.org/10.1176/ajp.2007.164.6.936

Elliott, R., Bohart, A. C., Watson, J. C., & Murphy, D. (2018). Therapist empathy and client outcome: An updated meta-analysis. *Psychotherapy*, *55*(4), 399-410. https://doi.org/10.1037/pst0000175

Ferenczi, S. (1928). The elasticity of psycho-analytic technique. In M., Balint (Ed.), *Final contributions to the problems and methods of psycho-analysis* (p. 87-101). Basic Books.

Frankel, Z. E., Levitt, H. M., Murray, D. M., Greenberg, L. S., & Angus, L. (2006). Assessing silent processes in psychotherapy: An empirically derived categorization system and sampling strategy. *Psychotherapy Research*, *16*(5), 627-638. https://doi.org/10.1080/10503300600591635

Geller, S. M., & Greenberg, L. S. (2002). Therapeutic presence: Therapists' experience of presence in the psychotherapy encounter. *Person-Centered and Experiential Psychotherapies*, *1*(1-2), 71-86. https://doi.org/10.1080/14779757.2002.9688279

Hermans, H. J. M. (2001). The Dialogical Self: Toward a Theory of Personal and Cultural

Positioning. *Culture Psychology*, *7*(3), 243-281. https://doi.org/10.1177/1354067X0173001

Hermans, H. J. M. (2012). Dialogical Self Theory and the increasing multiplicity of I-positions in a globalizing society: An introduction. *New directions for child and adolescent development*, *2012*(137), 1-21. https://doi.org/10.1002/cad.20014

Hermans, H. J. (2014). Self as a society of I-positions: A dialogical approach to counseling. *The Journal of Humanistic Counseling*, *53*(2), 134-159. https://doi.org/10.1002/j.2161-1939.2014.00054.x

Hill, C. E., Kline, K. V., O'Connor, S., Morales, K., Li, X., Kivlighan Jr, D. M., & Hillman, J. (2018). Silence is golden: A mixed methods investigation of silence in one case of psychodynamic psychotherapy. *Psychotherapy*, *56*(4), 577-587. https://doi.org/10.1037/pst0000196

Hill, C. E., Thompson, B. J., & Ladany, N. (2003). Therapist use of silence in therapy: A survey. *Journal of clinical psychology*, *59*(4), 513-524. https://doi.org/10.1002/jclp.10155

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*(2), 139-149. https://doi.org/10.1037/0022-0167.38.2.139

Jackson, M. (2004). The prose of suffering and the practice of silence. *Spiritus: A Journal of Christian Spirituality* *4*(1), 44-59. https://doi.org/10.1353/scs.2004.0011

Knox, R. (2008). Clients' experiences of relational depth in person-centred counselling. *Counselling and Psychotherapy Research*, *8*(3), 182-188. https://doi.org/10.1080/14733140802035005

Knox, S., Wiggins, S., Murphy, D., Cooper, M. (2013). Introduction: the in-depth therapeutic

encounter. In R. Knox, D. Murphy, S. Wiggins & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (p. 1-10). Palgrave Macmillan.

Knutson, H. V., & Kristiansen, A. (2015). Varieties of silence: Understanding different forms and functions of silence in a psychotherapeutic setting. *Contemporary Psychoanalysis, 51*(1), 1-30. https://doi.org/10.1080/00107530.2015.954218

Koudenburg, N., Gordijn, E. H., & Postmes, T. (2014). "More Than Words": Social Validation in Close Relationships. *Personality and Social Psychology Bulletin*, *40*(11), 1517-1528. https://doi.org/10.1177/0146167214549945

Koudenburg, N., Postmes, T., & Gordijn, E. H. (2013). Resounding Silences: Subtle Norm Regulation in Everyday Interactions. *Social Psychology Quarterly*, *76*(3), 224-241. https://doi.org/10.1177/0190272513496794

Kridon, C.A. (2009). Toward an ethnography of silence: The lived presence of the past in the everyday life of holocaust trauma survivors and their descendants in Israel. *Current Anthropology*, *50*(1), 5-27. https://doi.org/10.1086/595623

Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., & Pilkonis, P. A. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 64*(3), 532-539. https://doi.org/10.1037/0022-006X.64.3.532

Kurzon, D. (1998). *Discourse of silence*. John Benjamins.

Kurzon, D. (2009). Thematic silence as metaphor. In K. Turner and B. Fraser (Eds.), *Language in Life, and a Life in Language: Jacob Mey – A Festschrift* (p. 255-263). Emerald Group Publishing.

Ladany, N., Hill, C. E., Thompson, B. J., & O'Brien, K. M. (2004). Therapist perspectives on

using silence in therapy: A qualitative study. *Counselling and Psychotherapy Research*, *4*(1), 80-89. https://doi.org/10.1080/14733140412331384088

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 357-361. https://doi.org/10.1037/0033-3204.38.4.357

Lane, R. C., Koetting, M. G., & Bishop, J. (2002). Silence as communication in psychodynamic psychotherapy. *Clinical psychology review*, *22*(7), 1091-1104. https://doi.org/10.1016/S0272-7358(02)00144-7

Lehmann, O. V. (2014). Towards dialogues with and within silence in psychotherapy processes: Why the person of the therapist and the client matters? *Culture & Psychology*, *20*(4), 537-546. https://doi.org/10.1177/1354067X14551298

Lehmann, O.V. (2015). Something Blossoms in Between: Silence-Phenomena as a Bordering Notions in Psychology. *Integrative Psychological and Behavioral Science*, *50*(1), 1-13. https://doi.org/10.1007/s12124-015-9321-7

Lehmann, O. V. (2018). *The cultural psychology of silence: Treasuring the poetics of affect at the core of human existence* [Unpublished doctoral dissertation, Norwegian University of Science and Technology]. NTNU Open. https://ntnuopen.ntnu.no/ntnu-xmlui/handle/11250/2484902

Lehmann, O. V., Kardum, G., & Klempe, S. H. (2019). The search for inner silence as a source for eudemonia. *British Journal of Guidance & Counselling*, *47*(2), 180-189. https://doi.org/10.1080/03069885.2018.1553295

Lehmann, O. V., & Valsiner, J. (2017). Deep feelings in actions: Where cultural psychology matters. In O. V. Lehmann, & J. Valsiner (Eds.) *Deep Experiencing: Dialogues Within the Self* (p. 93-103). Springer, Cham.

Levitt, H. M. (2001a). Clients' experiences of obstructive silence: Integrating conscious

reports and analytic theories. *Journal of Contemporary Psychotherapy*, *31*(4), 221-244. https://doi.org/10.1023/A:1015307311143

Levitt, H. M. (2001b). Sounds of silence in psychotherapy: The categorization of clients' pauses. *Psychotherapy Research*, *11*(3), 295-309. https://doi.org/10.1080/16506079509455978

Lieberman, M. (2011). Why symbolic processing of affect can disrupt negative affect: social cognitive and affective neuroscience investigations. In A. Todorov, S. Fiske & D. Prentice (Eds.), *Social Neuroscience: Toward Understanding the Underpinnings of the Social Mind* (pp. 188–209). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195316872.003.0013

MacDonald, F. F. (2005). Why do we talk so much? The art of silence in psychotherapy. *Annals of the American Psychotherapy Association*, *8*(2), 43-44.

Matarazzo, J. D., & Wiens, A. N. (1977). Speech behavior as an objective correlate of empathy and outcome in interview and psychotherapy research: A review with implications for behavior modification. *Behavior modification*, *1*(4), 453-480. https://doi.org/10.1177/014544557714002

Matejka, M. M., Kazzer, P., Seehausen, M., Bajbouj, M., Klann-Delius, G., Menninghaus, W. Jacobs, A.M., Heekeren, H. R. & Prehn, K. (2013). Talking about emotion: prosody and skin conductance indicate emotion regulation. *Frontiers in Psychology*, *4*, 1-11. https://doi.org/10.3389/fpsyg.2013.00260

Mearns, D. (1996). Contact at relational depth. *Counselling*, *7*, 306-311.

Mearns, D. & Cooper, M. (2005). *Working at relational depth in counselling and psychotherapy.* Sage.

Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy*, *48*(1), 4-8. https://doi.org/10.1037/a0022180

O'Keeffe, S., Martin, P., Target, M., & Midgley, N. (2019). 'I Just Stopped Going': a mixed methods investigation into types of therapy dropout in adolescents with depression. *Frontiers in psychology*, *10*(75), 1-14. https://doi.org/10.3389/fpsyg.2019.00075

Orlandi, E.P. (1995). *As formas do silêncio: no movimento dos sentidos* (6th ed.). Campinas: Unicamp. https://doi.org/10.7476/9788526814707

Price, P. B., & Jones, E. E. (1998). Examining the alliance using the Psychotherapy Process Q-Set. *Psychotherapy: Theory, Research, Practice, Training*, *35*(3), 392-404. https://doi.org/10.1037/h0087654

Price, S. (2012). *Development and testing of a measure of relational depth in counselling and psychotherapy* [Unpublished doctoral dissertation, University of Strathclyde]. EThOS. https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.576407&fbclid=IwAR3oGRj0d4g5mfRPeq0nMb5VzF1wCyZysEmyebcRUtrhRSEEENn9zPOAaZQ

Puchalska-Wasyl, M. (2010). Dialogue, monologue, and change of perspective - three forms of dialogicality. *International Journal for Dialogical Science*, *4*(1), 67-79.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*(2), 95-103. https://doi.org/10.1037/h0045357

Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of science* (p. 184-256). McGraw-Hill.

Salgado, J. (2007). The feeling of a dialogical self: Affectivity, agency and otherness. In L. M. Simão & J. Valsiner (Eds.), *Otherness in question: Labyrinths of the self* (p. 53-72). Information Age Publishing.

Salvatore, S., Tebaldi, C., & Potì, S. (2009). The discursive dynamic of sensemaking. In S.

Salvatore, J. Valsiner, S. Strout, & J. Clegg (Eds.), *YIS : Yearbook of Idiographic Science* (p. 39-71). Firera & Liuzzo Publishing.

Salvatore, S., & Zittoun, T. (2011). Outlines of a psychoanalytically informed cultural psychology. In S. Salvatore & T. Zittoun (Eds.), *Cultural psychology and psychoanalysis: Pathways to synthesis* (p. 3-46). Information Age Publishing.

Schore, A. N. (2014). The right brain is dominant in psychotherapy. *Psychotherapy*, *51*(3), 388-397. https://doi.org/10.1037/a0037083

Sharpley, C. F., & Harris, M. A. (1995). Antecedents, consequents, and effects of silence during cognitive-behavioural therapy interviews. *Scandinavian Journal of Behaviour Therapy*, *24*(1), 3-13. https://doi.org/10.1080/16506079509455978

Sharpley, C. F., Munro, D. M., & Elly, M. J. (2005). Silence and rapport during initial interviews. *Counselling Psychology Quarterly*, *18*(2), 149-159. https://doi.org/10.1080/09515070500142189

Shirk, S. R. (1988). Introduction: A Cognitive-Developmental Perspective on Child Psychotherapy. In S. R. Shirk (Ed.), *Cognitive development and child psychotherapy* (p. 1-16). Springer Science+Business Media.

Stringer, J. V., Levitt, H. M., Berman, J. S., & Mathews, S. S. (2010). A study of silent disengagement and distressing emotion in psychotherapy. *Psychotherapy Research*, *20*(5), 495-510. https://doi.org/10.1080/10503301003754515

Valsiner, J. (2011). Talking and acting: Making change and doing development. *Narrative Inquiry NI*, *12*(1), 181-192. https://doi.org/10.1075/ni.12.1.25val

Watson, J. C., & Bedard, D. L. (2006). Clients' emotional processing in psychotherapy: A comparison between cognitive-behavioral and process-experiential therapies. *Journal of Consulting and Clinical Psychology*, *74*(1), 152-159. https://doi.org/10.1037/0022-006x.74.1.152

Wertsch, J. V. (1991). A sociocultural approach to socially shared cognition. In L. B. Resnick, J. M. Levine, & S. D. Teasley (Eds.), *Perspectives on socially shared cognition* (p. 85-100). American Psychological Association. https://doi.org/10.1037/10096-004

Zilcha-Mano, S. (2017). Is the alliance really therapeutic? Revisiting this question in light of recent methodological advances. *American Psychologist, 72*(4), 311-325. https://doi.org/10.1037/a0040435

Appendix A

Vil du delta i forskningsprosjektet «Psykologers Persepsjoner av Terapeutisk Stillhet»?

Stillhet i terapi kan ha ulike betydninger og funksjoner (Ladany, Hill, Thompson, & O´Brien, 2004). Kommunikasjon og interaksjon mellom terapeut og klient er viktig for å forstå de interne dynamikkene for relasjon i en terapeutisk setting. I dette forskningsprosjektet er formålet er å undersøke psykologers persepsjoner av stillhet i terapi. I tillegg vil vi undersøke psykologers opplevelse av *"relational depth"* i en terapeutisk setting. Vi ønsker å se på hvordan psykologer forholder seg til stillhet i behandlingen; hvorvidt og hvordan stillhet benyttes og hvilken plass stillhet har i behandling. Som klinisk psykolog har du den kompetansen studien trenger og vi inviterer deg herved til å delta. Dersom du takker ja til deltakelse vil dette innebære å møte til en intervjusamtale organisert rundt nevnte tema.

Intervjusamtalen vil vare rundt 45 minutter og det vil bli tatt lydopptak. Du vil få spørsmål om blant annet din opplevelse av stillhet, bruk av stillhet i terapi og din opplevelse av terapeutisk allianse. Det er frivillig å delta og du kan når som helst trekke samtykket tilbake. Da vil lydopptak bli slettet. Du har krav på å få innsyn i opplysninger innsamlet om deg og få disse slettet når som helst. All informasjon vil bli anonymisert og lydopptakene vil bli lagret på en passordbeskyttet ekstern harddisk som ikke er knyttet til internett. Alle lydopptak vil bli slettet ved levering av hovedoppgaven. Transkribering vil bli gjennomført av Emilie K. Brandsæter og/eller Vårin Hauge. Transkripsjonene vil også bli lagret på en passordbeskyttet ekstern harddisk uten tilknytning til internett. Ingen personidentifiserende informasjon vil noteres her. Innhentet informasjon vil kun brukes til oppgitt formål. Opplysningene vil behandles til prosjektslutt som er 15.06.2021.

Denne studien er en del av hovedoppgaven til Emilie K. Brandsæter og Vårin Hauge ved psykologisk institutt, NTNU, som er behandlingsansvarlig institusjon.

Dine rettigheter

Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke personopplysninger som er registrert om deg,
- å få rettet personopplysninger om deg,
- få slettet personopplysninger om deg,
- få utlevert en kopi av dine personopplysninger (dataportabilitet), og
- å sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?

Vi behandler opplysninger om deg basert på ditt samtykke.

Hvor kan jeg finne ut mer?

Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med:

- Psykologisk institutt ved NTNU: Hroar Klempe, hroar.klempe@ntnu.no
- Emilie K. Brandsæter, 91585661, emiliebrandsaeter@hotmail.com
- Vårin Hauge, 47685680, varin.hauge@gmail.com
- Institutt for psykisk helse ved NTNU: Olga V. Lehmann, olga.lehmann@ntnu.no
- Vårt personvernombud: Thomas Helgesen 93079038 thomas.helgesen@ntnu.no
- NSD – Norsk senter for forskningsdata AS, på epost (personverntjenester@nsd.no) eller telefon: 55 58 21 17.

Med vennlig hilsen

Hroar Klempe	Olga V. Lehmann	Emilie K. Brandsæter & Vårin Hauge
Prosjektansvarlig	Prosjektansvarlig	Studenter
(Forsker/veileder)	(Forsker/klinisk psykolog/veileder)	

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet *Psykologers persepsjoner av terapeutisk stillhet?*, og har fått anledning til å stille spørsmål. Jeg samtykker til:

- ❑ å delta i intervju (med lydopptak)

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet i juni 2021

(Signert av prosjektdeltaker, dato)

Appendix B

Facebookpost

Forskningsprosjekt: Stillhetsfenomenet i terapi

Stillhet er et uunngåelig og tvetydig fenomen vi opplever daglig (kanskje spesielt i disse korona-tider). Stillhet i terapi er noe alle psykologer møter på i sin yrkesutøvelse, men er disse stillhetene bare et tomt mellomrom? Hva betyr de og hvordan utfolder de seg i en terapeutisk kontekst? Hvordan relaterer stillhet seg til den terapeutiske alliansen og forekomsten av relasjonell dybde i terapi? Dette ønsker vi å finne ut mer om. Kanskje du kan hjelpe oss?

Vi ønsker å komme i kontakt med ulike psykologer som arbeider klinisk. Psykologer og psykiatere/overleger fra ulike teoretiske retninger/spesialiseringer/arbeidsområder inviteres til å delta i vårt forskningsprosjekt. Denne hovedoppgaven er veiledet av Hroar Klempe (NTNU) og Olga V. Lehmann (IPR). Deltakelse i studien innebærer et hyggelig intervju (ca. 45 min) som vil foregå via Whereby (eventuelt andre løsninger, e.g. telefon/Skype for business) på et tidspunkt som passer deg.

Du kan nå oss på vrhauge@stud.ntnu.no eller emiliekb@stud.ntnu.no. Vi setter stor pris på om du har mulighet til å dele din kunnskap og erfaring med oss i disse spesielle tider. Vi håper på å høre fra deg!

Med vennlig hilsen,

Vårin Hauge & Emilie K. Brandsæter

Appendix C

Semi-structured interview guide

1. Introduksjon

Introduksjon til studiet

- Hvem er vi og hvorfor vi er interessert i temaet
- Formidle at vi er interessert i å lære av deltakerne, komplekst fenomen, vil vise kompleksiteten
- Sikre samtykke til lydopptak

Introduksjon av deltakernes bakgrunn

- Navn skal ikke oppgis
- Videreutdanning/erfaring
- Foretrukket tilnærming/terapeutisk retning
- Arbeidsoppgaver/type klienter deltakeren har jobbet med.
- Arbeidsoppgaver/type klienter deltakerne jobber/ikke jobber med (deltakerne skal ikke oppgi arbeidsplass) for tiden
- Informere om at vi kommer til å spørre om situasjoner som forekommer i terapi, men at det selvfølgelig er viktig at deltakeren ikke gir personidentifiserende opplysninger om klientene sine. Dette kan være ting som bakgrunn, kjønn, alder, diagnose og eventuelle spesielle hendelser. Det er først og fremst deltakeren sine erfaringer og opplevelser vi er interesserte i, og ikke klientenes.

2. Terapeutisk allianse

- Hva betyr terapeutisk allianse for deg?
- Hvis du tenker på en klient der du opplevde en spesielt god terapeutisk allianse, hva kjennetegnet denne interaksjonen? Gjerne utdyp, men vennligst ikke gi noe identifiserende informasjon om denne klienten.

→ Dette er interessant, kan du utdype nærmere?

→ Hvilke følelser ble vekket hos deg i denne timen? Hva følte du i etterkant av timen?

- Hvis du tenker på en klient der du opplevde vanskeligheter med den terapeutiske alliansen, hva kjennetegnet denne interaksjonen? Gjerne utdyp, men vennligst ikke gi noe identifiserende informasjon om denne klienten.

  → Dette er interessant, kan du utdype nærmere?

  → Hvilke følelser ble vekket hos deg i denne timen? Hva følte du i etterkant av timen?

- Nå vil jeg spørre om et spesielt signifikant øyeblikk eller hendelse som du har opplevd i en terapitime. Vennligst bruk et minutt på å tenke tilbake på din relasjon så langt med denne klienten. Vennligst velg et øyeblikk eller en hendelse som står frem i tankene dine som spesielt viktig. Vennligst beskriv dette signifikante øyeblikket eller hendelsen (Price, 2012).

  → *Dersom respondenten har vanskelig for å svare, kan man si; tenk på de to siste ukene.*

- Hva anser du som dine styrker i utviklingen av terapeutisk allianse med klienter?
- Hva har vært dine hovedutfordringer i utviklingen og opprettholdelsen av terapeutisk allianse med klienter?
- Har du hatt en opplevelse av gjensidig forståelse mellom deg og klienten i terapi? Utdyp gjerne. (Price, 2012).
- Hvordan viser du klienter at du er til stede i rommet?

  → Hvordan uttrykker du empati/medfølelse ovenfor klienter?

  → Hvordan uttrykker du omsorg og bekreftelse ovenfor klienter?

3. Stillhet

- Hvordan oppfatter du stillhet i samtale med bekjente?
    - (Altså noen du ikke kjenner så godt; en venn av en venn eller en kollega du ikke møter ofte)
- Mange mennesker frykter pinlig stillhet i samtale, hva tror du de er redde for?
- Hvordan tror du det faktum at du er norsk former ditt syn på stillhet i samtale?
- Hvilken rolle har stillhet for deg i nære relasjoner?
- Her vil jeg spørre om et øyeblikk eller hendelse der stillhet var til stede i en terapitime. Vennligst velg et øyeblikk eller en hendelse som står frem i tankene dine. Vennligst beskriv dette øyeblikket eller hendelsen. (Price, 2012)

    → Hvilke følelser var sentrale for deg? Hva tror du klienten følte?

    → Hvordan føler du at denne hendelsen påvirket den terapeutiske alliansen mellom dere?
- Hva er dine tanker rundt bevisst bruk av stillhet i terapi?
- Opplever du noen ganger vanskeligheter med å skape rom for og/eller opprettholde stillhet i terapi? Utdyp gjerne.

    → *Dersom respondent fokuserer på klient-egenskaper, still spørsmålet: Er det noe du legger merke til ved deg selv som kan gjøre det vanskelig?*
- Hvis du tenker på din erfaring som psykolog, når har du opplevd stillhet i terapi som hensiktsmessig eller nødvendig, og hvorfor? Gjerne utdyp.
- Når har du opplevd stillhet i terapi som uhensiktsmessig, og hvorfor? Gjerne utdyp.
- Hvilke tanker gjør du deg rundt forholdet mellom stillhet og terapeutisk allianse?
- Har du opplevd stillhet som ubehagelig i en terapeutisk setting? Har dette endret seg ettersom du har fått mer erfaring?
- Hva kan du gjøre for å føle deg mer komfortabel med stillhet?

- Hva kan du gjøre for at klienter skal føle seg mer komfortable med stillhet i terapirommet?

4. Avslutning

- Takke for svært nyttige refleksjoner og innsikter
- Er det noe vi ikke har spurt om, som du tror kan være nyttig for oss i dette forskningsprosjektet?
- Har du noen spørsmål til oss?
- Dersom vi trenger å kontakte deg ved et senere tidspunktet i forbindelse med dette prosjektet, er det i orden for deg?

Appendix D

Table 2.

Overarching themes and corresponding codes

Theme	Codes
Silence-phenomena as a therapeutic tool	Using silence-phenomena intuitively Interdependence with language Using silence based on contextual factors Silence as a way to convey empathy Silence as a way to facilitate exploration and reflection Silence as room for integration Silence as a way to induce affect Silence as a way to induce responsibility in the client
Silence-phenomena as amplifying ambiguity, ambivalence and affect	Silence and ambiguity Silence as room for affect Silence and ambivalence Silence and presence Uncertainty Self-regulation
Silence-phenomena and the therapeutic relationship	The influence of the therapeutic relationship on perceptions of silence The influence of silence on perceptions of the therapeutic relationship Silence and the therapeutic process and outcome
Meeting without words	Realness Affirmation Silence and presence Meeting without words Moments of meeting Empathy and silence

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