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MANIFESTATIONS OF SILENCES IN THERAPIST-PATIENT INTERACTION AND THE  
PSYCHOTHERAPEUTIC PROCESS

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*To my Parents and Diego, for loving and believing in me.*

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<b>SUMMARY</b>	

This research addresses the manifestations of silences in the therapist-patient interaction and along the psychotherapeutic process. It is intended to establish the participation of silences in several forms of interaction between patient and therapist and also throughout the sessions of a long-term therapy.

To achieve these objectives, a mixed methodology, consisting of two sequential studies. To achieve these goals, was created a Coding System of Silences for Therapists and Patients (PICS-TP), based on the adaptation of a coding system of silences for patients in psychotherapy, and created categories of silences for therapists.

A study of the reliability of the PICS-TP from the encoding of a long-term therapy psychodynamic counselling.

Results of descriptive and inferential statistical analysis are presented. Those results allow to set and describe characteristics of the participation of silences between patient and therapist and the psychotherapeutic process.

The central points of the discussion and conclusion indicate that it was not possible to determine strategies for the participation of the silences that were statistically significant, with good predictive and explanatory properties. However, it exposed the strengths and contributions possible PICS-TP, emphasizing its descriptive results of the types of silences in types of interactive scenarios and results

obtained by actor (therapist or patient), as well as their potential contribution to the training of therapists in training.

Key words: silences, interaction therapist patient, regulatory function.

## INTRODUCTION

The therapeutic process can be seen as a dialogic process, where the verbal and non-verbal aspects in the therapist-patient interaction are involved in the process of change (Martinez, Tomicic & Medina, 2014). In recent years, the non-verbal dimension has been researched and its relationship with change has been subject to further study, addressing aspects such as body expression (Lankin & Chatrand, 2003; Nagaoka & Komori, 2008; Ramseyer & Tschacher, 2011, 2014), facial expressions (Sharpley, Jeffrey & Macmah, 2006; Merten, 2005), qualitative aspects of the voice (Bady, 1985; Tomicic, Martinez, Chacón, Guzmán, & Reinoso, Tomicic, 2011; Martinez & Krause, 2014; Wiseman & Rice, 1989) and silences (Frankel & Levitt, 2009; Levitt, 2001, 2002; Nagaoka, Kuwabara, Yoshikawa, Watabe, Komori, Oyama & Hatanaka, 2013; Sharpley, Munro & Elly, 2010; Stringer, Levitt, Berman & Mathews, 2010; Xiao et al., 2014).

Despite being part of the human interactions and the narrative production (Levitt, 2002), there are not many empirical studies that address this topic. The more recent studies describe the silences as a complex phenomenon, emphasizing that it can only be conceived of by taking into account multiple factors from the context of its appearance. However, these investigations have focused on patient or therapist, have been carried out in English-speaking contexts, restricting the emergence of possible functions, meanings and/or interpretations of silences, in general terms and also in contexts where we relieve the contextual nature of silences. Similarly, it is unknown how silence can act as a space for meeting and opening up to the other party, as part of an intersubjective space (Tomicic, Martínez, Altimir, Bauer & Reinoso, 2009) in which silence is part of the dialog (Lehmann, 2014).

Seen from this perspective, and bearing in mind the fact that silences are a type of non-verbal communication, they can feasibly be conceived of as a phenomenon that contributes to the regulation of psychotherapeutic interaction (Tomicic, Pérez, Martinez & Rodriguez, 2017), in articulation with other communicative aspects, both verbal and non-verbal cues. Therefore, by considering silence as a phenomenon that forms part of human communication, addressing it will allow a description to be made



of its participation in therapeutic interaction, its role as a regulator of the therapeutic relationship, and also its possible forms of participation in the psychotherapeutic process.

The present investigation aims to establish the participation of silences in the interactive regulation between therapist and patient in different interactive scenarios, and throughout one psychotherapy. This will be done using a mixed descriptive and relational design, enabling a comprehensive approach to the phenomenon of silences in psychotherapy. The research will consist of two sequential studies, with the first being qualitative, and the second, quantitative.

The main contribution of this research will be to qualitatively describe silences from the perspective of therapists, patients, and outside observers; to contextualize different silences in a Spanish-speaking culture; to create a system for coding silences in psychotherapy, enabling a description of their appearance throughout, in different interactive scenarios; and to determine their regulatory role in therapist-patient interaction

This thesis is organized into chapters. The first is the theoretical framework where we review the theoretical and empirical background of relevant research associated to silences in psychotherapeutic and cultural contexts. Subsequently, presents the objectives and guidelines.

Subsequently review the methodological framework, summarizing the most important points about the purposes that addressed each of the sequential studies.

Then presented the Study 1, describing in detail the methodological framework - participants, technical data production, analysis plan and procedure - Main results and subsequently to discussion.

In the next section, presents the Study 2, explaining central points of the method and the discussion of the most relevant results of this study.

The last chapter is devoted to the main conclusions reached from each of the studies, explaining how they responded to each of the specific objectives, the strengths and limitations of this research and its possible contributions in other contexts of research in psychotherapy.

## **THEORETICAL AND EMPIRICAL FRAMEWORK**

## **What is the silence? From The Silence to silences**

The silence as a phenomenon, has historically been a difficult to define or delimit, because it does not have one only meaning nor is there only one word to refer to silence.

The word silence comes from the Latin noun *silentium* (Mateu, 2001). Latin has two verbs for this state: *sileo* and *taceo* (Mateu, 2001; Barthes, 2004). The first was used for inanimate objects, denoting calm and the absence of noise or movement (Mateu, 2001; Barthes, 2004), while the second referred to a verbal silence, a silence from speaking (Barthes, 2004). Corominas' etymological dictionary (1987) defines silence as the opposite of noise, and specifies that different words allude to different types of silence – *silentium*, *discretio*, *taciturnitas*, *taceo*, *concupiscitium*, *sedatio* – describing states of calm, lack of complaint or upset, the omission of a theme, nocturnal silence, etc.

The Real Academia Española Dictionary (2011) has six accepted meanings for the word Silence:

1. m. Abstaining from speaking.
2. m. Lack of noise.
3. m. Lack or omission of something in writing
4. m. Law. Inaction by an Administrative body toward a request or appeal, which is understood by the law to uphold or dismiss the said request.
5. m. Mil. A military curfew ordering silence from the troops at the end of the day.
6. m. Mus. A musical pause.

From these definitions, it can be seen that all of them support, tacitly, the idea that each one of the possible meanings of silence is going to depend directly from other contextual conditions, to refer to different states that are associated with the lack of noise, stillness, passivity, pause, etc.

More explicitly, the perspective of the sociopragmatic point of view, Jaworski (1993) defines silence as a necessarily interactional space, including it in a context of dialogue. Definitions by Kurzon (2007, 2009, and 2013) and Lovelady (2006) also reveal that silence has a particular nature in terms of context, taking on a specific meaning in each different situation. Similarly, Ramírez (1992) suggests that silence be interpreted in connection with a determined context, and acquires meaning as it is used in speech. Along these lines, Ramírez distinguishes between “Silence” 6 and “silences”: while the

second reflects the aforementioned ambiguity and need for context, the first can be termed reified silence, with an unambiguous meaning regardless of context.

Similarly, Gallardo (1993) distinguishes between “silence”, “a silence” and “a pause”. The first refers to reified silence. The second refers to interactive silence, where there is a lack of sound between interacting people. The third is a silence, but within a single turn of speaking, where a person remains quiet for a moment, but after which he or she continues his or her discourse.

### **The silence as a socio-cultural phenomenon**

In a manner consistent with the contextual view of silence that is explicitly posed from the sociopragmatic perspective, the sociocultural vision appears. From here, the silence is conceived as a sociocultural behavior, and as such, is created according to the context in which it develops (Keller, Yovsi, Anacarolina, Kärtner, Jensen, & Papaligoura, 2004; Matsumoto & Huang, 2004), varying their possible meanings and interpretations according to this one (Jin, 2014). In such a way that, to understand the phenomenon it is necessary to consider how silence is conceived according to the sociocultural framework in which it is found and located.

Según Ronningstam (2006), el silencio culturalmente es un fenómeno heterogéneo y controvertido, siendo relevante la diferencia entre las concepciones de oriente – culturas orientadas más al colectivismo –y occidente – más tendientes al individualismo. En las primeras en silencio es visto como algo apreciado y deseable, mientras que en las segundas, es algo mucho más complejo de vivenciar y lidiar, puesto que no es valorado socialmente.

Dentro de este marco cultural, se hallan los estudios dedicados al silencio y su relación con la cortesía (*politeness*), donde el silencio ha sido concebido como algo ambiguo (Ronningstam, 2006), ya que podría indicar posturas tales como neutralidad, como algo insultante, como una estrategia para proteger territorio, como una estrategia para protegerse a sí mismo y mantener una buena impresión (Goldstein, Pon, Chiu, & Ngan, 2003); or to evade confrontation, being imposed upon or embarrassment (Nakane, 2006);

Other texts address the functionality of silence depending on cultural context. Kurzon (2007; 2009; 2013) distinguishes four types of silence, namely conversational, textual, situational and thematic silences. The first refers to non-participation by a person in a conversation, in which he or she is physically present, but psychologically outside the interaction (2007; 2009; 2013). The second occurs when a person is in silence when they are reading a text or when they are in the presence of someone

reading a text (2007; 2009; 2013). Situational silence is similar to the above, but without the involvement of a text, and occurs in contexts such as ceremonies or museums. Finally, thematic silence (2009) alludes to when a person does not speak about an issue in particular. Here, a person is able to speak, but does not refer to a specific topic; for this reason it is not feasible to measure this silence in terms of time, in contrast to the other three.

Tisljár & Pléh (2014) conducted an investigation about the silences and the ability to attribute emotional states to other people, concluding that this is not a universal phenomenon, but that the pauses in the discourse are interpreted according to the cultural-regional context, and that, therefore, a silence can be seen as the expression of a positive or negative affect depending on the cultural framework of the person interpreting the pause. Following this same line, Vlăduțescu (2014), conceives silence as a communicational element with the quality of being a message in itself, which lacks a single code to be interpreted and used. By not being a discourse in itself, it is an expressive language, more incomplete; and that silence would be a communicational element that induces uncertainty in messages. Finally concludes that there is no way to teach or learn silence, because it, in spite of being something inherent to human communication, does not have an univocal ontology or hermeneutics.

Jin (2014), based on a research carried out in group communication, conceives silence as a phenomenon that must be considered as something negative and passive in interactions and that must necessarily consider the context where it appears to be able to interpret it, thus existing diverse types of silences.

More recently (Chowdhury, Stepanov, Danieli and Riccardi, 2017), a study was conducted at an Italian university, where the functions of the silences were explored through the analysis of 10 telephone conversations of an Italian Call Center to which customers call to solve doubts. They were able to identify 24 clusters for silences between shifts of speakers and 26 clusters for silences that were within a turn of a same speaker. It was able to estimate that the silence would have different functions, including: preparing the response that is going to manifest to the interlocutor, expressing doubt or hesitation and questioning the interlocutor. As a general conclusion, the authors propose that silences help to understand the flow of information in a conversation, helping to generate a plausible explanation for it.

Thus, it can be said that in human communication the silence is taking different forms and meanings depending on the cultural context and the immediate context where this is seen, so that there would be as many conceptions of silence as cultural differences can be found.

Therefore, and in summary, silence would be a fundamentally ambiguous, cultural and heterogeneous phenomenon, which acquires a particular meaning depending on the cultural context in which it is inserted - or from the cultural perspective from which it is interpreted - as well as the various possible uses that are being granted in a particular interaction, depending on the effects that are generating in that interaction.

### **The silence in psychotherapy: From a restrictive to a productive**

In the field of psychotherapy, silence is defined as the temporary absence of any open, verbal or paraverbal communication between therapist and patient in sessions (Feltham & Dryden, 1993).

Theoretically, silence in psychotherapy has been conceptualized in various ways, depending on the theoretical model used to study it.

In the early stages of psychoanalysis, silences were considered resistance, which could be one of two types (Freud, 1912): resistances related with self-censorship, in which the patient avoids revealing conscious content; and resistance in which the patient is left speechless, which directly reflects with unconscious matters.

Silences have also been interpreted by this current as regressive phenomena, in which the patient returns to a primary state in which he or she is undifferentiated from his or her caregiver, an experience where words are unnecessary in order for the therapist to understand what is happening to the patient in the moment of silence, thus dispensing with the need for verbal communication (Caruth, 1987) as the patient has returned to a pre-verbal state (Arlow, 1961).

Thus, in psychoanalysis it has tended to conceive silence as a restrictive phenomenon, interpreted as a factor that would obstruct a process rather than contributing to it.

A more recent approach in psychoanalysis is generative silence, in which silence is productive, and allows the therapist to gather important information, focusing on what is happening at the time of the pause that prevents the patient from expressing him or herself verbally (Sabbadini, 1991). Likewise, silence can be a space for protection, preserving the patient's privacy (Trad, 1993).

In Humanist Psychotherapy, specifically in Client Centered Therapy (Gendlin, 1978; Greenberg, Rice & Elliot, 1993; Rogers, 1958), silence has been seen as an important productive phenomenon, given that at the said times the patient may be having an insight or experiencing a complete interior state, in which he or she is attempting to attain greater symphony with what her

experiences at that specific instant. Likewise, Gendlin's concept of "felt sense" (1978) makes reference to the said contemplative state, in which the person pays attention specifically to his body in terms of the situation he or she is experiencing. Therefore, silences are important for the patient to be able to locate his or her internal senses, and consequently protecting and fostering these spaces is an important intervention in the course of the therapy and change process.

In Cognitive Therapy, little importance has been given to silences as a phenomenon for interpretation or consideration. Those who do take them into account see them as an intervening factor in the preparation of discourse, in which subjects tend to remain in silence or pause when they think about what and how they are going to verbalize that what they wish to say, with a positive correlation between pauses and the preparation required to create the discourse regarding what they desire to manifest in words (Preffti & Papi, 1985).

Theoretically, from these different perspectives, it has tended rather to a conception of silence closer to the univocal, with a specific meaning or function, independent of the context in which it appears. However, despite this trend, the significance of silence in the theoretical perspectives of psychology has expanded slowly, ceasing to be seen only as an obstructive or limiting phenomenon for the subject and for the therapeutic process, becoming valued as a space that can be productive for work in psychotherapy and, therefore, a space that should be allowed, respected and even - in some cases - encouraged.

Among older research, Mahl's 1956 study is worth mentioning, in which he relates silence and anxiety. In this investigation, silence is established as a possible defense motivated by the anxiety arising from cognitive matters or aspects specific to the therapy relationship. It was observed that changes of subject in the conversation were common after silences, leading to a new line of therapeutic discussion.

Another relevant older investigation was Salzberg's (1962) study on group therapy, which concluded that silences can help guide the therapist's and other participant's activities. Silences create less structured situations, encouraging interaction between participants. Similarly, Cook (1964) found that the proportion of silences is related to the productivity of the psychotherapeutic process, as is empathetic understanding. Sessions with higher proportions of silences are more successful than those with lower percentages.

Research on rapport has found that how silence is used by the therapists influences the patient's sense of rapport (Sharpley, 1997). Therefore, it is necessary to begin to conceive silences as a part of

therapeutic interaction rather than a lack thereof, allowing these spaces to become productive for insight, therapeutic alliance and change processes (Sharpley, et al., 2005).

On the other hand, more recent research has broadened the perspective from which silence is conceived depending on the subject that deploys and/or experiences it, in which functions or meanings other than silence have been found, including research in a psychotherapeutic context, as in other contexts that can be therapeutic, such as art therapy (Regev, Kurt and Snir, 2016, Regev, Chasday and Snir, 2016).

Among these studies in therapeutic context, there are research led by Clara Hill (Hill, Thompson, & Ladany, Ladany, 2003; Hill, Thompson & O'Brien, 2004), which investigated the use that the therapists give to silence. Among their findings highlighted the use of silence in psychotherapy as an intervention in itself or as a strategy to deepen in a particular subject or to develop what they will say later as an intervention. In the same way, was that silences can be positive or negative for the therapy, although most are conceived as positive. They also acknowledged that in the absence a specifically created formal space for the use of silences, therapists have learned to make use of them through the clinical practice itself or through spaces for supervision.

For its part, Heidi Levitt (1998) has been dedicated to study silences from patients' perspective, opening a productive research line with her doctoral thesis. Based on an Englishspeaking cultural framework (Canada), from patients' experiences, and coding with Grounded Theory, Levitt created the only coding system for silences in psychotherapy (Pausing Inventory Categorization System, PICS, Levitt, 1998; 2001; 2002; PICS II, Levitt & Frankel, 2004), establishing the coding of seven types of silence, which were also categorized into broader categories according to their macro-functionality in psychotherapy, being some of them more productive than others. At this level, silences are grouped according their macro-functionality in psychotherapy, in which some are more or less 11 productive than others. However, it is argued that obstructive silences are also productive in the psychotherapeutic process (Frankel & Levitt, 2009; Levitt, 2001).

Levitt (1998, 2001, 2002) was able to generate 3 central categories of Silence: Productive Silence, Obstructive Silences and Neutral Silences. These categories were named according to their contribution to the progress of the session and/or the goals of therapy. Within each of these categories, there are specific types of pauses (silences), each with a particular function.

Within the Productive Silences are the three silences: emotional, reflective, and expressive. The first are characterized by moments where the patient is experiencing an emotion or experientially is moving toward them.

The Reflective pauses are moments where patients can challenge ideas and/or realize the complexity of the subject, and are able to make connections or insights about their own experience. These include "High Reflective Pauses" and "Low Reflective Pauses", depending on the depth of reflection performed.

In expressive silences patients look for words or phrases that are "correct" or attentive to be able to label what they are experiencing, having as a main function the power to symbolize their experience, whether they are new experiences that occurred during the session or experiences they had already experienced but that they had not been able to symbolize due to its complexity.

Within the obstructive silences are disengaged pauses and interactive pauses. The first refers to pauses where patient disconnects from what the discussion topic or disconnects from therapist. Interactive pauses refer to moments in which the patient focuses on aspects of the therapist or therapeutic interaction, paying attention to the reactions of their interlocutor and in the self-presentation.

Finally, within the neutral silences are the breaks and pauses of associative memory (or mnemonic). In the first the patient changes the topic of conversation without being able to register a thread between the new idea pop-up and the previous one. In the pauses of remembrance, patients actively try to remember details of situations or objects that are describing.

Some research results using PICS-II show that pairs where good therapeutic results are obtained demonstrate more productive silences and fewer obstructive ones (Frankel, Levitt, Murray, Greenberg & Angus, 2007). However, the possible positive-generative character of the obstructive silences in the change process has not been explored. It has also been observed that productive pauses reflect highly fruitful moments, given that they are where emotions are experienced, in which these are symbolized and linked to personal meaning (Stringer, Levitt, Berman & Mathews, 2010).

One of the relevant findings of the investigations of Levitt and his team, evidences this relativity of how productive a silence is or not, depending on whether long-term results are considered or how a session is progressing. It was found that silences that are categorized by this system as obstructive, could eventually be productive at other times of therapy (Frankel & Levitt, 2009, Levitt, 2001).



In more recent research, you can find other findings related to the silences in the psychotherapeutic context.

A doctoral thesis of the Istanbul Bilgi University in Turkey (Ünlü, 2015), working with a case study on a therapy with a patient of five years. She audiorecorded some sessions, also worked with their respective transcripts and the analysis of some of the instruments to assess overall functioning and the process of game within the therapy. Described mainly the non-verbal behavior of the patient. As general conclusions, the author states that the dynamics of interaction of the child were modified only when she changed her own way of considering the silences of her patient. In this sense, he explains that he stopped seeing them as an obstacle or as worrisome and anxious moments. Thus, by accepting silences as a useful tool, he was able to begin to pay more attention to his patient's internal world and to his own internal world, using fewer interpretations and opening up to a more container role. As a result of this change in perspective, his patient became more cheerful, open, flexible and talkative.

Another study (Daniel, Folke, Lunn, gondán and Poulsen, 2018) examined whether the quantity and the quality and quantity of the silences in the sessions were associated with the attachment of the client, the therapeutic alliance, and the results of the therapy. Secondly, these associations were compared between two different types of therapy (psychoanalytic and cognitive behavioral). The authors worked specifically with patients with symptoms of bulimia nervosa, selecting 175 sessions of beginning, middle and end of the therapeutic process. The Silences were coded with the PICS-II (Levitt and Frankel, 2004).

Within the main results, it was found that a better alliance is related to a lower frequency of silences in general and a lower relative frequency of obstructive silences; a high relative frequency of productive silences, and low relative frequency of obstructive silences were associated with better outcomes of treatment; the frequency of silences varies between the two types of therapy, having more in analytical therapy (it was 4 or 5 times higher in this type of therapy); in both types of therapy, silences increase in the middle and at the end of the process; and that a greater relative frequency of obstructive silences are associated with worse outcomes.

Of this work are five hypothesis: it is hypothesized that at the beginning there is less silence because both are concerned to establish a good alliance and to seek and receive information, while the silences are more frequent in the phases of work. The second hypothesis suggests that the number of pauses associated with good results will depend on the theoretical approach of the therapy analyzed (i.e.: the analytical therapy dyads with good results had a greater overall frequency of breaks, otherwise

occurring in cognitive-behavioral therapy). The third hypothesis is that the therapies with the best results are characterized by having more silences in the beginning, above all in the middle of the process. Finally, the fourth hypothesis refers to the fact that the poorer outcomes of the therapies could be explained by characteristics of the clients, based on our proposed by Frankel et al. (2006) about the customers "slow starters", which are only able to commit themselves to the process of therapy to the final sessions of treatment. On the other hand, the results associated to the silences and the attachment of the customers, it was found that, in general, the frequency of silences will depend on the type of therapy and the type of attachment. As a final tip, the authors point out that the results found suggest that it is possible that the therapists use the silence of the meeting as a possible source of information on the characteristics of the client, as well as the current quality of the therapeutic alliance and the likely outcome of therapy.

Therefore, as reviewed on empirical investigations of silences in psychotherapy, it can be established that these have contributed to broaden the perspective regarding the meanings or possible functions of silence in psychotherapy, which will depend on whether they correspond to patient or therapist, of whether they contribute or obstruct the results in psychotherapy, of the type of intervention and elaborated objective that is intended to be achieved in psychotherapy or of the response that is given to a certain interpellation.

In this way, the contextual and interactive nature of the silences has been incorporated and relieved, approaching more and more to a more relational and dialogical view, as it begins to be investigated - from one perspective or another - how a silence acquires a meaning and different function depending on the intention with which it is deployed - the "concrete" use that is given to it in speech - and the particular way in which it is received by the interlocutor or by the effect it generates in him.

### **The silence and its regulatory function in the psychotherapeutic process**

In human communication, silence has been studied as a co-occurring with speech, taking a particular sense depending on that dimension (Schuessler, 2003) and also with the non-verbal dimension (Bucci, 1988). In spite of the coexistence of both systems, much of the human interaction occurs at non-verbal (Schore & Schore, 2008; Tomicic, Martinez, Altimir, Bauer & Reinoso, 2009).

This is also in the psychotherapeutic interaction (Bernieri & Rosenthal, 1991), which is distinguished from the other types of interactions because it is a cultural practice (Willig, 2008) with specific "rules" of interaction. In this, the participants affect their own behaviors (Keller et al., 2004)

and also the conduct of the interlocutor, and may modify the deployments of both parties (Beebe, 2006; Tronick, 1989). As well, participants will adapt their behavior to each other (Buck & VanLear, 2002), in a bidirectional way (Beebe, 2006), both in the verbal and non-verbal dimension. This phenomenon is known as mutual regulation and generates particular relational dynamics, creating predictable patterns of interaction, which are expressed, among others, as patterns of non-verbal coordination/incoordination between the interacting subjects (Beebe & Lachmann, 1998; Bänninger-Huber & Widmer, 1999; Tomicic, et al., 2009).

At the verbal level, both patient and therapist expressed in his speech positions that mark perspectives on the interaction and the content of the speech (Martinez, Tomicic and Medina, 2014), which, in turn, are influenced by the role that each participant has in the interaction. In this way, the exchange is bounded to a culturally determined (Martinez et al., 2014), with rules and standards that define the relationship and maintained as a discursive gender specific (Lehmann, 2014), where there would be a polyphony of voices, forming machines of different discursive positions, interacting with each other (Bakhtin, 1986).

Lehmann (2014) positions psychotherapy as a discursive genre, conceiving it as a social regulator of speech and silence, where the latter would also have a polyphonic and polysemic character. Consistent with this, Levitt (2002) defines them as part of human interactions and narrative production. From this perspective, psychotherapy is not only dependent on the context, but on how the participants find themselves moment to moment, fulfilling a regulatory role in mutual interaction.

Thus, considering the exposed background, we will consider silences as a phenomenon that is ambiguous, contextual, heterogeneous, cultural and polysemic, since its functions, meanings, impacts and functions in the interactions will necessarily depend on the context in which it is occurring, in sociocultural terms as context of the particular moment in which two or more people are interacting. Also, moments that have a minimum duration of three seconds will be considered as silences, and shorter times can be considered as shift pauses, as well as pauses necessary to regulate certain physiological processes, such as breathing and salivation.

In this sense, it is necessary to understand the context and the experience of each of the participants of a particular interaction in order to limit the possible meanings and functions of the silences. In this case, the silences will have a regulatory function in the interaction between therapist and patient, always within a specific sociocultural and normative framework, which is also regulating possible forms of interaction between both participants.

Understand these different contextual elements that would help to understand the meanings and functions that regulate the therapeutic interaction and also the process of patient change.

## **OBJECTIVES**

### **General Objective**

To establish the participation of silences in the interactive regulation between therapist and patient in different “interactional stages” and throughout one psychotherapy.

### **Specific Objectives**

1. To adapt and complement PICS-II system to its use in a Spanish-speaking context and the identification of categories of silence for therapists.
2. To establish differences in the presence of categories of silence in the therapistpatient interaction based on different interactive scenarios.
3. To establish the variations in the presence of categories of silence throughout the psychotherapeutic process.
4. To describe the interactive regulatory function between therapist and patient performed by different silence categories in different interactive scenarios and throughout the psychotherapeutic process.

### **Guiding Questions**

1. Which silence categories do therapists distinguish in therapeutic interaction? What type of functions do silences have for therapists in therapeutic interaction and how do they use them? Which silence categories do patients distinguish in the therapeutic process? What type of functions do silences have for patients? How do patients experience silences and how do they help patients in their psychotherapy process? How do patient and therapist silences differ?
2. Which silence categories are manifested in different interactive scenarios and what functions do they have? Which silence categories are manifested by therapists and patients in different interactive

scenarios? What differences are there in the manifestations of silence categories in the different interactive scenarios?

3. How do different silence categories manifest themselves at different stages of the psychotherapeutic process (at the beginning, halfway through and at the end)? Are there differences in how the therapist and patient manifest different silence categories throughout the psychotherapeutic process? If so, how do they differ?

4. What functions of interactive regulation between therapist and patient are performed by different categories of silence in psychotherapeutic interaction, in different interactive scenarios and throughout the psychotherapeutic process? How are the variations the interactive regulation between therapist and patient performed by different categories of silence throughout the psychotherapeutic process? Which categories of silences and its regulatory functions can be obstructive for the psychotherapeutic process and how so? How can these obstructive moments contribute productively to the psychotherapeutic process?

## METHODOLOGICAL FRAMEWORK

The design of this investigation is mixed, which allowed a comprehensive approach to the phenomenon of the silences in the context of psychotherapy. The scope of the investigation is descriptive and relational, as it pursued to identify and describe different categories of silences and how these are manifested in different interactive scenarios of the therapeutic process and along the same. In addition, we sought to determine the regulatory functions in the interaction between therapist and patient of these categories of silences.

The investigation consisted of two sequential studies: the first, of a qualitative nature, sought to respond to the first specific objective. The purpose of this first study was to make an adaptation and extension of the PICS system-II (Levitt & Frankel, 2004) to a Spanish-speaking context, adapting the categories of silence for patients created by Levitt, so that they were consistent with a Spanish-speaking context. On the other hand, sought to create a coding system of silences for therapists. Therefore, the central objective was to have instruments that would consider the silences of both actors in order to understand their participation in the interaction along a therapeutic process.

To achieve the objectives of this first study, we conducted semi-structured interviews with therapists and patients, and *micro-phenomenological* interviews with therapists.

The first interviews were made to 8 patients and to 8 therapists, with the purpose of being able to adapt the categories of silences of patients belonging to the PICS-II, can count on the perspectives and experiences of both patients and therapists on the silences of patients, in order to make the necessary adjustments. This type of interview was analysed with the open coding procedure of Grounded Theory (Strauss & Corbin, 2002).

The *micro-phenomenological* interviews were carried out in order to raise the categories of silences for therapists from the experiences that these actors have had during their years of experience as psychotherapists. This was possible by analysing every interview with *micro phenomenological* analysis, which is composed of two different types of analysis: synchronic and diachronic.

The diachronic allowed to raise different experiential categories, those that particular feature the type of process that the therapist was experiencing at a particular instant, associated

with what was happening during this specific time of the session. In addition, these categories were complemented with the synchronic analysis, where they allowed to raise descriptive categories of the different experiential moments of the silences of therapists.

In turn, the micro phenomenological analysis was complemented with the encoding of the Grounded Theory of the semi-structured interviews with 8 patients and 8 therapists (the same ones that were considered to adjust the PICS-II). These interviews were considered because respondents referred to the silences of therapists and the characteristics associated with the interaction of therapist and patient during therapy sessions.

The second study of this thesis dealt with the second, third and fourth specific objectives, using the categories developed from the adaptation and extension of the PICS-II (Levitt & Frankel, 2004). The aim of this study was to carry out the study of the reliability of the system adapted and extended silences. To achieve this purpose, silences from both therapist and patient using relevant episodes were coded (Change Episodes and Episodes of Rupture) of a long-term therapy. After the coding, specific analyses were conducted to assess the differences in the frequency and types of silences between therapist and patient, and also differences between the different types of relevant episodes. At the same time, relevant analyses were conducted in order to determine which way the silences along the psychotherapeutic process manifest.

## **STUDY 1**

### **Adaptation of the PICS-II for Spanish-speaking context**

#### ***Participants***

8 patients and 8 therapists participated, of both genders and age, according to Chilean legislation (over 18 years).

Considering a type of sampling of maximum variation, the participating patients were men and women over 18 years old, with an average age of 31.87 years old and a standard deviation of 12.68 years. The criteria for inclusion was that they have participated at least once of a psychotherapeutic process of some of the four main lines (psychodynamic, systemic, cognitive and humanistic), both those who had completed the process as those who had abandoned the psychotherapy. This last point was included as a criterion to take into account

the possibility that any of the participants has abandoned the process by some characteristic of the therapeutic relationship related to the silences in psychotherapy.

There were no exclusion criteria for patient selection.

In the case of therapists, a sampling of maximum variation was considered, being constituted in the following manner: 3 men and 5 women with an average age of 38.5 years old and a standard deviation of 12.5 years. The selection criteria were: therapists in one of the four theoretical lines (both classical and contemporary), and that their level of expertise was beginner (between 1 and 3 years of experience) or expert (12 years of experience or more).

There were no exclusion criteria for selection of therapists.

On the other hand, involved two independent coders, familiar with the PICS- II (Levitt & Frankel, 2004), and with the encodings to the semi structured interviews of patients and therapists. His work was to codify the silences of patients found within relevant episodes of a long therapy, complementing that encoding with information from interviews and the characteristics found in each of the episodes. These participants belong to the research team of FONDECYT Project No. 1150639 and were introduced to the central theme of this thesis and their materials by the author.

The relevant episodes of the long therapy were used as the unit of analysis in order to supplement the data from the PICS-II and the interviews. These episodes were 44 episodes of Change (Krause et al., 2006, 2007) and 14 Episodes of Rupture (Safran & Muran, 1996, 2000, 2006) of a long orientation psychodynamic therapy (a.k.a. N1). These episodes were selected for having as a feature a particular emotional intensity and because they have proven to be interactive scenarios that allows to see behaviours that are involved in the regulation between patient and therapist, both verbal and non-verbal (Moran et al., 2016).



### ***Technical Data Production***

We conducted semi-structured interviews with all participants.

These were conducted with the support of a script theme, one for patients and another for therapists. The fundamental objective of both scripts was to deepen into various aspects of the silences in psychotherapy, covering dimensions such as ideas about them, emotions and feelings, functions, interpersonal context of the appearance of the silences, etc.

The script of the patients was divided into 5 thematic axes: a. The silences in everyday life; b. The silences in the psychotherapeutic context; c. The silences of the patients in the psychotherapeutic contexts; d. The silences of the therapist in psychotherapeutic context; f. Types of silences in psychotherapy.

The script of the therapists was divided into 7 thematic axes to characterize the features of the silences: a. The silences in everyday life; b. The silences in the psychotherapeutic context; c. The silences of the patients in the psychotherapeutic contexts; d. The silences of the therapist in psychotherapeutic context; e. The silences as a psychotherapeutic tool; f. Types of silences in psychotherapy; g. The silences in psychotherapy and the spaces of formation and training as a therapist.

During each interview, we deepened in each topic taking as a guide not only the thematic axes, but the experience of each participant, so there were some more explored than others.

On the other hand, these emerging categories were used in conjunction with the PICS-II and the selection of episodes of change and episodes of rupture in order to create the adaptation of the PICS-II for patients.

### ***Data analysis procedure***

The data collected through semi-structured interviews were analysed using open coding of the Grounded Theory (Flick, 2004; McLeod, 2001; Strauss & Corbin, 1990), making a description of the phenomenon of the silences. The encoding is performed separately: an encoding for therapists and one for patients, thus generating specific categories for each actor. The purpose of this analysis was to be able to create categories that describe possible functions and characteristics of the silences, both patients and therapists, based on the experience of the interviewees.

To generate the data analysis for interviews, were considered to be part of the interview associated with specific topics of the script for the interview. In the case of the patients, we considered the following topics of the script: b. The silences in the psychotherapeutic context; c. The silences of the patients in the psychotherapeutic contexts; f. Types of silences in psychotherapy. In the case of therapists, the topics considered were: b. The silences in the psychotherapeutic context; d. The silences of the therapist in psychotherapeutic context; e. The silences as a psychotherapeutic tool; f. Types of silences in psychotherapy.

Using software Atlas.ti, 7.5.7., hierarchical categories of silences in psychotherapy for a Spanish-speaking context were built, on the basis of conceptions of therapists and patients. In this way, encodings were obtained on the silences from these two actors in the psychotherapeutic process: an encoding on the silences of the patients from the perspective of patients and another from the perspective of the therapists.

To ensure the quality of the data, we used the triangulation of interpreters (Patton, 1990), with the participation of researchers from the investigation team, FONDECYT N°1150639, validating the emergent categories of intersubjective agreement for each category and their characteristics. The triangulation of data was carried out separately, dedicated to triangulate the data of the encodings carried out on the basis of the interviews of patients and another process of triangulation of the encodings created from the interviews of therapists. In this process, we were reviewing the emerging categories and the hierarchy in which they were distributed.

Subsequently, to adapt the PICS-II to a Spanish-speaking context, encodings with this system to episodes of change and rupture, belonging to a long therapy which took place in a Spanish-speaking country (N1).

These encodings were revised in a detailed and systematic manner with the PICS- II, by three encoders familiar both with the PICS-II as the open encodings of the semi-structured interviews.

The process carried out by the encoders consisted in: (a) identify silences in each one of the episodes of change and rupture of the therapy, (b) encode, independently, every silence with the PICS-II, and (c) reconcile each of the encodings.

In total, there were 5 conciliation meetings. During these sessions, the coders agreed on the silences codified, and presented and shared the difficulties, discrepancy, the coincidences and agreements with the PICS system-II on the basis of the episodes analysed and according to the encodings open that had been generated previously.

These agreements, matches, difficulties and discrepancies were agreed upon by intersubjective agreement, adding or by specifying new aspects of each category of silence of the PICS-II. This was done only in cases where there are specifications and discrepancies in where the three coders agreed unanimously. In the categories of silence in which encoders considered that it was not necessary to change something, were left as they appear in the PICS system-II.

This last step was performed until saturation of data, for which purpose it was necessary to make these adjustments until the revision of the 29<sup>th</sup> episode of change and 8<sup>th</sup> rupture. These final agreements were made at approximately 2 conciliation meetings.

### **Creation of a Coding System of silences for therapists**

#### ***Participants***

To lift the coding system for the silences of the therapists, attended the 8 patients and 8 therapists who had participated in the interviews described above in the section on adaptation of the PICS-II, and 8 more therapists.

These 8 new therapists, occupational therapists compounds were men and women of the four main theoretical approaches (cognitive, humanistic, psychodynamic and systemic, both classical and contemporary).

Thus, in this part of the study, 24 participants in total (16 semi structured interviews and 8 micro-phenomenological), since in all the interviews addressed the silences of therapists in psychotherapy as the main theme.

The participants were convened from people who had contact with psychotherapists that comply with the requirements of the sample. However, due to obstacles such as availability of potential interviewees, the sample was finally constituted by: 3 women and 5 men, with an average age of 43.37 years (SD: 12.5); 3 humanists, 2

2 Cognitive, systemic and psychodynamic therapist; 3 1 Beginners (2-3 years of experience as a maximum) and 5 experts (12 years or more of experience).

On the other hand, involved two independent coders, its work consisted in detail the experiential categories get up from the analysis of interviews and encode silences of therapists in relevant episodes of a long therapy. These participants belong to the research team of the FONDECYT Project No. 1150639 and were introduced to the central theme of this thesis and their materials by the author.

The analysis units corresponded to relevant episodes: 83 Episodes of Change (Krause et al., 2006, 2007) and 79 Episodes of Rupture (Safran & Muran, 1996, 2000, 2006) From a psychodynamic orientation long therapy, that is different from the one used for the adaptation of the PICS-II and the interviews. The reason to choose this kind of relevant episodes was the same that guided the selection of those used in the adaptation phase of the PICS-II, that is to say, the intensity of affective particular and different types of interactive scenarios.

We chose to work with a different therapy, mainly for two reasons: first, because the therapy N1 had a much lower frequency of silences of therapist and because the moments of silence - although they may be artificially divided by actor- there are moments of interaction and relational type, so that in order to have a different quality of these moments, he chose to work with a different therapy.

### ***Technical data production.***

In order to address the experience of therapists in the moments of silences in psychotherapy, we opted for the micro-phenomenological interview technique.

This technique emerged in the 70 with Pierre Vermersch (1994, 2003; Valenzuela, 2017) in order to understand the processes of the experience that are involved in such phenomena as the resolution of problems, which up to that date it had been studied from behavioral perspectives rather simple. From this and the proposals of Varela (Depraz, Varela & Vermersch, Petitmengin, 2006; 2002; 2017; Vermersch, 1994, Valenzuela-Moguillansky, 2013) in order to study the experience of a non- objectifying, emerges this type of interview.

Within its basic foundations, is taking the phenomenology of Husserl (ValenzuelaMoguillansky, 2016; Valenzuela-Moguillansky, 2017) and the enacting of

Francisco Varela (Petitmengin, 2006; Valenzuela-Moguillansky, 2016; Valenzuela-Moguillansky, 2017; Varela, Thompson and Rosch, 1997; Varela, 2000).

The phenomenology relates to suspend the natural attitude of an experience, redirecting the focus toward aspects or processes that allow a content to emerge as such thanks to them, allowing you to understand how emerging experience. The redirection of the observation allows implicit aspects will be apprehended.

The enactive prospect from Varela, comprises the cognition as an action embodied, being inseparable what sensorimotor of the cognitive. The experience is understood as a do individually, and at the same time, shared by more people - to the extent that share different contexts of cultural, social, historical, etc. - which would be able to understand the experience of something like a particular structure that appears on the basis of individual invariants, but also of invariant group. It is thanks to these similarities or regularities shared by members of a group that can get to establish common structures in the emergence of a specific phenomenon.

This approach and type of interview give a central role to the observation and description of the experience you have with respect to a particular situation. What is important is that the participant will observe in detail your own experience, so that the interviewer should play the role of facilitator of this process.

The prefix micro refers to go into the details of the experience, coming in at a descriptive level detailed enough as to address and clarify time to time the way in which an experience is emerging. In the interview process, you can work with both experiences evoked as caused.

This type of interviews has been conducted previously in studies related to the human experience in first person in a clinical context (i.e.: Katz, 2011; Petitmengin, Navarro & Le Van Quyen, 2007, Valenzuela-Moguillansky, 2013). In research in psychotherapy, this type of interview has already been conducted previously for research in relevant experiential processes involved during the development of a psychotherapy (Duarte, 2017; Fischersworing, 2017).

Working with an experience evoked, chosen by the respondent, referring to moments of silences that have been lived in psychotherapy sessions as a therapist. We chose this technique because it allows you to understand the temporary experiential flow of therapists during the moments of silence, allowing lift them from categories to distinguish different experiential typologies. In addition, these typologies experiential can be characterized in a crosscutting

manner, detailing every moment of the therapist's experience in the moments of interaction with the patient during the occurrence of a silence.

The slogan was explicit: *"(name of participant), I want to ask you, if you agree, you come a moment of silence you've lived in therapy as a therapist and that you may have seemed relevant. When you have that moment, you can notify me"*.

It is also working with the same interviews that were used in the adaptation of the PICSII, in which 8 patients and 8 therapists.

### ***Data analysis procedure.***

To analyse the interviews, micro-phenomenological analysis was used, which consists of a process of abstraction, comparison and formalization of the content of the interviews (Valenzuela, 2017). This process is iterative in nature, which allows you to go making improvements in the process of analysis in case of being necessary for the objectives of the investigation, as well as of possible topics that appear in the conduct of the interviews. Although the analysis has certain steps to follow (Valenzuela, 2017), the process is rather intuitive, so that these steps can be modified depending on, for example, the aims of the research and other contingencies.

The micro-phenomenological analysis is composed of two levels: diachronic and synchronic. The first objective in order to understand how it is that an experience of temporarily deployed, identifying phases and sub-phases that make up the temporary level experience, allowing to establish a temporal sequence of the experience of the therapist.

The synchronic analysis has as a guide lift semantic network using different types of processes, being able to identify major themes and their characteristics within each moment Or phase corresponding to the experiential categories raised with diachronic analysis. This type of analysis is similar to the encoding of the Grounded Theory.

Both types of analysis include a stage of individual analysis and other genetic analysis, being able to identify structures diachronic and semantic networks, group and individual.

For the purposes of this thesis, a diachronic analysis and synchronous one, both for each therapist individually, as a generic analysis, that is to say, a synchronic and diachronic one that will represent the experience of therapists as a group.

On the other hand, data collected through semi-structured interviews were analysed using open coding of the Grounded Theory Grounded Theory; Flick, 2004; McLeod, 2001; Strauss & Corbin, 1990), making a description of the phenomenon of the silences. Was carried out in the same way as in the first part of this study. The encoding is performed separately: an encoding for therapists and one for patients.

In this case, the parts used to make the encodings of the patients on the silences of his therapists corresponded to the axes: b. The silences in the psychotherapeutic context; d. The silences of the therapist in psychotherapeutic context; f. Types of silences in psychotherapy.

For therapists, the thematic axes for the encodings were: b. The silences in the psychotherapeutic context; d. The silences of the therapist in psychotherapeutic context; e. The silences as a psychotherapeutic tool; f. Types of silences in psychotherapy.

Finally, the encoders lifted the Coding System for therapists as follows: (a) took each experiential category was lifted des the diachronic analysis and described in terms of general function and temporal characteristics (phases and subphases); (b) detailed the functions and interactive features of each silence using the categories that emerged from the analysis of the interviews, the synchronous analysis and observation of episodes of change and rupture belonging to a long orientation psychodynamic therapy (a.k.a. B).

The analysis was carried out to reach the saturation of the data that, in this case, it was up to the 42 Episodes of Change and the 46 Episodes of Rupture.

## **RESULTS STUDY 1**

According to our methodological framework, this first study aim was to respond to the first specific objective of this thesis, which was achieved on the basis of the adaptation of the PICS-II to a Spanish-speaking context, and the creation of a Coding System of silences for therapists. Both systems were brought together in a single large system called PICS-TP.

This system was created using different sources: the analysis of semi-structured interviews with therapists and patients on the silences of patients in psychotherapy; the adaptation of the PICS-II from the contributions made by coders; and micro-phenomenological, and semi-structured interviews with therapists on the silences of therapists in psychotherapy.

The results will be exposed in the following order: (a) In the first place, the silences of the patients in psychotherapy, according to the perspective derived from the open coding of the interviews to patients therapists; (b) the silences of the therapists, including first open coding of the interviews and the synchronous coding of the interviews, and subsequently microphenomenological describing the diachronic encoding that allowed the lifting of the categories of silences of therapists; and (c) The description of the coding system PICS-TP.

### **Adaptation of the PICS-II for a Spanish-speaking context**

From semi-structured interviews to patients and therapists, emerging categories were created associated with the functions and features of the silences in psychotherapy. 4 central categories rose up: 2 from patients, referring to the silences of patients and another of the silences of therapists; and 2 from the therapists, one that speaks of their own silences in psychotherapy and another category that talks about the silences of the patients.

Then describes in detail each of the above categories, explaining the functions and characteristics that make up, illustrating the highlights using excerpts from the interviews with participants.

#### **Moments of silence according to patients**

##### ***Silences of the patients: What do patients say about their own silences?***

The central category is called *silence of the patients*, which basically refers to the meanings or characteristics of these moments that patients were able to identify and describe at the time of the interviews. Each of the subcategories that are parties to the largest category, refer to the aspects that "surround" or are associated with the silences and that help to understand its meaning or function at a given time, according to the perspective of patients.

The first subcategory, *silence to reflect*, refers to those moments of silences are identified as spaces where they can more deeply on any subject, aspect or process.

Specifically – as it is shown in the characteristics of this subcategory -, patients explain that the silences of reflective qualities have helped them to analyse situations, either reevaluating the perspective they had or looking at a situation that they had not considered before.



Also, patients identify these moments as spaces to realize aspects of themselves or others, so many people who were already conceptualized or as new characteristics they had not previously consciousness. In the same way, can also take on a specific subject consciousness that previously had not considered as something relevant in its history and process of psychotherapy.

Another reflective function identified by patients is that it has helped them to understand their own experience, either understanding an aspect never seen before or reevaluating from a new perspective, highlighting this aspect as a fundamental element to advance in their therapeutic process.

As a last reflective function, patients identified that these spaces have allowed them to be able to symbolize their experience, going a step further to understand it, relieving that thanks to this function, they have been able to name or describe in a finished any experience that previously had not been able to communicate with words.

In the following excerpt, an interviewed patient explains how it is that the silences helped him during the therapy, to be able to think and understand that was what was happening to a specific time, being able to be seen internally and develop their experience, Particularly at a time when the silence was an instance-induced, through meditation as a tool:

54. *I: Yes. I remember some silences that we had when... in a kind of meditation that we had during therapy.*

55. *E: Ok.*

56. *I: And that also were silent, and they were very... very nice. Usually these silences preceded insights very strong and after that, I began to describe what was happening during those periods, what I saw, what I felt, I don't know.*

*Then those silences preceded this sort of meditation as induced... helped me M... (EP 8, p.54-562).*

The subcategory *Emotional Silence*, basically refers to a time where patients can connect directly with their affective experience, whether positive or negative, making a connection with this dimension of them more quiet spaces where you can see more flooded by intense emotions.

The first characteristic of this type of silences, said with regard to a first level of connection to the emotions, are where patients indicate that have recently begun to make contact with their emotional experience associated with an event or person, referring to this as something new, such as a sensation which they had not connected before, either outside or inside of the therapy. Or - if they had experienced fairly - had been able to connect with that emotion without evading it, leaving to shy away from that kind of experience. In this sense, would be as the initial step for the patient to be live or look at your experience only from the rational, but they begin to experience it from your feelings, without fear or discomfort.

The second characteristic of the emotional silences is that it allows patients to establish connection with intense emotions that had avoided or that they had not experienced that way before. This feature of silence is characterized primarily because emotion over completely to the patient, being flooded by the excitement, preventing that can immediately regain his speech, or - in case of being able to retake it - staining clearly the way in which they are communicating with the therapist.

The last characteristic of this type of silences alludes to a level that goes beyond just connect with the fact of living and openly show an emotion, but allows them to put a name to that emotion or feeling that is in progress, allowing patients being able to understand in a more discursive their affections, integrating them also more clearly to his speech and history.

The following quote reflects a moment of silence where the patient reports having lived emotional silences, where he was able to connect with his emotions, particularly with the death penalty, to experience the catharsis of that emotion, which was allowed on the basis of the trust with the therapist:

*uhh... (thinking) Yes, I think it was ... almost one of the last session... when I had more confidence... and as that in the background, I was looking for that space... unlike when I started therapy... umhh... for example... the moments as, of emotional catharsis, where one starts crying as well... when he realizes certain things or connect... uhh... how the spaces of crying, for example, where the therapist... remains in silence... I feel that the time I lived I was super important because... er... I feel that I needed that space of silence... just to stop thinking and just leave it as in the excitement of the moment... only as moments of*

*silence... uhh... I feel that it seems... you have... can have like... a plane as rather a cognitive level... as well as... of relevance to cognitive level and another plane at an emotional level... in that moment... the silence as on an emotional level was, it was necessary... (EP 1, p.123)*

The third subcategory is called "*Blank*" Silence or Silence in white, which is mainly spoken in a moment of silence where the patient is left with his thoughts "blank" or without a very clear or specific content that allows you to think of something to say later. It was called the "*Blank*" Silence because the feeling that accompanies this moment is that they have nothing in mind or that there is very little content in thoughts.

This may occur primarily by two situations. The first, which corresponds to the first category, explicitly states that the patient is blank because they do not know what to say in the session to continue the conversation, which can occur because it is surprised or unseated by something that the therapist mentioned or because it has been too shocked by a subject that has been talking in the session. The second option that allows the patient to stay in white, is that it does not remember any event that is trying to evoke, either because the therapist is requested on a voluntary basis, or because the patient tries to remember a person, event, name, etc.

The following quote illustrates the first situation, where the patient doesn't know what to say, because they cannot remember something specific to be able to respond to the question of the therapist:

*E: uhh... that silence was the most terrible with her... (brief pause) and with the other... (brief pause) not... (pause) happened to me that I was uncomfortable when I ask something and I didn't know what to say... not because I wanted to and I will cause discomfort, but because... I don't remember... What did you do this weekend? (Short pause) Nothing... and was waiting to continue to respond (laughs slightly)... nothing... sometimes these silences were uncomfortable with her.... Were not as strong as the, the first was much stronger... (EP 3, p.198).*

The fourth subcategory is called *silence to express disagreement* and illustrates that these moments of silences are useful to patients to be able to show disagreement or discomfort to the therapists, without the necessity of having to verbalize and/or having to enter into a discussion with them. In this sense, the silence serves to show that they are not necessarily aligned with

what the therapist has said during the session, but without the need to enter into a "conflict" with them, thus avoiding a conversation that may generate some level of discomfort.

As shown in the characteristics of the category, this situation can occur for two situations. The first occurs when the therapist makes a judgment in his speech - consciously or not - either directly on the patient or about something that the patient has said, to what the patient feels a little discomfort, either because they disagreed with the trial and also because it considers it as little or as a comment out of place. Once this happened, the patient chooses to stay in silence, to avoid conflicts with the therapist, "bypassing" the judgment of the therapist.

The second situation occurs when the therapist performs an intervention that can be an interpretation or a similar type of intervention where the therapist expresses his point of view in respect of a fact or about something that you could be having the patient, but that is not a correct interpretation of the facts or the experience that the patient is experiencing. When this happens, the patient, instead of correcting the therapist, choose to remain silent and not to continue with the topic they were talking about.

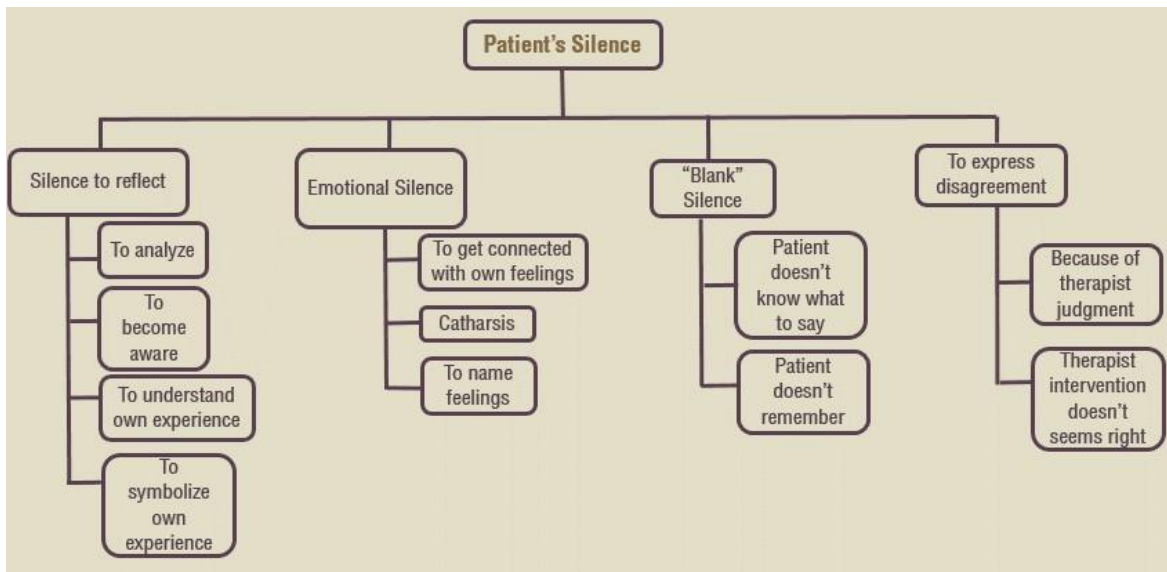
The case reflected in the quote presented below, shows the second situation, where the patient is not in agreement with the statement made by the therapist, since they did not agree with the interpretation that he had been raised:

*E: I think, I felt that it was like a little inductive...er...and there the space of silence...I decided to say...er...and the therapist also remained in silence...there in such situations for example like that...er...at least on my part was...I stayed in silence...because...uhh...like a way of...of...make it understood that I was not making much sense your interpretation...I don't know if I am... what if?*

*I: mmm...(nods) does the therapist as responded...or she stay quiet?...*

*E: uhh...she stayed a while in silence...because she hoped that I will respond ..and did not respond...that...did not connect their interpretation as with what I was feeling...but...she started to speak also...I feel like that was a bit by the branches after live as those moments..*

Figure 1. *Silences of the patients from the perspective of patients*



***Silences of the patients: What do therapists say about silences of their patients?***

The therapists talked about the silence of their patients in therapy, referring to specific cases in some descriptions and speaking of global assessments in the event of a talk about another type of situation.

The central category is called ‘silence of the patients’ and has four subcategories that allude to the aspects that will help give a particular meaning to silence. That is to say, the therapists take into account the emerging four subcategories and associated features to be able to interpret each moment a silence that belongs to a specific patient and interaction.

The first subcategory corresponds to the idea that *different silences are related to different types of patients*, referring that each silence has a particular quality depending on features that are specific to the patients and therapists or the ongoing interaction. The therapists explain that the silences are going to have specific characteristics depending on four main qualities: the clinical aspects, the history of life, the age group and if the patient is introverted or extroverted.

The first characteristic relates primarily to the diagnosis which has been associated with the patient, establishing differences in duration or intention of the silences depending on the patient's diagnosis. For example, a patient who is depressed will tend to do more silences because, perhaps, their course of thought is slower, versus a patient who has a diagnosis related

to pictures anxious, that perhaps it's going to have less tolerance to silence. This, of course, will depend on a variety of clinical aspects of the person, including the structure of personality.

On this, in the following quote is clearly reflected how the interaction with a patient with a specific diagnosis can directly influence the meaning and also the use of the silences in psychotherapy, where, in this case in particular, were used in order to establish a positive relationship with the patient, being able to start to work together in the therapeutic work:

*I remember the case of a girl who had something that could be diagnosed as selective mutism, then in certain contexts she spoke and in certain contexts not. I remember that we come to meeting, and she only said "yes, no", then I said "how are you?" and she moved the body and do not speak, it was super difficult. Then one day I said, "You know what? Let's not talk about, let's stay quiet" and we spent an hour silent, looking at us, we looked at, smiled... it was a silence that initially was super uncomfortable, super uncomfortable and that after, how that connotation of discomfort, the time, I believe that we as two meetings as well and in a third began to talk and talk like a parrot, I then asked "what happened that you started talking?" And she said "is always required me to speak and you gave the space to stay quiet, this made me trust and made me relax, then I didn't feel pressured and I could not speak, not that I don't like but it's hard for me". (ET 6, p.41).*

The second feature that helps therapists to interpret the silences of their patients referred to what kind of *process* is going on the patient, referring rather to processes limited to what is specifically on course at a specific time of the session. In this sense, this category does not refer to processes more macro that can understand an entire session or several weeks of therapy, but refers to what is happening with the patient data and bounded in the session.

The therapists were able to distinguish five different processes. The first refers to the affective content and means that patients are in the midst of a process in which the core are emotions and feelings, which may be connected with their affections and becoming conscious of them. The therapists recognize that their patients tend to stay in silence when the affections are new and/or intense, so that patients need a moment of silence in order to process those affections.

The following quote shows how the therapist consciously chose to promote the silence as a space for the patient to be able to achieve connect with their emotions, becoming conscious of them and you can express it openly in the session:

*Then I think that with this patient, it was something different this question that a silence, but a silence for she recognize that finally... was not the emotion she was showing me with his face what she was going on, and there I decided to make silence. "To see, but tell me, what's wrong with this? Why don't you tell me as well? Is there anything going on with you?", until after several sessions where we occupied the silences, she cries and explains what happened with the theme of her dad. Then I believe that if it was used the silence but for... that she is, connecting, because if no..." What should I do....?', I believe that a person cannot be with, with its interior if you don't make your processes of spaces. (ET 2, p.154)*

The second process to find the patients is to symbolize their experience, where the central focus is to find words to describe their experiences, which had not been able to be put into words or reassessing and returning to symbolize something that if it had been put into words, but which have now been able to look from a different perspective. Patients are silent when they are actively looking for the right words to illustrate and communicate their ongoing experience.

In the next paragraph is expressed as the therapist has used the spaces of silence for the patient to slowly comprehending what happens, because it lacks the ability to define their experience, not only for the patient to be able to find the precise words to describe their experience, but the silence are also used by the therapist to be able to understand what may be living the patient. In this particular case, it is not a moment in particular, but there are several times throughout the process of therapy to help the patient to symbolize his experience:

*And of course, there for example did not know what they were, their silences and if I had to press for example with more closed questions to get information, because it was super complex to understand her... then I started to catch that actually is not that missing answers, but that she could put it all in words and she found it hard to put everything in words, emotionally and with a very limited vocabulary, then, imagine how to translate that to a stranger then ..., give you more time and hence the silences have been very challenging for my part as well*

*as, how it helped her to try to understand what she is going on, because she found it hard to put into words, much to define it. Part of the work is how to set code or vocabulary in common to be able to understand each other in one way or another with a sense and I believe that the silences are more challenging, there becomes more challenging because as I said, we are so different that I poses a very... invites me to move plenty of energy in trying to understand how your life can translate into a thought, a feeling for herself because if she does not have clear... but little by little we have been achieving (ET. 3, p.50)*

The third is the process of reflection, where patients are looking in a conscious and deep some aspect of their history or their experiences, being able to evaluate them in a deeper way, looking at their ideas in a more critical. Patients may need to stay in silence when you are focused on making a reflexive process, being able to think calmer and more acutely.

The quote below shows how the therapist can explain that the silences of patients in psychotherapy help that can come up with new ways of understanding different aspects of themselves, which means that she can feel confidence in the process that is underway with this particular patient:

*But I believe that what I was saying before, over the years, I believe that the faster I realize in a new relationship that occurs, the faster I hope. It is as an index of confidence, but in the therapeutic relationship does not apply, because... why not, perhaps what can happen and I say this in the purpose of what we are talking about, is how, images keep coming that perhaps what can happen is that I have more confidence in the process of a person who makes silences because, generally after that as a jump, the understanding of itself, its history, and so on (ET 5, p.44).*

The fourth process in which the patients can be, is reconsidering a perspective, being able to question directly a point of view that had previously maintained, changing the way people interpret their experiences or situations. It is similar to the reflective, but the fundamental difference is that the central focus of this type of process is that the re-evaluation of a perspective is more conscious and explicit. In this sense, according to the therapists, patients stay in silence when they are concentrated making this new look and change of perspective.



The following quote illustrates how the therapist presented to the patient an interpretation of his conflict with his partner, allowing to look from that perspective proposed by the therapist, considering that his relational anxiety with his partner may be influenced by other significant relationships in his life:

*Q: So, but you don't always process it entirely, then sometimes you 'chew' and say: "Look here is something that draws my attention, what do you think of that?" and one continues with the patient.*

*E: Yes. Do you have some concrete example of that?*

*Q: I don't know, has happened to me lots of times.*

*E: that is, if it is as everyday within the therapy.*

*P: Yes, Yes, it happens, it happens. Now that is the one...to see, I don't remember that one I said you in particular now but for example, I remember a patient, psychology student, that his motive was his girlfriend, that was his reason for consultation, because with the girlfriend they got bad, but he loved her very much, the girlfriend was very nice, but he got anxious with her, as that was overwhelmed with the girlfriend, because the girlfriend had an issue, she was very disqualifying. Then on a certain occasion, reviewing certain topics, I raised the parallel which had that with the relationship he had with his mom. It turns out that the father had died, then when the father died, he was a teenager, as well as 13, 14 years old, and after the father died, the mother, her deal was lived very far away from the children. That is, the mother ceased to be available emotionally for her children during their grieving process in a couple of years, then the point was that with the girlfriend, it also worked as needing the attention of her, such as attention, in the background is like the attention that he had, that he needed, then he wanted from her and was overwhelmed and felt anxious when he felt that she was not paying attention. Then there in that example, when I dis this parallel with the mother, he remains a good time in silence. There is silence, based on an interpretation. Why, then, what I understand that is doing at the moment is that this thinking in your*

*relationship with your girlfriend from the perspective of the transference, in the background. (ET. 1, p.202-206).*

The last type of process that therapists distinguish is to remember, where patients try to remember any events that actively lived, attempted to explore, and verbalize details to advance on a specific theme that are working at a time of the session. The therapists recognize that patients tend to remain silent if they need to concentrate to remember something in particular.

The following quotation shows that the therapist recognizes that silence can have multiple functions, and that one of them is to be able to access details of a situation that the patient is evoking during the course of a session, may order what you are thinking and, finally, what you want to say:

*Eh, in that sense I have been conceiving it finally in therapy. When someone is silent or quiet when I'm getting a lot of attention and I hope that the person, when is silent, is paying much attention in some aspect of it or in any phrase that I may have said or may have said it and I hope that this booming., you are looking for other corners, other thoughts, other memories, other connections perhaps or other analogies (Continued)... and there would be on the basis of what is produced or what you are looking for, of what is needed, it would be as clear, recognize or connect with an image, a knowledge, a memory... How to order as I was saying, it is sometimes necessary to sort, what one wants to say in this regard. (ET 3, p.26 and 78).*

The third subcategory is called *resistance* and refers to the fact that patients can use the silence to resist any intervention or process that is in progress during a time of the session. According to the therapists, there would be four possible ways through which patients can develop resistance. The first relates to resistance to disconnect from the subject covered in the session or the therapist. The main function of the silence is to pause the issue that is being addressed in session, or to disconnect from the interaction with the therapist, being able to pick up the flow of the conversation then, but speaking of another form or by joining in a more distant with the therapist.

The following is a quotation where the therapist explained that the patient expresses its resistance to express discomfort and responding with a topic that has no relationship with the therapist had proposed works at that particular time:

*I believe that we had 6 months of therapy, he had talked of the father, or, he had talked a long time of the mother, the mother, the mother, his relationship with the mother, with his friends, etc. and I agree that in general there were many uncomfortable silences, because I didn't know what to say, and there was one in particular that... I don't know why it occurred to me to ask for the father. He was silent... I think it was for a few seconds, and stomping the ground... and he told me something that I do not recall on this minute, but something that was or that I understood that there was nothing to see to what always talked. Always talked of the mother, his companions, not to know that, and I think that in that minute, after stomp, which I plop, because it is very strange that someone do that, because it does not... nothing, nothing that I will explain that, and then he tells me that he had gone... I don't know, to give you an example, I don't recall... to fish. I remember that this silence was the most difficult, the more complicated because I do not know exactly whether he played well what happened, but the next session I remember that, well, after monitoring the situation, the father was like a stone in the shoe. And of course, I mentioned the stone in the shoe, I felt his resistance, his annoyance, the strong stomping scared me (ET 8, p.28)*

The second way of resistance is to boycott the therapeutic work, leaving to respond to the therapist and therefore not working with the item that you are working on.

The quote below shows how staying in silence can be unproductive for the therapeutic work and to hold silence for so long may mean that the patient did not connect with the issues that are really important to be able to contribute actively to the therapeutic work:

*That is, that is a resistance. This is a resistance. Now what happens is that clear, the resistance we have to work on it, is putting at stake, but deep down I'm going to stay in silence two minutes or half an hour? In the fund does nothing more than I stayed more time in that silence. There is no more. And at times I have heard stories of people who have gone to the psychologist and have had a session in which have not wanted to talk and the psychologist has left not to mention the entire session, and ends the session and have not spoken. Already, that, that for example, for me, I don't know, for me, I don't... I don't do that or I would like to do what*

*you look? Because in the end, I feel a loss, do you understand? Then you are not going to be able to say. Yes, perhaps you're working the resistance, but I find how to spend the session It does not serve us. No, then no. a silence which seems to me to be unproductive. (ET I, p.102).*

The third way is by changing the subject or focus of the conversation. Here the silence is used by patients as a space of disconnection, which serves as a transition to a new topic of conversation, leaving even the issue that was being addressed above.

The last way to patients of resistance is to delegate the responsibility to the therapist. This kind of silence can be viewed as similar to the others, but the intention of this silence is to challenge the therapist in a passive manner, requesting implicitly that is he or she who continue with the flow of the conversation. In this way, the patient can be loosen temporarily to get involved with the issue that is being addressed, but in a way a little less clear that change the subject or turned off completely. In this sense, it installs a collaborative way, but a little more passive.

The following case illustrates both cases, both the change of topic and how to delegate the responsibility to the therapist. The therapist said that there are patients who fill the space of the therapy with topics that do not contribute to the work, but on the contrary, they respond with silence and subsequently leave the responsibility to the therapist to address some issues or continue to make a count of stories that help to avoid the relevant topics:

*Well, something that happens a lot, thinking again how in the interviews is that silence which is not here, that it is as if a patient with that silence to say "Ask me" or "here I don't want to deploy my word, I don't want to say, I do not want to risk that, say, and I want you to ask me or want you to me passes a projective test or want the item you put your, and so on. Then again, the easiest thing to do would be to say "ok, surveyed or you step a test or, for example, when the processes are often part of the session and patients say how, happened to me like: "Well do you remember?" I have been told as well as: "I come from the street, and in another, what were we? And although I agree or I don't remember where we were, I think that it is always better to tell you how to "start from what you remember you, let you say your now, even if you do not have a direct relationship with the line that we came following from last week, as that there is a resistance to work in psychotherapy on the part of the patient, which is often*

*expressed in the silence, in the 'not to say'. Can also be expressed in another way, for example, saying things that do not serve for nothing... many times patients fill the meeting at the beginning of things... that actively prevent reaching the point or that only leaves something more than the more involved or something more important (ET. 4, p.49).*

The last subcategory is called *Emotions*, and refers to the silences of the patients acquire a meaning or particular function when the patient is fundamentally connected on an emotional level. The therapists identified four distinct ways in which patients can get in touch with their emotions. The first is by performing a first approach by connecting with emotions that have not been seen or considered or that had been evaded. In this way, the silence serves to pause and pay attention to what is happening to them at the affective level.

The quote below explains how the silences can allow an emotion to emerge from the patient, when he can see more clearly what is feeling when pauses his speech:

*It is as if the other person is telling me a story, ...Eh, where no, she didn't stop, continued, talking to me, talking to me, talking to me, speaks to me. And, and I feel that things are happening to her, very intense things. Then remain silent favors that there will come a time when she didn't have to say anything, that that person is in front of me I didn't say anything, no, there is nothing more that I have to explain. I have not asked anything. Then, that allows you to stay in that area, and the emotion. Usually that gives the possibility to display the emotion, and in the background I do not know if the amplified, but in the end, the amplifies the view, it's like that allows you to appear at the hearing: Eh, not only of what I... not only in relation to what I intuited that couldn't be happening, if not that appears in full view of the other, of the subject that perhaps speaking, was leaving outside. (ET 8, p.22)*

The second way that patients can stay in touch with their emotions is from an emotional charge, where the emotions that are in progress are especially intense, so that patients are unable to continue with the flow of their story, needing to stop.

*I remember that at that moment, she is silent and instead of dry her tears, and I believe that in these minutes one does not have to interrupt these silences because it is space of one. If now that I think about it, perhaps may have been uncomfortable (laughs) because, now I remember, I said as well as "Oh, that silly, I am crying." I get the impression that perhaps for this to stop,... talking and crying. Oh, but I hadn't thought of that, on this as well as "I cry", that is, "She Cries", "I try to contain it in that silence," because it was her space with the power to release your sadness, but of course, she quickly took the, their handkerchiefs, dry and "Oh you silly," she said. "Why?" she asked me, "because I'm already crying", how humiliated. "Again I am crying."(ET 3, p. 122).*

The third way that therapists identified is the stress, explaining that patients may be experiencing high amounts of anxiety or distress that generates a feeling of stress in their patients, so they are flooded by that feeling and need to keep silence for a moment, by way of a pause or a respite.

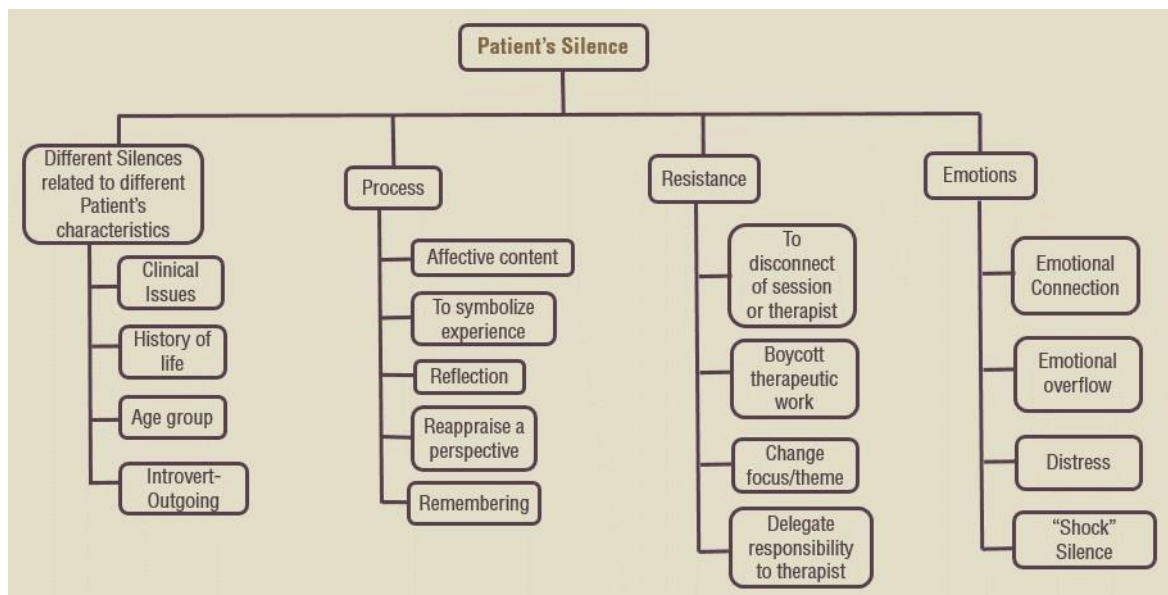
*No one in particular comes into my mind right now....came the image of a teenager who was very furious... with a friend had many previous suicide attempts, her parents forced her to be there and her clothing was very aggressive, she is not the word, but in his way, then... she crossed her arms, angry, and she tended to be often very silent, and sometimes was silent and the tears, after a while... well that was not so ...you treated..., what I would like another example to come... umm.... it was so tense and so uncomfortable... it was painful, very painful, I argued on the idea to accompany her In these silences, although cry...do you understand me? Eventually ask, but eventually there, because she was, I say to you, as well as angry, how... Then my idea was to accompany her, until it was happening... it was a good therapeutic process... Hard....(ET 7, p. 42).*

The last way that therapists identified of silences associated with emotional aspects is the silence of shock, where patients experience extremely strong emotions, so much so that they don't know what to say or how to follow the flow of the session. The big difference in this silence with the previous two is that it disrupts the whole flow of the meeting, including speech, but

also the cognitive and emotional processes. In this way, it is as if the patient did not know what to say, what to think or what to feel.

*Then, when he finally decides to count the fact, he starts to cry, which is what was likely to happen, and then starts crying, and crying, uhhh, crying out loud. Then, and this time he cries, are 10 minutes that we are the two silent, uhhmmm, then here is no longer has to do with an interpretation that I did, in the background just what I have done, is to give the interactional conditions necessary so that he can put into play the content. (ET 1, p.68).*

Figure 2. *Silences of the patients from the perspective of the therapists*



**Creation of a Coding System of silences for therapists**

## **Moments of silence as therapists**

### ***What therapists say about their own silences?***

The central category is called *silence of the therapists*, that speaks, in broad terms, on the functions that the spaces of silences have for therapists during the course of a psychotherapy.

As it is shown in the chart, there are only a subcategory in the following hierarchical level, and alludes to the fact that the therapists see the different moments of silences and their potential roles as spaces that are inevitably linked to his role as psychotherapists. And that, therefore, its meaning and utility cannot be dissociated from what they have to achieve to bring to their patients from moment to moment, so that they can move forward successfully in their own processes. In this sense, a silence is always going to be interpreted and managed according to what you are going to serve the patient, either directly or indirectly, having a positive effect in the long or short term. So, it is stipulated that the therapist is making a constant effort to use silences strategically for therapeutic purposes, taking many times to overcome the silences that can generate the immediate need to react as you would any other person who interacts daily with his patient, taking many times to develop and to redirect your first reaction.

In the following quote the interviewee makes it clear that the silences are directly related to the role of the therapist in psychotherapy, which are mainly useful to stay centred and positioned in the place that the therapist must have or with tasks that you must perform to be able to carry out the role depending on how it is necessary to work in therapy:

*... I think it has a lot to do with the role of the therapist, or I think it has a lot to do, I think it has a lot to do with, to see, to be silent you have to be quiet, um and to be calm, you have to be centred, then the place of the therapist is a place in which one has to be focused. You are well placed in your role, and your role is a role that is a restful role, is a reflective role. Then, that goes with silence, that is, it could hardly be otherwise. Then, um, I would say to you, for me the theme of silence in the place of the therapist is an intrinsic part of positioning of that place. Because you asked me as a feeling, and in general terms, it seems to me*



*that is intrinsically linked to my role of therapist and me to be focused and quiet... (ET 1, p.208)*

On the same idea, the next interviewee expressed something similar but emphasize that these roles in therapy are defined in advance, specifying what each of the actors must do or not do in the process:

*Mmm... of course. Is that clear, thinking about what I said before that in general, or outside of the therapy, the silences have to do, or how one lives the silence depends on which position this one, of course, the position in which the people are in a process of psychotherapy is very specific, it is very artificial in the background, is one which is called to say something, to express themselves or to speak of their son... Eh... that, as the roles of the two parties in that communication that is psychotherapy are more, they are defined in advance, then is how much more... can be much more limited the role of the silence, or be used as a tool... (ET 4, p.25)*

The next hierarchical level, is composed of four subcategories that describe the specific functions of the identified moments of silence, always being interpreted from the role of therapist.

The first of these is called *reflective skill and be focused* and explains that the silences can be useful for therapists to stay in a thoughtful and focused, in order to be able to move forward during the course of a session, and that can help them to be able to tolerate more these moments in cases that may become uncomfortable. That is to say, the therapist can better tolerate the moments of silence, can help them to maintain his concentration and reflection to follow the flow of a meeting, above all to be present with the issues and processes that are in progress during the session.

In the following case the therapist makes it clear that the silences are a space that will allow you to be focused and to help you to think and reflect on the ideas that are emerging. And also to be able to concentrate on other relevant aspects to be available for the patient and the topics covered during the session:

*To think, to connect. Part of the idea to engage them as in therapy is precisely on the basis of my experience with silence. I, uh, having begun to attend young,*

*I spent with older people who understood the silences as ignorance and went and went, and when I was in the follow-up I said "is that it is very young, I need someone with more experience" and I was fed up with the silence, for example, appears an idea and I keep quiet, looked at another point, because if I look at the person I am, I am aware of the relationship, then I focus and go inside and I think and pulled an idea. Or expressed, in the background the feeling or... and that explicit in therapy when we talked about how space is. Sometimes I remained silent and looked to the side because I devolved if I or the stared at him, then...and delivery of the idea that if I used to that, people can use the to do the same. Then it serves as a space to talk about myself, to think or to connect with something that I am feeling when he did not do so automatically as it tends to give in the session. It happens that something strikes me more, or disturbs me more or calls me more and I need to do that in interventions... (ET 6, p.53)*

The second subcategory is *that it belongs to the patient and that does not* illustrate that the moments of silences can be used intentionally by the therapists, to be able to distinguish clearly when something of what appears in session may or may not belong to their patients, being able to know when they are acting on the basis of their own motives, thoughts and feelings and when they can be moved only in function of the patient and their needs. This helps them to be more available for their patients, as they may prevent their role will see interfered with more subjective aspects of them as persons. Thus, therapists can be more available for the patient to be both cognitive and emotional.

*... And after the time I also learned to know more, as the difference from the time of the consultants, because many times that silence interpreted by me with some anxiety was that the pace of someone, I felt that there was something that I had not said or what he had to say, and I wondered all that, because there was a very long time without words for me...and then I learned to distinguish that, and even if we don't always distinguish, to wait for these could be some possible answers, that is to say that their time was different from mine, therefore my consideration of silence was subjective, and it may be only a matter of time within the meeting, and then that the case that, in many cases give good results, that is to say that of waiting...and the time to be as well, because now that I thought about it, was that it was at that time, at your own pace thinking about something... and then it*

*flowed as if nothing... and that has been very useful, not to have, to be able to stay entrusted in the time of who is with you, that it is not always possible to read it so easily, because sometimes someone can speak very slow, but can't stop talking about, that is not necessarily give pauses of silence, and others if you need to suddenly retro brought in and after a while back, then that facilitated being able to tolerate the silences, then also my own safety, to be able to be in the therapeutic spaces (ET 7, p.38).*

The third subcategory is called to *be connected with the patient* and refers to the fact that therapists can use the moments of silence as a resource that allows them to follow the flow of experiences of their patients throughout the sessions. This occurs on two levels: the first speaks of the capacity of the therapist to keep pace with their patients during the sessions and the process of therapy. This happens because therapists can use silence as a space where patients can express themselves and be as they are, taking the time necessary to express themselves in ways that need it, and that the therapist is there to be able to accompany them in the process. The second level refers to being connected with the patient in a more empathetic sense, being able to feel and know that is what you are feeling at a particular moment. Another feature of the third subcategory is that it allows the therapist to understand the experience from the patient to maintain a posture of listening and reception of the patient, giving emotional support and also availability.

In the following quote is illustrated in a detailed way how the silence can be a time of respect to the pace and needs of the patient, as well as tacit understanding of the experience that is in progress at that particular time, which in this case is a particularly sensitive moment for both therapist and patient:

*I met a girl a few years ago, we had been two or three years of therapy, no, two years ago, eh... And she... already from the second year onwards, the mother had been very sick. And it was in a period of examinations and suspected that it could be a cancer and... I remember that... in a week of vacation I called her sister to tell me that the mother had been very badly and died and the next week we had with this girl and... of course, she was strong because I already had a lot of time with her and she was well, and I also knew the to mom... for me it had been very strong, in fact I was even to the church where they were watching but*

*it just was not, I found myself with the rest of the family, the brothers and sisters, and I remember that when it came to the meeting, was a 'Hello', a greeting, a hug, and then we sat, a silence. A silence that was clearly well... we already knew what it was. Distressing... Yes, obviously, but I think that was the silence that more, as I always say there are silences... but I remember a silence that obviously for me and she was strong because the situations of death is super hard to know how to react exactly. It is my turn to very personally also was then... let arrive, fits, put what they wanted from the beginning not more. Good sat, silent, cried and then to talk about more or less than what had been that last week for her.(ET 3, p.30).*

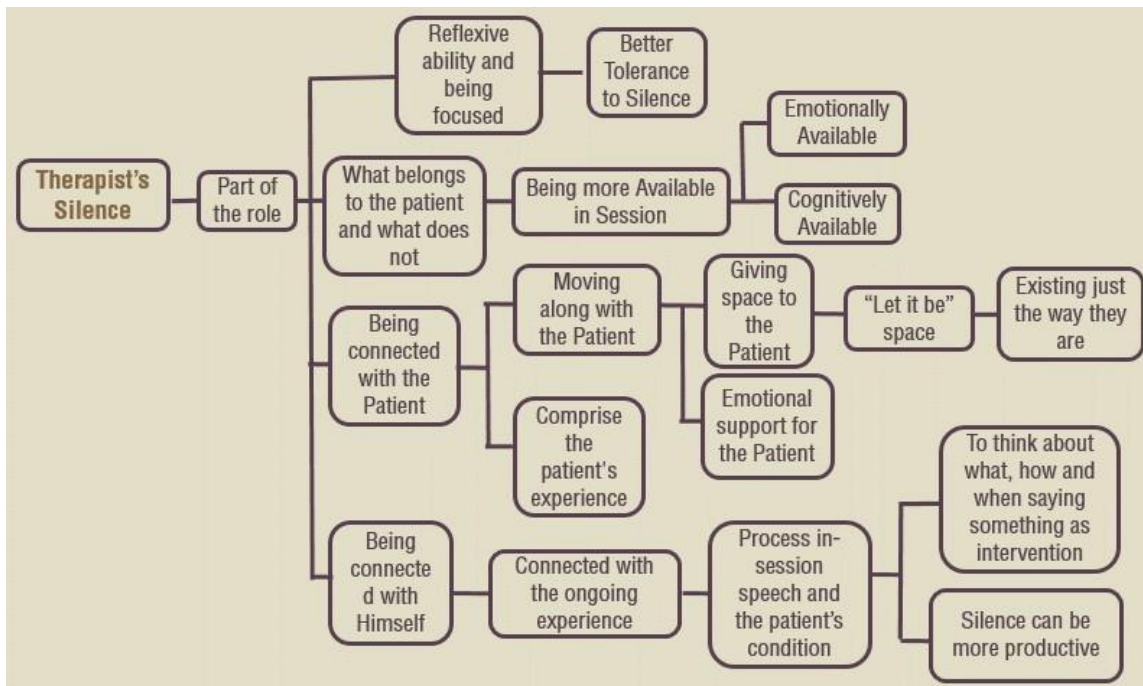
The fourth subcategory is called *be connected with himself*, and alludes to the fact that silence can help therapists to be connected with its own experiential flow, paying attention to what is happening moment by moment in the session, both with what is happening to the patient, in terms in which state and also with the speech of this. This allows the therapist to be aware of what is happening to him and be clear about what to say, when to say it and that way to express what they want to express. In this way, this silence acquires another quality, and is to be productive, in the sense that you can make the best possible intervention to know what to do, when and how.

In the following quote, is expressed in general terms how the silence allows the therapist to take consciousness of itself, in terms of thoughts and also on an emotional level, being able to assess that it is pertinent to perform any intervention with specific content, and that is not something that is oriented only to play strategically some particular point of the patient, but is a process that occurs in an integrated manner to the consciousness that the therapist has about himself:

*As my part of the material that contributes to the construction of the space, as I like to understand the space as a mutual building; that is, how to speak the systemic, from the constructionist language or the language, but it can also be from the silence or from thousands of other things. In the background, there are two or more that we build the space and... and what is appearing in my, consciously or unconsciously, rational or intellectually or emotionally or physically even, is material here if it is contingent and put it into play or explain*

it, or if it is pertinent for me to stay indoors for a subsequent analysis of mine, too, but in the background allows me to be better as a therapist. Then you exit or experience, as not only the specific material of an affirmation or intervention, but also to be aware of me and be better as a therapist (ET 6, p.57)

Figure 3. *Silences of therapists from the perspective of the therapists*



***Silences of therapists: What patients say about the silence of their therapists?***

The central category is called *silences of therapists* and explains the patients' perspective on the silences of the therapists, referring not only to ideas, but also to experiences that patients have had during the sessions of a therapeutical process. In this way, explains how they see the silences of the therapists, in terms of how it affects them, depending on what they believe that the therapist is trying to communicate to them.

The first subcategory we called *silences to challenge the patient*, shows that in those moments when the patient feels questioned directly by the therapist, forcing them to have to say something, although they don't want to do so or does not feel the need of having to do it. This generates a discomfort in the patient, since it feels a little coerced to have to say something only

to please the therapist. In that sense, the patient does not agree with the therapist and may or may not give in to this obligation.

In the following case, the patient explains how during the first session of the therapy was challenged by the therapist, but which were initially seen as irrelevant or uncomfortable, since the patient was not willing to talk with the therapist, and that, although she was aware that the therapist was questioning so that she could speak, and wasn't really ready to do so, and gave in to the demand of the therapist. You can also see how this situation was changing with the passage of the sessions:

*E: mmm... (thinking) in addition to the comment... (pause) ehh... depending on the situation... I feel that the silences of my therapist... in the beginning of the session... er... I feel that... that equal to, or be seen from now, I feel the same... er... were uncomfortable... let's say, I feel that the therapist felt uncomfortable... because I didn't want to talk to the principle... but... I feel that... I could see how... ehh... my reactions to his silence... ehh... and on that basis, I believe that the silences of the therapist... ehh... from the therapist, as that was also necessary...*

*I: mmm... (nods)*

*E: As Well As... I guess that also looked like a... ehh... a space of silence that I was appealing to me... let's say that does not work, as that was not working at the beginning like that questioning... that was also the factor of interpellation... ehh... mmm... and after the... the... the therapy, say... the silences of the therapist... I think that I lived as more relevant... I believe that the therapist also as it was... er... it was realizing... such as processes... how that their silence that left me to my... er... spaces to talk... er... I think it was... feeling like the most relevant...(EP 1, p.170-172)*

The second category is referred to *accompany the patient*, where it is explained that the patient feels accompanied by the therapist, seeing that the closely followed the flow of the emotions and/or the story of the patient, following the same trend during the moment of silence. Thanks to this connection that the therapist will show to the patient, this feels respected, thanks to two main feelings: the first is that the patient feels accepted, in the sense of not being judged by what he says, what he feels or what he thinks, that is to say, he feels he is unconditionally

accepted. The second feeling that helps the patient feels respected is that the therapist not only accepts, but also supports it, provides the necessary emotional support so that you can feel sufficiently understood and content during the course of the session and, especially and specifically, during that moment of silence.

The following quote shows that the patient felt accompanied and respected by your therapist to show that he allowed to be able to express their emotions without invade:

*E: I did all the effort, I got up, because I was not going to college, nothing... ehh... and I arrived and didn't ask me anything... as I knew that I was super bad... not ask me anything... And I believe that if... It was... If it was comforting...*

*I: mmm... (nods)*

*E: Because I was able to relieve without anyone asking me nothing, do you understand?*

*I: mmm... (nods)*

*E: How he left that I... I don't know... that I... not speak...*

*I: mmm... (nods)*

*E: Not Ask me anything... not arrived and "Hey, what happened to your dog?" I don't know , I don't know what...*

*I: mmm... (nods)*

*E: I sat down, I started to cry... He watched outside, crying... I looked at the phone... looked at him... I believe that we spent an hour as well...(E3, p.120-128)*

The third subcategory is *to judge the patient* and explains that, during that moment of silence, the patient feels judged, for as far as you can see from the non-verbal attitude of the therapist, you can clearly feel that the therapist is issuing (mentally) a negative on the or on a behavior or situation that has been reported and to involve them directly. This causes the patient

to feel evaluated in a negative way by your therapist and feel annoyed by this, not only because it can be unpleasant to be judged by one another, but also because it considered it inappropriate that your therapist makes a value judgment about what or who is, in terms of what they feel or think about something or someone. In this sense, the patient feels that it is not productive for the therapist to judge him, but, on the contrary, it is counterproductive for the therapist to take that position.

In the following excerpt, the patient stated that they felt judged by your therapist throughout the course of therapy, and that was manifested from long moment where none of them tried to strike up a conversation. This feeling was so recurrent and unpleasant, and eventually the patient decided to desert the process:

*E: (Brief pause) mmm... (thinking) I believe that at the end... I realized that in reality... (cough) that in reality that space was not helping at all...*

*I: mmm... (nods)*

*E: uhh... and find a way how to... to... how to get out of the... from the depression that was....*

*I: mmm... (nods)*

*E: said: "Already, with this type I will... I feel uncomfortable... don't want to talk about it... I don't want to talk... uhh if I cry... how that feels uncomfortable... uhh... not talking to me, do not ask me anything..." umm... I think that at the beginning of the therapy... I was so bad that it, not what I thought...*

*I: mmm... (nods)*

*E: How it was going and not really... how not they streamlined what was happening the space... how that will happen no more...*

*I: mmm... (nods)*



*E: And if I was half an hour silent and I cried... not really, not analyzed, it was something important for me at that time, if he was or was not speaking... I was going because I had to go...*

*I: mmm... (nods)*

*E: Ehh... at the end... I began to realize that in reality... Go, go talk to him was not of any, any support from any help... that at the end I felt uncomfortable with him, I felt judged... how... and there I said: "already... that I'm going to waste time going to a psychologist? If in fact what I need is another thing... is not talking to someone but do other things or... I don't know... wait that it passes only... edge there I'll see what I do, but I don't want to come to this thing..."*

(ET 2, p.167-177)

The fourth subcategory is referred to as *the style of the therapist* and illustrates how is that moments of silence can be more or less present at the meetings and in the process of therapy. This category does not refer to a function itself of silence or of an effect that is generated in the patient for the silences of the therapist, but it refers to the fact that the patient can tell if the therapist - as a person - tends or prefer to spend more time in silence or, on the contrary, prefer to speak more during the session. That is, the patient can get to know the therapist, even partly, a level a little more personal, even knowing him or her out of his role as a therapist. It is from the repetition of consistent subtle during the course of the meetings at which the patient can infer how is your therapist.

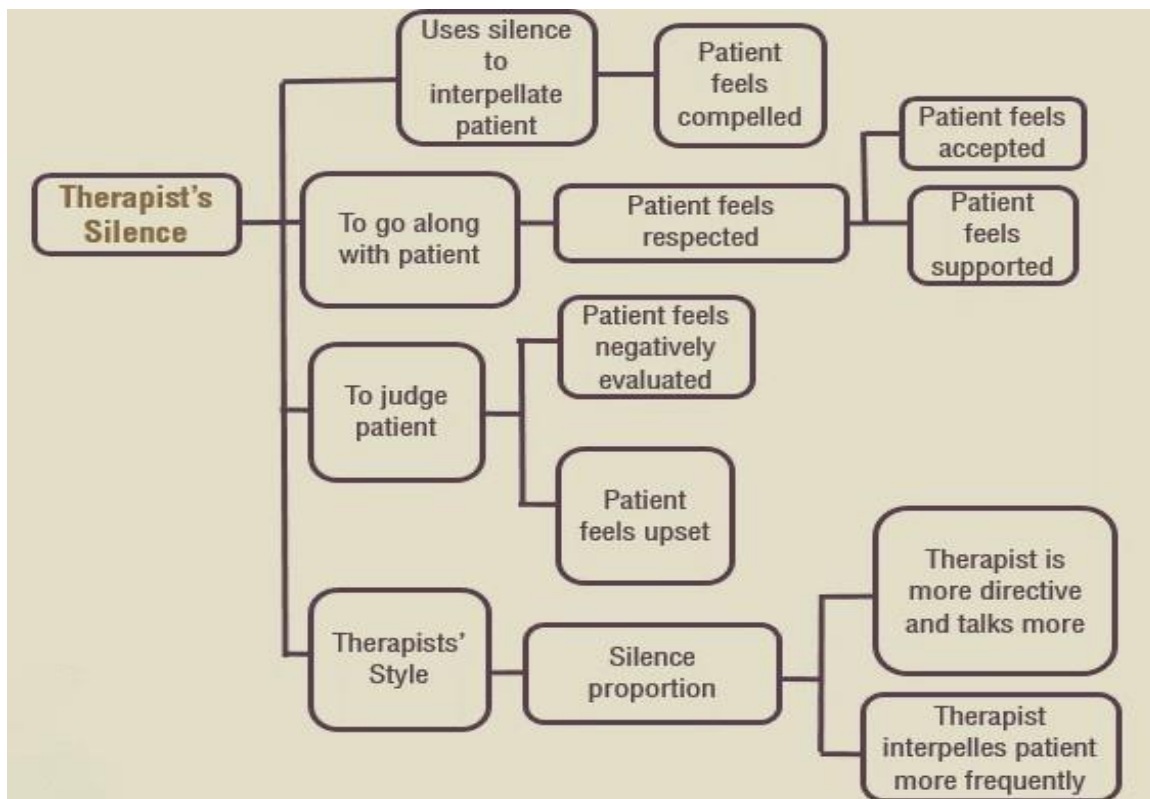
In this sense, emerged two principal and general characteristics on the style of the therapist: the first is that the therapist is a person more directive and prefers to go giving instructions or go proposing topics more frequently, with less proportion of silences in the therapy. The other option is that the therapist prefer to remain silent more often, looking more to the patient and also interpellating more to him to continue with the flow of the session.

In the following excerpt, the patient's account of her experience with two different therapists that she was in therapy through the same process. Here, the difference between the two therapists in the style of both. The patient explains that the first therapist was very selfreferential and that there were a few moments of silence with her. Sets the parallel with

another therapist, who if allowed that these moments were becoming more frequent, and that he was feeling much more heard by him.

*To see another... in fact I believe that what I did not like... is that generated very little silence... That was a constant as 'blablabla... she, he, she, she, she'... then I felt, it made me feel uncomfortable... because I felt that I could not speak... I could not express... On the other hand, Paul was the opposite... then, sometimes... that, perhaps, that could be... have been... sometimes generated many silences... to listen to me... and I... I suddenly felt lost...(ET 3, p.189).*

Figure 4. *Silences of therapists according to the patients.*



### Micro-phenomenological Interviews

Both types of analysis were made, starting first by the diachronic analysis, which had as its objective the power to understand the experience of therapists as a process that is temporarily deployed as "chronological", being able to put some phases first or later following a temporary criterion. With this analysis, identified the stages, phases and most relevant moments for the structure of the experience of the participants.

In addition, synchronous analysis was performed to characterize in detail each phase or time identified in the diachronic analysis. As well, it could be to establish the central characteristics or the most distinctive characteristics of the most striking structural components of the experience.

Interviews were carried out between April and August of 2017. All were analysed thoroughly with synchronic and diachronic analysis both individually and in a generic way. The interviews were conducted in Spanish, but for the presentation of this thesis, were translated into English by a professional translator.

## **Results of Diachronic Analysis**

Diachronic Analysis was performed for the 8 interviews. We found a total of 23 individual diachronic structures in total, where each one of them speaks of a moment of silence for the therapists, so each diachronic structure has different characteristics in relation to the temporary deployment, specifically in the background that exist before the moment of silence, the phases that make up the deployment of this silence, and the way that this silence ends or breaks.

For the purposes of this thesis, be submitted only the generic categories, since, while the individual structures can provide a good illustration of particular cases, this does not respond to the objectives, as they aim to develop categories of silences that are similar for therapists in general rather than to explore and describe specific cases, due to the fact that the individual diachronic structures alone reflect only the experience of a subject in particular instead of a group.

On the basis of the generic analysis, a total of five, the diachronic structures that were created from the similarity between individual structures and also of relevance in terms of novelty and rich descriptions of the various moments of silence. Each of these structures describes a specific type of silence, with different functions and communicative intentions at specific times of the therapy sessions.

Each diachronic structure was given a name that describes briefly what happens at the level of experience in the therapists during the moment of silence described, mainly taking into account the experience that passes during that time with the patient, that is to say, were taken into account in interactional components in order to raise the phases, sub-phases and structures. That is to say, these experiential structures will not be built only on the basis of the individual and what happens internally to the therapist, but that were generated from that goes with the therapist in relationship with the patient at a given time.

Then, each of the generic categories of silence erected to therapists will be described.

### ***Accompaniment Silence***

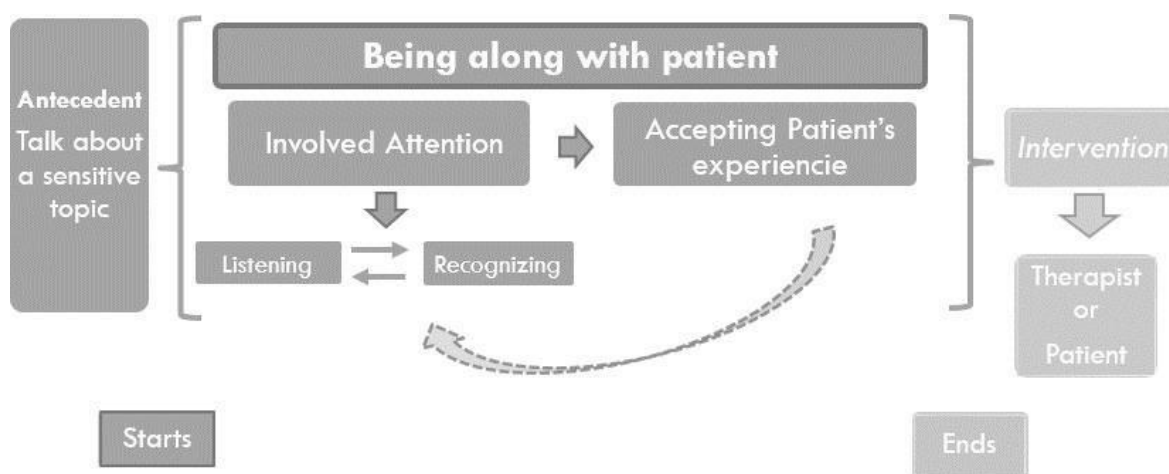
The first of the silences identified was called *silence of accompaniment* or *Accompaniment Silence*. Here, we describe the silence as a space where the therapist is available to-be-with the patient from moment to moment, and may be attached to the patient's experiential

flow, or at least what the therapist can perceive it. In this type of silences, the therapist develops a care envelope that you can listen to and recognize the patient, and, as well, to apprehend and accept the experience that relates.

It is important to mention that this silence does not appear only when the therapist and patient are in silence, but it is a process that also occurs when the patient is talking about, but that can be seen more clearly when both are silent.

In the following figure you can see graphically the diachronic structure of this first category of silence

Figure 5. *Diachrony of Silence of accompaniment*



This kind of silence would begin with the time 0, which would play the role of precedent at the time in which the silence begins. At this time, therapist and patient are talking in meeting on a subject that is sensitive or delicate. In the following quotes from therapists can be seen in a more concrete this time that precedes the occurrence of a silence of accompaniment, including the time 1 (part of the stage area with the patient), in which can be seen in that moment in the beginning of the next phase.

*I see in front of me (to the patient), I see in front of me, I see where I sit, I see the light... "You" or "How are you?", and like all of a sudden he say: "I now see you like a giant" (EM 1).*

*... Because when played as the specific topic, played as meat, so to speak. And the patient passed on being, so to speak, normal to cry deeply and about something very significant. (EM 3).*

*... I asked him what he wanted to be when he is grown up... suddenly as I wanted to get on the other hand, and it occurred to me to ask that, I rather like him like... that he'll think in him" (EM 7)*

When the silence starts- when the therapist and patient are not talking-, the area is displayed with the patient, in which the therapist is following closely the experiential flow of the patient. This silence is composed by a large phase to follow and accompany the patient, which is composed of two sub-phases: the surround attention and accept the patient experience. This phase is characterized primarily because the therapist listens carefully to the patient and recognizes their expertise as a valid and proper perspective of the patient. In the following quota this can be appreciated, this phase with its corresponding sub phases. In this example, the patient had requested the company of the therapist because he felt bad emotionally, stating that it was the only thing he needed, was to be with him in that difficult time:

*I was looking at her, and I felt like a "click", it's like... like that of certainty, as a feeling of "Yes, that is," you know? But it is a certainty that is not going from the head, is how the whole experience. It is precisely the sense of company, area, as I am here, I managed, I accept you, it is your space, is what you need. It is as affection also, and here I am, but I'm not disconnected, I am connected, as with the need for companionship, as together. I think that this is the word that defines all that: we are together. And we stayed silent. But as that just felt like the weight, how it was quiet, but that sensation as difficult as this heaviness, although was comfortable, it was comfortable, we were both imbued with a bit on that as a general feeling of gravity, as down, you know?, as my head down, how... how to go down, as well off. As we looked at, laughed, and continued and then how that relaxed the atmosphere again (EM 2)*

In the last phase, the silence can end with a verbal intervention, whether therapist or patient. If the silence continues, the therapist can maintain the rhythm of the patient, which may be extended by the time that chronological order by the spread of that time. In the following excerpt from one of the interviews shows how it is that the silence ends, showing - in this case - which is the same patient that takes up the flow of the conversation after having shown more retrieved:

*As the patient recovers and she breaks the silence, alone, the same patient speaks after (EM 5)*

The following quote shows another case, where is the therapist who intervenes after the patient has been connected with an emotion associated with a sensitive subject, trying to ensure that the patient put in words what he experienced during that moment of silence:

*... And then ask you to confirm, ehm... if he felt something, that emotion felt and what happens to him in relation to that, to realize where it appeared that, as you see it, feel it now, as it means, as seen from the outside, that is what you want to do... guide you a bit, to be able to express that you saw or guide you in that emotion, which is unexpected. (EM 3).*

### ***Alert Silence***

The second experiential category is called *silent alert or Alert Silence*, and is similar to the *silence of accompaniment*, but in this case the therapist is more active, waiting for the moment-to-moment and monitoring the patient in detail.

Here, the background is that the patient stays in silence because something happened to him, but the therapist does not know what could have happened exactly, but thanks to the nonverbal cues the therapist can realize that something happened, but that it is necessary to explore to find out which can be associated. In the following quote we see clearly the time history, where the therapist clearly realizes that something is happening because the patient is silent intentionally. In addition, it tells an alternative, where the therapist has not reached to realize in time that something happens to the patient, and that notice, the therapist installed deliberately pause to allow the patient's experience can emerge in the session:

*... Because it has to do with something that I say and that the patient stays silent on purpose... sometimes I don't stop and reached to have a dialog, when I realize that the patient is touched in any way, it is intended, is where I stop for that process to occur... (EM 4).*

The first thing that happens is that the therapist enters the standby phase, in which the first is vigilant waiting for the patient to say or do something. If that does not happen, moves to the next stage, which is the monitoring, where the therapist observes the patient, monitoring carefully and being able to focus on the general state of the patient or focus on a specific aspect of the patient, as his gaze, his facial expression, some micro-gesture or some sudden movement,

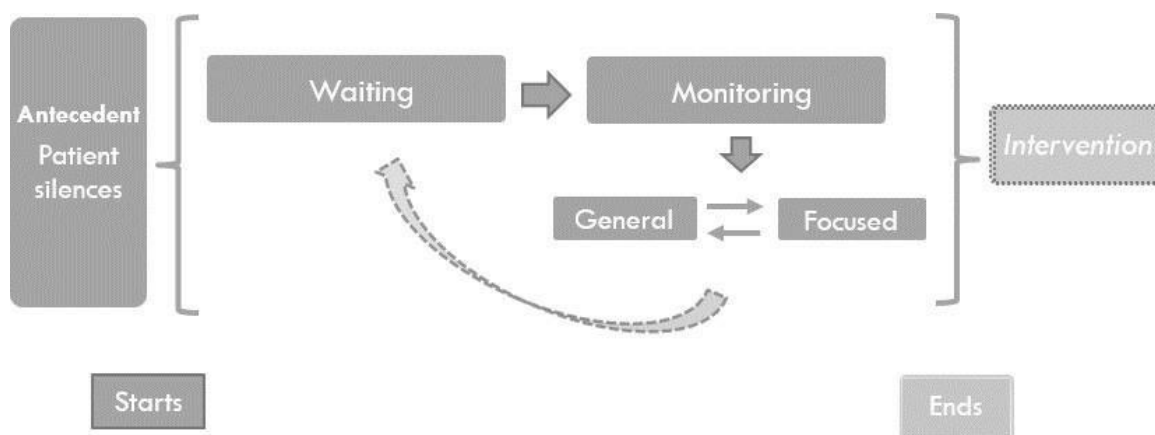
for example. In the following case the therapist find monitoring what happens to the patient, but realize that nothing happens, that the patient remains static with the same expression:

*... And to me in the first place, the question arises when it occurs, if he is thinking about something or is lost, with these two alternatives I hope, I looked at him and I see that he have the eyes fixed on a point... It is a gaze, in a neutral, and always the same and how that is suspended, it is as if we had said "one, two, three, mummy is" ... I look, he looks, I am in peace, hope and very quiet, as in a full attention in what you're thinking... we were looking for a while there in that connected visual, there are signs super... micro signals visual and gesture... you can continue with that poker face... how that I feel like that even this silence is saturated because there is no more in his face, nothing changes, there is nothing.(EM 5)*

The silence may end up with an intervention, but it is not very clear, that type of intervention and by whom. In the interviews could not be found explicitly with ending this kind of silence, but that it was implied that at some point ended, but no further details of this.

As in the *silence of Accompaniment*, the process can be repeated again and again depending on how much time the duration of the silence.

Figure 6. *Diachrony of Silence Of Alert*





### *Self-Regulatory Silence*

The third type of silence identified for therapists is the *Self-Regulatory Silence or self-regulatory silence*. In this kind of silence, the therapist realizes that experience negative emotions in relation to what the patient has reported or toward the patient directly.

The history of this type of silence is that the therapist is experiencing an emotion that qualifies as negative for the course of the session and the therapist chooses not to say anything considered as useless, aggressive or ill-mannered. On the other hand, chooses to keep quiet to be able to say something that is a contribution to the process that is in progress at that point in time.

In the following case the therapist experience sorrow and pain to put themselves in the place of the person on which the patient is expressing anger and frustration in an aggressive manner. The therapist chooses to shut up and listen to what the patient has to say. In this case, the excitement could not be so regulated, but he was able to continue listening without making an intervention:

*Suddenly I crossed the image of my son and I imagined how terrible it would be to have a son saying something like that, and I cried... "Now, yes, tell me, tell me..." (EM 7).*

In the following quote is another case in which the therapist reacts in shock at the story of the patient. Here the therapist does not choose to be silent, but muted before the story, experiencing anger:

*Mom told me that she attacked her son, her baby, you know? And he had choked on Monday night and was in danger of life... I was frozen, I didn't know what to say... (EM 3)*

Once the silence started, begins the phase of awareness, where the therapist realizes that you are experiencing a negative emotion. Within this phase, are the phases of observation and care, where the therapist pays attention by controlling negative emotions by observing and checking time to time the body and the thoughts. If the therapist can observe and take care of their emotional state, moving on to the next stage, which is the self-regulation. Here the therapist initiates two sub-phases: controlling the negative feelings and checking the body and the thoughts. The therapist can be maintained between these two phases until it achieves selfregulation.

The following case illustrates the phases and sub-phases, in which the therapist

describes in detail how each of the moments, and the strategy that he used to be able to regulate negative emotions of grief that he was feeling at that moment:

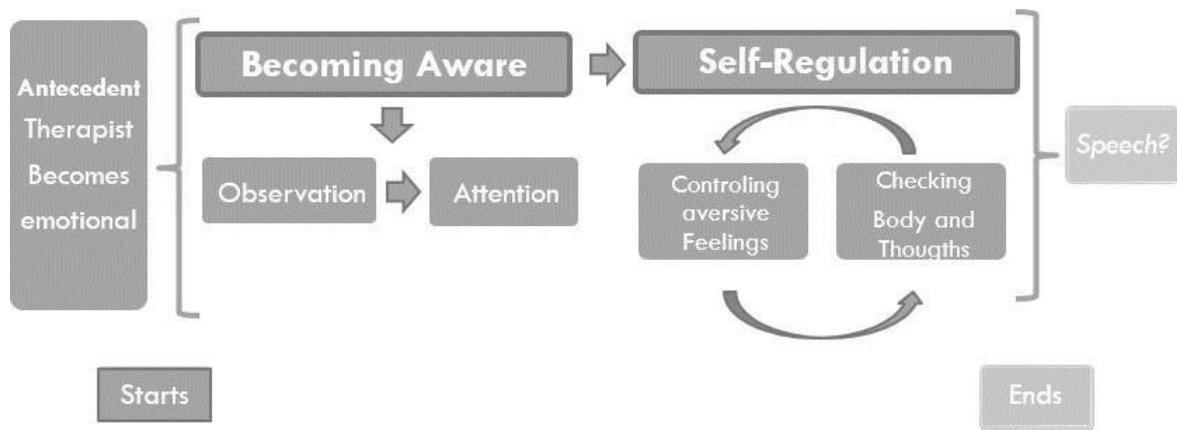
*I wait, look... I pay attention, if my body, because sometimes I was thrilled I, too, as I focused on my eyes, my nose... my eyes, my nose, my chest, what happens in the nose, at the same time by the eyes. How do I do a check-up as well, such as automatic fast mode, of, of, of if there is an emotion there. How much, how much I am expressing that emotion... I think that under a little look, which looked at the patient and under a little look... and coughing, which allows me to how to divert the...it's like a kind of self-regulation with the body (EM4)*

After passing through the phases that are intrinsic to the moment of silence, this can end because the patient or the take up the speech. As in the time of the *Silence of Alert*, is not so clear who is speaking and what they say, but it is clearly stated that the conversation is being taken up. This is manifested in different ways in the following quotes, including the moment just before, to understand how the flow of the session. In both cases, it is the therapist that takes up the conversation and ends the silence:

*How to fix a bit, as it can be a bit, help, I hope and I laugh, I return and do another question of something else (EM 7)*

*... And Anxiety also, in relation to speak, say something. Or... there is a posture take... the act a little. On the basis of, I scolded her... I said that what had happened was very serious. I couldn't go back to pass. And that the substance of your order or reason for consultation had nothing to do in the background with what they see as a matter of priority, in the background was the health of the child (EM 3)*

Figure 7. *Diachrony of Auto regulatory-Silence*



### *Puzzled Silence*

The fourth experiential category is called *Puzzled silence*, where the therapist is confused on the topic discussed at the meeting, feeling off and inconsistency in relation to the patient.

The history of this type of silence is that the patient is talking about something in a way off, both on an emotional level and at the level of discourse.

Once the silence starts, the therapist enters the stage feel the inconsistency or disconnection of the patient, where you cannot understand what the patient is trying to say or what is the central point of what the patient is trying to tell you. This phase consists of the phases of lack of meaning and feeling negative emotions. The therapist can be maintained between these two sub-phases, generating a kind of vicious circle, where the negative emotions would be maintained to the extent that the lack of meaning or sense persists.

To try to get out of that loop of negative emotions and nonsense, the therapist begins the second phase, which is the (over)thinking in order to find a possible meaning of what the patient tries to tell you. In parallel, negative emotions are maintained, with less intensity, because the centre is to think of possible options on the meaning of the record of the patient.

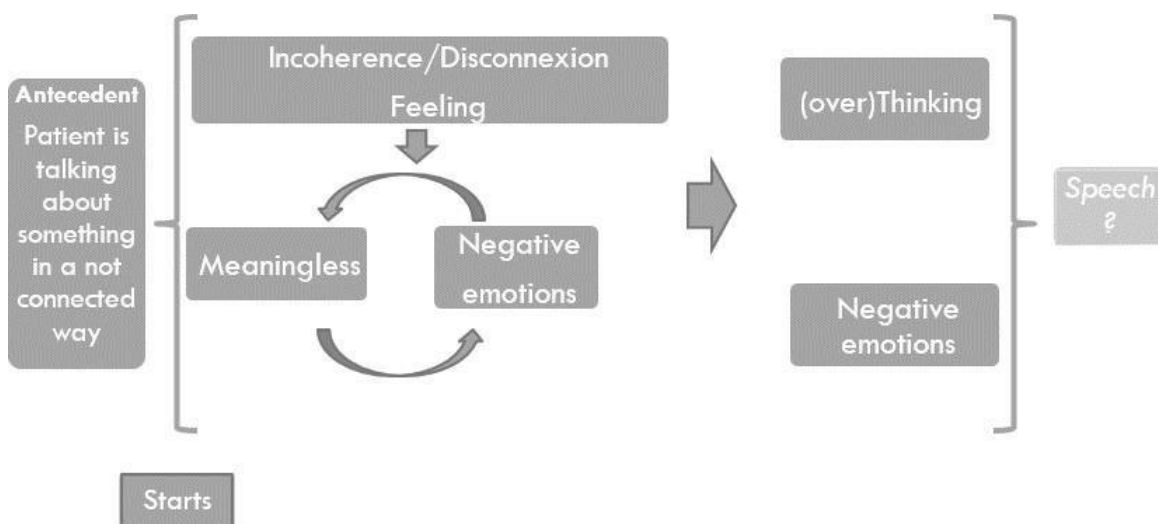
Finally, the silence ends because the therapist or patient resumes the conversation, though it is unclear in what way, happening a situation similar to that of the silence as described above. The clearest is that the therapist will not pass out of negative emotions.

In the following quote, it can be seen clearly how the therapist describes the sensation

of perplexity silence, stating that didn't understand the intent of the patient to relate something specific or the manner in which the story did not allow the could get to fully understand the meaning of what he was saying:

*Hence the silence was as nothing, there is nothing, as... How to separation of disconnection... This is how the feeling of strangeness, as something... "Why am I here" Uuugghh, go, was also like: "Why did you come from?", and how thinking a lot, you know, developing ideas, imagining many possibilities, and in the other very, very... developing things, possibilities... but they are also a lot of images (EM 2)*

Figure 8. *Diachrony of Perplexity Silence*



### ***Strategic Silence***

The latest experiential category is called *Strategic silence*, in which the therapist starts the silence with a particular purpose and useful for therapy,

Intentionally delliberating its occurrence. Is this the first intention which is the antecedent of this silence.

The following case shows how the therapist intentionally installed a silence, taking a very clear idea about to install that specific time:

*... And in that meeting, I didn't want to go easy, so to speak, then when he stopped talking, I didn't answer, I replied, as I wanted to emerge something from him (EM 8)*

The following extract is from the same therapist, performing an intervention of the same type, but in a context with more participants in the meeting, since it was a meeting you family therapy:

*And what began to happen is that well, I passed the paper to the son, the son spoke, the mother wanted to say and raised his hand, "May I speak?" he passed the paper to her, and after the mother started to talk about a lot, then began to change the subject, began to return to the complaint, instead of seeing how for example what the son wanted to tell, and I began to bring the hand and the mother began to lower the tone of voice (...). Then I started to do that, how that not even reached to remove the paper and began to lower his voice as I grabbed. Until, precisely, the silence at the home, the mother I think was going to explode from everything I wanted to say in a moment we were all silent. (EM 8)*

The quote below shows another possible case, where the silence occurs naturally, but the therapist choose to hold it deliberately, in order to be able to give a time to the process that was in progress at that specific moment:

*Because when played as the specific topic. And the patient went from being normal, so to speak, to cry deeply and about something very significant. First of all give a time without interruption, so as not to take away as genuine at the time and waited for a while, I watched him no more, look at the body, look into the eyes... (EM 3)*

To start, the therapist enters the stage to maintain the silence deliberately. This phase consists of the sub-phase of the silence by way of imposition.

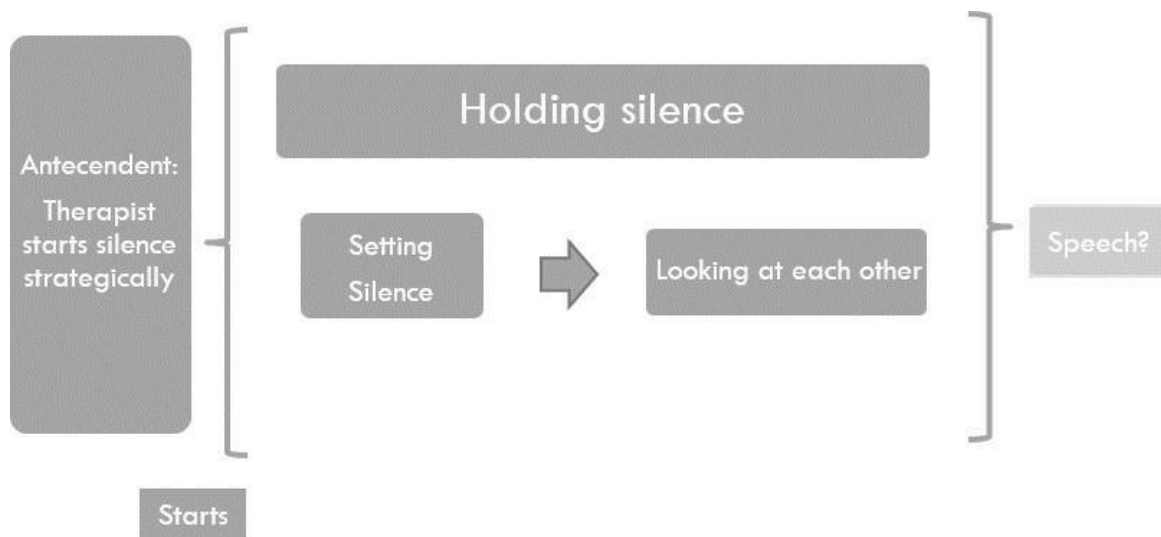
Later, appears the sub-phase where the therapist will look at each other with the patient or the therapist tries to be individually regulated to support a moment of silence:

In the following case, the therapist is trying to be regulated in order to sustain the silence by the tempo that necessary, so that the patient could be connected with the important process and novel that was happening at this particular moment:

*I started to get a little bit more tense, I had the time, but at the same time a certain tension is transformed into a tension that I imagine collective bargaining as a squeeze, as a squeeze I feel like the typical grip here in the chest, mild some concern. As an anxiety as the typical oppression in the chest, a certain restlessness in the body as well. As if he were going in crescendo that tension. But said nothing, didn't say anything, he did not say anything... Then I started the tensions and hold that tension here in the pit of her stomach began to appear, for example, now that I remember, began to appear the presence on the other side of the mirror, but I began to appear, as well as...the next door are also waiting for you, they will want to say, to say something, I don't say anything I started to interfere in some way that as part of the tension, my attention to what might be happening on the other side of the mirror...but there was silence. My tense side toward which all of a sudden I also, I was outside my mind how to think on the other side of the mirror, but, on the other hand, I said to myself: "This is very significant," this is very significant because the first time that a silence so long at the beginning, something is costing you, something has interfered. All those ideas I began to come to the head. And in parallel this another thought, as well as "leave it, leave it, leave it," part of my thoughts were: "Hold this is good, this is significant". My breath...that is how to feel the rhythm of my breath as in an effort to agree to maintain, by regulation, to maintain at the same time I was happy that it was something. (EM 4)*

The silence ends to resume the conversation, but it is not clear when or who is that breaks the silence. In the interviews it was mentioned that the silence ended, but, considering that it is a generic structure, it is not very clear who is the actor that ends the moment of silence, nor with that kind of intervention.

Figure 9. *Diachrony of Strategic Silence*



At the beginning, it had been considered to include a sixth experiential category, called *Flowing Silence*, but finally it was decided to remove it, due to its similarity with the *accompaniment silence*. For this reason, it was decided to merge some phases of this type of silence at the *accompaniment silence*. In addition, both silences were similar in structure, only differed in some denominations or changes in the content of the topic dealt with in general, so it was decided to merge to the *accompaniment silence*.

### **Synchronic Analysis Results**

Synchronic analysis was performed for the central phase of each silence that was generated from the diachronic analysis. The central phase of each one of them is framed by the start and end of the silence. Thus, descriptions for each one of them take on greater relevance at the time in both therapist and patient is not, interacting verbally.

There were descriptions of previous or later phases to the silences, since the keys generated from the diachronic analysis are clear enough to be able to discern each one of the types generated for the therapists.

Results of the generic synchronic analysis will be presented for each type of experiential category presented in the results of the diachronic analysis, following the same order.

### *Accompaniment Silence*

During this type of silence, the therapist is mainly focused to the patient, paying attention to the experiential flow of the patient, as it is touching a sensitive subject. Because of this, the therapist fixes its attention to key patient facial, body and vocal also. As mentioned in the diachronic analysis, the therapist attends to these keys to be able to be there with the patient.

On the other hand, the therapist also pays attention to their own keys for both body and face. Within these, we have that the therapist directs their look to the patient or his or her around, being able to observe it completely.

Also the therapist describes his look not only as directed toward the patient, but has a quality of being a warm look, which is consistent with the phase of being connected with the patient and his/her experiential flow.

The therapist pays attention to their proprioceptive key, being able to identify some sensations. Within these, the therapist distinguishes the sense of openness, where is willing to listen and receive the patient. At the same time, the therapist feel that their body has relaxed while holding this attitude of accompaniment, poor muscle tone.

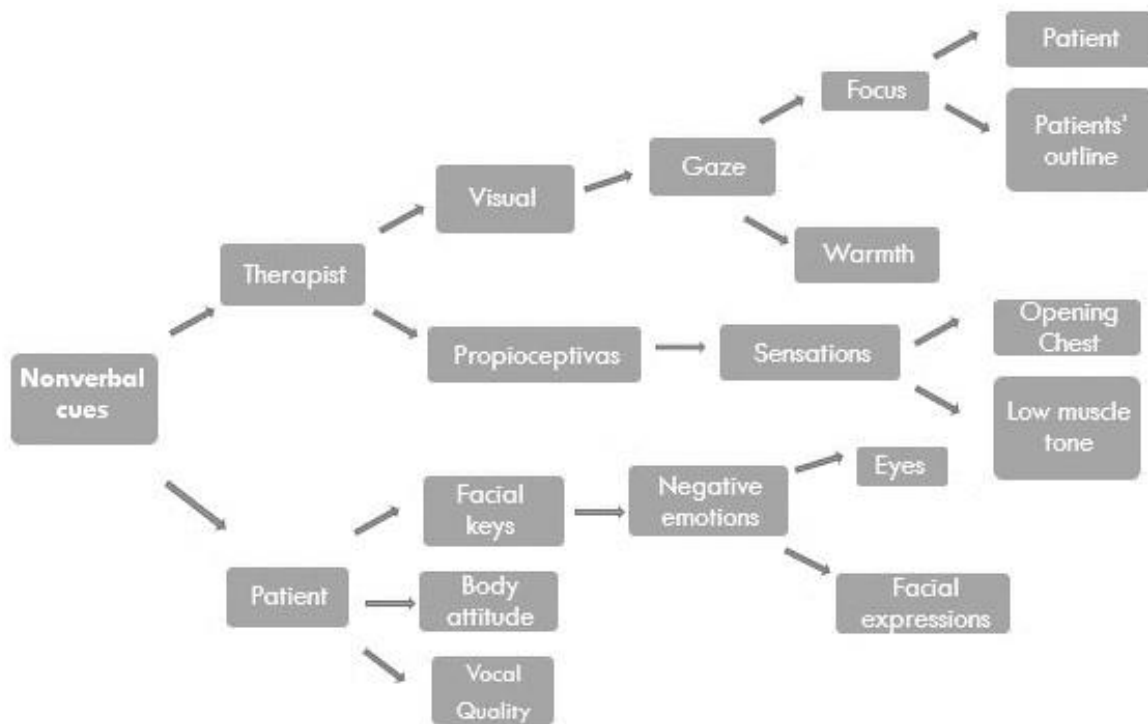
In the following quotes are reflected the main themes found during the phase in which the silence occurs.

*She sometimes looks, sometimes goes with the look for another part... I like... like moving, but always as directed toward her... always very attentive to any signal where she could, say, give me a sign that she is feeling uncomfortable, invaded or whatever... If it is true a look still say, but why, as my feeling, I don't know how to speak, such as surround. How to not focused on the nose, put on your, but as in the silhouette (EM 1).*

*Then at that time did not interrupt... as the patient recovers (E: Where do you notice that?)... in the face, her whole body... are micro movements, such as chin shivering, like a... or eyelid. Ehm... mini movement of the mouth (EM 5)*

Figure 10. *Synchrony of accompaniment silence*






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### *Alert Silence*

During this type of silence, the therapist is dump also toward the patient, but in a different way. Here, the therapist's look is directed toward the patient, but not in an envelope as in the previous, but in this case is focused in order to be able to detect possible changes in the patient, both in facial keys as in their body attitude. This is to be able to understand that "something" that occurred, but that the therapist is not very clear.

On the other hand, the therapist experience bodily sensations to be more tense and with a muscle tone increased during the course of this silence.

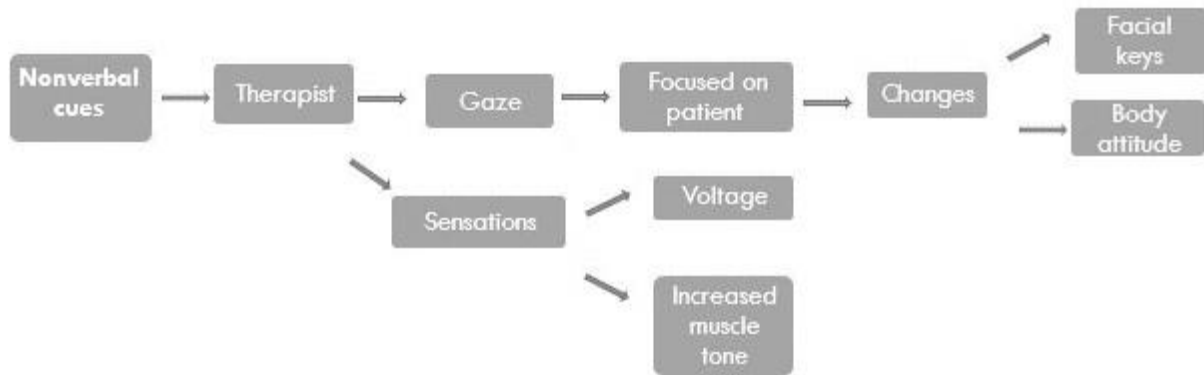
In the following extracts you can appreciate what the therapist during these silences, showing that focuses primarily on the patient, trying to search changes, and also in their own bodily sensations.

*Then as that, I just stood there staring. As saying "something happened", as a kind of look, it's like a slight tension, but a kind of tension waiting... there is something that tells me, the face of the patient Uhhm I... who says to me, "Shut up, leave it" (EM 4).*

*... It started as a bother, as well as to disturb, as well as... "dressed up", such as "I caught, and I didn't want to say wait how didn't respond anything I felt like a*

*little uncomfortable. I hold up the more I could and then move on to another topic. But I spent very to another topic, for that will be installed the idea of 'silence grants', but also my own silence, (EM 7).*

Figure 11. *Synchrony of Alert Silence*



### ***Self-Regulatory Silence***

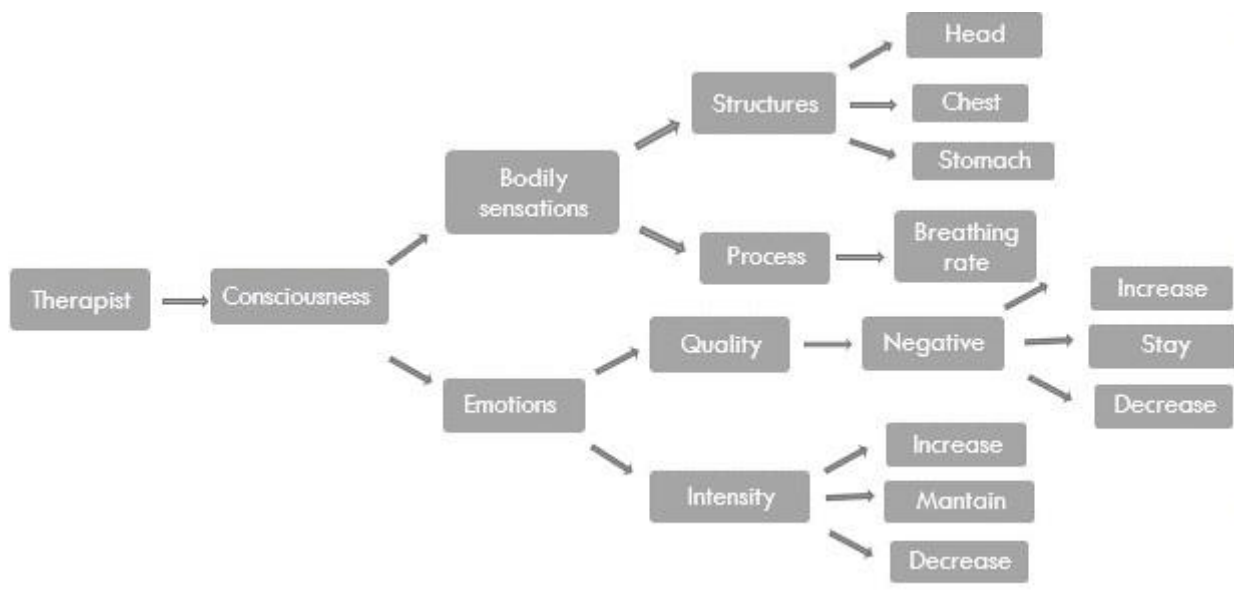
In Self-Regulatory silence, the focus is mainly the therapist. Here the therapist regulates emotions that is feeling. For it takes awareness of what they are feeling at a given time. For this, it focuses on their bodily feelings, where the therapist, paying attention to structures or processes. Within the structures, we can notice that the therapist pays attention to the chest, the stomach and to the head. Within the processes pays special attention to the rhythm of the breathing.

At the second level, pay attention to the emotions that are in progress. Primarily, the therapist experience emotions of negative valence, such as anger or grief.

Not just pay attention to the valence of the emotions, but also become aware of the intensity of these, which can be maintained, increase or decrease. In the following quotes are evidence that the focus is the therapist

*because sometimes I get emotional too. As I concentrated on my eyes, my nose... my eyes, my nose, my chest, what is happening to my nose and in my eyes at the same time, and sometimes there is a little bit of anxiety too(EM 4).*

Figure 12. *Synchrony of Regulatory Silence*



### ***Puzzled Silence***

In this silence, the patient goes to the background and the focus is on the therapist, who is living in three different levels of experience. In a level is feeling negative emotions. Within these you can find emotions such as anger, surprise and annoyance.

At the cognitive level, the therapist looks for options that might seek to explain the speech and/or attitude of the patient, as it would be a point that is not understood. On the other hand, the therapist not only think in possibilities that allows to understand the speech of the patient, but can also imagine these options, being able to stage them.

At the level of nonverbal cues, the face of the therapist expresses mostly strangeness, anger and annoyance.

The following quotes show what are the central focus of the therapist, where shown mainly the emotions and facial keys associated with them:

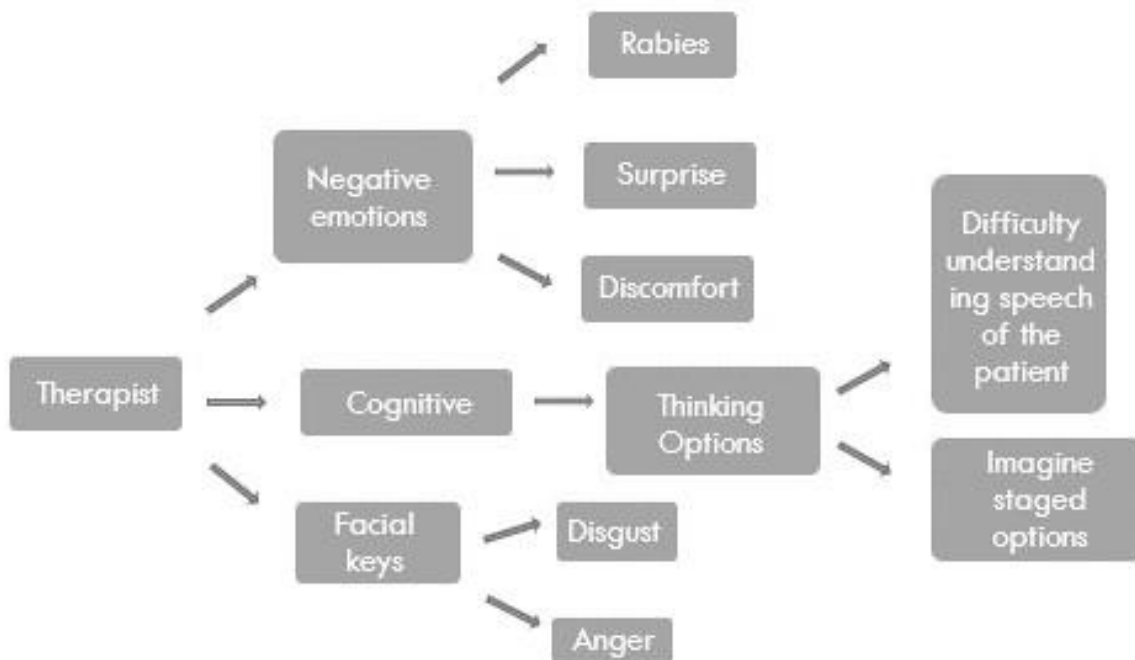
*And also of disconnection. As... as of separation, of disconnection, already... that feeling of strangeness, as something... they were like "Why did you come from?", then*

*Were silences as "already, if... you..." And I as well as: "any idea, as something.?", "Why am I here? Uuugggh, go away! (EM 2)*

*I didn't know what to say, first of all I felt like... a little... anger, surprise and also sadness (EM 3)*

*As he thought about how to rearm myself and say something fairly adequate, not aggressive, not too much defense, not embarrassing, and ... not angry but... in that think at the same time, connect with the anxiety that I am feeling, because I am living the angré as well very strongly (EM 4)*

Figure 13. *Synchrony of Puzzled Silence*



### *Strategic silence*

In the silence, the therapist has a particular expectation on the patient, either to say something, to develop something, think about something particular, connect with an emotion, etc. In this sense, the therapist, while the silence, is actively waiting for the response of the patient, and therefore their attention is primarily focused on the patient.

On the other hand, the therapist should also pay attention to their own nonverbal cues, since it has regular deliberately the time that remains in silence so that the patient to respond. Here, the therapist focuses primarily on aspects: the first is the breathing. Second, the therapist can pay attention to the body sensations, being able to notice that has tension and also something of concern. In the third place, the therapist pays attention to the emotions, where to be a standby voltage and also, anxiety.

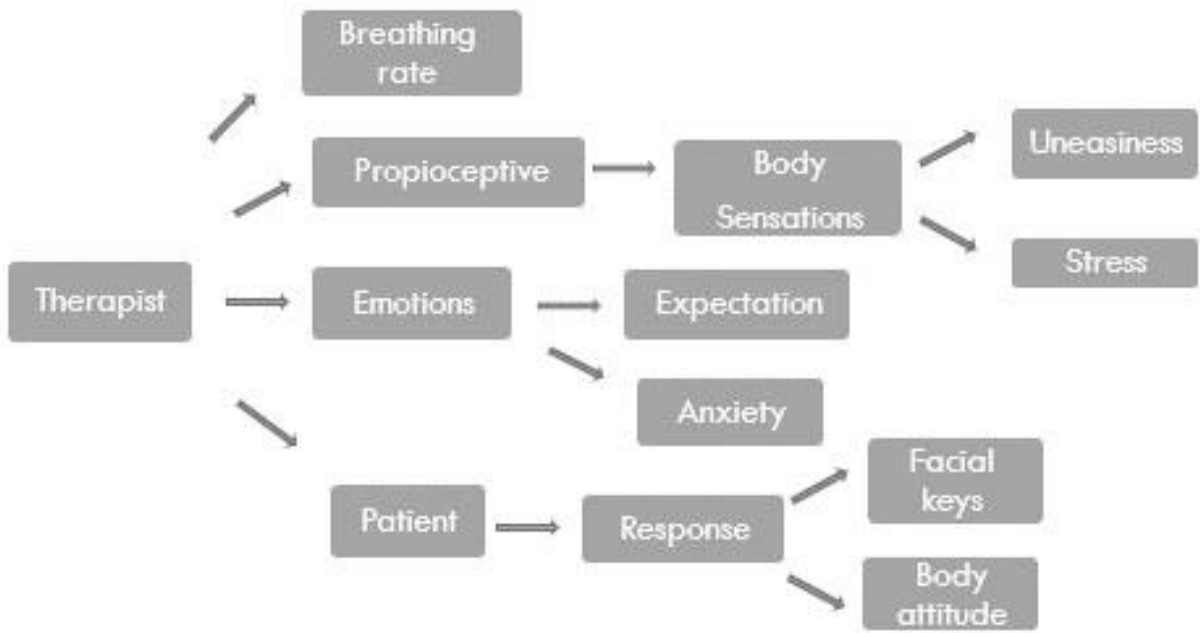
The last element, the therapist focuses its attention on the patient, to closely monitor the response of them. For this, focuses primarily on the nonverbal cues, such as their facial expression and body language.

In the case of the next appointment, it may be noted that the therapist choose to stay in silence after he has said something that might seem inappropriate for the patient:

*Silence caused by me, I am processing I am going to say or I'm going to questions or that... because I am ordering internally. And I'm thinking: "already" as well as preparing the next question, feeling what we just talked about and living the relevance of the following intervention (EM 5)*

*Until, precisely, the mutes. At the beginning, the mother I think it was going to explode from all I wanted to say... at a time when all of us are silent and I looked to me, especially the mother, such as waiting for me to give the pass to talk... and I even took aim, as they did not see how or anxiety or anger (EM 8)*

Figure 14. *Synchrony of Strategic Silence*



## STUDY 1 DISCUSSION

The purpose of this study was to *adapt and complement the PICS system-II for use in Spanish-speaking context and for the identification of categories of silence for therapists.*

To achieve the purpose, qualitative analysis was carried out using two different techniques of semi-structure and micro-phenomenological interviews and two classes of analysis that allowed to encode the interviews of therapists and patients. These two techniques allowed to describe and adapt the categories of silences for existing patients in the PICS systemII, experiential and create categories of silences for therapists.

The analyses conducted to interviews , in addition to the contributions made by the encoders, helped lift the *Coding System of silences for therapists and patients (PICSTP)*. This system was created on the basis of the modifications made to the PICS-II (Frankel & Levitt, 2004) and the categories of silences generated for the silences of therapists. It was decided to create a unique system of silences that includes both actors, because this research was oriented from the beginning to be able to understand the participation of the silences in the regulation of the interaction between therapist and patient.

In the first place, the silences for patients were primarily based on the PICS-II created by Levitt (1998, 2001, 2002), since the categories remained largely intact. Although the proceeds raised from the interviews with therapists and patients on the silences of the patients are not exactly the same, they are fairly similar, mainly in terms of functions that the silences have for patients in session. The modifications made to the complement of the encoders broadened slightly these functions.

The first difference found with the system of Levitt, is that the PICS-TP does not classify silences in function of its contribution to the therapeutic results. PICS-TP dealt to classify each silence considering the features that each one of them has at a specific time, without projecting beyond that particular moment.

One of the differences associated to this point, is that the interactive silences came to be regarded as instances in which patients can interact with the therapist in both negative and positive manner. In the PICS-II (Frankel & Levitt, 2004) the interactive silences are defined primarily as silences where the patient is related with the therapist to pay attention to the aspects

of self, requesting something. According to the investigations carried out in this system, this silence has been classified as obstructive and therefore negative for the therapeutic process, which is consistent with the subcategories associated with this silence. However, encoders that generated the PICS-TP, noticed in the videos reviewed that patients may require communication with the therapist, but in terms of complicity. We were able to see in the videos that the patient may propose this type of interaction, resulting in a positive response from the therapist. Even, it was observed that many times this complicity emerged spontaneously, and that this was evidenced from nonverbal cues that show mostly positive affects of both participants. On the other hand, you could see that this not only happened after an awkward topic, complicated or uncomfortable for the patient, but can also occur when the participants are interacting in a positive way, without expressing disagreement between them.

It was proposed, as well, after the final revisions to the encodings and the manual, characterize the quality of the interactive silence in positive or negative, depending on the emotional climate between therapist and patient. This is conceived of as an optional specification, depending on who wish to use the PICS-TP, in function of the research objectives.

Another fundamental difference with the Levitt is that the authors of the PICS-TP was considered necessary by the clarification of the valence of emotional silences. This was taken as the decision to agree unanimously observations of episodes where the emotions expressed correspond to mixed emotions or that could even be classified as positive. Despite the fact that this was considered as a specification that may be relevant to be able to understand the interactions between therapist and patient, it was decided to propose only in the manual, was not included in the codification in the study 2, since it was something that was agreed after the completion of the encodings and the analysis, after reviewing the manual coding.

Another difference with the PICS-II, is that the PICS-TP does not propose differences the silences reflective in low or high, since it is difficult to know if the process that is making the patient really does belong to one category or another. In order to differentiate it, it would be necessary for the patient to verbalize much of the content of their reflection. The encoders considered that it is not easy to be certain of the degree of complexity of the reflection only from what the patient verbalizes after the silence. However, encoders, identified that there may be other kind of visible manifestations that may indicate that the patient is thinking. The indicator that is observed quite recurrence was the existence of adaptors (Ekman & Friesen, 1969). The



patient can lead his hand to his chin, tighten the lips or other similar expressions. While this is not a factor necessary nor sufficient to encode a silence as reflective, is proposed as one of the possible indicators.

The encoders decided to leave the rest of the categories as they are in the PICS- II, as it found no differences with the characteristics proposed by Levitt. This decision has a direct relationship with the saturation of the results, because the interviews performed to patients not yielded new results that the encoders will be considered as other than those described by Heidi Levitt (1998, 2001, 2002; Frankel & Levitt, 2004). The results of the silences of the patients - as therapists and patients - that coincide with the functions and meanings raised by Levitt are: emotional silences (emotional connection, overload (catharsis), silences that allow symbolize experience (naming feelings), reflective silences (analyse, understand experience, becoming aware, reconsider a perspective), silence to remember and disconnected silences (express disagreement with the therapist, boycott the therapeutic work, change the subject, delegate responsibility and disconnect from the session or the therapist).

An important point in which the results do not match what Levitt are the associative silences (Frankel & Levitt, 2004), since they were not mentioned as such in the interviews, but that appear as part of other categories. For example, Levitt believes that a type of associative silence would change the subject (end of one, start a new one or try to change it), but this appears to relate to the *resistance* of the Silences of the patients according to the therapists.

One of the most striking results thrown by the patient interviews, is that continually alluded to attitudes of therapists, including specific descriptions, in considerable detail. This not only could be seen at the time of conducting the interviews, but appeared in the results of the interviews, allowing the emergence of a result specifically referred to the patients can say about the silence of their therapists.

The interview script always contemplated asking for it, because it was considered the most coherent in function of the central theme of the research. However, to achieve a characterization of the silences of therapists from the perspective of patients was not part of the objectives stated in this research. In fact, questions were guidelines that will aim to do this. The questions of the interview were added in order to generate more detailed descriptions of the interactions between therapist and patient. Thus, these results constitute a surprise factor that

contribute to and complement the interviews with therapists on their own silences in psychotherapy.

It is even more striking that several of the categories of therapists' silences, described from the perspective of patients are very similar to what was said by the therapists, both, semistructured and micro-phenomenological interviews.

The subcategories in the category "to go along with patient", described that patients may feel respected, accepted and supported emotionally by their therapists in the moments of silence. This category is consistent with what is described by the therapists in the subcategories within the categories "be connected with the patient," where therapists claim that they can follow the flow of the patient at the experiential moments of silences, and can serve both emotional support as well as a space so that the patients can exist as they are without being judged.

These results are also consistent with the category of *Silence*, and in which the fundamental characteristic is that the therapist is following and respecting the patient's experiential flow from listen and acknowledge their experience, which allows them to accept the patient experience as valid.

Also, it is very consistent with the classical approaches of Rogers (1958), in which it is stated that one of the basic conditions for the therapy is the unconditional acceptance of the patient, as well as the empathetic attitude that the therapist will be able to maintain during the session.

The category "silences to challenge the patient" obtained in the interviews of patients is similar to the category of *Strategic Silence* obtained in the diachronic Analysis of the microphenomenological analysis. Here the therapist chooses silence in a strategic manner for the patient to perform a particular task, which can be connect emotionally, to return to the therapeutic work, speaking, etc. This is also illustrated in the subcategory of *silences to challenge the patient*, which illustrates that the patient will feel obligated to do something in therapy, particularly to speak at the meeting.

In the case of the silences of the therapists, these were identified with the microphenomenological interviews, which allowed for the lifting of the typologies of silences in function of the current experience of therapists and descriptions that allow you to characterize in more detail the stages of each of the categories.

This technique proved to be a good tool to be able to urge the evocation of moments of silences in the therapists. The interviewed demonstrated that they connect quickly with the dynamics of the issues addressed, as well as the questions in order to achieve the evocation and characterization of their own experience, being able to explore into details not only of themselves, but they were also able to mention details associated with the experience of the patients, which could be inferred from the conduct of these in relation to them as therapists. This could be achieved on the basis of the identification of the issues treated in therapy and the attitude that each of them maintained as long as a specific issue is being worked throughout the sessions.

On the other hand, the micro-phenomenological analysis technique allowed to describe the experience of therapists at two levels: temporary and descriptive. In this sense, the experience of therapists could be rebuilt in terms of experience, with a shaft and principle of diachronic, and to be able to characterize the diachrony in greater detail. This could be achieved by a descriptive analysis of sentences of therapists, being able to identify issues associated with them. The identification of these characteristics served as a guide and support to the coders, since they were unable to find specific keys and observable characteristic of each type of silence of the therapists.

In this sense, this technique is not only useful to describe the "internal" experience of therapists, but private experience that could also be associated with keys that are accessible to third parties. This is a strength of the PICS-TP, since this system was created with the intention of that third parties may make the identification of silences from video taped sessions, so that the participants in the interaction therapist are not there to be able to guide the interpretation and coding of the silences.

On the other hand, some of the results found with this interview technique and analysis were consistent with some of the results that were generated from the analysis with the Grounded Theory of the semi structured interviews. No matches were found between the results of the interviews and the microphenomenological interviews both therapists and patients on the therapists' silences.

The matches are not as identical as those found between the therapists' silences from the perspective of patients, with the silences of the patients from the perspective of the therapists. However, there is overlap between subcategories of the semi structured interviews of therapists

on the silences their own silences and diachronic results of microphenomenological interviews. For example, therapists indicate that their silences help them to become more available in meeting, both cognitive and emotional level to be able to be connected with its own experience in course, which would enable them to plan their interventions. This is similar to what is expressed in the *Regulatory silences*, in which therapists seek to control their emotions in order to perform an intervention that will be useful, but also constructive, respectful and polite. This is also consistent with what was mentioned both by patients and by therapists about silence as a space for respect to the patient, in the sense that they can allow the patient to not feel judged.

This point is very relevant, since it is consistent with the issues raised by the team of Clara Hill on the silences as a strategic tool that allows therapists to plan what they will say how intervention (Hill, Thompson, & Ladany, Ladany, 2003; Hill, Thompson & O'Brien, 2004), similar to what was presented to the classical cognitive perspective (Pfeffer & Daddy, 1985).

These matches are relevant, because it shows that similar results can be found not only with different techniques, but also by interviewing the various participants in the therapeutic interaction. This allows to set conjecture about the procedural knowledge that each participant develops on its counterpart along the psychotherapeutic process. Both therapists and patients can give a detailed account of the experience that the partner is having in the course of the session. This may be related to the knowledge that both therapist and patient can achieve the other from content and dynamics that come into play to relational level during the session, particularly tacit level (Beebe, 2006, Tronick, 1989), knowledge that is achieved on the basis of recurring dynamic where both actors adapt their behaviour to each other (Buck & VanLear, 2002), framed by adjusting the specific relationship given by this framework of socio-cultural relationship that is psychotherapy (Martinez et al., 2014; Willig, 2008).

The silences, to be a fundamentally cultural phenomenon (Keller et al., 2004; Matsumoto & Huang, 2004; Ronningstam, 2006) and contextual (Gallardo et al., 1993; Jaworski, 1993, Kurzon, 2007, 2009, 2013; Cornwall, 2006), would acquire their possible meanings and uses depending on the context that this regulating. In this sense, the meanings, uses and functions between therapist and patient would be bounded by both explicit and implicit rules that regulate the relationship, as well as the recurrent relational dynamics that develop from the mutual adaptation of behaviour throughout the sessions. Thus, the possible meanings and functions of

the silence in therapy would be more restricted features and possibilities than the silences that occur in everyday life.

This hypothesis could be supported by the matches found between therapists and patients, and in the two different types of interviews and analysis, since less possible functions of silence, it would be more likely to get to matches in the use and effects of this, taking into account that they are the same actors that relate repeatedly under the same rules and agreements, both therapeutic (framing, therapeutic approach, goals, tasks, interventions), cultural (i.e.: country, language, traditions, etc.).

## STUDY 2

This study had two main purposes: the first was to answer the specific objectives, two, three and four of this thesis, and the second, the test of reliability of the Coding System (PICS OF SILENCES-TP).

To be able to develop both reliability studies, it was necessary to codify silences of therapist and patient in episodes of change and rupture of a long-term psychotherapy, which will be awarded on the details below.

The first step to achieve the purposes mentioned was to carry out the adaptation of the PICS-II, below, describes the steps followed to do this:

### **Adaptation of PICS-II**

As mentioned above, the study 1 had as objective to be able to put a system of categorization of silences for patients and another for therapists. In the case of the patients, it was decided to adapt and extend the PICS-II created by Levitt (Levitt, 1998, 2001, 2002), since it was considered that descriptive account with the rigor and robustness of the kappa index was needed to make a new one. However, as the silences - as mentioned in the background - are associated with socio-cultural and contextual factors, it was decided to adapt the system to a Spanish-speaking context, you can add, remove, and clarify, if necessary, the characteristics of the silences that were described by Levitt (To see in detail the organization of the system, see Annex N°2).

To do this, two observers were trained to the issue of silences in psychotherapy, including theoretical and empirical background, and in the PICS-II. The main objective of this training was able to generate a global and historical understanding of the relevance of the phenomenon and generate minimum knowledge to be able to encode silences later in a long-term therapy.

Considering these initial objectives, the training was divided into the following Phases:

### **Training**

#### ***Phase 1: Familiarization with the silences and PICS-II***

Each observer participated in two training sessions, which included theoretical and empirical readings of silences in psychotherapy, the reading of this project and the reading and study of the PICS-II, including the empirical studies with this system. During these sessions, consultations were associated with the readings, as well as the detailed explanation of this project, including its objectives and procedures to perform.

### ***Phase 2: Pilot Coding of silences of patient***

This coding was performed with a long-term therapy (67 sessions), with 44 episodes of change and 14 episodes of rupture. The determination of these relevant episodes was conducted prior to the development of this project by a trained team.

With help of the software Adobe Audition CC 2015, identified the amount of silences present in each of the relevant episodes, considering only those who had a duration of 3 seconds or longer.

These silences were recorded in an Excel spreadsheet, which clearly identifies that therapy belonged, as well as other features such as: number of meeting, episode type, silence location (interturn or intraturn), duration of silence (in seconds), start time of silence and time of end of the silence. It is also identified if the silence "belongs" to therapist or patient, considering that the silence belongs to who starts it, that is to say, who is speaking and shuts up after finishing what he was saying. The other actor was considered to be a follower of that silence proposed, choosing to remain silent or to continue with the conversation.

The following figure illustrates the form used to encode silences. It can be seen the variable chosen to characterize each silence found in the relevant episodes chosen to carry out the relevant analysis.

Figure 15. *Matrix of Excel sheet for encoding of silences in the training*

	A	B	C	D	E	F	G	H	I	J	K	L
	Terapia	Sesión	Nº Episodio	Tipo Episodio	Turno	Rol	Ubicación	Duración	Tiempo de Inicio	Tiempo de término	Silencio	Frase
2	N1	2	1	cambio	185	terapeuta	intraturno	3.887	0:07.386	0:11.274		mmm
3	N1	2	1	cambio	185	terapeuta	interturno	11.303	0:14.196	0:25.500		no lo siente un poco
4	N1	2	1	cambio	186	paciente	intraturno	10.033	0:26.136	0:36.169		es que
5	N1	2	1	cambio	187	terapeuta	intraturno	11.000	0:39.000	0:50.000		mmm
6	N1	2	1	cambio	189	terapeuta	interturno	16.426	1:28.573	1:45.426		mmm
7	N1	2	1	cambio	191	terapeuta	intraturno	3.495	1:51.653	1:55.148		mmm
8	N1	2	1	cambio	191	terapeuta	intraturno	3.057	2:22.239	2:25.296		lo que faltó lo que no hay
9	N1	2	1	cambio	191	paciente	intraturno	4.009	2:28.392	2:32.402		sí
10	N1	2	1	cambio	193	terapeuta	intraturno	5.649	2:35.422	2:41.071		mmm
11	N1	2	1	cambio	193	terapeuta	interturno	5.547	3:23.756	3:29.303		siente más bien

In total, 207 silences were identified, 174 of patient and 34 of therapist. In this phase, the objectives of this phase of the study 1, were coded only the corresponding to patient.

For the codification of the silences, the video of the corresponding relevant episode was used, the transcript of the relevant episode and the Excel spreadsheet.

The encoding is carried out separately, codifying the two observers in training and another person who acted as judge between the encoders. Later, 4 sessions were carried out in order to agree on the encodings. These sessions were conducted with the judge and the observers, but separately, having a total of 6 consensus meetings: 3 with the observer 1 and 3 with the observer 2.

### ***Phase 2.1: Consensus coding pilot:***

In addition, there were 5 joint consensus meetings where they resolved doubts on the categories of silences, as well as the review of the description of the nonverbal factors associated with each category of silence, including some more in-depth features or removing or extending some of the descriptions. This was done by observing the video and also seeing the results of the interviews of the patients, mainly using trees of categories that were obtained from the interviews of patients, and also the PICS-II. The features added, removed or expanded were of the unanimous consensus of the three encoders.

After the training, the final definitive coding was elaborated.



## **Reliability Studies**

### ***Final encoding of a long-term therapy***

To develop the reliability studies for the PICS-TP, proceeded to encode a long psychotherapy.

The following describes the general characteristics of the psychotherapy to work:

#### ***General characterization of the case: B***

The patient, referred to as "B", has 29 years at the beginning of the therapy. Belongs to a low socioeconomic level and lives with his mother, a brother, a sister and a little niece. Has technical studies and works in a Call Center.

The therapist is a woman of 45 years old at the time of initiating therapy. Of psychodynamic theoretical orientation, and with more than 20 years of experience as a psychotherapist.

During the first session, "B" tells she is with pharmacologic therapy for 2 years ago, now that they had consulted a psychiatrist because of her father's death, with whom she maintained a very close relationship. The patient reports that it was "the daughter of father", and thinks that maybe her mother might have felt jealous of her. Her father worked in the air force, and when he was out for service, "B" lived with an uncle and an aunt. On one of these occasions, the uncle, his mother's brother, sexually abused her when she was 5 years old.

Years later, the patient begins to suffer from flashbacks of the episode of abuse after having found fortuitously with the perpetrator. Considering this, "B" contact her uncle by social networks and sends a message, that he had generated a lot of harm and that she needed to talk with him.

In addition to relate this fact, she says that she is attending a psychiatrist and that she doesn't want to follow a pharmacological treatment. In spite of that, openly say that needs to heal and that the only way she considers that can be achieved is through talking with his uncle, in order to have an explanation of the aggression.

At the time of consult, maintains an informal relationship with a man that is - according to what it says - as a son.

The therapy lasted 3 years, in those that were carried out 88 sessions, with a weekly frequency. Took place in the mirror of the Psychodynamic Psychotherapy Unit of a Psychiatric Hospital of Santiago de Chile. It was part of the training activities of a graduate program in Psychoanalytic Psychotherapy and all the sessions were recorded in audio and video.

### *Interrater agreement*

After performing the corresponding encodings, interrater agreement was calculated using Cohen's Kappa (Cohen, 1960).

### *Displays*

The unit of analysis chosen corresponds to relevant episodes (interactive scenarios), to observe micro processes of therapist-patient interaction. These episodes were chosen for having as a feature a particular emotional intensity and because they have proven to be interactive scenarios that in a different way to observe behaviours that are involved in the regulation between patient and therapist, both verbal and non-verbal (Moran et al., 2016).

Specifically, the sample was composed of a total of 161 episodes, 83 episodes of Change (Krause et al., 2006, 2007) and 79 Episodes of Rupture (Safran & Muran, 1996, 2000, 2006), corresponding to different times of the psychotherapeutic process (beginning, middle and end) of a long-term therapy, psychodynamic counselling.

For the inferential analysis, the unit of analysis was silences. A total of 298 silences identified episodes of change and rupture of the therapy.

### *Variables used in the measures*

For the inferential analysis, the following variables were used for the models.

#### *Independent Variables.*

*Duration.* The duration of the silences was measured in seconds, so it is a continuous variable, with a minimum of 3 seconds to a maximum of 42 seconds.

*Type of episode.* As a second independent variable, the type of episode was considered, that is to say, if it was an episode of change or another type. This variable was coded as dummy variable (1= Episode of change, 0 = another episode).

*Actor.* It is also incorporated who of the actors, patient or psychotherapist, was the one who stayed in silence. However, in further analysis, this variable was eliminated for not submitting variability according to the type of silence.

*The dependent variable.*

*Kind of silence.* The kind of silence was coded according to the theoretical classification previously made. In total, 13 types of silence were coded, those who were transformed into dummy variables (1= 0= Not silence; Silence).

### ***Procedure***

The coding was carried out with the "B" therapy. At first, it was identified both the silences of patients and therapist, describing the following qualities of the silences: actor (therapist or patient), duration (in seconds), location (intraturn or interturn), start time and end time.

It was coded both the silences of patient and therapist, using the PICS system-TP generated from the study 1.

In the case of the system for patients, first made in training described above, and then proceeded to make the final coding. In this case, the encodings were conducted separately, both by the trained observers, such as the judge. A first encoding, which subsequently were revised doubts with regard to the categories of silences of patient. Finally, after clarifying the doubts, there was a second encoding, where the three encoders returned to the encoding of the silences.

### ***Data production***

The data were based on the coding of the PICS-TP. Were coded all silences identified in the Change episodes and episodes of rupture, following the procedures described above.

### ***Data analysis***

Descriptive and inferential analyses were conducted. Descriptive analyses were performed with the software Excel 2016 (Microsoft, 2016). These analyses were carried out to be able to have an overview with regard to the distribution in terms of frequencies, percentages,

and the temporal distribution along the therapy of the different types of silences described by the PICS-TP.

In the case of the inferential analysis, to test the hypothesis in study used the technique of logistic regression, because the dependent variables (types of Silence) are binomial or dichotomous variables.

Logistic regression is a statistical analysis technique that is used to assess the contribution of a series of variables on the occurrence of a simple event. In this sense, by means of the logistic regression analysis, it is possible to estimate the probability of occurrence of a particular event.

As a first step, it is tested whether the assumptions of logistic regression and the variables under study. In a later step, 13 models were analysed, according to the number of dependent variables: Types of silences.

Inferential analyses were conducted in the software r (R Core Team, 2017). packages psych version 1.7.8 (Revelle, 2017), car version 2.1-5 (Fox & Weisberg, 2011), RMS version 5.1-1 (Harrell, 2017) and logistf version 1.22 (Heinze & Ploner, 2016).

The variables considered were: actor and type of episodes as independent variables, while the variables type of silence and duration of silence were considered as dependent variables.

Tests were conducted separately for the two types of dependent variables. For the variable duration of silence were used analysis of variance and logistic regressions to assess the statistical differences according to type of episode and actor. For the variable type of silence was made the chi-square test and logistic regression.

## **RESULTS STUDY 2**

### **Results Study of Reliability PICS-TP**

The new adaptation has a coefficient of inter- observer (Cohen's Kappa) of 0.909 for the categories of silences for therapists and 0.852 for the categories of silences for patients. This

is classified as a very good level of interrater agreement, which makes it a system with good level of reliability (Landis & Koch, 1977).

### Results Descriptive Statistics

Then, the most relevant descriptive results of this research will be presented.

The first chart illustrates the frequency distribution of the silences of the therapy B throughout the sessions. In general, it is noted that the silences tend to increase from 13 to 46-47, focusing "half" of the therapy.

In the same chart it can be seen that the silences tend to decrease in frequency from the session 47.

Figure 16. *Frequency of silences along the therapy*

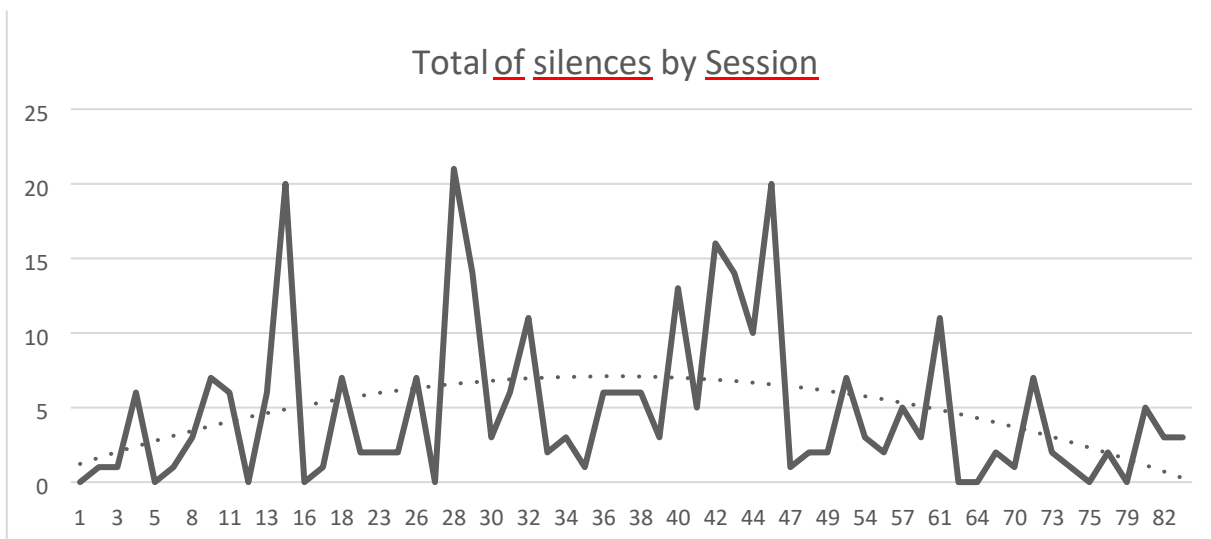
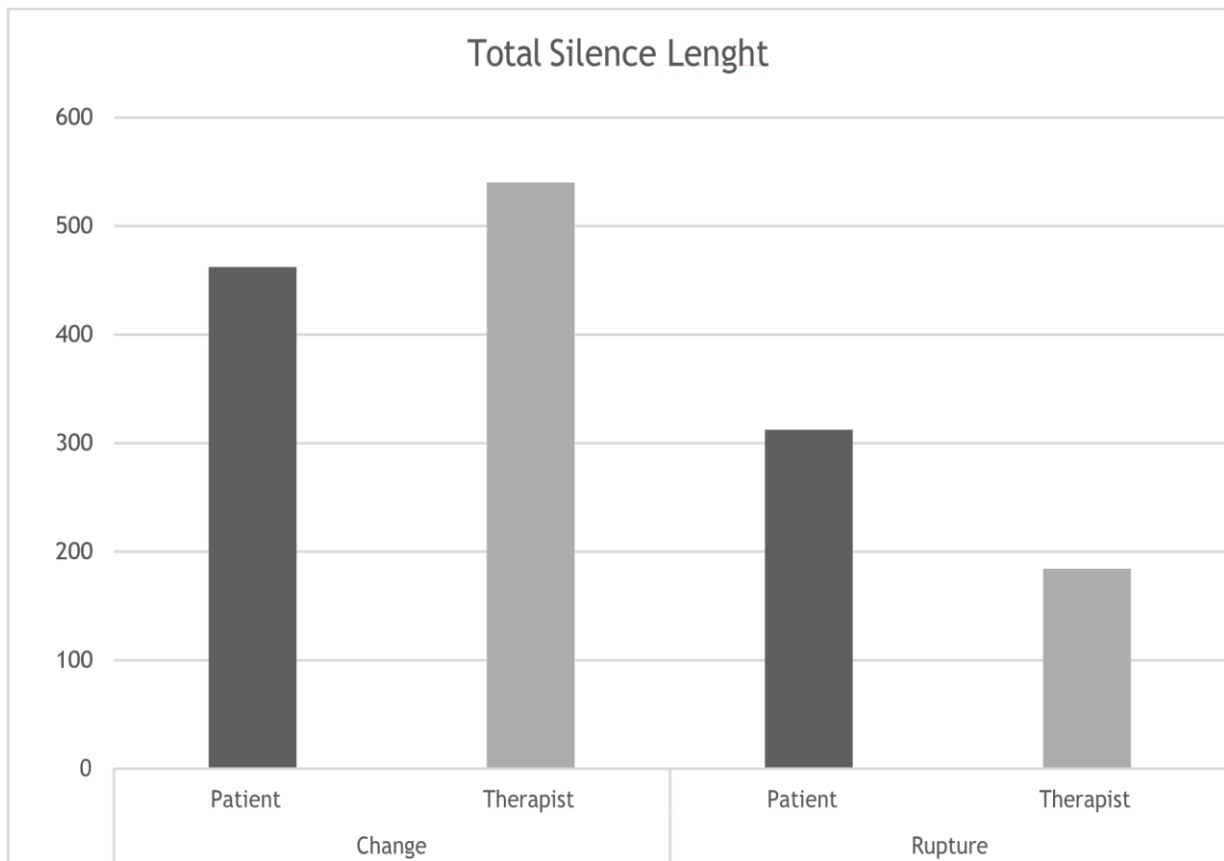


Figure 17 illustrates the duration of silence (in seconds), distributed by type of episode as actor. It can be seen that in general the silences that appear in episodes of changes have longer duration than the silences that appear in episodes of rupture. This occurs in both therapist and patient.

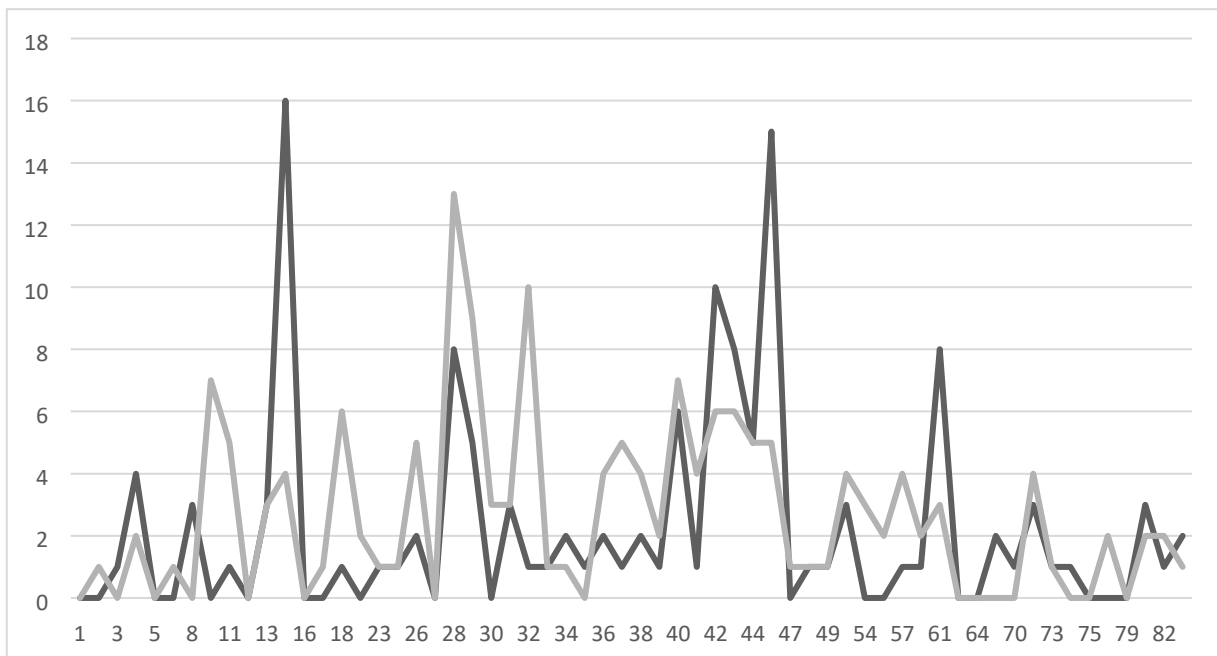
Figure 17. *Duration of the silences according to type of episode and actor*



In the next chart, frequency of the silences can be seen distributed throughout the sessions, according to actor. The darker line represents the therapist and it can be seen that the frequency of silences of therapist tends to increase from the middle to the end of the therapy, more or less from the session 28. The frequency starts to increase slowly but steadily until the session 40. After that, the silences of therapist increase, tending to decrease toward the end of the therapy.

About the silences of the patient (gray line), it can be seen that they are kept more or less constant until the session 26. From the 28 onwards, the frequency increases dramatically, decreasing progressively from the session 36 until the end of the therapy.

Figure 18. *Frequency of silences distributed throughout the sessions*

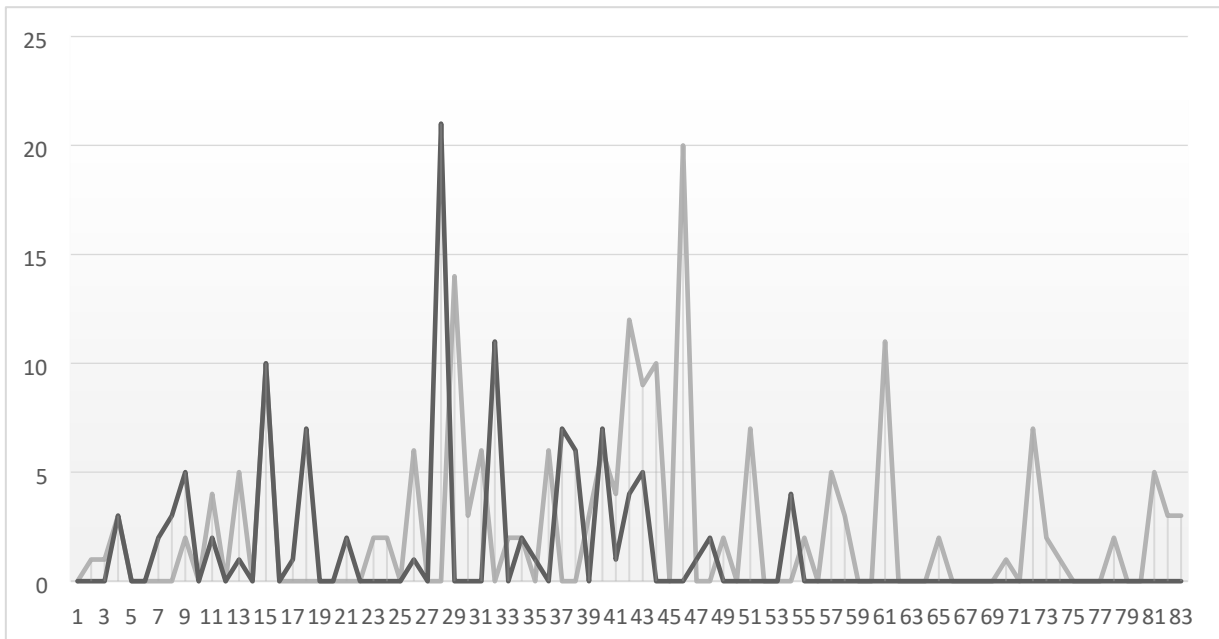


The following chart describes the average duration of the silences by type of episode of throughout the sessions. It can be seen that the average duration of the silences in the Episodes of rupture is rather constant throughout the therapy. It can be seen a peak between 27 and 31 sessions, and then return to average duration. Both the length and the frequency of the silences in the Episodes of Rupture tend to decrease from the 45 onwards. From the session 53-55 no longer appreciate this type of silences.

Frequency of the silences in the Episodes of Change, is quite different from what happens in the Episodes of rupture. From the beginning until the session 27, there has been a constant average duration and with peaks that reach hardly between the 4-5 second. However, since the session 29, the average duration of silences in these episodes begins to increase, taking a significant increase between 41 and 46 sessions.

From there, the average duration of silences in these episodes begins to decrease, presenting visible variations in the graph toward the end of the therapy.

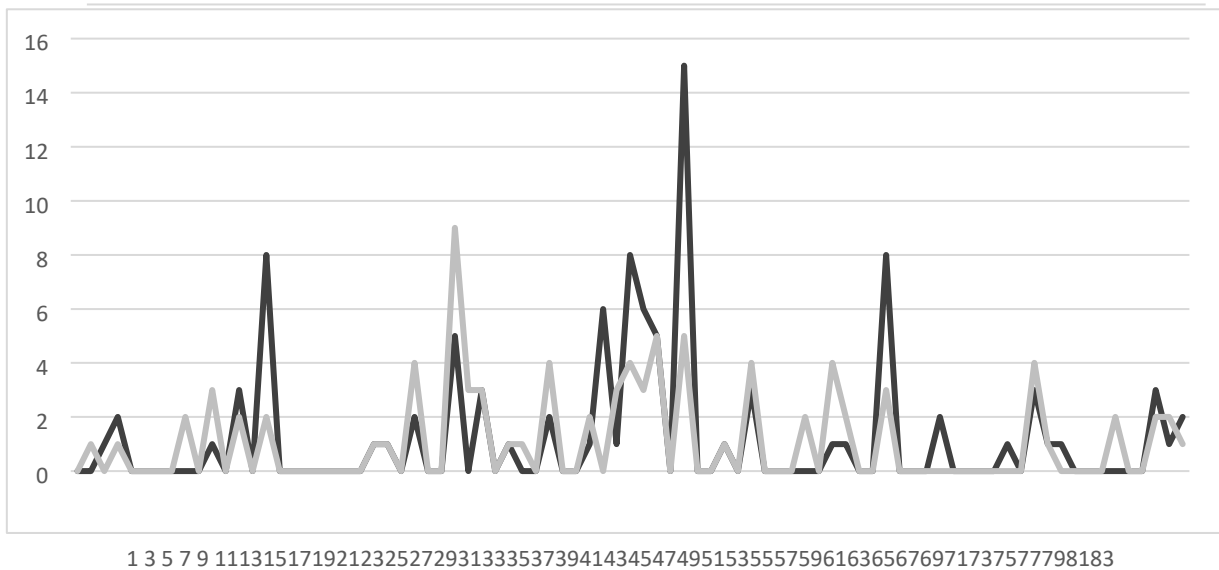
Figure 19. Frequency of silences according to type of episode throughout the sessions



The following chart illustrates the frequency of silences in episodes of change according to role (therapist patient in dark grey and light grey). It can be observed that, as the sessions, the patient begins to spend less time in silence, occurring otherwise in the case of the therapist.

The therapist shows greater variations in its peaks, showing a higher frequency of silences from the 29 to the 47 session.

From the 48 onwards, the frequencies tend to be equated. Figure 20. *Silences by actor in episodes of Change*





In the case of the Episodes of rupture, Figure 21 shows that in both therapist and patient there are quite a few variations in the frequency during this type of episodes. In the case of the patient (in light grey), frequency of the silences in the Episodes of ruptures begins to increase, reaching peaks of 27 frequency between the session and the session 40. From the session 43, the frequency of the silences begins to decrease progressively. From the session 53-55 are not observed silences.

In the case of the therapist, it can be seen that the opposite is true: in general there is little frequency of silences of the therapist in this type of episodes, there remain some peaks in the 15 and 28 sessions. From the session 31, the frequency of the silences of the therapist in the ruptures is kept constant.

Looking closely, you can see that there are silences of therapist from the session 48 or 49.

Figure 21. *Silences By Actor In Episodes Of Rupture*

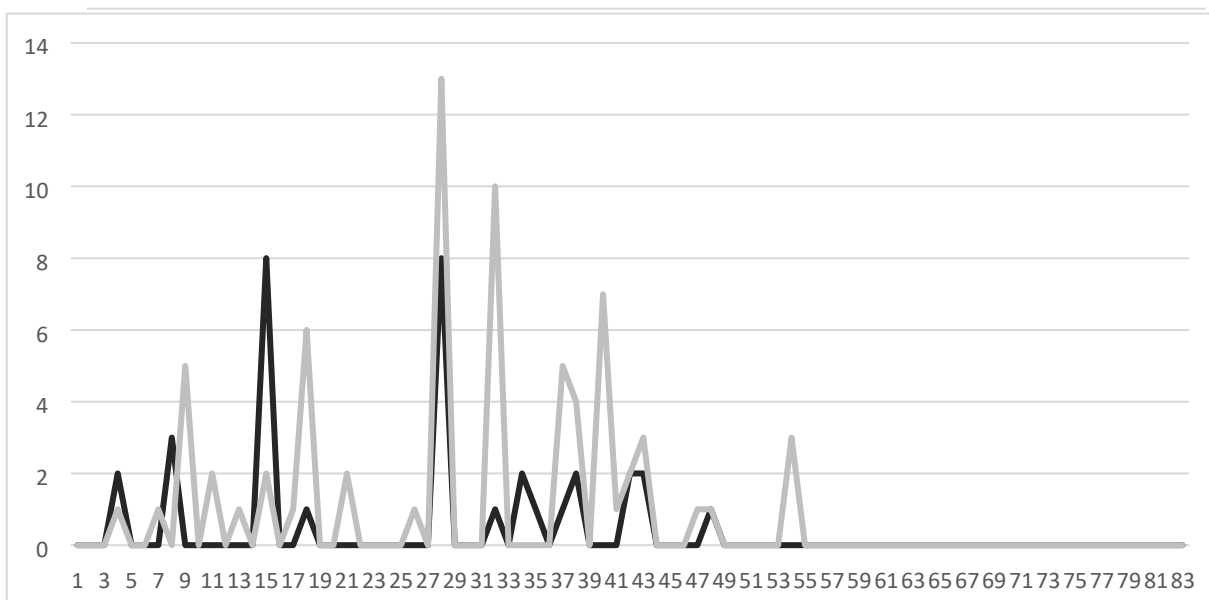


Table 1 summarizes the frequencies of silences according to type of episode and actor. In this measure, not codifiable silences are included, which corresponded to the silence that was not able to allocate a specific category due to the deficit of the material with which they work or because there was little information in the episode in terms of non-verbal content and features that are not allowed to discriminate the kind of silence.

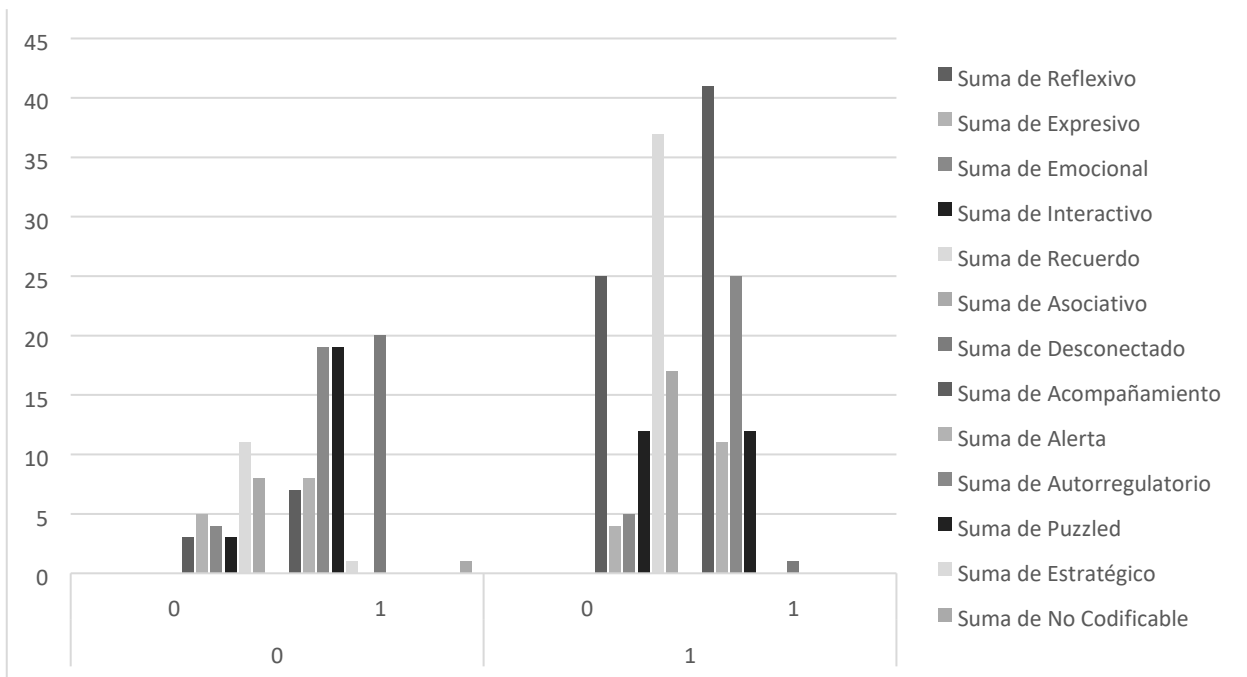
The most frequent silences, independent of the type of episode, were the silences thoughtful, strategic, emotional, interactive and accompaniment.

Table 1. *Frequency of silences, according to actor and type of Episode*

Type of Silence	Refl	Expr.	Emo	Interac.	Mne	Asoc.	Disg	Acomp	Alert	SelfReg	Pzzled	Strategi	Non	Codifiable	
<b>Rupture</b>	<b>7</b>	<b>8</b>	<b>19</b>		<b>19</b>	<b>1</b>	<b>0</b>	<b>20</b>		<b>3</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>11</b>	<b>9</b>
Therapist	0	0	0		0	0	0		3	5		4	3	11	8
Patient	7	8	19		19	1	0	20		0	0	0	0	0	1
<b>Change</b>	<b>41</b>	<b>11</b>	<b>25</b>	<b>12</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>25</b>	<b>4</b>	<b>5</b>	<b>12</b>	<b>37</b>	<b>17</b>		
Therapist	0	0	0	0	0	0	0	25	4	5	12	37	17		
Patient	41	11	25	12	0	0	1	0	0	0	0	0	0		
<b>Total</b>	<b>48</b>	<b>19</b>	<b>44</b>	<b>31</b>	<b>1</b>	<b>0</b>	<b>21</b>	<b>28</b>	<b>9</b>	<b>9</b>	<b>15</b>	<b>48</b>	<b>26</b>		

Figure 22 summarizes the frequency of the silences by Type of episode and Actor. The left chart represents the frequency of silences in the Episodes of rupture, where 0 represents the patient and therapist 1. In the graphic on the right are represented the frequencies of types of silences for episodes of change.

Figure 22. *Types of silences according to type of episode and Actor*



In the following chart (on page 98, horizontal distribution in the sheet), it can be seen the frequency of the types of Silence of the Therapist, distributed along the therapy.

The therapist presented mainly Strategic Silences and accompaniment throughout the therapy and to a lesser extent Puzzled Silences.

On the other hand, along the therapy there were two times when concentrated in an increase in the frequency of silences, the first is between 11 and 24 sessions, and the second between 38 and 48 sessions.

In the first moment is presented in high amounts of strategic silence, alert and puzzled, while in the second it also presented the Strategic silence, but in addition the Accompaniment followed by the puzzled. Finally, the regulatory silence was presented on fewer occasions than the other silences and their distribution was along the therapy.

In the case of the patient (in page 99, horizontal), it can be observed that some silences tend to be more present in the early and middle of the therapy and less toward the end of the therapy, as is the case of the emotional, disengaged, interactive and expressive silences. In the case of the latter, their frequency tends to remain more stable over the therapy.

Unlike these silences, the Reflective tend to be more present toward the end of the therapy. Finally, the silence and the associative memory have low presence along the psychotherapy.

Figure 23. *Types Of Silence of therapist throughout the sessions*

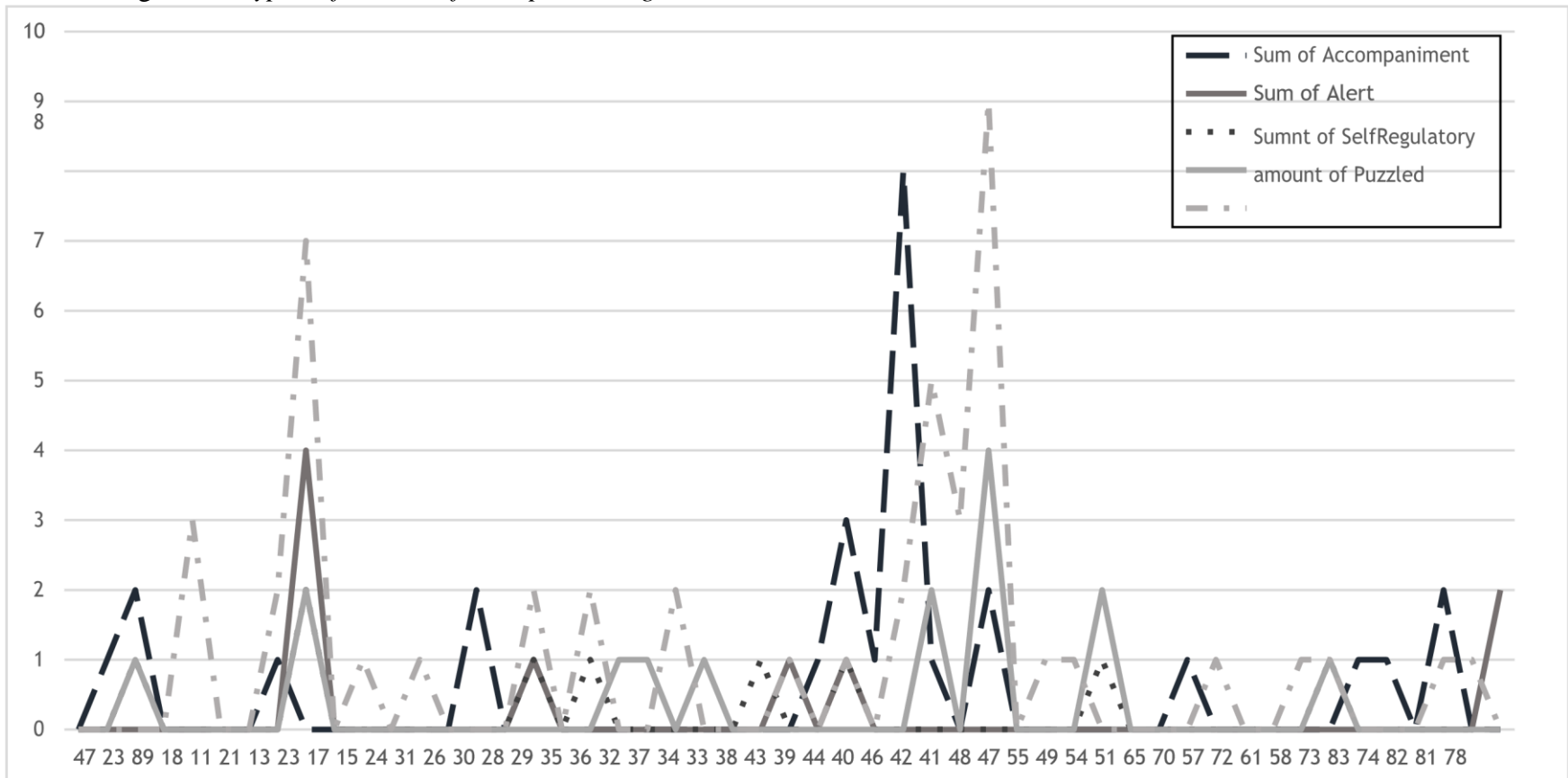
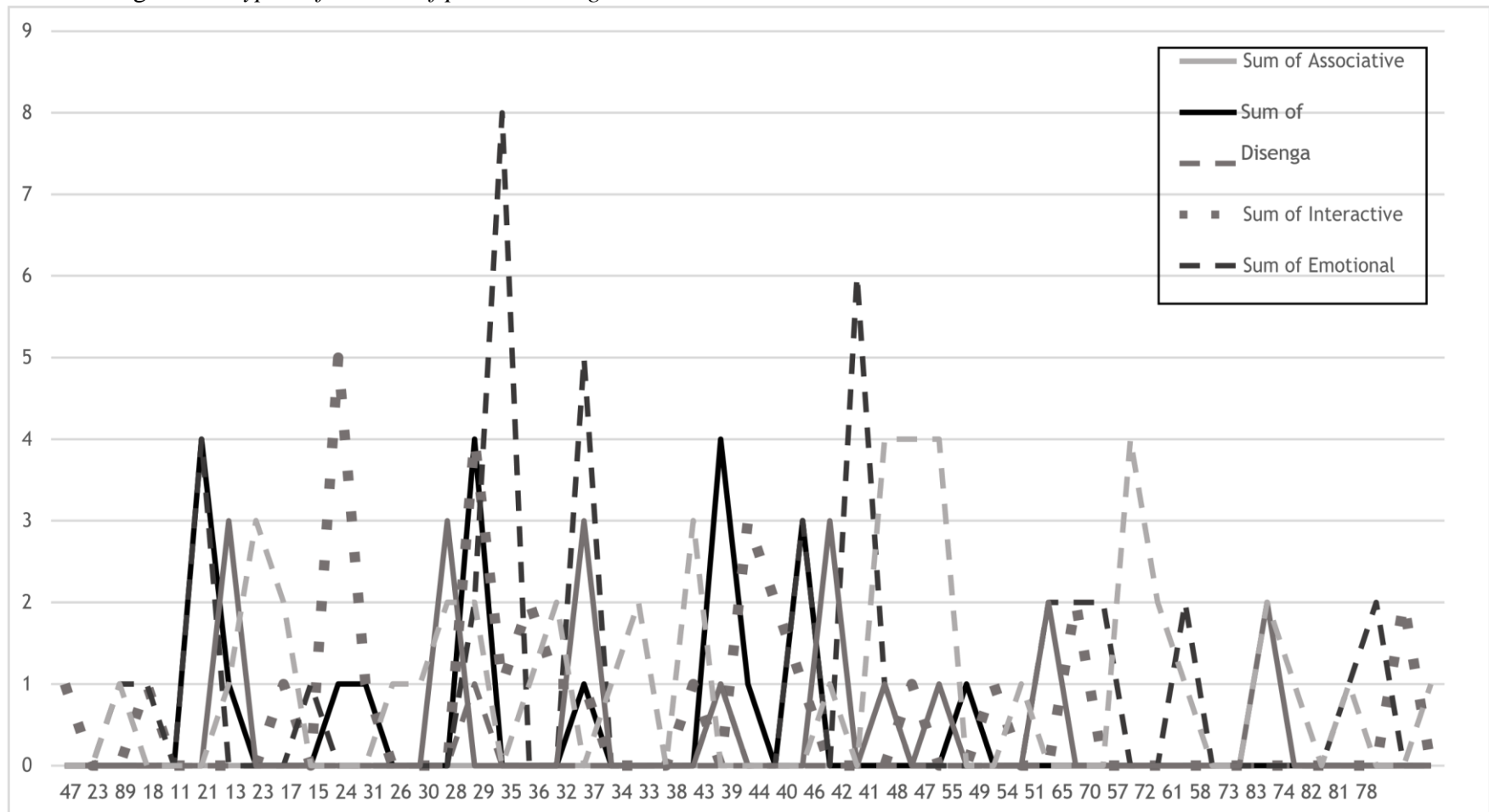


Figure 24. *Types Of Silence of patient throughout the sessions*





## Inferential statistical results

### Chi square analysis

Chi square analysis was performed to test the independence of the variables episode type and kind of silence.

As can be seen in table 2,  $\chi^2(11, N = 298) = 71.428, p < 0.05$ , which rejects the null hypothesis. In this way, it can be said that both variables are not independent. To view the value of the Cramer's V coefficient, it can be established that the strength of the association between the two variables is moderate.

Table 2. *Chi Square Test*

	Value	Df	Asymp. Sig. (2-Sided)
Pearson Chi-Square	71.428 <sup>to</sup>	11	,000
Likelihood ratio	80.487	11	,000
Linear-by-Linear Association	,029	1	,865
N of Valid Cases	298		

A. 4 cells (16.7%) have expected count less than 5. The minimum expected count is ,37.

Table 3. *Measure of symmetry*

	Value		Approx. Sig.
Nominal by Nominal	Phi	,490	,000
	Cramer's V	,490	,000
N of Valid Cases		298	

A. Not assuming the null hypothesis.

B. Using the asymptotic standard error assuming the null hypothesis.



## Factor Analysis

We conducted a factorial analysis of 2x2, considering as independent variables, type of episodes and Actor, the dependent variable considered was duration of silence (in seconds).

As can be seen in table 4, there is no interaction between the variables, nor the simple effects are significant. In this way, the duration of silence is not dependent on any of the independent variables considered.

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	66.350 <sup>to</sup>	3	22.117	1.279	,282
Intercept	6409,575	1	6409,575	370.565	,000
EpisodeType	13.392	1	13.392	,774	,380
Actor	29.398	1	29.398	1.700	,193
EpisodeType * Actor	14.209	1	14.209	,821	,365
Error	5085,247	294	17.297		
Total	12747,403	298			
<u>Corrected Total</u>	<u>5151,597</u>	<u>297</u>			

Table 4. *Analysis of variance for the dependent variable duration of silence*

A. R Squared = ,013 (adjusted R Squared = .003)

## Tetrachoric Correlation analysis

To verify that the independent variables presented absence of collinearity, we calculated the tetrachoric and point biserial correlation as appropriate to level of measurement of the variables.

As it can be seen in Table 5, none of the correlations between the independent variables have values greater than .4.

Table 5. *Correlation between independent variables*

	Episode	Actor	Time
Episode	1		
Actor	-0.34	1	
Time	0.10	-0.10	1

In a second stage, it became evident that the dichotomous variables of the model 0 had no cells in relation to the dependent variables.

The results indicate that the variable "actor", presents 0 cells in the majority of the dependent variables tested, this is due to the fact that there are types of silences that are made only by the patient, while the rest is done by the psychotherapist.

Taking the above into account, it was decided to leave out this variable in the logistic regression models.

In the same way, were left out the following types of Silence: Silence and Silence associative, mainly by its frequency in the therapy. (See Annexes).

### Logistic Regression Models

After verification of the assumptions of logistic regression, the hypothesis was tested. To do this, we built a model where the probability of making a Type of silence would be predicted by the duration of silence and the type of episode of therapy, for each of the 10 types of silences.

#### *Model 1: Reflective Silence*

Table 6. *Logistic regression Reflective Silence*

	Dear	OR	PE	Is	Z	Pr(> Z )	IC 95%	
(Intercepted )	-1.84	0.16	0.14	0.58	-3.19	0.00	21.05 -0.65	**

Duration	-0.20	0.82	0.45	0.10	-1.89	0.06			
							-0.45	-0.04	
Episode	1.46	4.30	0.81	0.43	3.39	0.00	0.67	2.38	***

---

The results of the model indicate that only the type of episode is significant to predict the kind of silence ( $p < .05$ ), as well as when the episode and duration are constants (Table 5).

To analyse the logit values point estimates of the model, it is noted that the type of episode increases the likelihood that the silence is reflective. With regard to the probability of having a reflective silence, this increases when the episode is changed to 40.6%.

#### *Model Adjustment*

With regard to the deviances of the model it is possible to identify that the null deviance (263.10;  $df=297$ ) and residual (242.86;  $df=295$ ) has different values. However, the low of the residual deviance of the model is not significant ( $p > .05$ ).

Model 1 has a good fit (2LL= 20.24;  $gl=2$ ;  $p < .001$ ), although its explanatory power is low, because the independent variables chosen explained only 11.2% of the variance of the reflective silence ( $R^2=.112$ ;  $R^2$  Adjusted= .0636). On the other hand, it is possible to affirm that the residuals of the independent variables used not correctly estimated the probability distribution for a given number of cases, i.e., of the total sample ( $n=298$ ), 9 cases have extreme values less than -2.

In this sense, the model predicts better moments of other kind of silence, and not reflective.

#### *Model 2: Silence Expressive*

Table 7. *Logistic regression Silence expressive*

Dear	Is	IC 95%
------	----	--------

(Intercepted	0.05	1.20	-2.29	2.90	
)					
Duration	-0.63	0.31	-1.42	-0.07	***
Episode	-0.23	0.47	-1.15		
				0.73	

The results indicate that the duration is a significant silence expressive estimator, and their inclusion decreases the likelihood that the silence is expressive. Given that the estimate could only be carried out in a timely manner, it was not possible to calculate the probability of this decline.

*Model Adjustment*

Given that the estimated model has a perfect separation, it was decided to calculate the coefficient of logistic regression using Firth method, whose values of post adjustment indices indicate that the proposed model does not fit to the data (2LL= 5.68; gl=2; p >.05).

***Model 3: Emotional Silence***

Table 8. *Logistic regression emotional Silence*

	Dear	OR	PE	Is	Z	Pr(> Z )	IC 95%	
(Intercepted	-1.77	0.17	0.15	0.29	-6.02	0.00	-2.38 -1.21	***
)								
Duration	0.05	1.05	0.51	0.03	1.48	0.14	-0.02 0.11	
Episode	-0.37	0.69	0.41	0.33	-1.11	0.27	-1.02 0.30	

As it can be seen in Table 8, none of the independent variables is a significant predictor of emotional silence ( $p >.05$ ), but when the episode and duration are constant.

In this sense, in what refers to the probability of having a reflective silence, decreases the probability to a 15% if the time and episode are constant.

*Model Adjustment*

It is possible to identify that the null deviance (249.49; df=297) and residual (246.59; df = 3) of the model 295 has different values. However, the low of the residual deviance of the model is not significant ( $p >.05$ ).

Model 3 has a good fit (2LL = 9.22; gl=2;  $p<.001$ ), although its explanatory power is low, because the independent variables chosen explained only 1.7% of the variance of the silence emotional ( $R^2=.017$ ;  $R^2$  Adjusted= .0009).

On the other hand, it is possible to affirm that the residuals of the independent variables used incorrectly estimated the probability distribution for 16 of the cases, which have extreme values less than -2.

***Model 4: Interactive Silence***

Table 9. *Logistic regression Silence Interactive*

	Dear	OR	PE	Is	Z	Pr(> Z )	IC 95%	
(Intercepted )	-1.70	0.18	0.15	0.32	-5.377	0.00	-2.33 -1.07	***
Duration	0.03	1.03	0.51	0.04	0,778	0.44	-0.07 0.10	
Episode	-1.17	0.31	0.24	0.39	-2.954	0.00	-1.96 -0.40	**

The results of the model indicate that the episode of Change is a significant predictor of silence interactive ( $p <.05$ ), as well as when the episode and duration are constants (Table 8).

In this sense, in what refers to the probability of having a silent interactive, decreases the probability to a 10.5% when the episode is Change.

### *Model Adjustment*

If we analyse the deviances for model 4, it is possible to identify that the null deviance (198.97; df = 297) and residual (189.72; df = 295) has different values. However, the low of the residual deviance of the model is not significant ( $p > .05$ ).

The proposed model 4, has a good fit (2LL = 9.25; gl=2;  $p < .001$ ), but its explanatory power is low, because the independent variables chosen explained only 6.3% of the variance of the interactive silence ( $R^2 = .017$ ;  $R^2 = .03$ ) of the total sample (n=298), 12 cases have extreme values less than -2. That is to say, the residuals of the independent variables used not correctly estimated the probability distribution of this 12 cases.

### *Model 5: Disengaged Silence*

Table 10. *Logistic regression Silence Disengaged*

	Dear	OR	PE	Is	Z	Pr(> Z )	IC 95%	
(Intercepted )	-0.81	0.45	0.31	0.77	27.55	0.29	-1.98 0.90	
Duration	-0.16	0.85	0.46	0.17	-0.91	0.36	-0.57 0.07	
Episode	-3.71	0.02	0.02	1.03	-3.595	0.00	-6.61 -2.12	***

The results of the model indicate that the episode of Change is a significant predictor of disengaged silence ( $p < .05$ ) (Table 4).

In this sense, in what refers to the probability of having a disengaged silence, decreases the probability to a .01 % when the episode is Change. This result should be taken with care, given that the intercept is not significant.

### *Model Adjustment*

If we analyse model 5 deviance, it is possible to identify that the null deviance (151.89; df = 297) and residual (115.08; df = 295) has different values. However, the low of the residual deviance of the model is not significant ( $p > .05$ ).

The proposed model is a good fit (2LL = 32.22; gl=2;  $p < .001$ ), while its explanatory power is high, because the independent variables chosen explain 29.1% of the variance of the disengaged silence ( $R^2 = .291$ ;  $R^2 = .109$ ). On the other hand, it is possible to affirm that the residuals of the independent variables used not correctly estimated the probability distribution for a given number of cases, i.e., of the total sample (n=298), 2 cases have extreme values less than -2.

### ***Model 6: Accompaniment Silence***

Table 11. *Logistic regression accompaniment silence*

	Dear	OR	PE	Is	Z	Pr(> Z )	IC 95%		
(Intercepted )	-4.14	0.02	0,016	0.64	-6.50	0.00	-	-3.06	***
Duration	0.11	1.11	0.53	0.04	2.95	0.00	0.04	0.18	**
Episode	1.62	5.05	0.83	0.63	2.56	0.01	0.52	3.09	*

The model results indicate that all the independent variables are significant predictors of the accompaniment silence ( $p < .05$ ) (Table 11).

In this sense, the probability that the accompaniment silence increases to 1.8% when silence is prolonged, and a 7.5% when the episode is Change. Analysing the effect on the whole, when silence is prolonged and the Episode is Change, increases the probability that it is a accompaniment silence to a 8.2%.

### ***Model Adjustment***

If we analyse model 6 deviance it is possible to identify that the null deviance (185.72; df = 297) and residual (165.58; df = 295) has different values. However, the low of the residual deviance of the model is not significant ( $p > .05$ ).

The proposed model is a good fit (2LL = 20.13; gl=2;  $p < .001$ ), but its explanatory power is low, because the independent variables chosen explained only 14.1% of the variance of the silence interactive ( $R^2 = .141$ ;  $R^2 = .063$ ). On the other hand, it is possible to affirm that the residuals of the independent variables used incorrectly estimated the probability distribution of 20 of the cases have extreme values less than -2.

***Model 7: Alert Silence.***

Table 12. *Logistic regression Silence alert*

	Dear	OR	PE	Is	Z	Pr(> Z )	IC 95%	
(Intercepted )	-2.99	0.05	0.05	0.64	-4.67	0.00	28.35 -1.44	***
Duration	-0.01	0.99	0.50	0.10	-0.11	0.91	-0.34 0.11	
Episode	-0.79	0.45	0.31	0.68	-1.16	0.25	-2.21 0.56	

The model results indicate that none of the independent variables is a significant predictor of the silence of accompaniment ( $p > .05$ ), but when the episode and duration are constants (Table 12). Along with this, the probability that the alert silence, when the duration and the episode are kept constant is the 5%.

***Model Adjustment***

If we analyse model 7 deviance it is possible to identify that the null deviance (80,723; df = 297) and residual (79,331; df = 295) has different values. However, the low of the residual deviance of the model is not significant ( $p > .05$ ), which means that the coefficients are close to 0.



The proposed model is a good fit ( $2LL = 1.39$ ;  $gl=2$ ;  $p >.001$ ), but its explanatory power is low, because the independent variables chosen explain only 2% of the variance of silence<sup>2</sup> Interactive ( $r = .02$ ;  $R^2 = .004$ ). On the other hand, it is possible to affirm that the residuals of the independent variables used not correctly estimated the probability distribution for a given number of cases, i.e. the total sample ( $n=298$ ), 9 cases have extreme values less than -2.

***Model 8: Regulatory Silence***

Table 13. *Regulatory Silence logistic regression.*

	Dear	OR	PE	Is	Z	Pr(> Z )	IC 95%	
(Intercepted )	-3.04	0.05	0.05	0.77	-3.96	0.00	-4.48 -1.16	***
Duration	-0.05	0.95	0.49	0.13	-0.38	0.70	-0.47 0.10	
Episode	-0.31	0.73	0.42	0.68	-0.46	0.65	-1.67 1.10	

The model results indicate that none of the independent variables is a significant predictor of silence regulatory ( $p >.05$ ), but when the episode and duration are constants (Table 13). Along with this, the probability that the silence is regulatory, when the duration and the episode are kept constant at 5%.

***Model Adjustment***

If we analyse model 8 deviance it is possible to identify that the null deviance (80,723;  $df = 297$ ) and residual (80,285;  $df = 295$ ) has different values. However, the low of the residual deviance of the model is not significant ( $p >.05$ ).

The proposed model is a good fit ( $2LL = 0.44$ ;  $gl=2$ ;  $p >.001$ ), but its explanatory power is low, because the independent variables chosen explain only .06% of the variance of the interactive silence ( $R^2 = .006$ ;  $R^2 = .004$ ). On the other hand, it is possible to affirm that the residuals of the independent variables used not correctly estimated the probability distribution for a given number of cases, i.e. the total sample ( $n=298$ ), 9 cases have extreme values less than -2.

**Model 9: Puzzled Silence**

Table 14. *Logistic regression Puzzled Silence*

	Dear	OR	PE	Is	Z	Pr(> Z )	IC 95%	
(Intercepted )	-3.04	0.08	0.07	0.77	-3.96	0.00	-4.44 -0.26	***
Duration	-0.05	0.78	0.44	0.13	-0.38	0.70	-0.79 0.02	
Episode	-0.31	2.51	0.72	0.68	-0.46	0.65	-0.26 2.42	

The model results indicate that none of the independent variables is a significant predictor of silence puzzled ( $p > .05$ ), but when the episode and duration are constants (Table 14). Along with this, the probability that the silence is puzzled, when the duration and the episode are kept constant is the 7%.

*Model Adjustment*

The null deviance (118.9;  $df = 297$ ) and residual (114.3;  $df = 295$ ) has different values. However, the low of the residual deviance of the model is not significant ( $p > .05$ ).

The proposed model is a good fit ( $2LL = 4.6$ ;  $gl=2$ ;  $p > .001$ ), but its explanatory power is low, because the independent variables chosen explained only 4.7% of the variance of the silence puzzled ( $R^2 = .047$ ;  $R^2 = .015$ ). Of the total sample ( $n=298$ ), 15 cases have extreme values less than -2, that is to say, its probability distribution is estimated incorrectly.

**Model 10: Strategic Silence**

Table 15. *Logistic regression Strategic Silence*

	Dear	OR	PE	Is	Z	Pr(> Z )	IC 95%	
(Intercepted )	-1.99	0.14	0.12	0.39	-5.12	0.00	-2.78 -1.22	***

Duration	-0.04	0.96	0.49	0.05	23.167	0.40			
Episode	0.80	2.22	0.69	0.37	2.17	0.03	-0.17	0.04	*

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The results of the model indicate the episode of change is a significant predictor of strategic silence ( $p < .05$ ), as well as when the episode and duration are constants (Table 15).

The probability that the silence is strategic increases to 23.3% when is an episode of change.

### *Model Adjustment*

The null deviance (263.1;  $df = 297$ ) and residual (257.31;  $df = 295$ ) of the 10 model has different values. However, the low of the residual deviance of the model is not significant ( $p > .05$ ).

The proposed model is a good fit ( $2LL = 5.79$ ;  $gl=2$ ;  $p > .001$ ), however, their explanatory capacity is low, because the independent variables chosen explained only 3.3% of the variance of the interactive silence ( $R^2 = .033$ ;  $R^2 = .019$ ). On the other hand, it is possible to affirm that the residuals of the independent variables used not correctly estimated the probability distribution for a given number of cases, i.e., of the total sample ( $n=298$ ), 11 cases have extreme values less than -2.

## **DISCUSSION STUDY 2**

The results of the present study had as purpose to respond to the specific target two, three and four. It will discuss the most relevant results that meet these objectives.

In the first place, it is necessary to discuss the reliability of the PICS-TP.

The kappa value reached for the interrater agreement is very good, both for the silences of therapist as the silences of patient. In this sense, the present system would be a good instrument to be able to encode silences both therapist and patient, taking the characteristics necessary for the encoders can be based on the same criteria in order to be able to identify each type of silences.

In comparison with the PICS-II, presented similar reliabilities, both of which are of very good quality.

The results obtained from the analysis of the coding of silences of the therapy B, enable to describe features of the distributions of the silences, according to the variables Type of episode and Actor. The results obtained at the descriptive level are illustrators, as quantitative descriptions allow to associate to the results obtained in the study 1.

In general, it was observed that the increased silence frequency is more toward the middle of the therapeutic process, having less frequency at the beginning and at the end.

In terms of silences duration, it was observed that both therapist and patient have similar frequencies of silences but are distributed differently according to the type of episode.

The most relevant differences between therapist and patient, is more quiet time in both types of episodes, while the therapist spends less time in silence than the patient in both types of episode.

In the activity of each actor during each different interactive scenario, it was observed that the therapist tends to be more silent in episodes of change and more as the sessions are nearing the end of the therapy. This could be explained by the role the therapist toward the end of the therapy would be more associated to promote the development of the patient, proposing and urging the patient possible alternative visions about their life and their meanings about himself and the world that enable new ways of understanding and behaviour.

On the other hand, the patient, in relation with the therapist, tends to stay more time in silence in the Episodes of change and also more time than the time that is kept in silence during the episodes of rupture. This may be related the level of processing required by the patient, as in the Episodes of change will require more complex elaborations.

Specifically, the most striking result of the descriptive statistics of the patient that there is a greater frequency of Reflexive silences in the Episodes of change, which is consistent with the emotional and cognitive processes required in this type of episodes. Thus, the patient would spend more time in the silence making insight, re-evaluating prospects for creating new ways to promote your change and well-being, analysing, questioning and analysing meanings about their experience and its history. This is consistent with the results of the team of Levitt (Frankel &

Levitt, 2009; Stringer, Levitt, Berman & Mathews, 2010) and other researchers (Daniel, Folke, Lunn, Gondan and Poulsen, 2018; Ünlü, 2015).

It was also observed a frequency of emotional silences, showing that in this type of episodes the patient would be more connected with the affective experience in course. In this sense, these episodes would have a significant emotional intensity (Morán et al., 2016).

In a consistent manner, the therapist would spend more time in the accompaniment silences during this type of episodes, recognizing and validating the experience and elaborations of the patient. Also, the therapist spends more time in silence. This may be interpreted as a kind of silence that would be helping to encourage patient to connect with the therapeutic work and himself, to be active agents of their own change.

In a contrary way, at the ruptures the patient would spend more time in disengaged silences. This makes sense to the extent that these silences promote the disconnection from the topic worked in therapy, as well as of the therapist and of therapeutic work in general. In the same way, there is also a high frequency of interactive silences. This can be interpreted from the intention that the patient has to demand attention of the therapist, particularly, delegating the responsibility for the work.

Seen from this perspective, it gives the impression that there is a "match" between the functions of each silence, associated with the role of each of the actors. This has a direct relationship with the patients' needs at every moment of the therapy. For example, if the patient is actively working, being connected to their emotional experience and expressing their feelings openly, it is necessary that the therapist will provide support and emotional support so that the patient can feel in confidence to work topics that may be sensitive and meaningful to its history.

However, this match is not supported by the results of the inferential statistics. To summarize, no model is good and reliable enough to predict the occurrence and distribution of some kind of silence in particular in some type of specific interactive scenario.

Nevertheless, most of the silences would be predicted by the variable type of episode, but with a low explanatory power of the variances of the types of silences. Also, models proved not to be good estimated indicators of the distribution of the silences in each type of episode.

Taking this into account, the descriptive results must be interpreted carefully, as it would not be statistically significant.

As an exception, it could be the case of model n°1, where the probability of occurrence of a reflective silence could be adequately predicted by type of episodes, specifically, of the Episodes of change. However, the explanatory power of this model is very low.

In addition, there was a matching result with the Study 1 in respect to the silences associative arrays, as in the encodings there is no kind of silence of this class. Taking into account that this was not possible to generate a good model and decided to be eliminated from the quantitative results, the silences codification team has decided to delete this type of silences of the coding system. This decision was supported on the grounds that this result is consistent with that reported by Levitt (2001), stating that this type of pauses is not very frequent (3/325 reporting breaks) and, in addition, it is very difficult to define. Considering these arguments and due to its characteristics, has decided to merge the off silence, mainly because of the coincidence of change of topic in these two types of silences of the patient.

Considering the results, it is possible that this could improve if you have a larger and heterogeneous sample. As a proposal, it could increase the number of pairs participants, patients of different gender, age and diagnosis. These criteria of variability are proposed because they are some of the categories that are associated with the types and forms of silences, as mentioned by the therapists in the qualitative interviews. This is important to take into account, because there are studies that have performed predictive models that associate quality of therapeutic results with relative frequency of breaks (Daniel, Folke, Lunn, Gondan & Poulsen, 2018), as well as other built predictive models that associated vocal quality and discursive positions with episodes of change and rupture (Moran et al., 2016), voice quality and change of the patient (Wiseman & Rise, 1989), and regulatory strategies Speech-to-Speech (Tomicic, et al., 2015).

Therefore, the objectives two, three, and four would be only a descriptive level of scope. Taking this into account, the results found in this study are only a description of a specific case and that, while there are results that are interesting and that in some way reflect possible regulatory strategies between patient and therapist in different interactive scenarios and along the psychotherapeutic process, would only be hypotheses that should be tested in future studies taking the necessary safeguards of sample and number of cases sufficient.

Nevertheless, taking into account that the reliability of the system is very good, it could be used for further studies, having as main purposes the objectives two, three and four of this thesis, being able to achieve them not only with a descriptive, but that relational database, that

can associate a statistically significant independent variables used in the study number two with the variable type of silence.

## CONCLUSIONS

Silence is a heterogeneous phenomenon, ambiguous and contextual inherent to human communication, because sound and narrative production cannot exist separately, which, which also occurs in the therapist-patient interaction.

In this interaction, and depending on the moment of emergency and other factors that delimitate, silence, would meet various regulatory functions, which would acquire a particular meaning depending on the immediate context in which this phenomenon appears.

In this context, and in order to understand their potential regulatory functions of silence, it is necessary to take into account the sociocultural context in which the silence emerges. How was defined, psychotherapy is a very unique and particular context, delimited by special rules (Tomicic, Martinez, Altimir, Bauer, & Reinoso, 2009). As it is delimiting the relational framework can also be specific matters that have to do in the regulatory process, achieving mutual understanding and see the scope of to what extent and how the participants of the therapeutic relationship are affecting each other, or how they affect themselves.

However, despite the importance of the relational context for that silence to acquire and to fulfil a particular role in the therapist-patient interaction in a particular time, existing studies have not addressed this phenomenon on a bilateral basis, but that only has been considered one of the possible prospects in that context(i.e.: Daniel, Folke, Lunn, Gondan & Poulsen, 2018; Frankel & Levitt, 2009;Ladany, Hill, Thompson & O'Brien, 2004; Levitt, 2001, 2002; Sharpley, Munro & Elly, 2010; Stringer, Levitt, Berman & Mathews, 2010).

From there, this thesis is a contribution to the discipline of the research in psychotherapy, because it proposes an interactive look of the silences, where both patient and therapist would be participating actively from its role, in order to achieve the change of the patient. In this sense, the present thesis not only contributes to the level of theoretical proposal, but makes a contribution from the empirical research, proposing a system of codification of silences for therapist and patient, based on previous research as results of interviews and analysis that reflect the experience of patients and therapists in the moments of silence in psychotherapy.



Following this same line of argument, the theoretical value of this thesis is to propose a comprehensive look of the silences in psychotherapy, having as central axis the subjective experiences of the participants of the therapy and also the meanings that those same subjectivities constructed from contextual factors that allow you to define their functions and interpretations. Thus, this research gives the silences the nature of subjective phenomenon, contextual and sociocultural context.

One of the contributions of this research is to have generated a suitable instrument to research the silence from an intersubjective approach. It supposes the use of methodological strategies that allow to gather information on the silence taking into account in detail the context in which this phenomenon is being studied.

Specifically about the system, it presents some points for and against. On the one hand, extends the meaning of one of the silences of the patients, proposing that interactive silences, could have both a positive and negative for the process of change of the patient. As well, the interactive silences can manifest or indicate the existence of a good alliance, where there may be complicity between the participants. silences for the own process of change of the patient, as well as with the utility to establish and maintain interaction with the therapist. At the same time, however, this diversification of the possible meanings of the silences evidence the ambiguity of the roles they can play in psychotherapy, adding the need to be able to add other variables that characterize more precisely the characteristics of those silences.

As the authors reviewed, the meaning of the silences necessarily depends on contextual factors that allow a specific silence acquire a meaning or particular use, such as, the looks and facial expressions of the participants, and the topic of conversation that is in progress. This can be a disadvantage at the time of encoding with this system, since the possibility of the functions of the silences it is broader and more dependent on contextual factors.

In this sense, it is required that the encoders can go through a rigorous training in the PICS system-TP, in terms not only to familiarize with the manual and follow the rules in the encoding, it is necessary that the encoders are familiar with the literature available about silences in psychotherapy, requiring to fully know existing research on silences in psychotherapy and its implications for the understanding of the therapeutic process.

This becomes a challenge for those who wish to train in this system, not only because it is required to know the literature related to silences in psychotherapy, but also would need to know the literature associated with the factors that allow the silence acquires a specific meaning in a given time. Some of the topics needed to review would be, for example, research associated to other non-verbal phenomena and paraverbal in psychotherapy (how the vocal quality, facial expressions, body movement, the look, etc.) and also literature related to the meanings of the silences and other similar phenomena that depend directly from the sociocultural meaning and use.

The greatest strength the PICS-TP is their level of interrater reliability, being a good instrument to be able to carry out subsequent investigations with this system, but with higher quality samples. In this sense, subsequent studies with this system would make it possible to establish conjectures about as a therapist and patient manage to develop a relational knowledge from participating on a recurring basis in a particular relationship which is, in turn, regulated by relational rules (some of these and others not) that allow the interaction between therapist and patient occurs in a regulated manner culturally (Martinez et al., 2014; Willig, 2008). This would allow the understanding of the development of these specific interactive patterns between patient and therapist, as well as mutual regulatory strategies (Beebe, 2006; Tronick, 1989).

For this, it would be necessary to raise a model to predict the occurrence of a specific type of silence of patients based on some kind of silence particular therapist, and vice versa.

Regarding the limitations of this study, the most important is the sample used in the study, which had a negative impact in the logistic regression models and, therefore, in the establishment of regulatory strategies between therapist and patient that are statistically significant in different kinds of interactive scenarios.

As well, the main weakness of this study is to not have been able to establish the participation of silences in the regulatory function in the interaction between therapist and patient in different interactive scenarios and along the therapy that are statistically significant, restricting the explanatory scope of this research.

However, although it was not possible to achieve the objectives two, three and four with the explanatory scope proposed, this coding system can mean a contribution in different contexts to the research process in psychotherapy. One of the possible uses of this research and, especially, of the coding system PICS-TP, is the educational framework in the training of therapists. As discussed in the background, there are different theoretical and empirical research that supports the importance of silences in the therapeutic results and positive interactions among the participants that can benefit the productivity in the sessions and the alliance (i.e.: Cook, 1964; Daniel, Folke, Lunn, gondán and Poulsen, 2018; Frankel, Levitt, Murray, Greenberg & Angus, 2007; Greenberg, Rice & Elliot, 1993; Regey, Kurt and Snir, 2016; Salzberg, 1962; Sharpley et al., 2005).

However under valued, the Clara Hill's team (Hill, Thompson and Ladany, Ladany, 2004; Hill, Thompson & O'Brien, 2003) found that the therapists report that they learn to use the silence in the exercise of the profession or in instances of supervision, but that is rarely learned in instances in which is taught the use of the silences as an intervention in a formal training. Taking into account the results and discussions of this investigation, it is considered important to create training programs with the silence as one important theme, not only by the positive it can be for a process, but also because the therapists should be aware of the possible contraindications of use (Frankel & Levitt, 2009). Therefore, it is important that therapists learn to use the silences in a positive way, being able to respond to the needs of their patients.

This can be a difficult topic considering that in some cultural contexts the silence is rather controversial, undervalued (Ronnisgtam, 2006), and in addition, therapists are uncomfortable using or tolerating silences (Back, Bauer-Wu, Rushton & Halifax, 2009). In this way, it would not be sufficient to create a formal program in which a review of literature on the silences, but it is necessary to create a program with an emphasis on the practical level, so that therapists can incorporate our lives the use of silences.

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## APPENDANT N°1

**APPENDANT N°1**

Summary PICS-II

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1



Type	Description	Subcategories	
<b>Disengaged</b>	Emotional disconnection of what was discussed in therapy	<ol style="list-style-type: none"> <li>1. Avoid Feelings <ul style="list-style-type: none"> <li>- Avoid damage, distress, fear</li> <li>- Reorganize</li> <li>- Lighten the therapist focus</li> </ul> </li> <li>2. Close <ul style="list-style-type: none"> <li>- Withdrawal</li> <li>- Arrested</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>1. Before <ul style="list-style-type: none"> <li>- Questions about a emotion of the pa</li> <li>- Give an account revelation follow distraction or negl</li> <li>- Patient seems very reveals a thematic</li> </ul> </li> <li>2. During <ul style="list-style-type: none"> <li>- Patient tends to silence seems to ir in the process.</li> <li>- Patient focused ir prematurely.</li> </ul> </li> <li>3. After <ul style="list-style-type: none"> <li>- New line of significance to</li> <li>- Refocusing the continue with th</li> <li>- Patient respons resume, stoppin</li> </ul> </li> </ol>
<b>Feelings</b>	Patient is experiencing an emotion or moves toward them. We identified a wide range of emotions.	<ol style="list-style-type: none"> <li>1. Deepen in emotional state <ul style="list-style-type: none"> <li>- Undefined Feelings</li> <li>- Overflow</li> </ul> </li> <li>2. Feelings <ul style="list-style-type: none"> <li>- Fear, vulnerability, uncertainty, stress - Sadness, grief, despair.</li> <li>- Anger, frustration. 5.</li> <li>- Other</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>4. Before <ul style="list-style-type: none"> <li>- Words of emotion</li> <li>- Non-emotional wo content.</li> <li>- Repetition of phra</li> <li>- Her voice tremblin</li> </ul> </li> <li>During <ul style="list-style-type: none"> <li>- Emotional express</li> <li>- Silence with emot</li> </ul> </li> <li>6. After <ul style="list-style-type: none"> <li>- Emotional conte</li> <li>- Non-emotional charged conten</li> <li>- Her voice tremb</li> </ul> </li> </ol>

<b>Interactive</b>	Patient focuses on aspects of the therapist or therapeutic interaction. Attention is paid to the reactions of the therapist and the self.	<ol style="list-style-type: none"> <li>1. Demands of communication <ul style="list-style-type: none"> <li>- Consider the therapist's experience</li> <li>- Get away from the feelings to articulate</li> </ul> </li> <li>2. Uncertainty of a task or product <ul style="list-style-type: none"> <li>- Fulfilment of the task Protect the Alliance</li> </ul> </li> <li>3. Search for approval/management of printing <ul style="list-style-type: none"> <li>- Check emotional reaction toward the therapist</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>7. Before <ul style="list-style-type: none"> <li>- Therapist says s obvious.</li> <li>- Therapist gives a understand or that</li> <li>- Therapist perform</li> <li>- Customer appea therapist. During</li> <li>- At times there see confusion.</li> <li>- Patient seems to e part of the therapi</li> <li>- Visual contact w indicate or seeking</li> </ul> </li> <li>9. After <ul style="list-style-type: none"> <li>- Patient requests</li> <li>- Therapist spontaneously confused during</li> </ul> </li> </ol>
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				<ul style="list-style-type: none"> <li>- Client gives a r does not under said.</li> <li>- Patient tries to conversation</li> </ul>
<b>Reflective</b>	Patients question ideas, realize the complexity of an issue or connections or insights about your own experience	<ol style="list-style-type: none"> <li>1. Questioning</li> <li>2. Awareness on a topic</li> <li>3. Making Connections</li> <li>4. Insight/realization</li> </ol>	<ol style="list-style-type: none"> <li>10. Before <ul style="list-style-type: none"> <li>- Therapist or patie consider</li> <li>- Expression of qu evaluating, ask.</li> <li>- Speech that exam options.</li> <li>- Speech that makes</li> </ul> </li> <li>11. During <ul style="list-style-type: none"> <li>- Patient appears to</li> </ul> </li> <li>12. After <ul style="list-style-type: none"> <li>- Expressions questioning, qu</li> <li>- Connection mad</li> </ul> </li> </ol>	
<b>Expressive</b>	Patients are seeking the right words or phrases listed in order to be able to label more accurately what they are feeling, trying to symbolize complex or new experiences felt during the session.	<ol style="list-style-type: none"> <li>1. Articulation of ideas. <ul style="list-style-type: none"> <li>- Find the right words.</li> <li>- Deciding on the correct way to express an idea.</li> </ul> </li> <li>2. Appoint Feelings</li> </ol>	<ol style="list-style-type: none"> <li>13. Before <ul style="list-style-type: none"> <li>- Patients try to an which had not be articulate a distre</li> <li>- Stuttering of the p</li> <li>- Patients Say some</li> </ul> </li> <li>14. During <ul style="list-style-type: none"> <li>- Patients seem t words for themsel</li> </ul> </li> <li>15. After <ul style="list-style-type: none"> <li>- Patient is an experience.</li> <li>- Patient indicate phrase.</li> </ul> </li> </ol>	
<b>Associative</b>	Patients change to new content without making the previous topic, so Change Theme perspective or context. In the IPR patients only identified the emergence of a new idea at the time of the therapy.	At the end of the theme	Sudden change in the topic a clear connection with the previous topic, so Attempt to change in theme	
<b>I Remember</b>	Patients try to remember details of events or objects that are describing	<ol style="list-style-type: none"> <li>1. Memory of an event.</li> <li>2. Reconstruction or ordering of history.</li> <li>3. Search in past history. - Patients seem to st</li> </ol>	<ol style="list-style-type: none"> <li>16. Before <ul style="list-style-type: none"> <li>- Therapists ask for</li> </ul> </li> <li>17. During <ul style="list-style-type: none"> <li>- Patients seen imagining th remembering.</li> </ul> </li> <li>18. After <ul style="list-style-type: none"> <li>- Patients recove seeking.</li> <li>- Patient indicates remember.</li> </ul> </li> </ol>	

## APPENDANT N°2 THERAPISTS' THEMATIC SCRIPT

<b>Topics</b>	<b>Questions</b>
<p><b>The silences in everyday life</b> Objective: To describe how the respondent defines and characterizes the silence in contexts of daily life.</p>	<ul style="list-style-type: none"> <li>✚ What is silence for you? How do you define/describe it?</li> <li>✚ How experience you silences in your everyday life?</li> <li>✚ How do you feel about the moments of silence? Do you think it is comfortable/uncomfortable? In what situations?</li> <li>✚ What do you think there are different kinds or types of silences in everyday life? If so, what role that distinguishes them?</li> </ul>
<p><b>The silences in the psychotherapeutic context</b> Objective: To describe the moments of silence in the contexts of psychotherapy in general terms, from the experience of the therapist interviewed.</p>	<ul style="list-style-type: none"> <li>✚ How would you describe silence in psychotherapeutic context?</li> <li>✚ Do you believe that the silences in therapeutic communications are different to the silences in other contexts? If they are different for you, in what sense will look different?</li> <li>✚ How has your experience been with moments of silence in psychotherapy sessions? What is the experience that you have now with the silence in relation to the experience at the beginning of its exercise as a therapist? What is the difference?</li> <li>✚ Have you had difficulty or discomfort in your experience with the silence in psychotherapy? What have been these difficulties? In what way has learned to cope?</li> </ul>
<p><b>The silences of the patients in the psychotherapeutic context</b></p>	<ul style="list-style-type: none"> <li>✚ How would you characterize the silences of his patients in the context of the sessions? What does the silence of their patients will have some difficulty? If so, in what sense have been a difficulty?</li> </ul>

<p>Objective: To describe the silences of the patients from the perspective of the interviewee</p>	<ul style="list-style-type: none"> <li>✦ What does the silence of their patients will have served as a tool for the development of a session or of a process of psychotherapy? If so, in what way will have been useful?</li> </ul>
<p><b>The silences of the therapist in psychotherapeutic context</b> Objective: To describe the silences of the therapist in psychotherapeutic context, from the perspective of the therapist interviewed.</p>	<ul style="list-style-type: none"> <li>✦ How would you characterize your own silences in the context of the sessions? Do your own silences have meant a difficulty? If so, in what sense have been? Do your own silences have been of help in session or in a psychotherapeutic process? If so, in what way have been of help?</li> </ul>
<p><b>The silences as a psychotherapeutic tool</b> Objective: To describe how silence can be used as a tool in a session or process of psychotherapy.</p>	<ul style="list-style-type: none"> <li>✦ Do your own silences have served as a tool for the development of a meeting or a process of psychotherapy? If so, in what way will have been useful?</li> <li>✦ In psychotherapy, do you use the silences of intentionally? If so, with what intent the use?</li> </ul>
<p><b>Types of silences in Psychotherapy</b> Objective: to categorize the silences in psychotherapy according to the criteria of the psychotherapist interviewed.</p>	<ul style="list-style-type: none"> <li>✦ According to their point of view, there are different types of silences in the psychotherapeutic context?, if so, could you describe them?</li> <li>✦ Are these kinds of silence the same types that you distinguish in everyday life? What are similar? How are they different?</li> <li>✦ Do depending on what criteria you can tell them apart?</li> </ul>
<p><b>The silences in psychotherapy and the spaces of formation and training as a therapist</b> Objective: To identify and describe instances of institutional training and education where I worked the silences in psychotherapy, from the perspective of the interviewee.</p>	<ul style="list-style-type: none"> <li>✦ In general terms, do you remember if in the process of training as a therapist there were references to the silence? What was thematized in a course or in another instance of formal training as a therapist?</li> <li>✦ How did you learn to tolerate or use silences in psychotherapy?</li> </ul>

These are my questions, is there anything that I have not asked that you think is relevant to say that could contribute to the study of the silences in psychotherapy?	

## APPENDANT N°3 PATIENTS THEMATIC SCRIPT

Topics	Questions
<p><b>The silences in everyday life</b></p> <p>Objective: To describe how the respondent defines and characterizes the silence in contexts of daily life.</p>	<ul style="list-style-type: none"> <li>✚ What is silence for you? How do you define/describe it?</li> <li>✚ How experience you silences in your everyday life?</li> <li>✚ How do you feel about the moments of silence? Do you find it to you comfortable/uncomfortable? In what situations?</li> <li>✚ What do you think there are different kinds or types of silences in everyday life? If so, in function of the characteristics that distinguishes them?</li> </ul>
<p><b>The silences in the psychotherapeutic context</b></p> <p>Objective: To describe the moments of silence in the contexts of psychotherapy in general terms, from the experience of the patient interviewed.</p>	<ul style="list-style-type: none"> <li>✚ How would you describe the silence in the psychotherapeutic context?</li> <li>✚ Do you believe that the silences that are given in the therapy sessions are different to the silences in other contexts of everyday life? If they are different for you, in what sense will look different?</li> <li>✚ How has your experience been with moments of silence in psychotherapy sessions? What is the experience that you had at the beginning of the therapy with whom he had in the final sessions? What can differentiate them?</li> <li>✚ Were there moments that will be difficult or uncomfortable in his experience with the silence in psychotherapy? What were these difficulties? In what way did you learn to cope?</li> <li>✚ Were there moments that will be more reassuring or simple to cope with on its experience with the silence in psychotherapy? What characteristics of that silence will seem to you that contributed to that was a moment easy to cope with, or a quiet moment/pleasant?</li> </ul>

<p><b>The silences of the patients in the psychotherapeutic context</b></p> <p>Objective: To describe the silences of the patients from the perspective of the interviewee.</p>	<ul style="list-style-type: none"> <li>† How would you characterize their silences in the context of the sessions? Do you consider that their silences contributed or hindered their own process of therapy? In what ways were found to be obstacles or a help? Could you give a concrete example that you remember?</li> <li>† The silences that you considered, at the same time that occurred, as an obstacle or an aid to the process, still watching them in the same way? If so, what has helped to keep this form of see them? Otherwise, At what point will change the way you see them?</li> </ul>
<p><b>The silences of the therapist in psychotherapeutic context</b></p> <p>Objective: To describe the silences of the therapist in psychotherapeutic context, from the perspective of the patient interviewed.</p>	<ul style="list-style-type: none"> <li>† How would you characterize the silences of your therapist in the sessions? What Do These silences led to a difficulty? If so, in what sense have been? Do otherwise, there were some that will mean a help? If so, in what way helped him?</li> </ul>
<p><b>Types of silences in Psychotherapy</b></p> <p>Objective: to categorize the silences in psychotherapy according to the criteria of the psychotherapist interviewed.</p>	<ul style="list-style-type: none"> <li>† According to their point of view, there are different types of silences in psychotherapy?, if so, could you describe them?</li> <li>† Are these kinds of silence the same types that you distinguish in everyday life? What are similar? How are they different? Do depending on what criteria you can tell them apart?</li> </ul>
<p>These are my questions, is there anything that I have not asked that you think is relevant to say that could contribute to the study of the silences in psychotherapy?</p>	



	Not reflective	Reflective	Not Expressive	Expressive	Not Emotional	Emotional
Episode D						
OES						
NOT CHA						
NGE	102	7	101	8	90	19
Episode change	148	41	178	11	164	25
Actor (therapist)	134	0	134	0	134	0
Actor (Patient)	116	48	145	19	120	44

	Non-interactive	Interactive	I don't remember	I Remember	Non-associative	Associative
Episode D						
OES						
NOT CHA						
NGE	90	19	108	0	109	0
Episode change	177	12	189	1	189	0
Actor (therapist)	134	0	134	0	134	0
Actor (Patient)	133	31	163	1	164	0

	Not disconnected	Disconnected	Not Accompaniment	Accompaniment	Not alert	Alert
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Episode D							
OES							
NOT CHA							
NGE	89	20	106	3	104	5	
Episode change	188	1	164	25	185	4	
Actor (therapist)	134	0	106	28	125	9	
Actor (Patient)	143	21	164	0	164	0	

	Non- regulatory					
	Regulatory	Not puzzled	Puzzled	Non- strategic	Strategic	
Episode D						
OES						
NOT CHA						
NGE	105	4	106	3	98	11
Episode change	184	5	177	12	152	37
Actor (therapist)	125	9	119	15	86	48
Actor (Patient)	164	0	164	0	164	0

**APPENDANT N°5 PICS-TP Manual**

# **Coding System of Silences for Therapists and Patients (PICS-TP)**

**Manual for training and coding silences of therapists and patients  
in psychotherapy for a Spanish-speaking context.**

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**Introduction**

Psychotherapy can be defined as a type of treatment based on a relationship of help - professional and empathetic - that is established between a trained professional for assistance and a patient (or several of them), where it seeks to promote change through the interaction of the participants, covering both verbal and non-verbal aspects (American Psychiatric Association, 1969; Mahoney, 1991; WOLBERG, 1977, among others).

Throughout the history of research in psychotherapy, it has tried to understand how change happens, including the way in which the verbal and non-verbal dimension contribute to this complex interpersonal process. Historically, it has been given greater attention to the verbal dimension, and although in recent years the non-verbal dimension has emerged with greater force in research in psychotherapy, there are still aspects that have been less studied in the interaction between therapist and patient.

Within the aspects least studied are the silences, despite being regarded as fundamentally constitutive of human interactions and of the narrative production (Levitt, 2002). However, it is known that silences would play an important role in patient-therapist interaction (Levitt, 2002) and as a product of this conception is that in the past 15 years have appeared more empirical research on this aspect of human interactions, not only in the psychotherapeutical context, but also in cultural research (i.e.: Daniel, Folke, Lunn, Gondán&Poulsen, 2018; Frankel& Levitt, 2009; Levitt, 2001, 2002; Nagaoka, Kuwabara, Yoshikawa, Watabe, Komori, Oyama&Hatanaka, 2013; Sharpley, Munro &Elly, 2010; Stringer, Levitt, Berman & Mathews, 2010; Xiao, Bone, Segbroek, Imel, Atkins, Georgiou, Narayanan, 2014).

These investigations have contributed to revolutionize the historical meaning given to silences from the theoretical currents in psychology, moving from being a homogeneous phenomenon and undesirable, a phenomenon that is fundamentally cultural and shortcut menu that would be serving a specific function depending on multiple contextual factors that surround its occurrence. In this way, the various functions that silences can be fulfilling in psychotherapy are going to depend directly not only of socio-cultural factors such as language, but also the situational aspects of how the topic of conversation being treated at a given time, until the facial expressions that participants have a specific point in time.

Although there have been important advances in the understanding of this versatile phenomenon, have not yet been carried out research in a context of speaking that may reflect the different meanings and interactive features that silences can have in a different sociocultural and historical context, to the context from where they have emerged as the majority of theoretical and empirical research. In the same way - although there are some substantive tracks - has not specified the way in which the silences are as a space of encounter and openness to one another, as an intersubjective space (Tomicic, Martínez, Altimir, Bauer and Reinoso, 2009) while the silence is part of the dialog (Lehmann, 2014).

Seen from this perspective, the silences can be considered as one of the phenomena that contribute to regulate the psychotherapeutic interaction (Tomicic, Pérez, Martinez & Rodriguez, 2012), not for himself alone, but articulated with other communicative aspects, both verbal and non-verbal cues. Therefore, conceiving silence as a shaper of human communication, its approach would allow to describe their participation in therapeutic interaction, its role as a regulator of therapeutic relationship and also their possible forms of participation in the process of change.

This handbook has been created from an empirical research which had as its central objective to *establish the participation of silences in the interactive regulation between therapist and patient in different interactual scenarios and along a psychotherapy*. From a mixed, descriptive and relational design, a coding system for both the silences of therapist as patients, allowing an understanding of the role of the silences depending on the context of interaction that has been co-created by both actors at a particular time.

This manual is organized in the following way: a first part dedicated to the conceptual framework that allows us to understand the background of the coding system (made up of paragraphs *What are the silences?*, *to study silences in psychotherapy?*, *What types of silences we can find in psychotherapy?* And *in what way was this coding system was made?*). A practical second part, which details the steps to follow in order to perform the encoding of silences in psychotherapy according to the different typologies of silences that can be found in this particular system (divided into a section for the silences of patients and another for the silences of therapist). And a third part formed by annexes that will help a better understanding of this manual, especially the coding procedure.

## **What are the silences and what is its relevance in psychotherapy?**

The word silence comes from the latin *silentium* (Mateu, 2001), which had different meanings (Mateu, 2001; Barthes, 2004), both for referring to inanimate objects (Mateu, 2001; Barthes, 2004), silences of human quality, i.e. silences speech (Barthes, 2004).

The etymological dictionary of Corominas (1987), defines the silence as opposed to noise, to speech, and specifies that there are different words to refer to different types of silence - *silentium, discretio, taciturnitas, TACE, concubium, sedatio* - being able to describe states of tranquillity, lack of complaint or grievance, the omission of a subject, silent night, etc.

At the Dictionary of the Real Academia Española (2011), the word silence also has different possible meanings, ranging from its use to refer to the lack of noise, a musical pause or an omission on the part of someone or an institution. Refraining from speaking.

From the sociopragmatic perspective, Jaworski (1993) defines the silence as an necessarily interactive instance, by including it in a dialogical context. Other authors have agreed with this perspective, relieving the contextual nature of the meaning of the word silence (Goldstein, 2003; Kurzon, 2007, 2009, 2013; Cornwall, 2006, Nakane, 2006; Ramirez, 1992), as well as its interactive nature (Gallardo et al., 1993).

Other authors have relieved their socio-cultural character, where its various functions (Keller, Yovsi, Anacarolina, & Papaligoura Kätnet, Jensen, 2004; Matsumoto & John, 2004) and meanings (Jin, 2014) are generated, depending on the place where this develops.

In summary, the silence can be defined as a phenomenon mainly heterogeneous, contextual and sociocultural.

In psychotherapy, the more recent conceptions of silence goes in this same line, considering that the meanings or functions of the silences are going to depend directly on the context in which it occurs. Various empirical research (i.e.: Daniel, Folke, Lunn, Gondán&Poulsen, 2018; Frankel& Levitt, 2009; Ladany, Hill, Thomson & O'Brien, 2004; Levitt, 2001, 2002; Sharpley, Munro & Elly, 2010; Stringer, Levitt, Berman & Mathews,

2010) have contributed to this meaning of silence prevails in the research in psychotherapy, allowing the emergence of understandings increasingly comprehensive and complex of the therapist-patient interaction during the psychotherapeutic process, as well as their influence on the results of psychotherapy.

### **What types of silences we can find in psychotherapy?**

In psychotherapy you can find fundamentally two lines of research that have considered the perspective of patients and therapists to generate meanings and functions of the silences in psychotherapy, depending on the role from where these are conceptualized.

Among these studies, we can find in the research guided by Clara Hill (Hill, Thompson, & 2003; Ladany, Ladany, Hill, Thompson & O'Brien, 2004), who focused on the use that the therapists give to silence. On the other hand are the studies led by Heidi Levitt, who has devoted himself to investigate from the perspective of the patients. Only the second has developed a coding system that enables to develop research in psychotherapy.

Based on a sociocultural context of English-speaking countries (Canada, specifically) and from the experience of the patient, and the encoding technique of the Grounded Theory, this researcher developed the only coding system of silences for psychotherapy (Pausing Inventory Categorization System, PICS, Levitt, 1998, 2001, 2002; PICS-II, Levitt & Frankel, 2004), coming to establish seven types of silence. These in turn are classified into three categories of greater hierarchy according to their functionality associated with the results of psychotherapy, some being more or less productive than others.

The categories of silences of the patients are: Thoughtful, expressive, emotional, memory, associative, interactive and disconnected. Its main functions and features are summarized in Annex 1.

Some of the findings of this research line from the PICS-II allude to the dyads with good therapeutic results are more productive and less silences obstructive (Frankel, Levitt, Murray, Greenberg & Angus, 2007). However, it has not been investigated in the possible positive character-generative obstructive of the silences in the process of change. It has also

been noted that productive breaks are at times highly fruitful, since it is in these where you would experience emotions, symbolizing them and also link to the personal meaning (Stringer, Levitt, Berman & Mathews, 2010).

In the case of therapists, there had not been developed categories of silences for therapists that would allow to classify them in psychotherapy. Considering the mutual regulatory perspective, where both therapist and patient negotiate the status of the relationship from moment to moment, and that, therefore, the change in this process does not occur in a unilateral way, but to be co-building at every moment in this specific interaction, it was considered necessary to be able to create a system that allows us to understand the experience of therapists with silences in psychotherapy.

### **How was this coding system made?**

The present coding system has been based on the created by Heidi Levitt, but has been adapted for a Spanish-speaking cultural context. This was done on the grounds that the silences correspond to a fundamentally cultural and contextual phenomenon, which was considered to adapt the necessary details so that it can be used in countries where psychotherapy is performed in Spanish language.

The adaptation has been carried out in Chile, from interviews with patients and therapist's participation. The interview addressed various themes on the silences in psychotherapy and on the basis of topics related to the silences of the patients, were open encodings with Grounded Theory were performed. Subsequently, three independent coders who are familiar with the encodings of the interviews and with the PICS system-II, proceeded to carry out the specifications of the categories of silences. This was done on the basis of the codification of change episodes and episodes of rupture of a psychotherapy long with the PICS-II, where the three encoders were generating the necessary changes from what is observed in the video and open encodings from the interviews. These changes were made only when the three coders agreed unanimously. Otherwise, the characteristics of each silence were left as presented in the PICS-II.

In the case of the silences of therapists, the system was lifted from interviews with



patients and therapists, and also from interviews *microfenomenologicas* to therapists.

This last technique allows you to grasp and understand the flow of a person at a specific time, both in a detailed way to transverse level, as a temporary,

The micro-phenomenological interviews were coded with an analysis specifically developed for this type of interviews, called micro-phenomenological analysis. This allows to create an experiential category from the understanding of the deployment time frame of the experience from moments and consecutive phases. Each phase is characterized to be able to describe the manner in which each of them passes during the experience.

Once lifted and described the phases and moments of silence, they proceeded to encode episodes of change and rupture of another therapy long, assigning a category of silence at each of the moments of pause identified that could be identified as silences of therapist. The characteristics of each one of the silences were complemented with the details seen in the videos of the episodes, until they came to data saturation. This process was attended by the same encoders of the previous stage. The details were included only in the case of unanimous agreement.

The PICS-TP has a coefficient of inter-observer (Cohen's Kappa) of 0.909 for the categories of silences for therapists and 0.852 for the categories of silences for patients. This is classified as a very good level of interrater agreement, which makes it a system with good level of reliability (Landis & Koch, 1977).

### **But, is it possible to establish who owns a silence?**

The silences are moments that are shared, in the sense that one of the participants proposed a silence, but it is the other who choose whether to respond to its counterpart or remain silent. However, for methodological purposes, it has been decided to establish that a silence belongs to who proposes it, that is to say, who in his turn to speak choose to pause or is silent because he has nothing more to say. This can be a little confusing, since in reality are both participants who respect the moment where there is no speech. However, although that time is co-constructed, that does not mean that both participants are having the same experience or who are experiencing exactly the same thing, since the meaning and function of a silence in particular is going to depend on the context and also of the role of each one of

the participants. This is supported by the latest research, specifically by the lines developed by Heidi Levitt and by Clara Hill. As well, the silence is a moment that is built between the participants of a specific interaction, but the meanings for each one of them can be different.

For the purposes of this manual, the silence will be considered as one or the other, depending on who has the turn, and that, in the same turn, propose a silence.

## **Patients' Silences**

### **PICS-II adapted to Spanish-speaking context:**

#### **Types of silences**

##### **Disengaged**

The patient has been disconnected emotionally from the topic discussed at the meeting, of the emotions that are emerging, the topic that is currently working on, or interaction with the therapist. This disconnection can occur before or after the silence. As an observer, it gives the impression that the process that is in progress to stop suddenly.

This type of silence can serve for the patient to avoid connect with feelings, avoid the damage, pain or distress, reorganize, close, stop or withdraw from the interaction with the therapist, of the meeting or of the item in question.

<b>Antecedent</b>	<b>During the Silence</b>	<b>Consequences</b>
Questions about a painful subject or about the emotions of the patient.	Patient turns his look toward the therapist or "out".	Start a new line of discussion and downplays the emotional Previous topic.

<p>Give an account of an emotion or emotional revelation and then say a joke.</p>	<p>Silence indicates that some process stopped.</p>	<p>Therapist tries to refocus the patient on the emotion or continue with the new Theme.</p>
<p>Patient seems very anxious. Patient comments on an emotional topic or reveals a content.</p>	<p>Patient is focused internally and stops abruptly.</p>	<p>Patient stops scanning through telling a joke, discard or summarize.</p>

## Emotional

Patient is experiencing an emotion, signs or indications that the patient begins to approach to them. The patient may be experiencing a wide range of emotions, which can go from anger to happiness. As an observer, you can "feel" a climate that is dying the silence. It is possible to identify words (verbs, nouns, adjectives), as well as nonverbal indicators (facial expressions) and paraverbal (vocal quality, pauses) associated with emotional states (i.e.: shaky voice if the person is crying or about to do so). In this coding system, it has been chosen to describe if the emotion is positive, negative or mixed.

This type of silence can serve to deepen emotional state (or indefinite feeling overflows), express feelings (fear, uncertainty, stress, anger, pain, etc.). In this version, positive emotions are also considered.

<b>Antecedents</b>	<b>During the Silence</b>	<b>Consequences</b>
Words associated to emotions	Emotional expressions	Emotional content.
Not emotional words, but that express such content.	Emotional With Voltage Silence	Not emotional words, but with emotionally charged content.
Repetition of phrases.		Trembling voice, tearful, etc.
Trembling or Tearful voice, Etc.		

## Interactive

Patient focuses on aspects of the therapist or therapeutic interaction. Attention is paid to the reactions of the therapist and the self. As an observer, it gives the impression that the patient was asking for something the therapist or you can see an interaction, where there is evidence

of complicity between the two. This type of silence - as well as the emotional - must be qualified as either positive or negative, depending on the patient's emotional expression, in the event that the therapist is not looking to the patient. In the case of patient and therapist are interacting visually, it must be characterised as either positive or negative depending on the emotional tone of that interaction.

This kind of silence can serve to: sue communication to the therapist (consider the therapist's experience, get away from the feelings to articulate), to express uncertainty of a task or comment (fulfilment of the task), protect the alliance (approval search/print management, control emotional reaction toward the therapist).

Antecedents	During the Silence	Consequences
Therapist says something uncomfortable or obvious.	It seems having tension or feelings of confusion.	Patient requests that the task is explained.
Therapist gives a task that the patient does not understand or that patient don't like.	Patient seems to expect more explanation on the part of the therapist.	Therapist explains spontaneously if you notice that the patient is confused During the pause.
Therapist performs a complicated question.	Visual contact with the Therapist, that can indicates standby or seeking support.	Patient to a response that indicates that he does not understand what the therapist has said.
Patient seems seeking therapists' approval.		Patient tries to change the focus or topic of the conversation.

### Reflective

The patient thinks thoughtfully on a particular subject, being able to question ideas, or consider alternative points of view to those who had until that moment. From this process, it is possible to

realize the complexity of a subject, or establish new associations or insights about their experience, whether it is more focused on themselves or more related to third parties. The reflections can be raised in abstract terms, or more specifically, for example, through memories, from where, on the basis of the history can be ripped off an idea more abstract than an indirect evidence that the patient has been questioned, established new connections or made any insight.

This kind of silence can serve to: challenge ideas, make associations, have insights or realizations.

Antecedents	During the Silence	Consequences
Therapist or patient presented a new idea to consider.	Patient seems to be intellectually involved.	Expressions of insights, continued the questioning, questions, Analysis.
Expression of questioning, analysing, judging, evaluating, ask.	Look at some specific place (empty look or outward).	Expressions of insight, continued the questioning, questions, Analysis, etc.
Speech that examines alternative or evaluates options.	Little visual contact with the therapist or no eye contact.	Connection done or search for it.
Speech that performs connections or insights.	You can Have Adaptors (Ekman & Friesen, 1969)	
	The rhythm of speech can decrease.	

### **Expressive**

Patients seek appropriate words or phrases to be able to communicate their experience or in Progress status. Try to label more precisely what they are experiencing, trying to symbolize an experience that before had not been appointed, either because of their complex nature or new. As an observer, it is possible to note that the patient is currently preparing his speech

actively, and there may be a speech interspersed with stuttering or fillers, corrections or ratifications semantic, grammatical changes in the order of the phrases, or similar indicators.

These silences can serve to articulate ideas, making tasks such as searching for the right words, deciding on the correct way to express an idea, appoint feelings.

<b>Antecedent</b>	<b>During the Silence</b>	<b>Consequences</b>
Patients try to articulate the present experience which had not been articulated before.	Patients seem to find the correct word or expression	Patient is an expression or symbol to your experience.
Stuttering of the patient.		Patient indicates have failed in the search or a phrase Precisely.
Patients Say Something Uncomfortable or vague.		

### **Mnemonic**

Patient tries to remember details of events or objects that is describing. Usually occur when the therapist asks for more information or accuracy on what was said. In this sense, this silence is used to be able to remember an event, rebuild or order a history, search in the past history and also use strategies of mnemonic.

<b>Antecedent</b>	<b>During the Silence</b>	<b>Consequences</b>
Therapists ask for information.	Patients seem to be centred inside or imagining the events that you are remembering.	Patients re over the information they were seeking.

Patients seem to strive to find details.		Patients recover information they were seeking.
		Patient indicates having failed in its attempt to remember.



## Therapists' Silences

### Types of therapists silences

#### Accompaniment silence

The *accompaniment silence* is a space where the therapist is available to be with the patient from moment to moment, that is to say, be attached to the patient's experiential flow, or at least what the therapist can perceive it. The therapist deploys surround attention that allows to listen to and recognize the patient, and, as well, to apprehend and accept the experience that relates.

This silence is divided into three main phases with some specific functions:

- **Surround attention**

It is characterized because the therapist listens carefully to the patient and recognizes their experience.

- **Accept the patient attention**

This is possible thanks to the fact that the therapist has paid attention carefully to what the patient has been reported, and also because attention has been given to the non-verbal and verbal keys, recognizing them as inherent to the patient and also as valid.

It is important to mention that this silence does not appear only when the therapist and patient are in silence, but it is a process that also occurs when the patient is talking about, but that can be seen more clearly when both are silent.

<b>Antecedent</b>	<b>During the Silence</b>	<b>Consequences</b>
There is talk about a topic Sensitive to the patient.	It is aimed at the therapist Patient,	Verbal intervention of therapist or patient.

	Body can also be directed to the patient	
	Therapists' look expresses warmth	
	Patient expresses negative emotions with the body and facial keys.	

### **Alert Silence**

Similar to the *accompaniment silence*. In this case, the therapist is more active, waiting for the moment-to-moment and monitoring the patient in detail.

This silence appears when the therapist has noticed that something has happened to the patient and need to pay more detailed attention, in order to understand the current experience of the patient.

<b>Antecedent</b>	<b>During the Silence</b>	<b>Consequences</b>
Patient is in silence.	Therapist focuses on the patient. Look at facial and body attitude keys.	Therapist performs an intervention, regarding what happens
Therapist does not know what could have happened exactly, but thanks to the non-verbal keys knows that something happened.	Therapist may be at increased muscle tone, manifesting a state of tension to be alert.	

The process can be repeated again and again depending on how much time the duration of the silence.

### **Self-Regulatory Silence**

In this kind of silence, the therapist realizes that experience negative emotions in

relation to what the patient has reported or toward the patient directly. The therapist chooses to stay in silence, to say anything considered as useless, aggressive or poorly educated.

On the other hand, chooses to keep quiet to be able to say something that is a contribution to the process that is in progress at that point in time. The main function of this silence lies in order to perform a useful intervention.

Consists of two major phases:

- **Phase of awareness:** the therapist realizes that is experiencing a negative emotion. There are two phases:
  - **Observation and attention:** the therapist pays attention by controlling negative emotions by observing and checking time to time, the body and thoughts. If the therapist can observe and take care of his emotional state, is passed to the next stage.
  - **Self-regulation:** here the therapist is regulated in two phases: 1. check the negative feelings and 2. Check the body and thoughts. The therapist can be maintained between these two phases until it achieves self-regulation.

Antecedent	During the Silence	Consequences
Therapist is in silence after something said by the patient.	Therapist takes conscience of body sensations.	Therapist or patient resume speech.
	Therapist tries to regulate his breathing to regulate emotions	

	There may be manifestations of negative emotions in the therapist. These can increase, maintain or decrease.	
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### **Puzzled Silence**

This type of silence appears in the therapist when is confused about the topic discussed at the meeting, feeling off and inconsistency in relation to the patient. The history of this type of silence is that the patient is talking about something in a way off, both on an emotional level and at the level of discourse.

It consists of two phases:

- **Phase of feel the inconsistency or disconnecting the patient:** The therapist cannot understand what the patient is trying to say or what is the central point of what the patient is trying to tell. This phase consists of two phases: a **lack of meaning and feelings of negative emotions.**

The therapist can be maintained between these two sub-phases, generating a kind of vicious circle, where the negative emotions would be maintained to the extent that the lack of meaning or sense persists.

- **Phase of (over) think:** Becomes to think about a possible meaning of what the patient tries to tell you. In parallel, negative emotions are maintained, with less intensity, because the centre is to think of possible options on the meaning of the record of the patient.

<b>Antecedent</b>	<b>During the Silence</b>	<b>Consequences</b>
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Therapist remains in silence after an off intervention of the patient	Therapist experience emotions such as anger, surprise or anger.	The patient or therapist interaction. It is unclear the issue or how resumes
	Therapist tries to think about possible options to understand patients' experience.	
	Facial keys of anger and disgust.	

### **Strategic Silence**

The therapist starts the silence with a particular purpose and useful for the therapy, intending its appearance. The first intention is the antecedent of this silence.

**Maintenance phase of silence:** the therapist keeps quiet until the patient's response.

This phase consists of two Sub-phases:

**- Set the silence by way of imposition. -**

**Look at each other with the patient.**

**Term:**

<b>Antecedent</b>	<b>During the Silence</b>	<b>Consequences</b>
The therapists remains in silence after an intervention	Patient takes awareness of his breathing. It is possible to see changes in it.	The patient resumes the conversation
	Therapist expresses tension or concern.	

	Therapist feel expectation and anxiety. This is not always possible to see.	
	Therapist focuses its attention in facial key and body attitude	

### **Procedure for the Codification of Silences in Psychotherapy**

The procedure suggested for the codification of silences in psychotherapy is identical to the one used during the training process that was used during the creation of the adaptation of the PICS system-II. This procedure is very similar to that used in the "Coding System of patterns of Vocal Quality of patient and therapist: Training Manual and Procedure for the Codification" (Tomicic, Guzmán, San Martín & Martínez, 2015). It was decided to use this procedure due to the reliability of the system and because it has been revised in order to clarify details necessary to generate a higher quality encoding. However, the encoding of silences has some special features relevant to the appropriate codification.

The steps are the following:

1. Listen once the unit of analysis chosen to encode (meeting, relevant episode, etc.) to get familiar with the rhythm of speech of each participant, as well as interaction between them.
2. Hear from the beginning of the segment analysed to identify the presence of silences in it. Considered **only** silences of 3 or more seconds. It is strongly recommended to use some support software to perform this task. The encoding of silences recommends some softwares like: Adobe Audition (any version), Audacity, Reason, WavePad, etc. You can use the software of your preference **as long as** the software allows measurements of length of time of some segment of the audio to use. The measure must be carried out as accurately as possible. **Should not** be considered as part of a silent sounds like: laughter, cough, filled pauses (like mhm, uh, eh, uhm or similar). Sounds that are considered as part of a silent are sobs (without speeches or sounds similar to them), sighs or other kinds of sounds that do not imply that the person is trying to talk.

If the silence identified to measure 2,999 seconds, shall not be considered silence.

3. Record in the spreadsheet data referring to the silence identified. In the form of encoding as shown in Figure 1. Should consider at least the following characteristics: The unit of analysis, actor (who owns the silence), duration of silence (in seconds),

Start time of the silence, time of term of silence, and the phrase said just before that the actor falling silent. Other features that consider necessary according to the specific job, can be used.

Hear from the beginning of the segment analysed, turn by turn and segment by segment defined, and perform a preliminary coding considering the phenomenological description of the PCV. In this step of the encoding, the phenomenological description of the PCV allows to confirm, disconfirm or clarify the segmentation carried out in the previous step.

Step 2 and 3 must be carried out to identify all of the silences corresponding to the total duration of the chosen analysis unit. For example, if you have chosen to work with episodes of change, and the episode to analyse lasts 3 minutes, you should identify all of the silences at once, from the beginning to the end of episodes.

Figure 1. *Matrix of Excel Sheet for encoding of silences*

Terapia	Sesión	Nº Episodio	Tipo Episodio	Turno	Rol	Ubicación	Duración	Tiempo de Inic	Tiempo de térr	Silencio	Frase
N1	2	1	cambio	185	terapeuta	intraturno	3.887	0:07.386	0:11.274		mmm
N1	2	1	cambio	185	terapeuta	interturno	11.303	0:14.196	0:25.500		no lo siente un poco
N1	2	1	cambio	186	paciente	intraturno	10.033	0:26.136	0:36.169		es que
N1	2	1	cambio	187	terapeuta	intraturno	11.000	0:39.000	0:50.000		mmm
N1	2	1	cambio	189	terapeuta	interturno	16.426	1:28.573	1:45.426		mmm
N1	2	1	cambio	191	terapeuta	intraturno	3.495	1:51.653	1:55.148		mmm
N1	2	1	cambio	191	terapeuta	intraturno	3.057	2:22.239	2:25.296		lo que faltó lo que no hay
N1	2	1	cambio	191	paciente	intraturno	4.009	2:28.392	2:32.402		sí
N1	2	1	cambio	193	terapeuta	intraturno	5.649	2:35.422	2:41.071		mmm
N1	2	1	cambio	193	terapeuta	interturno	5.547	3:23.756	3:29.303		siente más bien

4. Once each silence of the chosen analysis unit is identified, you can proceed to encode the kinds of silence for both patient and therapist. The ideal is to follow the chronological order of appearance of each one of them.

The typology chosen for each of the silences identified should be reflected in the form as shown in Figure 1. You can enter them by typing the corresponding categories or identify with any of the numbers in the following table:



Reflective	1
Expressive	2
Emotional	3
Interactive	4
Remember	5
Disengaged	6
Accompaniment	7
Alert	8
Regulatory	9
Perplexity	10
Strategic	11
Not Codifiable	99

