Silence in Psychotherapy: The meaning and function of pauses

by

Heidi M. Levitt

Dissertation to be submitted to the Faculty of Graduate Studies

in partial fulfilment of the requirements

for the degree of

Doctor of Philosophy

Graduate Programme in Psychology

York University

Toronto, Ontario

July, 1998

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"He went to the Yeshivah of Chittim and Tachtim which was thousand of yards deeper, nearer the center of the earth. There he studied the secret of silence. Because silence has many degrees. As Shiddah knew, no matter how quiet it is, it can be even quieter. Silence is like fruits which have pits within pits, seeds within seeds. There is a final silence, a last point so small that it is nothing, yet so mighty that worlds can be created from it. This last point is the essence of all essences. Everything else is external, nothing but skin, peel, surface. He who has reached the final point, the last degree of silence, knows nothing of time and space, of death and lust. There male and female are forever united; will and deed are the same. This last silence is God. But God himself keeps penetrating deeper into Himself. He descends into his depths. His nature is like a cave without a bottom. He keeps on investigating his own abyss."

(Bashevis Singer, 1961, p. 64).

Abstract

The psychological literature presents many conflicting understandings of the purpose and function of silences, or pauses, in psychotherapy sessions. Pauses have been thought to be indicative of such varied purposes as the heralding of insight, the demands of cognitive processing, the expression of rage, emotional attunement, interpersonal intimacy and therapeutic resistance. Despite such discrepant conceptualizations in the theoretical literature, a flaw of the existing empirical research is the study of silence as an indication of one homogeneous process, thus generally producing conflicting or uninterpretable results. To address this problem, this study develops an empirically-grounded typology of heterogeneous pausing experiences in psychotherapy; providing the foundations of a method which can enable the differentiated study of silences.

In this study, interpersonal process recall interviews (IPR; Kagan, 1975; Elliott, 1986) were conducted with seven clients within a day of their last therapy session. In these interviews, clients were asked to listen to moments from that session, in which pauses of at least 3 seconds occurred, and then to recall their experiences of those moments. The clients were participants in therapies of humanistic, psychodynamic and cognitive orientations.

These interviews were analyzed using a Grounded Theory method of analysis (Glaser, 1992; Glaser & Strauss, 1967; Rennie, Phillips, & Quartaro, 1988), a rigorous inductive process in which a researcher is guided by the analysis of data to develop an

understanding of phenomena grounded in empirical observation. From this analysis, the typology of silences was formed, distinguishing processes which occur during pauses in psychotherapy. The types of silent processes and the markers which were used to identify them within the therapy session transcripts are presented.

Moments of silence within the psychotherapy sessions were then examined in relation to the Narrative Process Coding System (Angus, Hardtke & Levitt, 1996), the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1970) and the Client Vocal Quality Scale (Rice, Koke, Greenberg & Wagstaff, 1979). Through the examination of each type of silence within the contexts of these psychotherapy process measures, in-session processes which were associated with each type of pause are described.

The contributions of this project include the generation of empirical data with which to evaluate theories of silence in psychotherapy, a Pausing Inventory Categorization System to allow for larger-scale projects researching pauses in psychotherapy, guidelines for clinical practice and suggestions for future branches of research. This system classifies pauses as Disengaged pauses, Feeling pauses, Interactional pauses, Reflective pauses, Expressive pauses, Associational pauses and Mnemonic pauses. Inter-rater reliability agreement and rater-client agreement are demonstrated. The major methodological contribution of this project is the development of a grounded psychotherapy process measure formed from the empirical analysis of clients' experience - a novel derivation.

Acknowledgements

I would like to acknowledge the assistance and support of my committee, friends and family. In particular, I would like to thank Lynne Angus for my introduction to psychotherapy research and for the opportunity to participate in the development and researching of the Narrative Process Coding System. If not for this productive and interesting foundation, I doubt I would be in a position now to continue on with my own research career, imbued with the passion for research which I currently possess. I would like to acknowledge Leslie Greenberg's contribution in helping to shape the process measure component of this study as well as to thank him for the psychotherapy supervision which he provided to me during my degree. His creative suggestions allowed for a more meaningful exploration of silences in the psychotherapy transcripts and his guidance has enriched both my understanding and practice of psychotherapy. I would like to thank David Rennie for his assistance with the qualitative portion of this dissertation, but more importantly for his encouragement throughout my graduate career. He allowed me to explore my thoughts with him and his interest gave me the confidence both to define my academic goals, one goal being the study of silence, and to pursue them.

The support I have received from my friendships, made at York University as well as outside of the programme, have made my graduate career a much richer experience. In particular, I would like to thank Karen Hardtke, for her assistance with psychotherapy

process measure ratings and for the pleasurable experience of our joint academic work, Sandra Jackson, for many stimulating and productive conversations on psychotherapy research (and on a wide variety of other topics), and Serine Warwar, for her kindness and for her company during the analysis and writing of this dissertation. I have been fortunate enough to have too many friends and colleagues to acknowledge each individually, but I think of each of them fondly and thankfully and I hope to return the supportive care which they have so generously given to me.

I thank my family for their love and their faith in me. My parents never doubted that I would succeed in my academic goals. This support has allowed me the continued confidence needed to overcome the challenges which have surfaced during the course of my degrees. It has been a great gift and has given me great comfort. My sisters, Tammy and Sheri, have always confided in me and respected me. Their trust has shaped me by requiring that I lead a thoughtful life and try to ensure that my beliefs are manifested in my behaviour. I treasure their confidence as I will always cherish them.

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Prologue

My interest in researching silence in psychotherapy has evolved from my interest in the processes associated with wisdom and its development. I view psychotherapy as a Western method of developing wisdom, and I feel that the quest for wisdom often is the drive behind psychotherapy. My understanding of psychotherapy is influenced by this perception and this prologue briefly explicates how my interest in silence has its roots here.

Sternberg (1990) defines wisdom as the ability to understand ambiguities and obstacles. I view wisdom as the ability not only to tolerate the anxiety that arises in the contemplation of ambiguity, but the ability to tolerate the anxiety of conflicting emotions to the point that they are able to be experienced, labelled, understood and judged. The ability to conduct this process and to integrate different ideas, perspectives and emotions can form the basis of "wise" behavioural decisions.

As I considered the development of wisdom to be the goal of psychotherapy, I became interested in other methods of developing wisdom (e.g., Levitt, 1997; in press). When researching methods such as meditation, artistic creation, and prayer, I noticed that all seemed to incorporate the element of silent sustained focusing. As well, silence is an element in monastic vows, in coming-of-age isolatory expeditions, and even in new-age

techniques like isolation tanks -- all methods of developing or enhancing personal wisdom.

It seemed to me that these processes of exploring emotional ambiguities required periods of silence, particularly in moments of deep concentration. These developmental processes all can be seen as providing a structure which can allay some of the anxiety which people experience when contemplating ambiguity. These processes appear to provide a task, a ritual procedure or a cultural context which provides support or guidance so that one might face and overcome difficult issues or emotions.

Reflective silences themselves in psychotherapy appear to me to be a potential indicator of the ability to sustain anxiety. To be able to hold an idea in one's mind and reflect upon it presupposes the ability to identify or experience some uncertainty with an idea: otherwise one would not have a motivation for contemplation. The ability to defeat anxiety in order to identify and/or explore uncertainty is a common goal of psychodynamic, cognitive and humanistic therapies. Processes of reflection can enable clients to overcome developmental obstacles and to find new solutions and perspectives. As such, I hoped that pauses could become a valuable marker of the development of clients' tolerance for anxiety.

My interest in silence in psychotherapy consequently is rooted in my view of psychotherapy as forum for exploration which provides an interpersonal structure that helps people to tolerate their feelings of anxiety so that they can enter into moments of

deep contemplation. Characteristics of therapy such as interpersonal support, and an explicit developmental agenda all work together to create an environment in which clients are encouraged to tolerate feelings of ambivalence and anxiety beyond their normal capacity. Drawing from my own personal clinical experiences, it appears to me that moments of silences are often associated with clients' experiences of meaningful inward reflection or with emotions which can lead to profound shifts and change. I considered these silences to be the height of cognitive and emotional processing and therefore became interested in identifying and examining silence in psychotherapy.

The Evolution of the Study

When initially planning this study of silence in psychotherapy I began by thinking that I would conduct this research by empirically examining silences in psychotherapy transcripts drawn from a completed study of brief therapy treatments (Greenberg & Watson, 1998). I wanted to identify speech patterns which precede silences and map out how productive pauses arise. Pauses in therapy, however, can stem from many different causes. For example, deep reflection as well as distraction can cause moments of silence. A difficulty with conducting a study based on transcript analyses alone was that I would have to infer from the transcripts the client's subjective experience of the silences that were associated with the patterns I observed. In order to avoid engaging in interpretive judgements about client experiences, the project shifted to include interviews with clients about their subjective experience of pauses in psychotherapy sessions.

After switching to an Interpersonal Process Recall (IPR; Kagan, 1975) interview method, however, it seemed premature to take the findings I had developed with one set of clients, a pausing categorization system, and then apply this system to the therapy sessions of different clients. In the context of therapy transcripts selected from a previous study, I was concerned that if two raters judged a pause differently it would be difficult to tell which interpretation was correct without some representation of the client's in-session experience. Particularly in the initial stages of a typology development project, I felt it would be better to resolve these difficulties with the insight of clients' experience as a check for the categorization procedure. Consequently, the focus of the dissertation became the IPR interviews with the clients and the analyses of the sessions upon which these interviews were based.

In order to develop an understanding of processes that were at play in relation to the different types of pauses, an exploratory study was conducted in which psychotherapy process measures were applied to the session transcripts. A complication in developing this design was the conflicting demands of this quantitative analysis with the prior qualitative approach to the study of silences. This was most evident in the difficulty in reconciling a method which calls for heterogeneity of subject with one which strives for experimental consistency and control of all factors other than silence type. My philosophy in psychological inquiry is to be question-driven and to try to make methodological compromises as needed in order to best preserve integrity of the question.

In this case, I felt the use of the two methodologies did not compromise each other to a point which exceeded the fruitfulness of their combination.

In the end, this project became one with a strong qualitative component and an exploratory quantitative component. In summary, I felt that the combined methodologies acted to enhance one another, adding richness to my findings and making them more compelling. At this stage of psychotherapy research, the study of silence warrants exploration in order to develop a grounded understanding of the phenomenon. Hopefully, after reading this dissertation, the reader will agree that this study has provided the basis for a programme of future research and has built a foundation upon which prediction and testing methodologies can be used more productively and meaningfully.

Introduction

An increasing number of theoreticians and practitioners are conceptualizing psychotherapy as a fundamentally narrative process (e.g., Polkinghorne, 1988; Howard, 1991; Angus & Hardtke, 1994). In this approach, the psychotherapy session is seen as a place where clients voice and shape their life stories. Unlike written narratives, client's stories are told in an idiosyncratic style; instead of being contained in traditional beginning-middle-end structures, they are often expressed as tangents with interweaving themes (e.g., Bruner, 1990; Angus & Hardtke, 1994; Korman, 1997). Clients present versions of their life stories which are then expanded, differentiated and revised through the co-constructive process of the client and therapist dialogue. Through this process, more adaptive versions of these stories can be developed which help clients to either to deal with their world more realistically or to recognize elements in their stories which were previously overlooked. In terms of narrative study of psychotherapy, the study of silence is important as it not only represents the unsaid within the therapy narrative, but also continues to develop a new understanding of the function of narrative in psychotherapy. This understanding will be elaborated upon more fully in the discussion section of this paper.

Metaphors of silence are often used to describe the process of therapy. By listening to and guiding the examination of the client's story, the therapist may be "helping her to pause long enough but not interminably in front of this mirror of

herself" (Marta, 1994, p. 153). "Pausing with oneself", "taking a moment for oneself" or "stopping to look at oneself" are powerful metaphors which people use when discussing therapeutic processes. It seems there is a certain type of pausing that is associated with healing.

The experience of shared silence is somewhat paradoxical. On one hand, therapeutic silence is necessarily a co-constructed event, as both therapist and client have to engage in silence together for it to occur. On the other hand, it is also when both client and therapist are most alone in the therapy session. Neither knows what the other is thinking, and silence can hold different meanings for both client and therapist. As such, these moments can create anxiety and can threaten the therapeutic alliance, perhaps one reason why novice therapists can experience difficulty in allowing silences in psychotherapy sessions (Murphy & Lamb, 1973).

It is not uncommon for silence to be addressed in introductory psychotherapy training courses or texts as an element in therapy which therapists should respect and to which they should attend. For instance, Benjamin (1981) discusses silences as having many different meanings from the client's perspective. In his description, silence can be indicative of clients' absorption in thought, resistance, confusion, or time needed to process information. These typologies are not empirically founded, but rather are comprised of listings of processes which their composers have come to associate with silence, based on their clinical experiences.

Although many psychotherapy theorists often view silence as a negative process, indicative of resistance, avoidance, or as a transferential reaction (e.g., Fliess, 1949; see Wepfer, 1996), it seems to me that the frequency and duration of shared silences are the very characteristics which most distinguish psychotherapy from ordinary conversation. In most other conversational contexts, sustained pauses are rare, often only indicating discomfort, whereas in psychotherapy shared silence is an accepted and common part of communication. I will use silences and pauses interchangeably throughout this dissertation as in psychotherapy sessions these are indistinguishable from one another. It is one of the few contexts in Western society where two people can come together and emerge themselves in silent contemplation. Although shared silence seems to be one of the differentiating elements of psychotherapy, there has been little empirical work examining its meaning or contribution as an element of change processes. My dissertation will examine the place and function of pauses in psychotherapy, particularly in terms of clients' experience.

The present chapter will examine the various theoretical understandings of silence within the psychotherapeutic literature. Next, I will discuss the empirical research on silence. This review will focus upon psychotherapy research and psychotherapy process measure research, but will also include interview research, anxiety research, linguistic research and research on disordered silences. The chapter will conclude with a discussion of the objectives of the present study.

Silence in Psychoanalytic, Psychodynamic & Object Relational Theory

Silence as resistance. Psychoanalysis, as the founding psychotherapeutic orientation, has had a formative structural effect on both the present day form of psychotherapy as well as on the way psychotherapeutic research is conceptualized. Strean (1969) commented that our current "emphasis on verbal interactions may exist because most psychotherapists maintain at least some allegiance to the classical psychoanalysis" (p. 236). He recalled "Anna O," the first patient treated by psychoanalysis, and her reference to her treatment as "the talking cure" (Breuer & Freud, 1957, p 235). Words, not dreams, were her golden road to mental health. Silence was seen as an obstacle to be overcome.

To the early psychoanalysts, patients' silences indicated resistance to revealing inner thoughts and experiences to therapists. Freud (1912) viewed silence in free association as indicative of the patient's awareness of the analyst's presence or of a concern about the therapist's interpretations and a subsequent halting of associations. Silence was a counter-therapeutic response as it was thought that associations were being censored or withheld from the therapist in these moments and instead clients were urged to say whatever came into their minds as soon as it arose. As interpretations were built upon what was said, the more that was said, the more building blocks an analyst had with which to work.

Interestingly, although psychoanalysts discouraged silence in their analysands, moments of silence were highly valued as *therapist* responses. Psychoanalysts' attempts to function as blank slates for their patients' transference projections often led to therapist silences. As well, analyst silence has been prescribed as the best way of encouraging free association (Langs, 1978), hence the popular view of analyst's repertoire as being composed of silences, nods and "mhms" (e.g., Roth, 1969).

Although this interaction of silence has become the salient public characterization of psychoanalysis, analysts themselves have conducted little empirical research investigating the effects of therapist silence in therapy. Instead the psychoanalytic literature is mainly comprised of case studies analyses of the "silent patient" and about the counter-transferential problems which can occur with this type of patient. "Normal" therapeutic silences are not addressed in this literature, and all silences are characterized in psychoanalytic terms. For instance, Fliess (1949) characterizes silences as oral, anal or urethral to which Sabbadini (1991) then adds a phallic category. These interpretations can create difficulty for the clinician attempting to apply this theory to silences in most "normal" psychotherapy sessions.

Silence as regression to the time before separation. In the psychoanalytic literature, silence has commonly been seen to signify regression to an earlier state of infancy, to the time before words (Reik, 1926). There have been two main interpretations associated with this regression: silence as a sign of anal eroticism (Ferenczi, 1916/1950),

wherein words symbolize food and so silence becomes a withholding or hoarding response, or silence as symbolizing an even earlier time of infancy in which the self is merged with mother.

Speech is considered to be the beginning of separation and hence of transference (Nacht, 1964). Words, and in particular proper names (Brett, 1981), are the strongest challenge to the fantasy of undifferentiation from the mother. The infant's ability to recognize objects, and ultimately to recognize itself as an object, force upon it a recognition of its own physical and psychic autonomy. Winnicott (1965) viewed silence as a regression to the state of "being merged with a subjective object."

This regression in therapy has been attributed to ego weakness, to transference from a love object associated with a preverbal stage into the therapy (Arlow, 1961), to a wish for an idealized, symbiotically undifferentiated relationship with the therapist (Ekstein, 1965), and to the analysand's attempt to halt individuation (Busch, 1978). The construal of silent moments in therapy as indicative of merger experiences in which a client fantasizes that the therapist is understanding the client without the need for speech (Caruth, 1987) is common to all these interpretations.

In psychoanalytic theory, silences have been interpreted to have many different meanings, based on the different types of experience an infant has of the process of separation. The absence of a love object has been viewed to be a motivator of large amounts of silence in therapy as it can cause individuals to regress to the fear they felt

when the love object was absent as an infant, particularly if the individual suffered the early loss of this object (Reik, 1926; Greene, 1982- 1983). Similarly, the fear of silence would be interpreted as representative of the fear of the loss of love objects in these cases (Reik, 1968). Sabbadini (1991) discusses this theory of silence in terms of the loss, or mourning of the loss, of the analyst.

With patients who are seen as being fixated at the anal stage, silences have been interpreted to indicate a series of anger, controlling or self-restriction tendencies. Marshall describes how he dealt with a patient who was using silence as a form of resistant control, "I ordered him to behave in a destructive manner... he lapsed into silence.... I then ordered him to maintain his silence, at which point he launched into a series of reproaches" (1972, p. 144). He illustrates how these clients can use silence as a way to control the psychotherapy session. Such moments have been considered indicative of a struggle with the analyst for control, a desire for revenge against the mother (Zeligs, 1961), as well as self-punishing and homosexual tendencies (Loomie, 1961).

Besides anger and merger fantasy, the helplessness of being an infant are thought to be re-enacted in some therapeutic silences. Theorists connect the meaning of silences to the specific unconscious fantasies of their patients, often relating to the process of individuation. For instance, in the context of describing infantile helplessness, Kaftal (1980) describes silence as an expression of the fear of abandonment and death. Dermen

describes silences in a patient as resulting from separation-individuation conflicts in which silence was an escapist alternative "to fighting in a situation where he felt he couldn't win" (1994, p. 192) generated by feelings of helplessness. Although these three interpretations of silence as regressive responses characterize the psychoanalytic literature, the interpretations of silence as indicating merger and anger fantasies are more dominant than the regression to helplessness interpretation.

Silence as generative. There have been some psychoanalytic theorists who have viewed silence as indicative of more generative processes. Balint (1958) describes patients as both escaping from something and escaping to something in moments of silence, and advises therapists to use these moments as opportunities to gather information about their patients and the issues that they are hesitant to express openly. Utilizing a psychoanalytic framework, Kelly (1955) discussed silence in terms of an adaptive regression to developmentally earlier non-verbal thinking processes used to overcome dualistic verbal thinking which can be overwhelming. Although the consideration of silences as generative or productive moments has not been as prevalent as the consideration of silence as a form of resistance or as a regressive phenomena, it does appear that this view is beginning to have some influence in the published psychoanalytic literature.

For instance, Sabbadini (1991) addresses silence as a space for words that can't be spoken. Instead of aiming to make her patients talk in these moments, she attempts to

find out why speaking is difficult for them: "The analysand lying quiet on my couch, whatever the meaning of his particular silence, is indicating that he is with me *to tell me that he cannot tell me anything.* Which is not a meaningless statement" (p. 411).

Trad (1993) presents three purposes of silence: a) to share deep interpersonal experience and to let a few trusted individuals, potentially the therapist, close to the inner core; b) to allow moments of clarity and self-revelation to take place, a strategy used by both patients and therapists; and c) for the therapist to get a sense of a client's personality and to analyze countertransference in processes. Silences are described as a protective process which maintain both personal privacy and "the inviolability of our personhoods" (p. 169). They can have adaptive functions as well as a deeper, meaningful purpose.

These psychodynamic theorists have expanded the views of silence to take into account silences that are generative moments which can provide insight into the psychodynamic therapeutic process if properly explored. Silence can then become an signal of and opportunity for productivity in psychotherapy. These interpretations of silence address a broader range of "normal" silent experiences, but they have been generated from the perspective of the therapist alone. The lack of clinical research in support of these perspectives can create difficulty for clinicians deciding which theoretical perspective they wish to endorse. As the contrast between the different psychodynamic and psychoanalytic theories is extreme, ranging from silence as an

indicator of rage to silence as an indicator of intimacy, this is an important issue to be resolved.

Counter-transference. Silence in psychoanalytic psychotherapy has long been thought to increase the potential for counter-transference reactions as therapists are often uncomfortable with these moments and tend to feel that clients are resisting engagement in the therapeutic process (Hamilton, 1966). The psychoanalytic literature repeatedly cautions therapists to be wary of counter-transferential reactions to patients who tend to be silent in order that they do not interfere with the way they interact with their patients.

As depression often is associated with silence in clients, this client presentation can contribute to difficult counter-transferential relationships (Lechevalier, 1988). One therapist writes, "because the emotional power of silence is very great, its effects upon counter-transference can render its comprehension doubly difficult .... For six months I was so immersed in our shared soundlessness and the affects it created that I could not see what the dynamic unconscious of the patient was attempting to communicate and achieve" (Morgenstern, 1980, p. 251). Particularly with severely depressed clients, psychoanalytic therapists may need to monitor their reactions to silences carefully in order to develop methods of dealing with these silences in a positive manner.

Along another vein, silence has been prescribed as a method to protect against counter-transference reactions. Rutan and Alonso (1994) recommended that therapists who have difficulty with counter-transferential reactions sit quietly for extended lengths

of time (i.e., up to 30 minutes). Stone, Karterud and Stone (1994) disagreed with this advice arguing that this length of therapist silence might evoke powerful rage reactions in their patients which would be counter-therapeutic.

Inappropriate silence from therapists can be misunderstood by patients as a form of angry reaction. Spinal (1984) identifies a group therapist response type as "*silent observing*.... the type of silence that occurs when the leader is feeling cornered, angry or defensive or when the group will not allow leader intervention" (p. 420). Interpretations of therapist silence are not uniformly negative, however. They have also been described in very positive terms, as conveying to clients the therapist's neutrality and acceptance (Torras, 1992), or as signifying the intimacy between therapist and client (Sanchez, 1971).

Traditionally theories on transference from either the client's or therapist's perspective are discussed in terms of the client's reactions alone, or the therapist's counter-transference alone. More recently, however, silence has begun to be acknowledged as a co-constructed phenomenon, generating interpersonal transference for both analyst and analysand and with both contributing to the process (e.g., Mertens, 1990).

Silence in Client-Centred Theory

In general, client-centred theorists have not dealt with silence as a topic in their writings. In their psychotherapeutic practice, however, therapists seem to be quite

tolerant of client silence. In his work with a schizophrenic client, Carl Rogers described psychotherapy sessions which were conducted almost entirely in silence and considered these very productive (Corsini, 1984). As well, the well-known videotaped session between Rogers and Kathy contains long silences throughout the session. In his analysis of the session, Rogers discusses the moments of silence as helpful for Kathy's process of developing personal insight (Shostrom, 1977).

Focusing is a client-centred technique which structures silences in such a way as to encourage clients to sustain silent inward contemplative states in order to develop a better attunement to their own internal experience. Gendlin (1996; 1978) stresses that therapists should avoid moving too quickly when in the "receiving" mode of focusing, while their clients are listening to their inward "felt sense" (a bodily awareness of a situation, person or event that is the sum of all they feel and know about a phenomenon). Lengthy periods of silence on both the parts of the client and the therapist are crucial during therapy sessions in which clients are trying to locate their inner felt sense. "Some people won't need any help except your willingness to be silent. If you don't talk all the time, and if you don't stop them or get them off track, they will feel into what they need to feel into. Don't interrupt a silence for at least a minute" (Gendlin, 1978, p. 125).

In describing group focusing techniques, Hendricks (1984) indicates the importance of balancing the silence and the structure in the following manner:

> The steps are timed by how long it takes the leader to get a bodily felt response to the given question, plus time to sense a next instruction and 10 or 20 extra seconds. The whole focusing process usually requires 20-30 minutes - composed largely of silence between spoken instructions.... Since the instructions arise from the leader's process often they are not right for others... (in the silences) they can ignore instructions and make up or follow their own timing. Still the minimal structure of someone giving instructions is important. Also, the depth of the leader's process helps deepen that of others - especially in silence when one's pace slows and inner sensitivity deepens. The inward-tunedness of another is keenly felt. (p. 164)

The method of focusing has been used as a framework for therapy itself, as well as being incorporated as an intervention into other emotionally-focused therapies (e.g., Greenberg, Rice & Elliott, 1993).

Although approaches to psychotherapy with a client-centered philosophy seem to have a more positive view of silence, this often is not made explicit. In particular, the research done within these approaches tends to focus on the level of the spoken discourse, despite the fact that this discourse may more regularly occur between moments of silence. Research on the silent moment is needed in order to distinguish between the therapeutic framing of useful and non-useful silences within client-centred approaches to psychotherapy.

Silence within Cognitive/Information Processing Theory

As with client-centred approaches, cognitive approaches do not tend to discuss silence in and of itself. Perfetti and Papi (1985) describe pauses as moments where activities are taking place which require attention such as the planning of future speech and the process of meaning-making. They describe a positive correlation between the duration of pauses and the level of processing required. Controlled processes are thought to take more time whereas automatic processes are considered to be rapid and, one can assume, would not require as many pauses in the rhythm of the conversation.

Using an information-processing framework, Toukmanian (1990) discusses psychotherapy with reference to automatic and controlled processing as well, outlining stages through which clients move when they experience change in their schematic configurations. Silence, however, is not addressed as a distinct topic in this transition from automatic to controlled processing. Overall, there is little discussion of silence as a phenomenon in the cognitive psychotherapy theoretical literature, making it difficult for clinicians to know how silence should be managed within a cognitive therapy orientation.

Silence in Group Therapy Theory

In group psychotherapy, the meaning of shared silences can become very complex and difficult to interpret in the context of the group interpersonal dynamics which can evolve. There have been a few attempts, however, to describe the different qualities of

silence within a group format. Slavson (1966) presents a comprehensive list of different types of silences which might occur in group therapy events: the lack of understanding of content, anxiety/insecurity, reflection, resistance, the introduction of a taboo topic, being actively silenced by another group member, intense emotion, negative attitude/emotion (i.e., anger or guilt), fear of self-revelation, and reactions to angry, or critical or awkward therapist interventions. Although this listing of silence types does not provide therapists with much guidance on how to distinguish or deal with the types of silence, it does begin to offer a way to differentiate different processes that may be occurring in group therapy sessions.

Strayhorn (1979) describes silences in terms of two categories. The first category, Communicative Silence, entails the client's expression of anger or the communication of a wish for nurturance. The second category, Avoidant Silence, entails the fear of feelings, the fear of loss of self-control, or the fear of social awkwardness. Strayhorn teaches clients who are in avoidant silences to practice "communication postponement" when they are too upset or fearful to speak. This strategy allows clients to collect their thoughts in the present moment and to express themselves at a later point in time. Meanwhile, individuals who are engaged in communicative silences are encouraged to verbalize their thoughts. Although this model does have some direct applications for psychotherapy, the two categories identified seem only to address the occurrence of silence due to the client's experience of restricted communication or fear.

This would seem to be a rather narrow and restrictive representation of the continuum of silent moments in psychotherapy.

Five types of group-silences are described in Lewis' (1977) typology and corresponding therapeutic responses are suggested for each type. "Transitional silences," in which a group is becoming oriented to a new task, should be addressed by allowing the group to collect its thoughts in preparation for the new task. Silences within a therapy task which are considered passive-dependent signs of anxiety are seen to signal the therapist to refocus the client. "Dawning awareness" silences within a group are seen to be productive and are thought to lead to insight unless the group is dwelling on something violent or dangerous to do with one client, in which case Lewis suggests therapists should prevent the group from becoming immersed in a negative judgement about a group member. Therapists are encouraged to prolong "Affective silences" so that all members can get a chance to relate to the emotions experienced. Lastly, "withholding silences"of a passive-dependent type are seen as calls for support (if a patient is emotionally withdrawing), but if they are of a passive-aggressive type, it is suggested that issues of power may need to be examined and re-negotiated.

Although his withholding and passive-aggressive silences seem to be close to the categories suggested by Strayhorn (1979), Lewis' strategies can be seen to be support-oriented in contrast with the didactic approach adopted by Strayhorn. The other types of

silence, however, do not have correspondents in Strayhorn's model, illustrating how theoretically-derived typologies can be quite different.

Lewis (1977) also details a moment-by-moment, and somewhat terrifying, "life-cycle of a silence" in a group which appears to be the result of a silence left unstructured by the therapist. For the first minute or so, clients look to other members or to the group "rescuer" to break the silence, until this seeking seems to take on a pleading quality. For the next minute, he describes members as beginning to look to the leader to rescue them, becoming acutely anxious and beginning to decompensate, and trying to think of something to say if they are called upon. Over the next 2 minutes members begin to forget what the issues at hand were, may become lost in individual fantasy and will try to block out the group, instead being engulfed in feelings of isolation and helplessness. Although therapists would likely intervene in most situations before this degree of distress occurs, it does indicate the frightfulness with which silence can be experienced. The interpersonal dynamics of groups may cause this anxiety to be particularly intense.

One use of silence as a tool in a group therapy is suggested by Meltzer (1982) who describes a silent patient in a group therapy as becoming a "co-therapist" in that a verbal member of the group would talk and project verbally onto the silent patient, and the projective interpretations then could be discussed. This use of silent patients seems to be an anomaly in the group therapy literature, although transferences of this kind may be present in group therapies but not being commented upon in the literature.

As the theoretical literature offers many contrasting explanations of the meaning of silence in psychotherapy, this body of writing is inconclusive if taken as a whole. Consequently, it can be difficult for clinicians to decide how this literature should be used to inform their practice. Interpretations differ according to the conceptualization and format of psychotherapy; some view silence as productive and generative while for others silence is an indicator of therapeutic resistance and regression. As a theoretical consensus on the meaning(s) of silence has not been achieved, it becomes increasingly important to look towards the empirical research that has been conducted on silence in psychotherapy.

Empirical Research on Silence

Psychotherapy research. In psychotherapy theory, silence has been seen as a marker of many different types of processes. The main difficulty that has existed in the corresponding empirical literature has been that this very heterogeneous process tends to be viewed as a completely homogeneous phenomenon. Often as a result, research findings are contradictory providing little guidance for practicing psychotherapists.

Although some researchers have suggested that silence is a productive element of therapy, this literature seems to be characterized by divisiveness. For instance, Wepfer (1996) found silence in a long term dynamic therapy to follow patterns. He noted that longer silences tended to follow interpretations and may be understood as signs of insight, and Cook (1964) considered a "larger silence quota as characteristic of successful therapies". In contrast, Brahler & Overbeck (1976) found that if the silence-quota was

small "the therapist considered the session to be good and the patient felt understood, motivated and concentrated." In terms of anxiety levels, Mahl (1956) found that in anxious states, there was a higher silence-quota whereas Siegleman (1967) found that anxiety is associated with a rise in in-session talk-quota.

Becker, Harrow, Astrachan, Detre and Miller (1968) found significantly more silences in groups led by a therapist than in unled or family groups. They interpreted this finding to mean that the patients are intimidated by the therapist's presence and that silence indicated feelings of discomfort. In contrast, Hargrove's (1974) study examined one hundred 5-minute excerpts from 35 sessions, and found that speech latency, or silence, was a better predictor of empathy than the duration of utterance or overlapping speech (empathy being measured on Lister's [1970] scale). Therapists who took longer to respond, interrupted less and allowed patients more time to talk were categorized into the high-empathy group in this study. It seems the literature on whether silences are positive or negative as outcome indicators or as indicators of emotional valence is indeed very discrepant.

There is one structural factor of sessions in relation to silences which seem less disputed. Silence has repeatedly been found to be associated with the beginnings of sessions (Becker, Harrow, Astrachan, Detre & Miller, 1968; Wepfer, 1996) when clients are in the process of orienting themselves to the therapy hour.

Psychotherapy Process Measures. The dominant method of psychotherapy evaluation used by psychotherapy process researchers has been the application of various psychotherapy process scales and measures to psychotherapeutic transcripts (e.g., the Client Vocal Quality Scale [CVQ; Rice, Koke, Greenberg & Wagstaff, 1979], the Experiencing Scale [Klein, Mathieu, Gendlin & Kiesler, 1970], the Core Conflictual Relational Themes [CCRT; Luborsky & Crits-Christoph, 1990]). These are nominal or rank-ordered scales which assess specific elements of the therapeutic process. Raters are trained to apply the measures to the sessions objectively and reliably in order to ensure the replicability of the findings. These raters are usually external to the therapy in the sense that they are neither the client nor the therapist. Psychotherapy process measures, such as the Experiencing Scale or the CVQ, largely began as a method to test Rogerian theory (Hill & Corbett, 1992). Since this time, an array of process measures have been developed, focusing on tracking a wide variety of psychotherapy discourse characteristics.

Research involving the use of psychotherapy process measures often examines linguistic elements within the session, looking at the unfolding of the session through verbal expression alone. A few psychotherapy measures, however, have alluded to the importance of pauses and the connections they may have with the process of psychotherapy. The Client Vocal Quality Scale (Rice & Kerr, 1986) indicates the importance of pauses as a marker of the client's "focused" voice. This voice has been

associated with heightened self-awareness and with positive therapeutic outcome (e.g., Butler, Rice & Wagstaff, 1962; Rice & Wagstaff, 1967). The Narrative Process Coding System (NPCS; Angus, Hardtke & Levitt, 1993) associates pauses with internal narrative sequences, where clients are focused inwardly on feelings. As well, the NPCS uses pauses as markers of topic or narrative process shifts.

Toukmanian's Levels of Client Perceptual Processing Scale (1994) describes seven levels of cognitive processing in which clients move from automatic to controlled processing. Level Six, Re-evaluation, is described as evidencing "a degree of doubt or uncertainty in the client's manner of communicating" from which one could infer that pauses might be likely to occur (p.8). Although these measures indicate that pausing may be associated with certain types of processes, their focus is still on the words, or the voice, versus the actual silence.

In contrast, the Hill Counselor and Client Verbal Response Modes (VRM; Hill 1986) identifies silence of a minimum period of 5 seconds occurring between client and therapist speech or within client speech as one of the scale's Response Modes. Various studies have used this method to examine the types of responses most frequently found in different types of therapy. Across seven studies reviewed in the Hill's 1986 article, silence was found to range from 1-11% of therapist verbal responses. Two sequential analysis studies that examined these VRMs in one therapy dyad (Hill, Carter and O'Farell, 1983) found that "experiencing" most often occurred after silences and that

insight, although it occurred rarely, often was preceded by moments of silence. Experiencing, insight and silence were associated with the most productive sessions as assessed by therapist and clients. These findings were not duplicated, however, when examining VRMs in a second therapy dyad (O'Farrell, Hill & Patton, 1986). Stiles (1986) dropped the "silence" category in his taxonomy of Verbal Response Modes in favour of the category of "acknowledgement," or minimal encouragers, as he argues silence is not a verbal response. In contrast, Hill's version of this measure identifies silence as a focus of study, but it continues to address silence as a homogeneous phenomenon, and codes silences as either a therapist or client response rather than an event co-constructed by both therapist and client.

Training therapists to tolerate silence. It seems that training is thought to have some effect on one's ability to tolerate silences. Gilmore and Barnett (1992), when training managers for organizational positions, encourage them to develop an "ability to tolerate silence (of 45 seconds or more) after (they) pose a question without joking or being visibly anxious"(p. 545). The authors do not report whether the managers are successful at learning this skill. As the topic of silence appears in many books on introductory psychotherapy skill training, it seems that therapists also are being instructed to develop the ability to tolerate silence comfortably (e.g., Evans, Hern, Ivey & Uhlemann, 1993; Benjamin, 1981) but, unfortunately, there is little evidence for the effectiveness of this training in therapy.

One analogue study by Murphy & Lamb (1973), however, found that the amount of silence increased over the course of interviews for practicum students who had been trained in psychotherapy while it decreased for students without training. Although this was an analogue study, the prevalence of the topic of silence in these introductory textbooks seems to support the idea that teachers feel this is a skill that can be enhanced through training.

Interview research. Although there is little research which focuses on silence in psychotherapy, there is a series of studies by Matarazzo and his colleagues examining speech in comparison with silence behaviours in interview settings. Matarazzo, Wiens & Manaugh (1975) found that subjects who scored higher on the Verbal subscales of the Weschler Adult Intelligence Scales (WAIS) tended to have longer silences (or latency periods) after interviewer speech when discussing occupational, education and family history. The greatest correlation between silence latency and WAIS subtests was the correlation with the digit span subtest, which is indicative of attention span, suggesting that the longer attention span one has, the longer one is capable of holding a silence. This finding may indicate that individuals who have a higher verbal IQ feel more comfortable to take the time they need in conversation to process the information that they hear. Alternatively, it also may indicate that individuals who do not allow themselves the time to pause somehow do not perform as well on WAIS subtests, perhaps due to higher anxiety levels.

Interviewee speech and silence durations were found to be highly reliable for any given individual over two interviews when separated by periods of 5 minutes, 7 days, 5 weeks or 8 months (Matarazzo & Wiens, 1959), so the tolerance of silence in individuals seemed to be a durable trait intrinsic to the individual. Within a single interview, however, interviewer behaviour was found to alter interviewee speech patterns by altering his/her own speech durations, speech interruptions, content changing, nodding, use of minimal encouragers (Matarazzo, Wiens & Saslow, 1965). "For data based on group means, even very small differences (of the order of hundredths of a second) in the latency of one conversational partner can have a significant effect on the latency of the other partner's verbal behaviour" (Matarazzo et. al., 1964, p. 112-113). So although the tolerance of silence may be intrinsic to the person, individuals will adjust the performance of their behaviours to mirror, and perhaps to put at ease, the person who is conversing with them. This evidence lends supports to the idea of pausing as a co-constructed phenomena.

The sustenance of silence in conversation has been found to be subject to interpersonal styles of the interviewer as well. Matarazzo and Wiens (1967) found that if interviewers purposely lengthened or shortened periods of silence prior to responding to interviewees, the interviewees would lengthen or shorten the latency periods prior to their own responses. A similar effect may be occurring in therapy, wherein therapists

who model silences may create an interpersonal environment where clients may feel comfortable being silent.

Research on anxiety and pausing. Matarazzo and his colleagues have produced an inconclusive body of research on the question of whether anxiety is related to pausing. Jackson, Manaugh, Wiens, & Matarazzo (1948) did not find that interviewee's speech latency was higher when talking about goals in life than when discussing a less personally salient topic, interior decorating, indicating that personal relevance may not affect silences. In this study, however, the participants did not identify a difference in their anxiety level when discussing these topics and so no conclusion can be made on the effect of anxiety on silence.

Job applicants were found to have shorter latency times when talking about employment histories than about their educational or family histories (Matarazzo, Wiens, Jackson & Manaugh, 1970). This finding could have been associated with the applicants' increased anxiety, but it is difficult to discern which condition was the most anxiety inducing for the patient, disclosing personal material or discussing the employment information. Manaugh, Wiens & Matarazzo (1970) did find a decrease in latency or reaction-time when subjects were instructed to lie. This is also hard to interpret as, although lying can be stressful for some people, the encouragement to lie may have removed this anxiety from the interview situation.

Craig (1966) found that psychotherapy patients talked more and had longer latency in response to accurate judgements about their personalities than to inaccurate judgements. Because hearing judgements that are true about oneself is more stressful than hearing statements that are obviously untrue, this study suggests that patients are able to hold longer latencies under less stressful conditions. This study can shed some light on the experience of the anxiety on pauses in psychotherapy, but is difficult to generalize beyond this finding due to the uniqueness of the therapeutic relationship.

One study examined how the galvanic skin response levels (GSR), which are used to assess anxiety, may change over periods of silence. Keelin (1973) found that GSR was higher in children when they were talking aloud than when they were thinking to themselves (Keelin, 1973). GSR values were also higher when the participants were thinking about an external object or interruptive internal feelings than when focusing on one internal memory or feeling. This indicates that one may experience more anxiety in talking to others than in thinking and that, while in silence, anxiety levels may rise and fall in relation to the different thoughts which move through one's mind.

Linguistic research. Linguistic analyses of conversational patterns indicate that most pauses can be predicted by linguistic structures such as clause or sentence breaks (e.g., Grosjean, Grosjean & Lane, 1979). This seems to be present when reading or orating and has been related to the usage of American sign language as well. Methodologically, studies entailing intensive linguistic analyses tend to examine very

brief pauses between words (i.e., in microseconds), noting when word production slows or changes pace.

Gee and Grosjean (1984) have found, when examining the oral reading of stories, that longer pauses in text relate to more important breaks or transitions in the plot of a narrative. These pauses were found to relate to the narrative structure of the stories. Based on this research, some narrative researchers have begun to use pauses to organize stories told in therapy sessions or divide oral discourse into stanza units (e.g., Gee, 1989; McLeod, 1997). Similarly, Scollon and Scollon (1979) suggest that pausing indicates a shift in attention, from the story to the story-telling, so greater care is placed in the reception of meaning at the points of discontinuity in narrative structure. More specifically, within-clause pauses (or non-structural/grammatical) have been associated with last-minute word selection while between-clause pauses have been associated with structural and semantic planning of speech (Goldman-Eisler, 1958). It is difficult to generalize these findings wholly to the therapeutic discourse, however, given that stories are not typically read or orated in the context of therapy and that the therapy tends to be a dialogical exchange in which story telling is but one of the many processes which occur (e.g., Korman, 1997; Angus & Hardtke, 1994).

Pausing can be important for the listener as well as for the speaker. This has been particularly studied in relation to processes involved in recall. Reich (1980) found that words could be better recalled and categorized more rapidly when presented in sentences

with pauses between clauses (grammatical locations) than if the pauses were within clauses (non-grammatical locations). She argues that the pauses do more than act as markers of clauses or of sentence structure, and instead provide the processing time required in order to comprehend the meaning of speech as well.

In supporting research, recall by students was found to be enhanced by introducing pauses into the presentation of material, both for learning-disabled and non-disabled students (e.g., Ruhl, Hughes & Gajar, 1990). Recall also appears to increase when pauses are inserted into digit or letter lists (Aaronson, 1968). Structural pauses tended to assist recall, while non-structural pauses hindered it (Ryan, 1969; Bower & Springston, 1970).

In this body of research, it seems that structural cues guide the analyses of pauses and that intra-personal or intra-psychic causes for silences are left unexamined. "Pauses attributed to extralinguistic causes, are in fact more or less explicitly denied any scientific dignity in that they appear less systematically than the ones for which a linguistic explanation can be found" (Perfetti & Bertuccelli-Papi, 1985, p.340). Perfetti and Bertuccelli-Papi (1985) discuss pauses as functions of the interaction between automatic and controlled cognitive processes. They consider pausing as reflecting both the time it takes to plan or organize speech, with controlled processes and the time it takes to produce familiar words using automatic processes (which is thought to take a shorter length of time). There has been some research which seems to support this understanding

of pauses. Speakers have been found to increase their ratio of pause-speech time as their discourse becomes more complex (Goldman-Eislerm 1968). Still, this cognitive understanding of pauses only examines causes which are related to linguistic phenomena and does not extend its scope to more abstract or emotion-related processes of consciousness.

Disordered Silence

This section focuses on silences within otherwise verbal clients which are thought to be disordered as a result of psychopathology. It does not address elective mutism, as the elective complete silences in the therapies of these clients distinguish themselves from the momentary silences which exist in the course of other therapies.

The disruption of pausing processes has been found in connection with severe mental illness. Maher, Manschreck and Molino (1983) found that, although those without thought disorders tended to pause only when introducing uncommonly-used words, schizophrenics with formal thought disorder tended to pause before expressing both common and uncommon words which were less contextually probable. It may be that the disruptive influence of the disorder necessitates greater attentional processes for certain types of verbal thought processing and articulation.

In terms of treatment, Gendlin (1990) notes that, due to their empty, resistant silences, schizophrenics are known to pose problems for therapists. He describes how in his work with schizophrenic silences, he attempts to articulate what he considers to be the

subtext or the motivation of the silence in his own mind and then tries to encourage the client to express their own explanation. By suggesting possible explanations, clients gradually learn to identify their own motivations and begin to express themselves.

With borderline and schizophrenic patients, silences of extreme lengths can be overwhelmingly powerful. Silence has been understood by some psychoanalytic therapists as "a form of prosodic communication, leading at times to a merger experience that allows for the awareness of separation to be even further obliterated in a fusion fantasy" (Caruth, 1987 p. 43). Caruth cautions that with these patients, therapists can experience particularly strong counter-transference reactions resulting from desires to escape the strong transferential merging, causing negative reactions to their clients and potentially interfering in the therapy.

Alexithymic clients, individuals who do not experience emotion, are another diagnostic subgroup which has been identified as engaging in long periods of silence in psychotherapy sessions. Overbeck (1977) found that alexithymic patients could be distinguished from within a group of chronic ulcer patients by their pattern of silences. Borens, Grosse-Schulte, Jaensch & Kortemme (1977), found that lower-class alexithymic patients were associated with lower IQ levels, were thought to be less able to engage in reflection and were found to have more silent periods than upper-class alexithymic patients:

> In the interviews of the upper-class group of patients there were only 2 longer periods of silence, silence which the therapist qualified as retentive and obstinate. In the lower class group, we found longer and more frequent periods of a silence qualified as boring and dull. (p. 196)

This study indicates that within disordered patients there still may be social variables which are very influential in our interpretations of the pausing behaviour of clients.

In summary, the psychotherapy research on silence published so far is controversial. A difficulty in this research has been that theories have different a priori perspectives on silence and its meaning in therapy. Findings from studies which consider silence to be a homogeneous phenomenon from one perspective tend to conflict with findings which are based in different understandings of silence. It appears that a study on silences in psychotherapy which recognizes the heterogeneity of the processes which these moments represent is warranted and may help to make this body of research more coherent. Another gap exists in this literature in that there has not been any empirical consideration of silence from the perspective of the client. This project is meant to address these gaps and to make it possible to conduct research on silence which can be better translated into clinical application.

Objectives of the Present Study

This study is meant to addresses a significant gap in current empirical psychotherapy literature pertaining to the meaning and function of silence in

psychotherapy by addressing the client's perspective and treating silence as heterogeneous phenomena. The research analyses that I have conducted provide the foundation for the development of a model of pausing within psychotherapy. As there has not been any manualized differentiation of silent processes in therapy, the development of a useful pausing categorization system can allow silent processes to become topics which could be analyzed fruitfully in further research, alone as well as in conjunction with different therapy process measures. The nature of this project is exploratory and oriented towards the creation of useful and grounded hypotheses and tools for future research.

The primary and larger objective of this study was to explore and represent clients' experience of pausing in psychotherapy so that a differentiated representation of pausing phenomenon can be addressed. In order to implement this goal, a qualitative analysis of clients' experience of pauses was conducted. A qualitative approach to the analysis of these interviews was the ideal way to develop a rich, comprehensive understanding of pausing processes as it allows for the intensive analysis and categorization of subjective experience. From this analysis a Pausing Inventory was developed, identifying different types of pauses experiences in psychotherapy.

A secondary objective of this project was to identify a pausing category system which can be applied to therapy transcripts so that the roles and functions of silences can be explored. In order to accomplish this objective, a Pausing Inventory

Categorization System was developed by seeking commonalities between the pausing processes identified by the clients and the corresponding therapy sessions transcripts.

The third objective was to examine the relationships between different types of pausing and therapeutic process measures. Three psychotherapy process measures were applied to the transcripts and tapes of the therapy sessions in order to examine when different types of pauses occur. Analyses of pause durations, speaker patterns, narrative processes, client vocal quality and client experiential involvement in therapy were then conducted to examine when different types of pauses evidenced themselves within the therapeutic processes. Descriptive statistics were used to seek trends in these data. Finally, as will be seen, qualitative and quantitative findings were integrated in order to explore the place of silence in psychotherapy and to develop some guidelines for clinical practice.

Method Section

"Mrs. A (35 years old) applied for help with her (8 year old) son Bob whom she described as sullen, withdrawn, depressed, and uncooperative in performing domestic tasks such as washing up, coming to dinner on time, etc.

As I studied the relationship between Mrs. A and Bob it became apparent that although Mrs. A was consciously motivated to be affectionate, she found it very difficult to be emotionally close to Bob or to most people. After some protestations and denials, she acknowledged her emotional unrelatedness but could not account for why this should be so. As she explored her relationship with her own mother, Mrs. A spent several sessions weeping and castigating her mother as offering very little warmth and recalled many experiences in which she was "mistreated" by her.

I offered sympathy and concern, but for many interviews she kept repeating that I was "not doing enough." We explored the void in the treatment relationship, but she said: "I can't say it;" "words don't come;" "I feel like a child who can't talk; " and "I want something you don't talk about."

At first her remarks sounded like forbidden sexual fantasies with the therapist. However, her bodily movements and stammering made her appear like a young hungry infant. In one interview she recalled receiving "a soft drink" from the maid in "a caring" fashion. As she recalled this, she became animated, spontaneous and more emotionally available than she had been heretofore. I asked if it was the coca cola that was missing from the therapy. Triumphantly she said "Yes!" I then asked how she would feel if I brought her coca cola for the interviews. With only mild resistance at first, she soon said, "That would be wonderful!"

She drank the coke with enormous fervour while silence pervaded the interviews. After two months of almost silent drinking but with constant smiles from patient to therapist and vice versa, Mrs. A began to report on how she could "really nourish Bob now." Like an enthusiastic child, she brought in story after story of her increased emotional relatedness, not only with Bob but with her husband and friends, as well.

Later, when problems at higher levels arose in the treatment, coca cola was not served." (Strean, 1969, p. 236)

I. Participants

Therapists

In order to recruit participants, therapists were asked to approach clients, who they felt would be able to participate productively in an Interpersonal Recall interview and might be interested in this study, and ask them if they would consider participating in an interview on psychotherapy process. A form (see Appendix X) which described the study as a psychotherapy process research project was prepared and was provided for the therapists to give to their clients. The clients were not informed that this study would

focus on silence as it was felt that this might affect their experiences of silence in the upcoming session. Instead they were told more generally that I would inquire about "their experiences of an hour of psychotherapy." If the client then expressed interest in participating in the study, they were contacted and the taping of a therapy session and an interview was arranged.

Four therapists participated in my study. These therapists, two male and two female, had different backgrounds in terms of therapeutic orientation and level of experience. This is a strength in grounded theory approaches wherein researchers seek to diversify sources of information in the service of developing results which are as encompassing and rich as possible.

Two therapists were humanistic in orientation. One female therapist described herself as a client-centred therapist, an orientation derived by Rogers (1951), in which the conditions of empathy, positive regard and therapist congruence are to be provided by the therapist to promote client self-actualization. The other, male, therapist was an originator of the process-experiential orientation, an integrative therapy approach based upon client-centred and gestalt therapy and interventions (see Greenberg, Rice & Elliott, 1993). The process-experiential orientation is emotion-focused and directed towards the evocation and restructuring of emotional schemes. Different client-centred and gestalt interventions, such as chair-dialogues, experiential focusing and problematic reaction

analyses, are used to facilitate clients' emotions and assist them in reorganizing and reconstructing these schemes.

One female therapist worked from an interpersonal therapy (IPT) approach which is a brief therapy approach (12-16 weeks in duration) which focuses on current interpersonal problems by improving interpersonal communication skills, testing perceptions, communication analysis, clarification of feeling states, encouragement of affect, behaviour change techniques, and transference analysis (Klerman, Weissman, Rounsaville & Chevron, 1984). The IPT model of therapy was developed based upon the Harry Stack Sullivan and Adolf Meyer's interpersonal schools, Bowlby's attachment theory, and the psychodynamic model.

A male cognitive therapist who participated in the study described his orientation to be Beck's cognitive therapy (Beck, 1976), which encourages clients to examine automatic thoughts that distort the way they process information about themselves and others. Cognitive interpersonal process research (e.g., Safran, Vallis, Segal & Shaw, 1986; Safran & Segal, 1987) which views cognitive structure as organizing interpersonal information in terms of how central and peripheral it is to overall cognitive organization, was described as the secondary influence on his practice.

In order to get some indication of the level of experience of these therapists, I distributed the Therapist Experience Questionnaire to the therapists (Strupp, Wallach & Wogan, 1964). The interpersonal-therapy and the cognitive therapists self-assessed their

level of experience on the questionnaire in Appendix X to be "fairly experienced". The client-centred therapist rated herself as "somewhat inexperienced" and process-experiential therapist rated himself to be "highly experienced". The cognitive and the process-experiential therapists were male while the other therapists were female.

Clients

Clients who participated in this study were met within a day of their session for the Interpersonal Process Recall Interview. At that time, they were informed of the specific interview topic, the study of silences in therapy, and completed a form which gave consent to be audiotaped for the purposes of this study. The length of interviews ranged from 1 to 2 hours. Five clients were paid for their participation and two volunteered to participate. I offered to send all clients the transcript of their interview and a written summary of the findings from the study.

The seven client participants who were interviewed for the study varied in terms of their gender, age, occupations and the degree of depressive symptomology they evidenced, as assessed by their therapists on the Therapist Perception Questionnaire (see Table 1). All dyads were in shorter-term therapy (under 30 sessions) with the exception of one of the process-experiential therapy clients who had been in therapy for approximately 2 years. All of the interviews with the participants occurred towards the middle-end of their therapy. No clients were interviewed about their first or last sessions.

At the onset of treatment, the clients evidenced a range of depressive symptomology, which is typical of clients who present themselves for psychotherapy. Therapists assessed the clients' pre-therapy levels of depression on a scale which ranged from 1 to 6, where 1 = extremely disturbed and 6 = not at all disturbed. Three clients were rated at level 2 (very much disturbed), three were rated at level 3 (moderately disturbed) and one was rated at level 4 (somewhat disturbed).

Table 1

Description of Clients within Therapy Dyads

Dyad	Therapy Orientation	Gender		Client Age	Client Occupation
		T	C		
01	Process Experiential	M	F	Late 30s	Business
02	Process Experiential		F	Early 50s	Professional
03	Interpersonal	F	F	Early 20s	Student
04	Interpersonal		F	Mid-30s	Business
05	Client-Centred	F	F	Early 30s	On Disability
06	Cognitive	M	M	Early 20s	On Disability
07	Cognitive		F	Late 30s	Part-time

Three clients were engaged in humanistic psychotherapies. Two clients were in process-experiential therapy with the same therapist and one client was engaged in client-

centred therapy. One of these clients was a business woman in her late 30s and the other client was a 50 year old professional woman. The client-centred therapy client was in her early 30s, was an unemployed business woman on disability leave due to her depression.

Two participants were clients involved in interpersonal therapy with the same therapist. One client was a student in her early 20s while the second client was a business woman in her mid-30s.

Two clients were in engaged cognitive therapy with the same therapist. One client, who was in his early 20s, was unemployed due to his depression. The second cognitive therapy client was in her late 30s and was a professional woman who engaged in part time work.

II. Therapy Alliance and Outcome Measures

Therapists were asked to complete the Working Alliance Inventory (WAI) - Short Form (Horvath & Greenberg, 1989; Tracy & Kokotovic, 1989) and the Therapist Perception Questionnaire (Strupp, Wallach & Wogan, 1964), based on their reflections on the therapy as a whole. The results given by these questionnaires provided some indication of whether or not the episodes discussed should be interpreted as part of a larger productive or non-productive therapeutic process and therapeutic alliance. As well, they provided some indication of whether the clients' reported experiences of the

episodes discussed correspond with the perceptions which the therapists reported on the therapy outcome and alliance.

Therapist Perception Questionnaire

Full results from the Therapist Perception Questionnaire are listed in Appendix X. These questionnaires were administered several weeks after the interviews were completed, and asked the therapist about their perception of the therapy outcome in general, in contrast to focusing on any one session. Specifically, this questionnaire provided information about the therapists' perceptions of their level of experience, of the degree of depression which the client experienced, and of the change and the visibility of change in the client as a result of the therapy.

Based on these responses, it appeared that all dyads were rated by their therapists to be moderately to highly successful with the exception of one of the cognitive therapy dyads (Dyad 6). The therapists in all therapies reported being moderately to highly satisfied with the outcome of their therapy with the exception of Dyad 6, where the therapist was "moderately dissatisfied" with the outcome. All therapists felt that their clients' "change as a result of therapy" has been at least somewhat visible to others, again with the exception of the Dyad 6 cognitive therapist, who felt change was not very visible. All of the therapies were terminated either by mutual agreement or external factors (e.g., insurance coverage ending). Therapists felt that upon termination that all clients were dealing "fairly" to "very" adequately and were "considerably" to

"completely" improved, with the exception of the Dyad 6 therapist who felt his client was functioning "very inadequately" and was "not at all improved".

Working Alliance Inventory

A summary of the therapist ratings on the WAI follows in Table 2. These questionnaires were also completed several weeks after the interview had been completed and asked the therapists about their alliances in general across the therapy. Ratings greater than 5 on this scale indicate positive alliances. All therapists in this study appear to have experienced their alliances as being positive.

Table 2

Therapist ratings on the Working Alliance Scale

Client	Therapy	Task	Goal	Bond	Overall
001	Process-experiential	6.50	6.75	6.50	6.58
002	Process-experiential	6.25	6.75	6.25	6.41
003	Interpersonal	6.50	6.50	6.75	6.58
004	Interpersonal	6.75	6.25	6.75	6.58
005	Client-centred	6.00	6.50	6.00	6.17
006	Cognitive	4.75	5.75	5.25	5.25
007	Cognitive	5.50	6.00	6.25	5.92

III. Qualitative Method

Inquiry: Interpersonal Process Recall Interviews

Interpersonal process recall (IPR) interviews consist of an interviewer and participant reviewing a taped event or therapy session and exploring the recollections of his or her experiences (Kagan, 1975). This method is very useful when an interviewer hopes to access the subjective experiences of the participant, as recalled, in order to generate data for later analyses. The IPR sessions for the present study were conducted in an exploratory manner. The interviewer replayed segments of the video taped therapy session which included pauses of at least 3 seconds in duration. The main question posed to each client was "Can you describe your experience during these moments?" The interviewer attempted to be as neutral as possible, using reflection and asking questions at times when clarification was required.

Participants were asked to distinguish moments of recall from reconstructed or new-awareness moments. In the IPR interviews, specifically, the clients were asked to differentiate whether they were a) recalling their experience during these silences, or b) reconstructing their experiences based on what they thought might likely have been happening in the session or c) generating a new insight about their experience in session. All participants were able to follow these instructions and volunteered information on their "degree of recall," at times using percentages to illustrate their degree of confidence in their recollections.

Due to time limitations (interviews ranged from 1-2.5 hours) not all the pauses in each session were able to be reviewed. Of the 325 pauses (of 3 seconds or longer) which occurred in the seven sessions, 52% of them (n=168) were focused on in the IPR interviews. Each interview began by reviewing pauses as they occurred, but when it became clear all pauses could not be reviewed in the time allotted, those pauses which seemed most complex, unusual or puzzling to the interviewer were reviewed with the goal of obtaining as broad a spectrum of pausing experiences as possible.

Due to the sensitive nature of the IPR process, if clients expressed being uncomfortable in any way (i.e., feeling tired or finding an issue difficult to discuss), they were asked if they wanted to terminate the interview. None of the clients chose to end their interviews at these points. At the end of each interview, clients were asked about their experiences in the IPR both so that problems experienced could be corrected in future interviews and to explore how the IPR interviews might effect client's perceptions of themselves and their therapies.

Qualitative Analysis

This study was informed by a method of analysis based on the grounded theory approach (Glaser & Strauss, 1967; Glaser, 1992) to analyze the data generated by the IPR interviews. This method has been advanced in psychological research as a way to explore subjective experience and facilitate the development of theories (Rennie, Phillips &

Quartaro, 1988). It is an inductive process in which a researcher is guided by the analysis of data to develop an understanding of phenomena grounded in empirical observation.

Before describing this procedure, it is important to note that since the formulation of this approach to qualitative analysis, there has been a rift between its founders, Glaser and Strauss, in terms of the method of grounded theory. Strauss along with his colleague Corbin have argued that this methodology should incorporate procedures of hypothesis testing, use data external to the interview transcripts, emphasize process in all cases, and entail the application of a particular coding paradigm to the data (e.g., Strauss & Corbin, 1990; Corbin, 1998). Glaser (1992) objected to these suggestions stating that they undermined the grounded nature of the analysis and that as the analytical procedure was inherently validational it did not need these checks to ensure validity. Entering this debate, Rennie (1998b; 1998c) argued that this conflict had resulted from different understandings of the philosophical underpinnings of grounded theory, neither of which were shown to be satisfactory. His resolution was the proposal of a methodical hermeneutics as a logic of justification for this methodology. This philosophy dictated that the Strauss and Corbin approach was not in keeping with the logic of grounded theory. Consequently this analysis will use a methodological approach which is more in keeping with Glaser's (1992) understanding of the procedures which comprise grounded theory research.

In the adaptation of grounded theory to the analysis of psychological text (Rennie, Phillips & Quartaro, 1988), such as transcribed interviews, to reduce the complexity of the analysis, the text is blocked into units of meaning, or "meaning units" (cf. Gorgi, 1970; Merleau-Ponty, 1962). In the procedure worked out by Rennie and his group, and followed in this study, the text is broken into meaning units and analyzed at the same time. That is, as the analyst proceeds through the text, it is progressively broken into units. Once a unit is established, then it is studied to ascertain the meaning(s) "contained" within the unit. The labelling of the categories is at first descriptive, staying close to the language of the text. Later, higher-order categories are developed which are more abstract and which serve to provide further understanding of the descriptive categories and their relationship to one another.

After categories are grouped, a core category is conceptualized which represents the thematic connections between category clusters. In this fashion, a hierarchy of units is formed from which a theory can be shaped, guided by memos and notes which are taken throughout this process. Memoing is used throughout the analytical process to record shifts in hypotheses and conceptualizations in an attempt to bracket theories which develop during the analysis so that they do not influence the data sorting. Data collection continues until the categories are "saturated," that is, no further categories appear to be forthcoming. The memos are reflected upon after the categories achieve saturation.

For the purposes of this study, the method of analysis was altered somewhat. Traditional grounded theory analysis is predicated on an unstructured interview; the interviews in this analysis were semi-structured. The procedure of focusing clients on distinct pauses created natural divisions in the IPR interview text. Accordingly these divisions were used as one method of unitizing, but then smaller meaning units were located within the discussions about each pause. Each meaning unit was given a label, trying to stay as close to the words presented as possible. The segment below illustrates how a segment of inquiry focusing on one pause was segmented into three meaning units and labelled.

Legend: C = Client, H = Interviewer (myself)

004 19a - struggling
C: /Yeah, I said it, that's really hard. It was like putting things on the table with T that we hadn't really done yet
H: mhm, so in that moment what's happening in the silence what were you doing
C: Struggling
H: Struggling (mhm) so kind of like A//

004 19b - needing to pull in a little after scary talk
C: (Sigh) - just needing to pull in a little, you know, I put a big scary out there
H: Mhm, so kind of like this is scary so I pull in to just like accept
C: Well, it's the safe space out there, I'm just pulling back a little (mhm) B//

004 19c - getting bearings again, pulling self together
C: But I'm still very comfortable, getting my bearings
H: Mhm so getting your bearings and getting that
C: that it's out there, we are sitting here having a conversation about all the things happening in my life
H: is it like acclimatizing yourself to this conversation even, that we're having this conversation?

C: mhm mhm, cause you can read the books but accepting it, owning it is a good way to do it
H: So I'm not sure if it's preparing yourself for the conversation or getting used to that you are having it?
C: pulling myself together
H: pulling yourself together
C: not that I was on / but breathe, just breathing in and just re-, taking yourself a moment C//

To illustrate how the IPR interview transcripts were analyzed, two meaning units from the IPR interview are provided (A and B), which were generated from the discussion of one pause. A method of open categorization was employed, each meaning unit being assigned to as many categories as possible. For instance, meaning unit 005 14a was assigned to the Sadness/Pain/Despair category, while meaning unit 005 14b was placed into the categories Sadness/Pain/Despair and Questioning.

//A *005 14a - feeling discouraged*
H: what is happening for you in this pause?
C: I feel I know I am discouraged
H: in the moment you mean?
C: yeah, A//

//B *005 14b - wondering why she feels discouraged*
C: it's trying to feel why at the same time. I feel as though I'm questioning why
H: why are you discouraged? (Mhm) so a feeling and a questioning together, is that right?
C: yeah B//

To aid of the process of categorization, labels assigned to each meaning unit were used to cue the investigator to the substance in the unit at hand, similar to Rennie's (1992) reductions or Glaser and Strauss' (1967) codes. The entire meaning unit was referred to, however, during the process of categorization. As each meaning unit was

formed it was assigned a label. After each transcript was divided into labelled meaning units, each meaning unit then was reviewed compared with all other meaning units so that categories were progressively formed on the basis of similarities between the units. After new categories were developed, meaning units which had been previously sorted were re-examined to see if they should be assigned to the newer categories as well.

The categories were decided upon only after the meaning units which seemed to hold a similarity were assembled. Likewise, clusters of similar categories were named only after similar groupings of categories had been assembled and examined. In the process of categorizing, the investigator attempted to create a category which would best represent the complexity of the meaning units or categories which were the properties of that label. For instance, initially this analysis contained a cluster entitled "Stopped Pauses;" this cluster was then called "Defensive Pauses" and finally "Disengaged Pauses." This final conceptualization seemed to most completely represent the different categories of pauses which constituted this cluster.

Thus, in order to aid the reader in understanding the different levels of conceptualization, a distinction is made between clusters, categories and sub-categories when presenting the results. Clusters are the highest-order of conceptualization in this analysis. The categories, which are the second-highest order of conceptualization, are considered the "properties" of the clusters. Similarly, sub-categories constitute the third

level of conceptualization and are properties of the categories subsuming them. The lowest level of category conceptualization are termed the "primary categories."

As the purpose of the analyses of the interview transcripts was to categorize clients' experiences of pausing in psychotherapy, the analysis focused on the clients' experiences during pauses instead of on the thematic content being experienced. Categorizations based upon the specific content descriptions would not address the research question and therefore was not seen as useful in this study. They would be too particular to each individual to assist in the description of the process of pausing in the psychotherapy session unless they related to the therapeutic context in which pausing occurred. For instance, the meaning unit below was labelled "*Feelings are starting to resurface,*" rather than "*Being battered in a meeting at work.*"

004 05a - Feelings are starting to resurface
C: /yeah I wasn't talking very linear, but when I started to remember the meeting, cause it took almost the whole session I think we talked about. I needed to talk it out with T to realize what the game was, basically a battering job. (Mhm) so just want to start
H: So that silence was what
C: That silence was ok, the next day, I can even hear my voice go down, the next day he brought us into a meeting
H: So what's happening in the silence, I'm not sure
C: Feeling , it's not fully aware, but it's the beginnings of awareness. (Mhm) The feelings are starting to resurface (mhm) about that meeting where I got just hammered
H: So what's happening is +your feelings are coming out
C: yeah feelings are arising as I'm beginning to talk about it (feelings are) surfacing

The meeting at work, the content, was not relevant to the search for the experiences which create or occur within pauses.

During the IPR interview, clients were asked to distinguish times in which they were recalling pausing experiences from times in which they were reconstructing likely pausing experiences or were having new insights on pausing experiences. Meaning units in which clients commented retrospectively upon their pausing experiences or made new insights were labelled and organized separately. These were drawn upon to provide contextual meaning about each process. For instance, the following two meaning units were used to stress the importance of allowing clients enough time to seek their own answers in sessions.

001 01 - [wish had asked for more time in pause]
C: //in a sense I wish I'd asked for more time there, I'm not really sure. //

001 01 - [wish hadn't needed more time in pause]
H://and a kind of wish that you could have taken more time, or could have asked for more time
C: Well, I wish I didn't blank out, I wish I could remember, I wish I had the answer right there (yeah yeah) Yeah, because I still would like to know what was the answer of what happened right there
H: what exactly it was //

Similarly, meaning units in which the clients' described their experiences of the IPR interview were grouped together to provide information about their experiences of the IPR interview context. These meaning units were not included in the analysis of clients' experiences of pauses, but were drawn upon to generate suggestions about future research using IPR interviews. An example follows:

//004 IPRa - little moments I wouldn't have been aware of or given myself credit for, a lot of missed, not missed, but a lot of layers unfolding in IPR, surprise

//C: (Yeah, this is just !blowing my mind. Like you know this is amazing, (mhm) I mean this was just !a session, any session and not not, you know if I was rating them all on a scale from one to ten I wouldn't have gone home last night and though it was any, you know, huge moments, but going through this again, it really was (mhm) or it really is. There's enormous things happening
H: In little moments that you may otherwise
C: In little moments that I wouldn't not have been aware of or given myself credit for (right) like hell, I'm talking about, like it's real growth to be talking about this stuff (mhm) A lot of, a lot of missed, not missed, but a lot of layers
H: mhm mhm I think it's really like this process
C: yeah, I'm getting more out of the session, much more
H: Yeah, oh good I'm glad
C: You can come back C//

As opposed to the traditional application of grounded theory, it was not a goal in this study to conceptualize a core category or to generate a singular theory of pausing experiences in psychotherapy. Instead, the aim of this project was to represent the variations in categories of pausing experiences, a goal at odds with the development of a core category. In this study, no new clusters were generated within the analyses of the last 2 interviews (with the two cognitive therapy clients) and the seventh interview was considered to be the point of saturation. The process of conducting repeated new comparative analyses of meaning units was not conducted as it did not appear likely that this would add substantively to the results and is a very labour-intensive exercise.

In order to preserve the immediacy of the interviews in the analysis, transcripts of interviews were analyzed progressively as they were conducted. Transcripts in this study were generated using some of the transcribing suggestions by Mergenthaler and Stinson

(1992), such as indicators of emphasis, nonverbal and paraverbal utterances. In this study the first three interviews were analyzed together, then the two more were added to the analysis and then the final two were added. The transcripts of the therapy sessions were generated after the grounded analysis of the interviews had been completed.

Largely, this analysis was conducted using WordPerfect 6.1. Each transcript was cut into meaning units, labelled and assigned a code-number on the computer. Above each meaning unit was printed the few sentences from the therapy transcript which framed the pause being discussed within that meaning unit. As printed copies of the segmented transcripts were compared, meaning units were sorted into the lowest-level of categories using these code-numbers. The meaning units which corresponded to these code-numbers were then cut and pasted into the categories which were formed. This procedure was found to be useful as similar meaning units could then easily be printed up together to be reviewed, could easily be located within the interview transcripts and it was useful as the pausing moments from the therapy sessions which had similarities could easily be grouped to be reviewed.

IV. Process Measure Analysis

In this study, the pausing processes derived from the qualitative analysis were analyzed in comparison with the Narrative Process Coding System (Angus, Hardtke & Levitt, 1996), the Experiencing Scale (Klein, Mathieu, Gendlin & Kiesler, 1970), and the Client Vocal Quality Scale (Rice, Koke, Greenberg & Wagstaff, 1979) in order to

examine the ways these different types of pauses are evidenced within the therapy session transcripts. Two challenges which had to be met in order to conduct an exploratory study of the interaction of process measure results with the types of silences.

Transcripts

Transcripts of the therapy sessions were generated by the author of this study for the purpose of process measure analysis using transcribing guidelines suggested by Mergenthaler & Stinson (1992). Silences within the therapy transcripts were timed and marked within each transcript, nonverbal and paraverbal utterances were indicated, as was emphasized speech and overlapping speech. After the first draft of transcripts were generated, therapy sessions were reviewed for a second time in order to check for any errors in transcription.

The Identification of Pausing Processes

It was found that many pauses were associated with more than one pausing process category identified from the analysis of the IPR interviews, the mean number of pausing processes identified per pause being 1.60 (SD = 1.09). Therefore the first challenge was to develop a method of examining the differences between types of pausing processes. To resolve this difficulty, a review of the IPR transcripts was undertaken and the dominant type of pausing process which was described in the interview for each pause was identified. During the IPR inquiry interviews clients often spontaneously identified the pausing processes which they felt were dominant. When no

spontaneous participant-identification was volunteered by the client, an assessment was made of which pausing experience expressed in the IPR interview appeared to be dominant. This judgement was based on the saliency of the experiences as indicated by the relative length of descriptions and by the relation of the experiences to one another (e.g., if one experience was described as a precursor to a more encompassing experience the more encompassing experience was considered the dominant one). Eleven pauses were eventually dropped from these analyses as there was not enough information in the IPR to distinguish which was the primary pausing experience.

To assess this process of identifying the dominant pausing process type, a second rater identified the dominant pausing process by reviewing the descriptions of 35 pauses randomly selected from the IPR interviews (5 pauses from each interview). An interrater agreement rate of .82 (Cohen's Kappa) was established with the primary investigator. Process measure ratings were then analyzed with reference to the dominant pausing process type for each pause established for each pausing episode focussed upon in the IPR interviews. The consensus on the dominant pausing processes was important as it allowed for the identification of the therapy session discourse characteristics of each pausing process, which was necessary for the development of the Pausing Inventory Categorization Manual.

Pausing Inventory Categorization Manual

The second methodological challenge raised the issue that not all pauses in all sessions were able to be reviewed in the IPR interviews conducted with the clients. Consequently, not all pauses were classified in terms of their dominant pausing process for the process measure analyses on the basis of the information from the IPR interviews. A Pausing Inventory Categorization Manual (see Appendix A) was developed in order to assist in the classification of pauses which were not reviewed with the client. As the selection of silences for the IPR interview was not random, the selection itself was not an adequate sample to suggest the experiences of clients throughout entire psychotherapy sessions.

In the Pausing Inventory Categorization Manual, the 7 pausing types which emerged from the qualitative analysis of the IPR interviews were described. As well, markers for these pauses were identified by reviewing the transcripts, in terms of textual cues which seemed to be associated with each type of silence. These markers will be described further in the results section of this dissertation.

Interrater Agreement. Using the Pausing Inventory Categorization Manual, a second independent rater classified 40 pauses selected randomly from five randomly selected sessions (at least one session from each type of therapy). This rater was able to obtain an agreement rate of .70 (Cohen's Kappa) with only 2 hours of training. This

result suggests that inter-rater agreement in terms of the identification of pausing processes can be reached fairly quickly.

As a test of validity, this same independent rater assessed 35 other randomly selected pauses using written transcripts (5 pauses from each session). When comparing this rater's judgements to the different pausing processes identified by the clients for their pauses in their IPR interviews, an agreement score of .83 (Cohen's Kappa) was obtained. This score might have been even higher had audiotapes been used, as vocal cues can be useful in detecting qualities, such as stammering or inward focusing, which are cues for certain pausing types. This finding indicates that this typology can be used in a reliable fashion to identify the pausing experiences of clients.

The Narrative Process Coding System

Description. The Narrative Process Model (Angus & Hardtke, 1994) views all psychotherapies as incorporating processes of telling narratives, of experiencing and evoking emotions associated with narratives, and of reflecting on the personal meanings embedded in these narratives. The Narrative Process Coding System (NPCS; Angus, Hardtke & Levitt, 1996) was developed as heuristic tool, from this model, which unitizes and categorizes psychotherapy text, enabling one to explore within-therapy process. This narrative approach is particularly useful when assessing integrative or differing therapeutic approaches by process measures. Instead of using units that prize interventions from one therapeutic orientation, the system creates common units based on

narrative processes inherent in the telling of personal experience, which cut across psychotherapy orientations.

The Narrative Process Coding System divides therapy transcripts into units and characterizes these units both in terms of content description and narrative process. By the same token, these units can be rated by other process measures. Topic Segments, first identified within the transcripts, describe the themes which are being discussed within the session. There are three types of Narrative Processes which are identified within these Topic Segments. They are a minimum of 4 sentences in length, but have been found to be 30 sentences in length on average (Hardtke, 1996): (1) External narrative sequences are focused on event-descriptions. A client may relay a story about a confrontation at work, for instance, describing the setting and the verbal exchange. (2) Internal narrative sequences are focused on client's experiential state. This client may continue on to discuss how upsetting this confrontation was and how it affected his/her emotional state. (3) Reflexive narrative sequences are indicative of analytical or evaluative processes. For instance, this client may shift into an analysis of how this confrontation makes sense in the larger scope of the client's history or current life events.

Interrater Agreement. The sessions upon which the Interpersonal Process Recall interviews were based were transcribed and a co-author of the Narrative Process Coding System divided these transcripts into topic segments and narrative sequences and identified the narrative processes in the session. This rater was blind both to the outcome

and the therapist of each session. Based on ratings from a process-experiential and a cognitive therapy session, a second rater was able to identify topic segments at an 88% percentage agreement rate and narrative sequences at a 74% percentage agreement rate (and were able to identify narrative sequence codes at a rate of .88; Cohen's Kappa, using 115 narrative sequences). Rating five sequences randomly selected from each of the seven therapy sessions, the raters were able to identify narrative sequence codes at a rate of .72 (Cohen's Kappa).

The Experiencing Scale

Description. The Experiencing Scale (Klein, Mathieu, Gendlin & Kiesler, 1970) is a seven-level measure of the clients involvement in therapy. It examines the construct of "experiencing" which is defined as "the extent to which inner referents become the felt data of attention, and the degree to which efforts are made to focus on, expand, and probe those data" (Klein, Mathieu-Coughlan & Kiesler, 1986). The Experiencing Scale is derived from Gendlin's experiential and Roger's client-centred theories and is one of the first widely used therapeutic process measures (Hill & Corbett, 1993). As one of the standard measures of therapeutic process, the Experiencing Scale has been used to validate therapy process measures under development (e.g., Maher, Stalikas, Boissoneault & Tauer, 1990; Sherman & Skinner, 1988) Tape recordings and written transcript units of 2 to 8 minutes were its original data base.

The Experiencing Scale evaluates clients' ability to explore their inner state and their ability to be guided by an inner referent. The first three levels of this scale reflect an increasing referencing to inner state within the therapy discourse. A shift takes place at the fourth level where the clients' focus of discussion becomes their experiential state. Levels five, six and seven reflect the identification and exploration and resolution of issues relating to the clients' experiential state.

In terms of applying the Experiencing Scale, units of transcript are assigned both a mode rating, which is representative of the most frequent rating within a unit, as well as a peak rating, which indicates the highest experiencing level within a unit of text. Modal ratings were examined in this project as they indicate the general experiencing level at which a client was functioning within a given unit. Ratings were scored in terms of low (1-2) middle (3-4) and high (5-7) Experiencing.

Interrater Agreement. Experiencing ratings were applied in two ways by an experienced graduate student rater. Ratings were assigned to each narrative sequence, to indicate the general Experiencing ratings of sequences in which different pausing processes seemed to be found. As well, Experiencing ratings were applied to the sentences just prior to and immediately following pauses in order to examine if there was a significant change in Experiencing levels over the course of pauses. The rater was blind to the outcome and the therapist of each session. A second rater, rating five sequences

randomly selected from each of the seven sessions, was able to obtain an agreement level of .72 (Cohen's Kappa).

The Client Vocal Quality Classification System

Description. The Client Vocal Quality Classification System (CVQ) was developed to assess the "quality of client's involvement in the therapy process" (Rice, Koke, Greenberg, & Wagstaff, 1979, p. 1). It delineates four different vocal patterns. External voice indicates moments wherein clients are engaged in the telling of their ideas to the therapist, with their attention directed outward towards the therapist. Focused voice indicates processes of inward exploration and attention, wherein clients are engaged in the symbolization of inner experience. Limited voice indicates a withdrawal of energy in which clients seem unfocused, tentative and distant from themselves. The emotional vocal pattern indicates absorption in emotion and is usually characterized by crying and speaking which is disrupted by emotional engulfment.

Interrater Agreement. The author obtained reliability ratings by comparing her own ratings on the CVQ Training Tape with expert ratings. Based upon 61 ratings from 10 therapy dyads, the author obtained an agreement level of .74 (Cohen's Kappa) with the expert ratings. Vocal quality ratings were given to the client speech before and after each pause in order to examine whether there were changes in client vocal pattern after different pausing processes and to examine whether certain vocal patterns were associated with certain pausing processes.

Data Organization

Data from each process measure was organized in a chart for analysis. This chart listed the session, line number, and duration of each pause as well as the context of each pause in terms of client and therapist talk (e.g., therapist-pause-therapist, therapist-pause-client, client-pause-therapist or client-pause-client). For each pause, the dominant pausing process, Narrative Process Coding System ratings, Experiencing Scale ratings and Client Vocal Quality Scale ratings were listed as well. These charts allowed for comparative analyses to explore the intersection of the qualitative and process measure findings from this project. The data then could be explored using descriptive statistics and charts, and trends in this data could be sought.

Results

I. Results of Qualitative Analysis

The qualitative analysis of the IPR interviews resulted in the identification of 287 meaning units, from the participants' commentaries on the 167 pauses discussed in the IPR interviews. The meaning in these meaning units was conceptualized as sub-categories and each meaning unit was assigned to as many sub-categories as judged appropriate. These sub-categories were then grouped into categories which were grouped into seven main category clusters of types of pausing experiences. As indicated previously, a core-category was not conceptualized.

The main clusters conceptualized included Disengaged Pauses, Feeling Pauses, Interactional Pauses, Reflexive Pauses, Expressive Pauses and Associational Pauses. Each of the clusters are described in the following section. Markers of the different pausing types were also identified by observing commonalities in the psychotherapeutic discourse which were associated with the different pausing experiences as identified by the clients in their IPR interviews. Markers are listed to suggest the types of session discourse (e.g., questions or statements) or discourse characteristics (e.g., stuttering or laughing) which seem to be related to the client's descriptions of different pausing processes. These markers are also listed here as the groundwork for the Pausing Inventory which was used in the quantitative analysis. All primary categories are listed in

Appendix D. A list of the seven category clusters and the number of meaning units which fell into each category follow.

Clusters of Pausing Processes from Qualitative Analysis

Legend: MUs = Meaning units

I. Disengaged Pauses - 48 MUs
1. Avoiding Anxiety/Feelings: 29 MUs
A. Avoiding hurt, angst, fear - 20 MUs (Dyads 2, 3, 4, 6 & 7)
B. Regrouping/Composing self - 5 MUs (Dyads 3 & 4)
C. Trying to lighten therapist focus - 4 MUs (Dyads 3 & 4)
2. Shutting down: 19 MUs
D. Withdrawing - 5 MUs (Dyads 2, 4 & 7)
E. Stopped - 14 MUs (Dyads 1, 2 & 7)

II. Feeling Pauses - Getting in Touch with Emotion - 61MUs
1. Moving deeper into feeling state: 18 MUs
A. Indefinite feelings - 12 MUs (Dyads 1, 2, 3, 4, 6 & 7)
B. Flood of feelings - 6 MUs (Dyads 1 & 4)
2. Feelings: 43 MUs
A. Fear, vulnerability, uncertainty, tension - 14 MUs (Dyads 1, 2, 3 & 5)
B. Sadness, pain, despair - 8 MUs (Dyads 4 & 5)
C. Anger, frustration - 11 MUs (Dyads 4 & 5)
D. Other feelings - 10 MUs (Dyads 2, 4, 5 & 6)

III. Effects of Interaction with Therapist - 65 MUs
1. Demands of Communication with Therapist: 22 MUs
A. Considering therapist's experience - 19 MUs (Dyads 1, 2, 3, 4, 5 & 7)
B. Pulling away from feelings in order to articulate them - 3 MUs (Dyad 2)
2. Uncertainty Regarding Therapist Task or Comment: 24 MUs
C. Uncertainty re: task fulfilment - 24 MUs (Dyads 1, 2, 3, 6 & 7)
3. Safeguarding the Therapeutic Alliance: 19 MUs
D. Approval Seeking/Impression Management - 9 MUs (Dyads 1, 4, 5 & 6)
E. Managing emotional reaction to Therapist - 10 MUs (Dyads 6 & 7)

IV. Reflection Processes- 75 MUs
1. Questioning - 21 MUs (All dyads)
2. Increasing awareness of issue - 8 MUs (Dyads 1, 2, 4 & 5)
3. Connection making - 40 MUs (Dyads 2, 3, 4, 5, 6 & 7)
4. Insight/Realization - 10 MUs (Dyads 2, 4, 5 & 6)

V. Expressive Processes - 23 MUs
1. Articulation of ideas - 11 MUs (Dyads 1, 2, 4, 5 & 7)
2. Naming feelings - 12 MUs (Dyads 2, 3, 4, 5 & 7)

VI. Associational Pauses - 9 MUs (Dyads 1, 2, 4, 6 & 7)

VII. Mnemonic Pauses - 25 MUs (All dyads)

1. Disengaged Pauses. These pauses are defined as silent moments in which the client has emotionally disengaged from a topic being discussed in therapy. In these moments, clients either described actively avoiding painful emotion or, more passively, feeling distant and withdrawn from the therapeutic interaction. At this point clients often reported feeling uncomfortable with the topic at hand and would either pause to find a way to halt the exploration or to shut themselves down emotionally. This was most often described as a conscious process but at times was experienced as an automatic process which was triggered by the building of tension.

There are different ways that disengaged pauses come into play in the therapy interaction. The first sub-category "Avoiding Feelings" describes pauses in which clients disengage to avoid emotionally sensitive topics. Meaning units from this category came from five of the dyads (Dyads 2, 3, 4, 6 & 7). Clients would distance themselves in different ways: by seeking some way to disengage the therapist from that topic, by

composing themselves to avoid entering a deep feeling, or by counselling themselves to avoid deepening a present feeling.

Two of the clients (Dyads 3 & 4) reported using pauses to re-group emotionally in order to avoid difficult feelings. They reported reassuring themselves, "swallowing" their feelings, or telling themselves to avoid feelings. In the following quote from an IPR interview, one client reported techniques she found effective in helping her calm down emotionally, including focusing her thoughts on parts of the therapy room.

C: I think at that point it was getting a little bit sensitive so I think it was more an emotional sort of thing more than anything else. (Mhm) Like I think I was trying to regroup and you know calm myself down, (mhm) and uh, just carry on after that so, at that point I think I might have been near tears, so that's why I paused there

H: So you felt sad or something?

C: Yeah, it was getting near that sensitive part so I started to feel myself choking up. (Mhm) and I think that's probably the closest I ever came (in the session) uhuh

H: And then so you're stopping to kind of, do what

C: "Stop, don't cry and just sort of finish the rest of your sentence without bursting into tears"

H: So you are telling yourself (yeah) to calm down almost (yeah) and telling yourself to not cry so you don't go towards that

C: Yeah. Not even like vocalizing it inside my head, like "calm down" or anything. I tend to just focus on one part of the room and just look at it and clear my thoughts for a little bit and then calm down (mhm) and then keep going

H: So it's not even like you consciously decide that you want to not cry? (Yeah) It just kind of happens without you deciding it (yeah) you just suddenly find yourself feeling sad and you're focusing

Strategies used to "lighten the therapist's focus" (Dyads 3 & 4) included making jokes, moving from experiencing feelings to analyzing feelings, and choosing topics that were "*not too heavy*" to discuss. One client describes such a pause:

C: It was sort of like I didn't want to approach such sensitive issues really (mhm) I just wanted to stay on the surface and I didn't want to get into anything deep. (Mhm) so I just, again I tried to lighten the atmosphere by making a really glib remark (mhm).... like once I get into that situation, when things start getting really sensitive, when that happens I find it very difficult to speak (mhm) like once you hit that territory (mhm) so I try not to go near that at all

H: mhm and what lets you know if your getting near? What lets you know your getting near?

C: Uh, actually sometimes it comes on without warning (mhm) but other times I can see her leading me into places

H: So in a moment like this what happened

C: Uh, I could see it coming

H: You could see it coming - like a warning bell or something

C: Yeah, when she does things like that. She does the fill in the blank sort of thing, or she asks me leading questions, I sort of, I know what's coming (laughs)

H: And then, then you know there's something that may pull you towards that sort of

C: so I pull back

H: and you pull back with something that's glib (that's right)

The second sub-category, "Shutting Down", was interpreted from the reports of four clients (Dyads 1, 2, 4 & 7) who would "shut-down" when emotions become too intense. Clients described this as happening almost automatically, often without any conscious awareness accompanying it. One client described her experience of a Withdrawing pause as follows:

C: the words are almost pro forma, (mhm) and I know that that's not what's happening, it's part of that not wanting to look at or wanting to name what's happening, so it's a silence of withdrawal or a silence of retreat

H: So kind of looking somewhere else, or you're retreated

C: Well I'm not somewhere else, but I don't want to be there, I don't want to be here where I am at that point because it's like there's something that I need to look at but I don't want to look at.

The Stopped pauses (Dyads 1, 2 & 7) and the Withdrawing pauses (Dyads 2, 4 & 7) seemed to have an even more passive quality than the Avoiding, Re-grouping or Lightening the Therapist pauses wherein the clients seemed to be resisting a dialogue on a difficult subject while either feigning engagement or initializing a new process.

The commonality which characterizes the Stopped sub-category of pauses is the process of disengaging from a train of thought or emotional experience. A sense of having prematurely concluded their exploration was described. Clients reported doing this because they were "too tired to think", because they were too confused, because they didn't know what else to say or because they thought it was the therapist's turn to speak.

C: I remember that I knew I was in therapy and was dealing with a struggle, but I had run out of things to say, and I didn't remember what

the topic was now. (ok) And I kind of left it with him. I kind of just stopped. It kind of, it really felt like a full stop at the end of a sentence.

Withdrawing responses occurred when clients were already experiencing an emotion and then would pull inward, retreating from a sensitive or confusing topic. These pauses had the quality of pulling away from difficult feelings or content without the emphasis on self-soothing that was described in the Re-Grouping pauses of the Avoiding Sub-category. They can be distinguished from the Stopped pauses as they were characterized by the sense of "retreat" whereas Stopped pauses seemed to have a feeling of "blank-ness."

THERAPY SESSION MARKERS. The dominant characteristic of Disengaged pauses was the movement away from emotion or emotional discourse. Clients seemed to be withdrawing into themselves, making jokes, summarizing or dismissing their emotion. The following therapy discourse markers were found to be associated with the occurrence of Disengaged pauses in therapy sessions:

Before the pause: Client disengages before the pause
- Therapist inquiry about a painful topic or therapist focusing client on emotion
- Client makes an emotional statement or disclosure followed by a joke, summarizing, dismissing or distracter response
- Client seems very anxious, is discussing an emotional topic or has just disclosed revealing content

During Pause:
- Client tends to look at therapist (as indicated on the videotaped sessions), or look outwardly, silence appears to indicate "stopped" processing
- Client seems to be inwardly focused and then seems to stop abruptly or prematurely

After the pause:
- Client continues in new line of discussion, or diminishes the emotional importance of previous topic
- Therapist either acknowledges that something has happened internally for the client, refocuses client on emotion or continues along in a new line of discussion
- Client replies with a joke, or a dismissing or summary comment that halts further exploration or discussion (e.g., "That's all." or "It's just something I have to do.")

Example
T: What do you think will help get you there? What do you think you need at this point to help get you there?
C: I don't know (laughs)
T: You'd say, I need
C: (p:04) a million dollars, no (laughs)

2. Feeling Pauses.

"Silence is the perfect herald of joy. I were but little happy if I could say how much."
- William Shakespeare, Much Ado About Nothing.

Feeling pauses are moments in which the client is experiencing emotion, or moving into contact with emotion. In meaning units which were assigned to this cluster, clients identified both calm emotional reactions as well as almost violent experiences of flooding emotions. Emotions ranged from fear, sadness and anger to delight.

All the clients interviewed for this study identified some of their pauses in their sessions as being associated with emotional experience or with moving into emotional experience. The "Feelings" sub-category contains meaning units in which clients described specific emotions which they were experiencing while in silence, such as Fear, Sadness and Anger. The meaning unit below is an example of a pause which fell into the Anger/Frustration sub-sub-category.

004 08c - angry about being angry

C: There's a sigh. I think I was angry about being angry

H: So in that moment a feeling of being angry

C: (sigh) Yeah I was angry for a day. I'm angry that they [those who upset her] took my time

The meaning units in the sub-category of "Moving Deeper into Feeling States" described moments in which clients attempted to connect emotionally with the therapeutic discussion or in which they struggled with conflicting or overwhelming emotions. An intriguing finding was that in this sub-category most clients (Dyads 1, 2, 3, 4, 6 &7) expressed having indefinite feelings at times. Often they seemed able to sense that a deeper level of emotion existed, even when its meaning was unclear, and would use this to guide themselves in therapy. Three of the clients who participated in this study expressed experiences of this type (Dyads 1, 2, & 3). For instance, one participant described this sense saying,

I knew there was something deeper in those things that I was saying, I can tell by the tone of my voice as I'm saying it. I'm kind of trying them out, tried and true, things one might be afraid of, or I might be afraid of, but I knew that wasn't it, that there was something deeper.

This sense of an unrealized depth appeared to function as a guiding force, which helped them to get in touch with their experiential state and to orient them to make meaning out of their felt emotional experiences.

Clients described Feelings pauses as being important therapeutic moments, using words like "profound, powerful, intense and overwhelming." One client said:

> *so far we've been talking about those silences, those little moments seem to be for me moments when I connected. Which is tough when you are talking about someone with depression, because we don't have feelings, well, we don't feel them, so any growth in that area is so wonderful to be talking about... It's tough to do this kind of work, cause it takes longer to get feelings out there so you can work with them ... so it seems like these silences are pretty profound.*

In order to understand the way Feeling Pauses appeared to be evidenced within therapy text, it can be helpful to distinguish this cluster from other psychotherapy process measures' conceptualizations of emotional experience. This category was not entitled "Experiential Pauses" as the pauses which comprise this category did <u>not</u> necessarily include the exploration of emotional meaning or needs which are associated with the higher levels of the Experiencing Scale (Klein, Mathieu, Gendlin & Kiesler, 1969). Additionally, Feeling Pauses are not always identified by the use of emotion words; a key in the identification of the Internal Narrative Processes in the Narrative Process Coding

System (Angus, Hardtke, Levitt, 1996). As these two scales assess discourse, they use the verbalization of emotion to discriminate process categories, but this explicitness did not always appear in the clients' discourse contexualizing silent emotional experience. For instance, in the present study, after describing the story of her brother's absence from her life, one client laments "*... and I haven't seen my one niece for eight years (p:07), so that's what's going on.*" Although no emotions are put into words, this is a Feeling Pause as the client is engulfed in emotion after recounting this disturbing story.

THERAPY SESSION MARKERS. Therapy discourse markers associated with Feeling pauses included the following:

Before the pause:
- emotion words (e.g., "I felt so sad. I just am so forlorn")
- non-emotional wording that has very emotionally-laden content (e.g., "I haven't seen my daughter for 5 years now. I can't understand what is happening with my life.")
- repetition of phrases (e.g., it's probably, it's probably going to be, real, real hard)
- voice sounds shaky, tearful, shouting,

During the pause:
- Expression of emotion (e.g., crying, tearfulness, sobbing)
- Silence with emotional tension

After the pause:
- emotional content (e.g., "I felt so sad. I just am so forlorn")
- non-emotional content that is very emotionally-laden (e.g., "I haven't seen my daughter for 5 years now. I can't understand what is happening with my life.")
- voice sounds shaky, tearful, shouting

Example:
[Re: The behaviour of a significant other]
C: (crying) And it's that conditional, I hate that. It's a conditional thing, like I'll give you something, like a joke or something, and then make a demand and its like danger, danger. I don't think I can do it, I don't think it will come [sobbing very hard] - - - It's just so typical. I hate that conditional stuff. It's really disturbing.

3. Interactional Pauses. Pauses sorted into this category were characterized by the client's focus shifting away from a focus on the self to a focus on the therapist or aspects of the therapeutic interaction itself. There appears to be three main reasons for this shift: an awareness of the therapist's experience in the session, confusion around therapist comments and tasks, and the safeguarding of the therapist alliance. In these moments, clients monitored both their therapists' reactions and their own self-presentation in the therapy discourse. When they felt uncomfortable with the interaction, this reflection would either result in an adjustment of their presentation of self or in an assessment of how important it was for them to remain genuine while potentially risking their alliance with their therapists.

Most clients relayed moments of silence in which they would pause to negotiate the demands of communicating with their therapist (Dyads 1, 2, 3, 4, 5 & 7 - subcategory 1). While relaying their stories, thoughts and emotions to their therapist, clients contemplated their therapists' in-session experience of listening. For instance, they would wonder whether what they just said was confusing or would notice that their therapist looked rushed or too concerned at different moments.

One client was able to articulate the process by which she would stop experiencing her feelings to move into an expressive mode in order to communicate her emotions to her therapist. There were times, however, when she did not feel ready to

shift from an inward focus to communicate with her therapist and this caused feelings of ambivalence in the session.

> *Partly it was not wanting to pull myself out of the feeling of the moment cause I was enjoying the feeling.... I remember then the delight at having made the revelation and just wanting to sit with it, to be with it, but at the same time aware that I'm in a situation where um, I need to communicate that, I need to find the words to communicate that.*

Interactional pauses also occurred when clients tried to figure out if they have succeeded at the therapy tasks at hand or if they understood a therapist task or comment correctly (Dyads 1, 2, 3, 6 & 7 - sub-category 2). Clients paused in order to decide if they needed to ask for more clarification, to try to understand the purpose of a therapist comment, or to decide how the therapist might really want a task to be performed. For instance, one client spent a lot of time questioning whether she was finding the "right answer" but then had difficulty taking the time she needed for exploration because she felt that in the ensuing silence she shouldn't leave the "therapist waiting." This client silently wrestled with performing the task of self-examination in a way that would feel true to herself but not upset the therapist.

Most of the clients also engaged in pauses in which they attempted to safeguard the therapeutic alliance (Dyads 1, 4, 5, 6 & 7 - sub-category 3), either by approval seeking or by managing their negative emotional reactions to their therapists. Pauses

motivated by the seeking of approval arose when clients did not want to appear to have a negative trait (e.g., such as arrogance or elitism); clients wondered about how an issue embarked upon would depict the self; or clients felt the therapist looked too concerned about something the client said. Engaging in impression management, clients decided what to reveal to their therapists, hoping that their therapist would judge their experience favourably and would see them as correct in their understandings of events. An example of this was provided by one client in which she stated, *"I'm trying to tell my therapist what happened and I'm dearly praying she's going to say, 'Yes, it indeed sounds like this person is doing a number on you'."*

Clients also used pauses to manage, withhold or adjust thoughts that they perceived as dangerous to their alliance with their therapist. These moments were difficult for clients as they were experiencing a negative feeling about something the therapist had said in the session. Client self-censorship seemed to occur even when a strong alliance was established. One client said:

> *Actually, I wasn't kidding about how my therapist doesn't make a mistake. She's fantastic. She is is this wonderful person. She is perfect, um not that anybody is, but, so that would be really tough. But I just wouldn't express anger to her, but I can tell you now I do feel it... because you're not her.*

Although it seems to be very difficult for clients to express complaints about their therapist in emotional terms, clients sometimes would question their therapists' comments on a more intellectual level or would object by making subtle or sarcastic comments which their therapist may not recognize. For instance in the following therapy dialogue, the client indicates that she is frustrated without making it clear to her therapist that the frustration was directed at the therapist. In the IPR interview, which follow the therapy discourse segment presented below, the object of the frustration is clear.

Therapy discourse:

T: Does the feeling get stronger or weaker as we talk about it?

C: Which feeling?

T: The feeling of hopelessness or tearfulness?

C: Um, (p:07) no, more frustration the more we talk about it

T: Frustration? (p:13)

C: Well, I don't know, I think what I said before about feeling resigned like I'm along for the ride now

IPR discourse about the first pause:

C: Yeah well in that case I was feeling this, is it going to get worse, thinking I'm going to feel worse as we talk about it more, I felt at that stage that I felt that it was kind of wasting our time talking about it. Why

are we wasting our time talking about the feeling of hopelessness I didn't feel it was advancing anything so that evoked the frustration

H: So it was frustration at talking about the feeling of hopelessness, is that right? C: well, I felt the current line of what we were talking about, I didn't see it going anywhere you know, I didn't see at that time how it was going to be of value

As reported below, the clients' discomfort during the second pause of the above segment of therapy discourse is even stronger, but the client still does not make this experience clear to her therapist. This discourse illustrates how reluctant clients can be to communicate their negative reactions to their therapist.

IPR discourse about the second pause:

C: I'm becoming even !more frustrated because I'm thinking, "oh yes, I've heard of this before. How to get people to talk about their problems? Repeat back what they just said in the form of a question"

H: Mhm

C: so that that stage I was kind of ughh, I was even more frustrated

H: What does that mean, what you just did

C: just "oh boy, I'm sure you get taught that in your first psychology class"

H: kind of like you're frustrated talking about it and you're just getting stuck in that and getting more frustrated

C: I guess he's trying to get me to talk about it more and see how I feel, but at that stage I was feeling, "get moving, lets go somewhere else!"

H: So was there anger there or just feeling..

C: well not really anger, basically the frustration wasn't a problem until we went down this avenue, so I thought, "What are we going to do, examine the frustration that's caused by this line of questioning?"

H: yeah so it felt like you were stuck on some detour you didn't really want to be on (yeah) So here the raising of the frustration is the main thing that's happening? (yeah).

A second client eventually became exhausted from attempts to make herself understood. This client began to misrepresent her experience in an attempt to comply with her perception of her therapist's agenda. This client gave a very vivid description of her experience of an Interactional pause:

H: What is happening for you in this pause?

C: Oh, disbelief in what I just said

H: yeah, so you're thinking I don't believe what I just said

C: I'm still grappling with that whole issue, with trying to accommodate an answer, a good answer.

H: So you're trying to give a good answer, but your mind is pushing you back with all those other issues (the "whole issue" discussed previously)

C: It is. I'm not, I'm just not able to come up with an answer to that. That I believed at that point

H: So you're thinking, "I don't believe what I just said."

C: "I don't believe what I just said. I don't want to say too much more because I can't get a handle on this right now."

H: So you don't <u>say</u> it to him, "I don't believe what I just said," or "I'm thinking about this stuff." (That's interesting.) You just keep it inside instead. You're being the good client, giving the right answer sort of thing?

C: What is that show where they say "Good answer! Good answer!"

H: Oh, like Jeopardy?

C: yeah

H: You feel like you're on Jeopardy?

C: (laughs) yeah!

In this pause, although the client was conscious that she was playing along with what she felt her therapist expected of her, she still was unable to risk threatening the alliance by informing the therapist that the direction he was pursuing did not fit for her.

THERAPY SESSION MARKERS. Therapy discourse markers associated with Interactional Pauses follow:

Before the pause:
- Therapist says something awkward or obvious
- Therapist sets a task that client doesn't understand or doesn't like
- Therapist asks a complicated question
- Client seems to seek the approval of the therapist

During the pause:
- There seems to be a tension at times, or a feeling of confusion
- Client seems to be waiting for more explanation from therapist
- Sometimes eye contact with therapist, indicating client waiting or seeking support

After the pause:
- Client asks for clarification of task
- Therapists will often spontaneously provide explanation of a prior statement if the client appears puzzled during a pause.
- Client responds in way that indicates that they haven't understood the therapist statement (e.g., repeating the statement or repeating their last assertion, sometimes with more qualifiers such as "well, I just think I felt unsettled in that situation for some reason").
- Client tries to change the topic or focus of the conversation

Examples

C: We're talking in rather vague terms at this stage
T: So what would a little accomplishment look like (p:07)
C: Well, I don't know, I don't know exactly what we're talking about, I mean.
T: I guess what we're suggesting if we just had little ones but saw that they were growing that that might constitute an increase in motivation (mhm, yeah, probably) so the thing is what do we count or what would we track or what (p:13)
C: I don't know it's (p:11) I'm not sure, it's hard to think of, it's hard to think of (p:05) an experiment at this time

4. Reflective Pauses. Reflective silences are defined as moments in sessions during which clients question ideas, develop an awareness of an issue's complexity, or make connections and insights about their own experience. The reflection which occurs in this pause is similar to the "Reflexive" narrative process which is described in the

Narrative Process Coding System's (Angus, Hardtke & Levitt, 1996). All of the clients interviewed reported experiencing pauses of this type during the sessions which were reviewed.

Most of the pauses in the Reflective cluster (81.4%) were pauses in the Questioning (Sub-category 1) or Connection Making categories (Sub-category 3). Pauses which are described as attempts to make connections are sorted into this category, whether a connection was found or not and similarly Questioning pauses do not necessarily indicate that answers were being found during the pausing sequence. During these Reflective pauses, clients asked themselves questions and undertook a search for answers. In trying to understand a questioning episode in which she lost her temper, one client described thinking, "*What part of me swore, a combination of 'Was it the depressed me?', because I feel uncomfortable talking about that - - - or was it, is that the angry me, and the angry me doesn't come out much. I'm not sure which, but that was just a questioning.*" There is a sense of puzzlement along with a process of exploration that marks these pauses.

Clients also described pauses of increased awareness (subcategory 2) in which they experienced a heightened sense of the importance of an event, although the meaning of the event may not yet be fully understood. One client said that within such a pause she had the following experience:

[It was] perhaps opening up the door of you know (sigh) I can feel it now. That this is a big thing. This is about - - this is like there is a good part and a bad part of seeing stuff. And I think I was seeing that this is about "like Wow". Like when you say "this is the first time you've stood up to someone," there's a negative and a positive. I think when my voice kind of dropped and that resignation was about, "Oh god I'm realizing this is about, this is about bigger stuff".

It seems that in these pause moments client can recognize the significance of experiences and then can begin to focus their exploration accordingly.

In the Connection Making (sub-category 3) silences the clients were linking together different experiences in their lives, such as memories, or feelings, and are identifying patterns. The pauses may not always be completed successfully, as the following description indicates:

I think what was going on was - - was a um, - - - - well, part of it was, - ok pausing a minute to think, do these fit? Are these related? Are they connected? (uhuh) and then just starting to speak to see if in the speaking the connection could be made. (mhm) I remember.... sort of searching for a a word, searching for a way to make them connect, not being able to do that, and so just starting to speak, in the um, expectation or hope that in the speaking the connection would be make.

Insight pauses (sub-category 4) have the qualities of the realization of new ideas: they were often discussed with excitement and pleasure. One client described this experience as follows:

> *In that moment I was literally doing an "!A-ha, !Oh my god" like maybe for me this might be a pattern. I might be depressed and not aware of it at all (So something new is coming into awareness?) Absolutely. It was very much an a-ha moment. Like oh my god. Maybe that whole period. So it was identifying something.*

Clients expressed experiencing joy at these moments and a desire to take the time to allow things to "click."

THERAPY SESSION MARKERS. The main characteristics for Reflective pauses are indication of client questioning, wondering or making connections or insights. Therapy session discourse markers associated with Reflective pauses included the following:

Before the pause:
- Therapist or client presents a new idea for consideration
- Expression of wondering, analyzing, judging, assessing, questioning
- Discourse examining alternatives, evaluating options
- Discourse making connections or insights

During the pause:
- Client seems to be engaged in intellectual processes

After the pause:
- Expression of insight, or continued wondering, analyzing, judging, assessing
- Connections made or continued to be sought

Example
T: I'm not sure why you said "Am I this messed up" or whatever
C: Well, just because (P:03) it's been six months since I've seen him and I don't think about him and I'm kind of at peace
T: So kind of like what are you intruding in my world for

5. Expressive Pauses. During Expressive pauses, clients are looking for the right words or phrases, or clients are trying to locate a more accurate label for a current feeling state. Clients described engaging in a rapid search process in which they tried to identify the words which felt "right" to them as well as struggling to symbolize fully novel or complex experiences felt during the session. One client described in detail the Expressive process of trying to find the words to convey her experience to her therapist, even though she felt she herself was clear about her experience.

> *H: That pause before that, do you have a sense of what was going on in that?*
>
> *C: What was going on there was, um, this was something that I wanted to tell him, and as I was speaking it occurred to me that it fit. Often when I am speaking I find I make connections that I haven't made, but what I was thinking was, or what was going on was, um, "This is going to seem like a really weird jump. I !feel that it fits, but how do I !say it so that I convey how it fits" (ok) and it's almost like, it was like, my mouth couldn't keep up with what was going on, what I was thinking*
>
> *H: Ok, anything else?*

C: Uh, I think that's (mhm)

H: so you're saying that your mouth couldn't keep up with what was going on.

C: Well, there was a whole lot going on, but the difficulty was finding the words to convey what was going on, finding the words to convey how I saw the connection, because, well that's interesting, because immediately I stepped outside of myself and thought, how is this going to sound, this doesn't sound, or this doesn't make sense, so how do I say this to make it make sense

H: So making it make sense

C: Yeah, cause it made sense to me on the inside, but I was aware that it may not make sense to anybody on the outside because they aren't making the internal connections that I'm making, so that's, how do I make sense of this for anybody else.

THERAPY SESSION MARKERS. Expressive Pauses are indicators that clients are struggling to find the word, phrase or label to accurately convey their experience to their therapists. Therapy session discourse markers associated with Expressive pauses included the following:

Before the pause:
- Clients are often trying to articulate present experience that hasn't been articulated before or are trying to articulate highly anxious content.
- Clients stutter (e.g., "*But you know I'm I'm I'm (p:03) there's a good way to put it (p:03) I'm, I admire beauty too much*"
- Clients say something awkward or vague (e.g., "*I felt it had to do with all kinds of work things like (p:03) not being ambitious*")

During the pause:
- Clients seem to be seeking the correct word, may begin to try on words to themselves

After the pause:
- Clients find an expression or symbol of their experience
- Clients indicate that they have failed or come up with an awkward phrase (e.g., "*I was able to uh (p:05) make it go back to how it used to be before.*")

Example
T: I get a sense of that shattered, my world view is shattered. and the pieces are all lying around and I have to reconstruct reality
C: And I have to give up almost the um - - - almost the illusions

6. Associational processes. Associational pauses are moments in which clients shift to a new content area but do so without making a clear connection to the previous topic. They are making an association using a prior frame of reference or an agenda which does not directly stem from the topic at hand. For instance, "*I've been aware that being my anger is harmful to my family lately, (p:03) but back to the larger picture of how this week has been.*" Often these pauses seemed to occur when clients had an agenda such as "covering the events of the week". The topic may shift to a prior conversation or a different idea may abruptly interrupt the preceding discussion. Clients did not explicitly describe their intentions to "change gears" in the IPR, but instead identified that a new idea occurred to them at that moment in the therapy session. This sense of a new idea emerging was described in the following segment from one IPR interview:

C: Well I remember saying something in my head, it was definitely a head game that was going on, well, no it wasn't definitely a head game 'cause it was partly feeling (yeah) well now I recognize the feeling of not wanting to fall apart but then at that moment, but also, - - an awareness, I was very aware of thinking of myself "So why don't I just let myself fall apart? - - So what's so bad about falling apart" (right) So that's where the comment, "well, if I was some other kind of person I could just go out and find a release" - - - - -

H: So it sounds there is first a questioning and then

C: - - - No it wasn't a questioning so much as an awareness, - - well, maybe it was a questioning, like a - - "so so fall apart, why don't you just fall apart", and "why" and and sort of picking a sort of a socially acceptable way to find a release (uhuh) that's not something I would ever do (uhuh) go out and get drunk (uhuh) but but seeing it as a situation that - - for which I could seek some sort of release, but which I didn't (ok) - -

H: So in this part [the silence] you are going through, the seeing? I'm not sure

C: Well, I'm not going through the seeing, but these thoughts are occurring to me like "why not fall apart?", I'm already starting to re-

frame falling apart as release (ok) - um so it's already backed off from this sort of catastrophic "Fall apart. Go mad" into release

H: Right so a change is happening there

THERAPY SESSION MARKERS. The main characteristic for an Associational pause is a sudden shift in topic, often from a more emotional topic to a less threatening one.

Example

C :.. cause I can't hold it all together I can't hold all the pieces
T: It sounds like you're very stressed you know (mhm) and this is the last straw
C: Yeah, it felt like this is the last straw
T: Uhuh
C: That's true. I'm juggling and doing and giving everything and now this and it's like I can't hold it all together anymore, it's just too much (p09) maybe if I was a different sort of person I'd go out and get rip-roaring drunk and fall apart, fly apart

7. Mnemonic pauses. Mnemonic pauses were described by the client participants as moments in which they attempted to recall details of events or objects they were describing. Clients used this time to recall specifics about memories or to try to "look back" through their histories to see if there have been events that might fit the present patterns being discussed in the therapy session. In terms of her depression, one client stated that this process was particularly difficult as she even has to *"struggle with knowing what day it is."*

The following segment from an IPR interview represents one clients' description of her process of recalling details of a story as she was relaying it to her therapist.

C: Well you want me to talk about this one [pause]? (yeah) Well, I know what I am trying to do is to reconstruct it, I'm going back into that place, I don't know, is this the [event descriptor] thing (yeah - that's what it is) then I know what I was doing was going back into the events, the chronology of the events and trying to reconstruct each one and just, have the spiralling down happen

H: So then you were

C: Reconstructing (uhuh) Right now I'm not, this is recall, but then I was putting myself back in time to when that all was happening and trying to reconstruct how the spiralling down occurred

H: Can you say a bit more about what you mean by reconstruct, I'm not sure

C: - - - well, I was trying to remember how it happened

H: So remember the sequence of what went on or?

C: Well, the sequence of what went on, but also how I was feeling as it happened, so perhaps reconstruct is the wrong word. I was trying to recall, well, it was more than just trying to recall (uhuh) because when I try to recall things like this what I do is I try to put myself back in the moment or in the time of whatever was going on (mhm) and try to remember how it was that I felt at the time

H: So it sounds both what was going on and also how you felt

C: Yeah, the events, the sequence of events and also how I felt at the time and with most memory there's partly recall and partly reconstruction

THERAPY SESSION MARKERS. Therapy session discourse markers associated with Mnemonic Pauses included the following:

Before the pause:
- Therapists often ask for information (e.g., *When did you decide that you wanted to pursue that career?*)
- Clients seem to be struggling with details (e.g., *Was it Wednesday or Friday? (P:03) It was Friday.*)

During the pause:
- Clients seem to be inwardly focused, or mentally "picturing" events

After the pause:
- Clients have retrieved the information they were seeking
- Clients signal that they have failed in trying to recall (e.g., *I went to a movie (P:03) I never remember what movies are called.*)

Example
C: As soon as she gets older she'll come
T: when will that be
C: probably in September she'll come back (ok) (p:03) she didn't say exactly when (mhm)

Effects of Interpersonal Process Recall Interviews (IPRs)

After each interview, clients were asked about their experience in the IPR interviews. Based upon participant accounts, it was apparent that the IPR interview procedure had quite different effects on the participants. Five of the seven clients experienced insights during the IPR interviews that they hadn't achieved during the session. One client described the IPR process as "*an extension of the therapeutic work,*" a

sentiment shared by several of the client participants. The exploration of their pausing experiences in the therapy session seemed to encourage clients to continue thinking about issues which they recently discussed in therapy.

A few of the clients seemed to have process-related insights, where they became aware of the way they interacted with the therapist in the therapy session. One client noticed that she was acting to avoid getting "*too deep*" emotionally. A second client noticed that she didn't ask for time to think when she wanted it in session and a third noticed that she kept moving away from important issues in session. In addition, two clients were able to label emotions they were struggling to describe during their therapy sessions.

The IPRs had a few less positive effects as well. One client reported feeling an initial discomfort at being audiotaped. She said this was mainly because she felt the therapist was initially uncomfortable being taped and that although it "*might have affected the way it started, beyond that it was ok.*"

The client who was identified by her therapist to be suffering from the most severe depression, however, noticed that she sounded depressed and emotionally flat on the tape and this aroused her own negative self-judgements. Her reaction highlights the importance of checking out with clients how the interview has impacted upon them. After this interview, we explored these feelings as signifying a part of her that "*beats up on herself*" and re-framed this voice as a part which probably plays an important role in her

depression and which she could continue to explore in therapy. This interview highlights the importance of interviewers' therapeutic skills when discussing personal and emotional issues with participants as well as the importance of asking about the client's IPR experience.

After the completion of the IPR interviews, some of the clients had altered perceptions of their therapies. One client said she developed a deeper appreciation of therapy after examining her process, "*I'm taking away goodies, but there's goodies I don't even know I'm getting. A lot of stuff is happening.*" Another client realized that she was not telling her therapist about her internal reactions to interventions during the session and resolved to change this at the end of the IPR session.

In summary, it appeared that the IPR interviews tended to have a positive therapeutic impact on the client participants. That is, the clients seemed either to leave with personal insights or with insights into the interactions which occur with their therapists, both which they could continue to explore in therapy. These findings stress how important it is that individuals conducting this sort of research have some degree of therapeutic skill in order to help clients negotiate negative self-judgements or insights which might unfold.

2. Process Measure Analysis

As this study examines a small sample of psychotherapy dyads and sessions, no claims can be made as to the effect of the therapeutic orientations on the pauses as

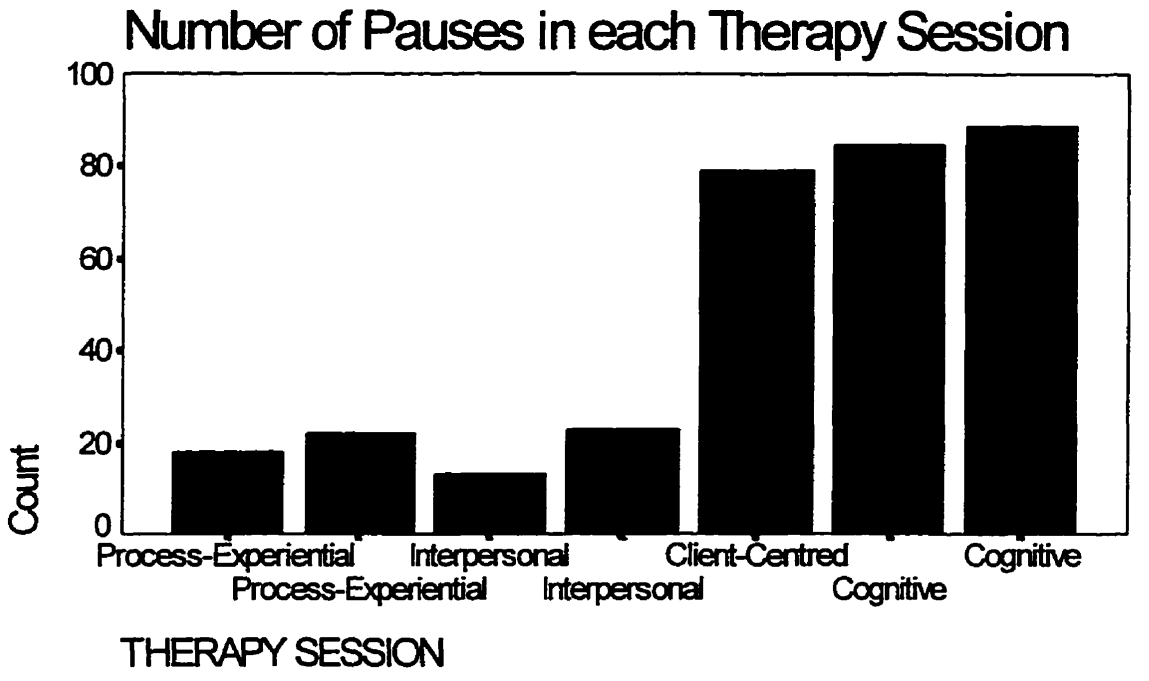
separate from therapist style. Therapists are referred to by their therapeutic orientations in order to distinguish one therapy dyad from another, not as an indicator of therapy orientation as a separate variable of analysis from therapist style.

This section will represent findings using descriptive statistics rather than inferential statistics due to the limitations of the small sample size used in this study. Results focus on identifying trends that emerge from the therapy session data, which can be explored further in future research. These analyses focused upon the different pause types identified in the seven therapy sessions upon which the IPR interviews were based using the Pausing Inventory Categorization System Manual.

Number of Pauses in the Therapy Dyads

There was great variability in the number of pauses (≥3 seconds) across the different therapy sessions (see Chart 1). The pattern of variability appeared to correspond with the therapists or therapy orientations so that clients of the same therapist appeared to have similar numbers of pauses occurring in the therapy sessions. The two Process-Experiential sessions had 18 and 22 pauses, which was similar to pattern found in the two Interpersonal sessions (13 and 23 pauses). In contrast, 79 pauses occurred in the one Client-Centred session, while 85 and 88 pauses occurred in the two Cognitive sessions.

Chart 1



Pausing Duration in the Therapy Dyads

Summing the total seconds of pausing (where a pause is defined as at least 3 seconds in duration) the two PE therapy sessions had 76 and 148 seconds of silence, the two IPT sessions had 49 and 97 seconds of silence, the CC session had 469 seconds of silence and the two Cognitive sessions had 681 and 867 seconds of silence, all within sessions of approximately one hour in length (see chart 2).

Duration of individual pauses seems to alter with therapist/orientation, but not by individual client. The mean duration of pauses were as follows: PE therapy, 6.0 seconds; IPT therapy, 4.06 seconds, Client-centred therapy, 5.95 seconds and Cognitive therapy,

9.01 seconds. The therapist-style or therapy orientation may contribute more to the duration of silences than the individual client.

Chart 2

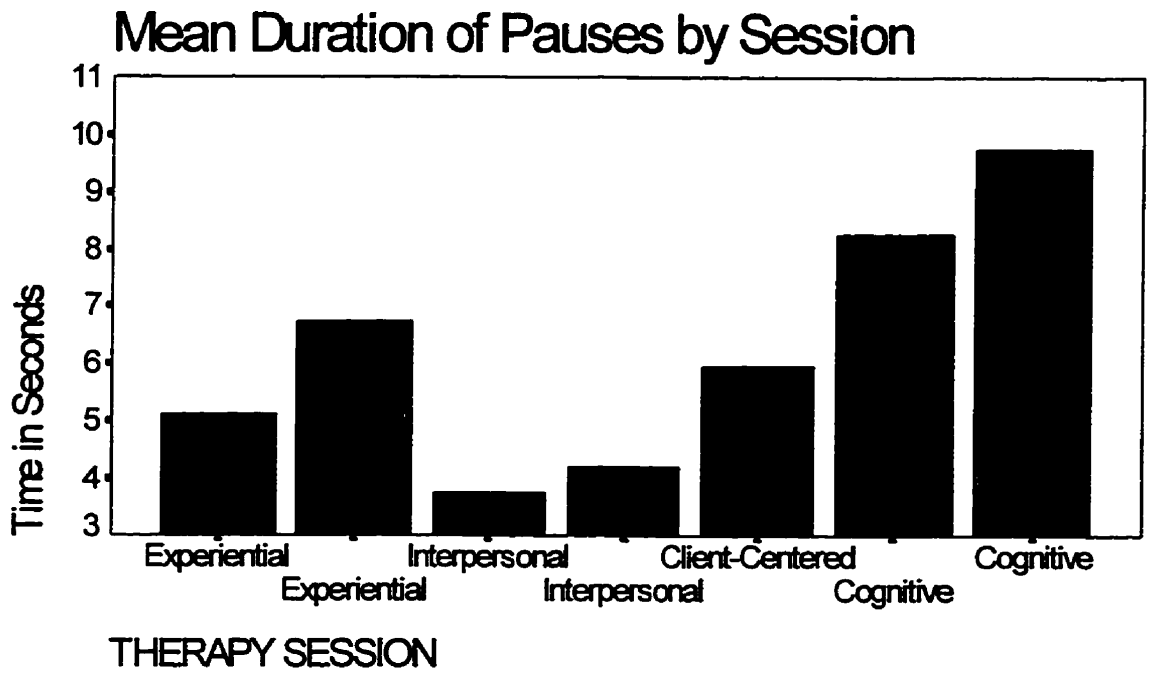


Table 3 breaks these total figures in terms of the number of pauses of varying lengths.

Table 3

Number of Pauses of Varying Lengths by Session

Client	Therapist	Duration in Seconds								Pause Total Time	Pause Mean Time
		3-5	6-10	11-15	16-20	21-26	39	45	70		
001	PE	12	05	01						076	4.2
002	PE	11	08	02		01				148	6.7
003	Interpersonal	12	01							049	3.8
004	Interpersonal	18	04							097	4.2
005	Client-centred	45	25	06	02					469	5.9
006	Cognitive	23	46	08	04	03				681	8.4
007	Cognitive	25	43	09	07	02	01	01	01	867	9.9

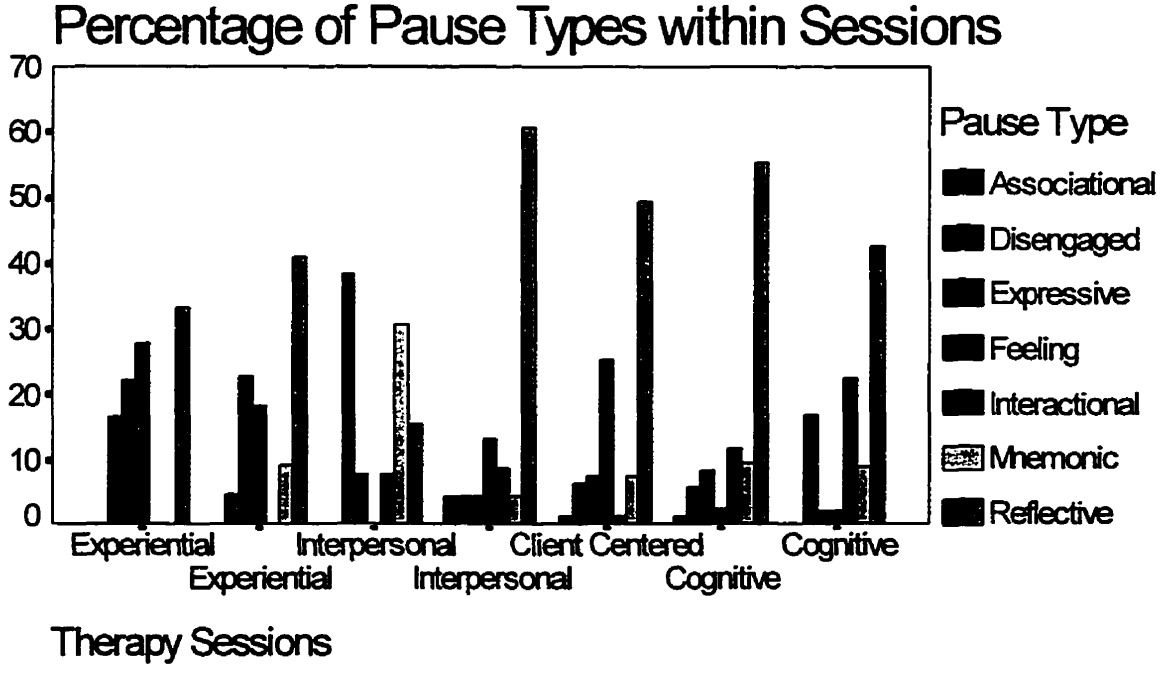
An examination of pause length across all the sessions, indicates that there is a moderate positive correlation between the length of the pause and their time of occurrence in the session. The correlation of .40 between pause length and the ordinal number of the pause within that session, suggests that the longer pauses tended to be later in the session.

Pausing Processes in the Therapy Dyads

The frequency of the different pausing types varied across sessions (see Table 4). When looking at the interaction between the different frequencies of pause types and the clients and therapist/therapy orientation, the patterns seem to indicate that pause types may interact with client, therapist or therapy orientation. See Chart 3 for a depiction of the ways all the pausing processes were distributed within each session.

Associational pauses were rare across the therapies (3/329 pauses). This is not unexpected as these pauses are characterized by sudden shifts in content which should not occur frequently within session.

Chart 3



Given that each therapist with two clients has one with a high percentage of Disengaged pauses and another with a lower percentage of Disengaged pauses (PE: 17% & 5%; IPT: Cognitive 6% & 17%; and 38% & 4%), this pausing type appears to be associated with clients instead of therapist or therapy orientation. It may be an individual difference variable which relates to the level of anxiety the client experiences around the emotional or sensitive topics discussed in therapy.

Table 4

Percent of Pauses of Different Types and Total Number of Pauses within each Session

	Session						
Pause Type	PE1	PE2	IPT1	IPT2	CC	Cog1	Cog2
Disengaged	17%	05%	38%	04%	06%	06%	17%
Feeling	28	18	00	13	26	02	02
Interactional	00	00	08	09	01	12	22
Reflective	33	41	15	61	49	55	43
Expressive	22	23	08	04	08	08	02
Associational	00	00	00	04	01	01	00
Mnemonic	00	09	31	04	08	09	09
Total Number of Pauses	18	22	13	23	79	81	88

Expressive Pauses occurred most frequently within the PE therapy dyads (22% and 23% of pauses). In these dyads the clients were often seeking ways to express novel feelings and thoughts which arose from their explorations. Clients in these dyads seemed to be either in the process of articulating their present experience before these pauses, prompted by therapist questions such as "*What's happening now?*" or "*Tell him about the danger, what's what's the danger?*") or in the process of articulating highly anxious feeling states (i.e., being vulnerable, feeling negatively judged, feeling shattered, or anxiety and fear).

Interactional pauses occurred most frequently in the therapies conducted by the Cognitive therapist (12% & 22% of pauses; see Table 5). These pauses appeared to be associated with a "question-answer" style of therapy. In order to examine this hypothesis, I tabulated the number of questions asked by the therapist in each session. (For this count, additions of "*right?*" to sentences, or reflections of a client question were excluded as these are not therapist requests for new information.).

When examining the relationship between the number of interactional pauses in each session and the number of therapist questions asked in each session a significant positive correlation of . 90 was found (see Table 6). Interactional pauses occurred most frequently in the cognitive and the IPT therapy sessions, the sessions in which the most questions were asked. The number of questions did not correlate as strongly with the number of pauses found in each session (r =.57), particularly once the interactional pauses

was removed from this number (r=.44), and so although the total number of pauses in these sessions is higher, interactional pauses appear to have more of an association with the number of therapist questions in a session.

Table 5

Number of therapist questions by session

Client	Therapist	Questions Asked Per Session	Mean Questions per Therapist
001	Process-experiential	23	17.5
002	Process-experiential	12	
003	Interpersonal	60	43.0
004	Interpersonal	26	
005	Client-centred	14	14.0
006	Cognitive	82	
007	Cognitive	110	96.0

Table 6

Correlations between the number of questions, number of interactional pauses, total number of pauses and number of non-interactional pauses

	Total No. Pauses	No. Interactional Pauses	No. Non-Interactional Pauses
No. Questions	.5665 (7) P= .185	.9049 (7) P= .005	.4359 (7) P= .328
No. Pauses		.7352 (7) P= .060	.9855 (7) P =.000

Mnemonic pauses did not occur frequently in most of the sessions (ranged from 00-09% of pauses). They were identified most often, however, in one of the IPT therapies (31%). As this therapy approach has psychodynamic underpinnings and a focus on analyzing interactional patterns across the client's life history, clients in this therapy learn to engage in recalling processes more often than in the other therapy approaches. For instance, this therapist asked the client to look into the past and try to recall interactional episodes (e.g., "*If something got you angry, how do you end up resolving it?*").

The reflexive pauses were dominant across all the therapies (ranging from 33%-61% of the pauses) with the exception of one the IPT dyads (15% of the pauses) where the

percentage of disengaged pauses was highest (38%). This client described her session saying,

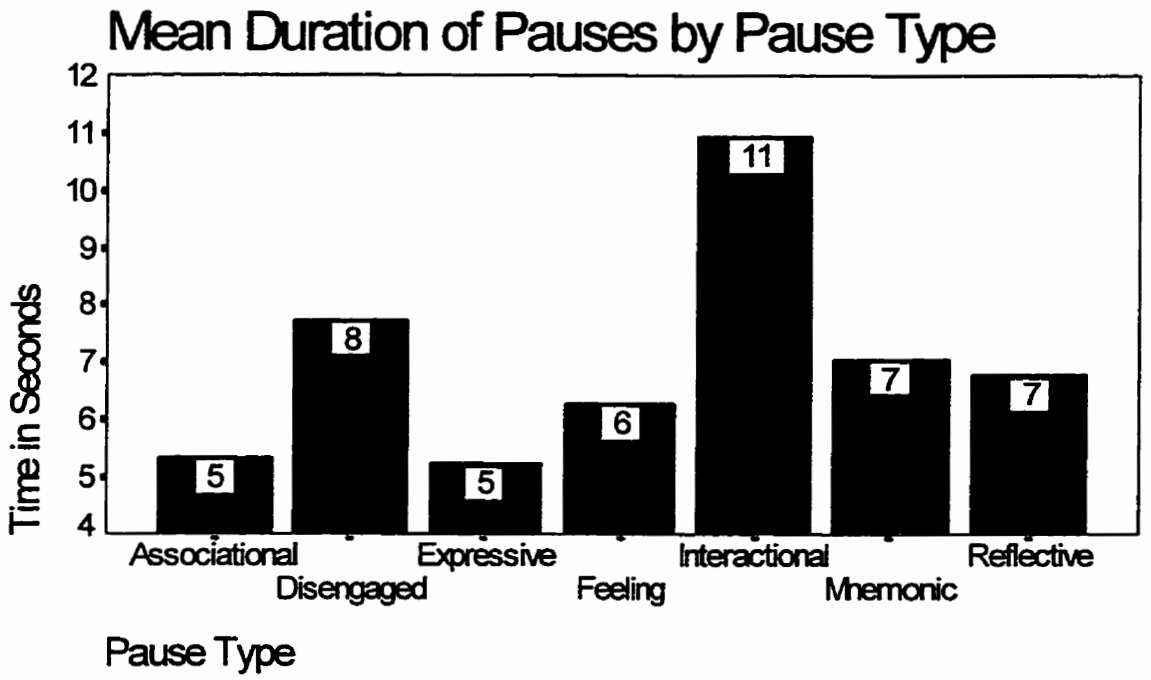
> *Throughout the entire session I was ambivalent about getting too deep. That's kind of a theme throughout the past couple of sessions, I think. That I stay away from heavy topics (mhm) and try not to get emotional (huh) so I think I was pretty much aware that I was doing that for the entire thing.*

It appears that this process of disengaging kept this client from being analytical within her session.

Pauses Types and Pause Duration

In terms of overall mean duration of pauses, Interactional pauses were the longest (11 seconds), followed by Disengaged Pauses (8 seconds), then Mnemonic and Reflective Pauses (7 seconds), Feeling Pauses (6 seconds) and Associational and Expressive Pauses (5 seconds). The mean durations of the pauses appear to be strikingly different, particularly when one considers the impact a 5 second pause would have in the context of a dialogue as compared with an 11 second pause. Chart 4 illustrates these findings.

Chart 4



Speaker-Patterns

In order to investigate the position of the pauses in relation to the therapist and client speech turns, pauses were classified according to four possible Speaker-Patterns (see Table 7). Either the client spoke, paused and continued (CC); the client spoke, paused and then the therapist spoke (CT); the therapist spoke, paused and then the client spoke (TC); or the therapist spoke, paused and continued speaking (TT).

The Associational Pauses were exclusively embedded within Client-Client speech patterns (100%). The Expressive and Feeling Pauses were predominately identified within this pattern as well (77% and 53% respectively). Reflective pauses were dispersed

throughout all the speaker-pattern categories, with the highest occurrence in the Client-Client pattern (35%), followed by the Therapist-Client pattern (26%).

Table 7

Percentage of Pause Types Within Different Speaker Patterns

	Speaker Pattern				
Pause	%CC	%CT	%TC	%TT	Total Number of Pauses
Disengaged	09	40	26	26	35
Feeling	53	22	14	08	36
Interactional	15	09	26	50	34
Reflective	35	21	26	17	155
Expressive	77	15	00	04	26
Associative	100	00	00	00	03
Mnemonic	38	17	45	00	29

Disengaged pauses were found mainly embedded within the Client-Therapist pattern (40%). Mnemonic pauses were identified mainly in the Therapist-Client pattern (45%) and the Client-Client patterns of speech (38%).

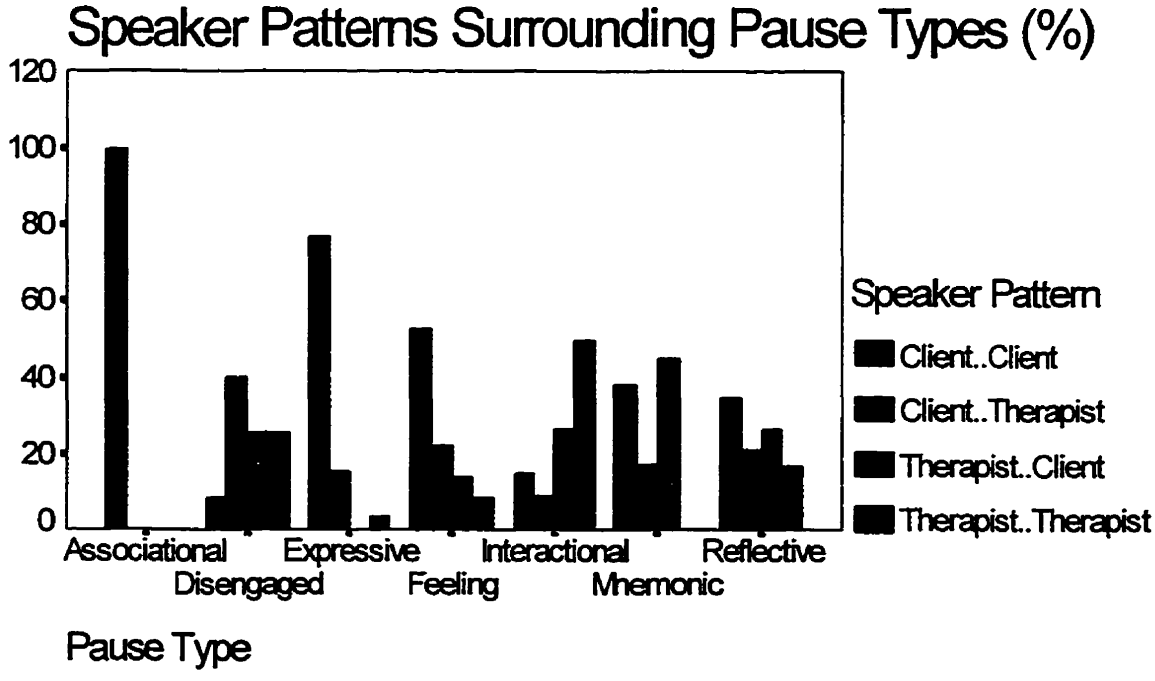
Interactional pauses were embedded mainly in the Therapist-Therapist speaker patterns (50%) or in Therapist-Client speaker patterns (26%). These pauses follow therapist speech most often. Often, these moments occurred when the therapist spoke then the client was puzzled or confused in silence and so the therapist spoke again either to clarify a statement or try to provide the client with more direction. For instance, the pauses in the following quote illustrate moments in which the client was uncertain about the line of discussion and did not know how to respond to her therapist:

> T: *Alright - so some of it created anxiety and some tired you out. Was there anything that was useful? You said resonated? Was that a good thing, or a bad thing?*
>
> *C: I think there was, I think there was just some post-traumatic stuff that goes on still - (mhm) That's the part that resonated*
>
> *T: Ok.* ***(p:07)*** *So it was having some ongoing effects.* ***(p:05)*** *(Mhm)*

Generally, moments in which the therapist was simply trying to locate a word or phrase were less than three seconds and were not included in this analysis, so, despite appearing within the therapist's speech, these pauses appear to be co-constructed events.

Overall, it appears that speaker patterns may be a useful marker to assist with the differentiation of different types of pause experiences in psychotherapy. The strongest associations were that the Interactional pauses generally were found to follow therapist speech (76%) and the Feeling, Expressive and Associational pauses were found to follow client speech (75%, 92% and 100%, respectively). As well, Feeling, Expressive and Mnemonic pauses were found to be followed by client speech most of the time (67%, 77% and 83%, respectively) and Disengaged pauses were found to be followed by therapist speech most often (66%). The figure below (Chart 5) illustrates the divisions of these pauses over all speaker patterns.

Chart 5



Pause Types and NPCS Sequence Types

All therapy session transcripts were coded with the NPCS and pauses were identified within the Narrative Sequence Types. Then, to examine the relationship of the different pause types to the narrative process sequence types, the narrative sequence type which preceded each pause was identified (see Table 8 and Chart 6). All pause types were most frequently found to follow Reflexive narrative sequence discourse, with the exception of Mnemonic pauses which were located most often after External narrative sequence discourse (48%).

Chart 6

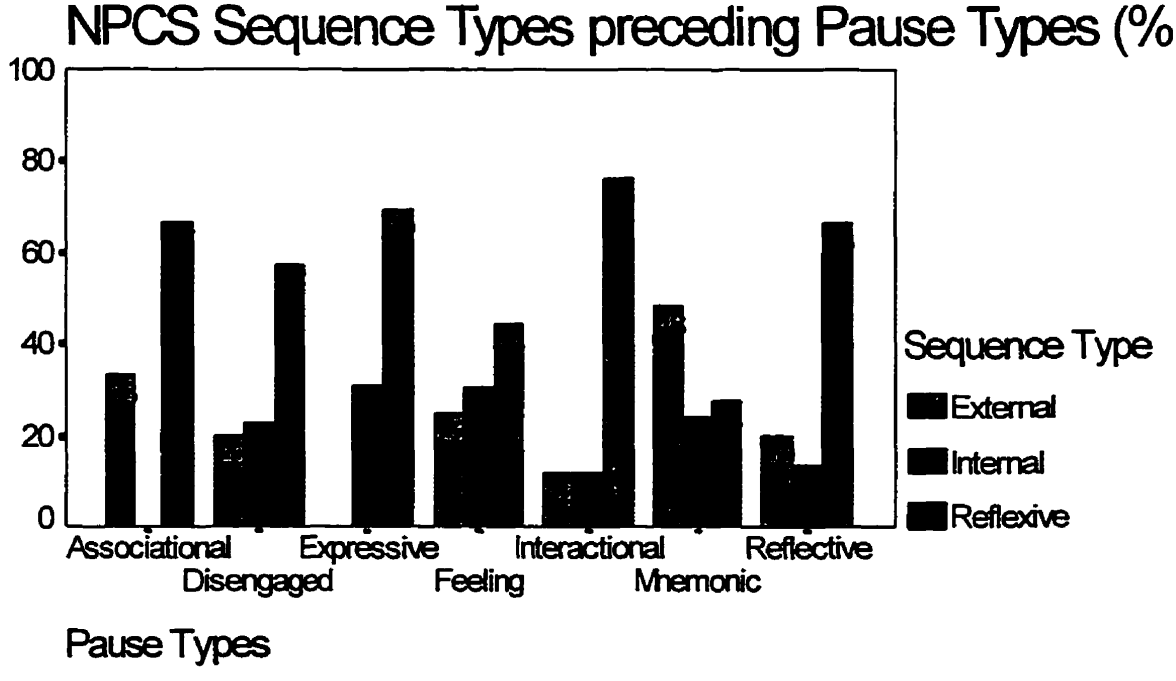


Table 8

Narrative Process Sequence Types preceding Pause Types

	NPCS Sequence Type Distribution			
Pause	N(%) Ext.	N (%) Int.	N(%) Ref.	Number of Pauses
Disengaged	07(20)	08(23)	20(57)	35
Feeling	09(25)	11(31)	16(44)	36
Interactional	04(12)	04(12)	26(76)	34
Reflective	31(20)	21(14)	103(66)	155
Expressive	00(00)	08(31)	18(69)	26
Associative	01(33)	00(00)	02(67)	03
Mnemonic	14(48)	07(24)	08(28)	29

The most common types of pauses found in the Internal narrative sequences were the Feeling and Expressive pauses (31%), indicating that there may be a relationship between emotional narrative discourse and these pauses. Approximately one third of Associational pauses were located after External narrative discourse (33%), suggesting that at times clients may switch topics when in the External narrative process. See Table 8 for a full listing of the distribution of the pause types across narrative sequence types.

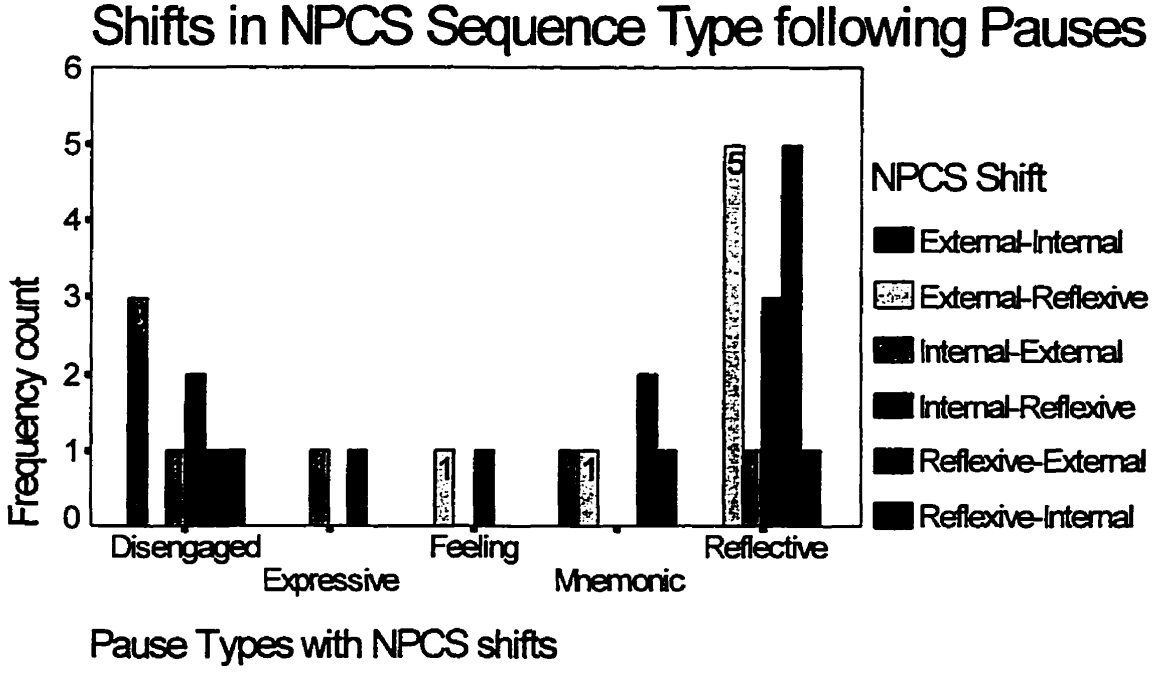
Overall, the narrative sequence type which occurred before any pause also continued on after the pause ended. In total, changes in narrative sequence type over the duration of pauses occurred 9.9% of the time. Changes in narrative sequence type occurred 24% of the time for Disengaged Pauses, 19% of the time for Mnemonic Pauses, 9% of the time for Reflective Pauses, 8% of the time for Expressive Pauses, 6% of the time for Feeling Pauses and did not occur in either Associational or Interactional Pauses.

Chart 7 depicts the patterns of narrative sequence shifting which was found in the therapy session transcripts after pauses. Patterns of shifts in narrative sequences which occurred more than 5% of the time included shifts after Disengaged pauses from External to Internal sequences (9%) and from Internal to Reflexive sequences (6%), and shifts after Mnemonic Pauses from Reflexive to External sequences (7%). Overall, it did not appear that shifts in narrative sequence were strongly associated with any pause type other than Disengaged (23% of pauses) and Mnemonic Pause types (17% of pauses).

In order to examine the relationship between pauses and shifts in the NPCS narrative sequences or topic segments, the number of pauses which occurred near (within one sentence) or at a topic or narrative sequence shift was tabulated. In terms of Topic Segment Shifts, 27.8% of these occurred at or within a few words of, a pause (22/79). In terms of Narrative Sequence Shifts, 20.4% occurred near a pause (54/265). Of the total number of pauses (329) 12.5% are Narrative Sequence Shifts and 6.7% are Topic Segment Shifts. It appears that, although most pauses do not occur at shifts in the narrative

discourse, narrative sequence and topic segment shifts tend to occur near pauses approximately one fifth and one quarter of the time, respectively.

Chart 7



Pause Types and Experiencing Scale Ratings

Experiencing Scale modal scores were assigned to the speech turns occurring before and after each pause. Units of rating were defined by changes in the Experiencing level ratings, such that the speech turn immediately before or after a pause was kept as a rating unit until a change in Experiencing level occurred. The majority of the Experiencing ratings remained constant for the units before and after pauses (78%). The Client Experiencing Scale modal ratings which occurred prior to the different pause types

are presented in Table 9 and Chart 8 (including Client-Client and Client-Therapist speaker-patterns).

Table 9

Experiencing Modal Levels preceding Pause Types

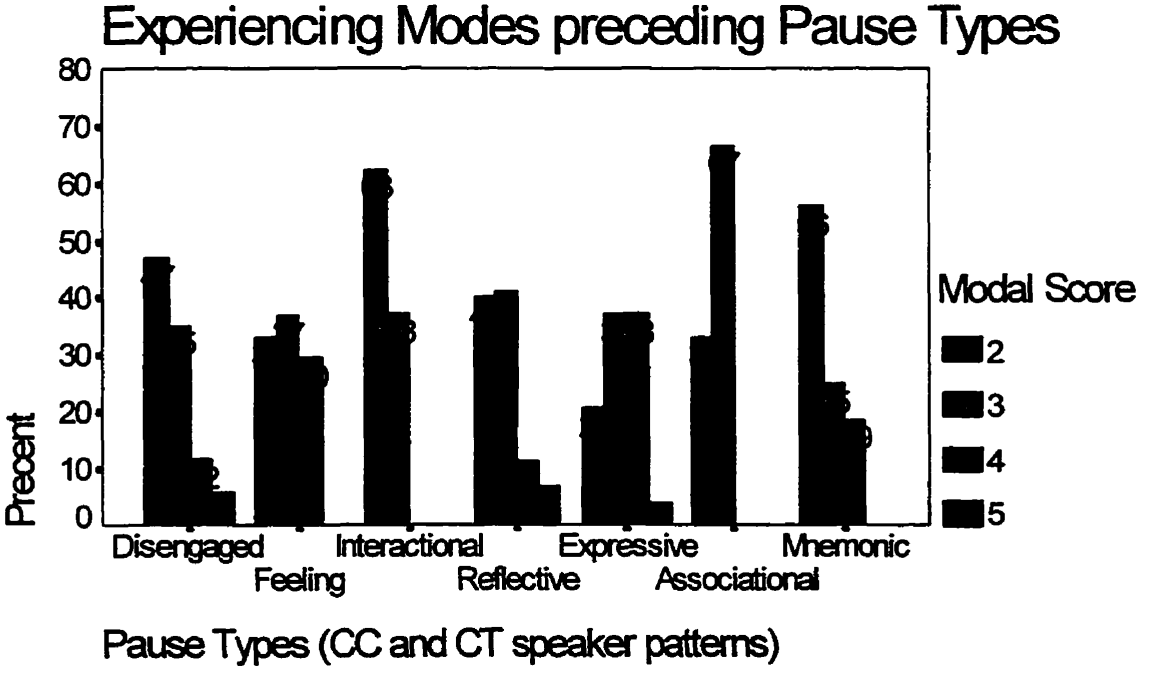
	Experiencing Level Distribution					
Pause	2 n(%)	3 n(%)	4 n(%)	5 n(%)	N. Pauses	Mean(SD) Exp.Mode
Disengaged	08(47)	06(35)	02(11)	01(06)	17	2.8 (.90)
Feeling	09(33)	10(37)	08(30)	00(00)	27	3.0 (.81)
Interactional	05(62)	03(38)	00(00)	00(00)	08	2.4 (.52)
Reflective	35(40)	36(41)	10(12)	06(07)	87	2.8 (.88)
Expressive	05(21)	09(38)	09(38)	01(04)	87	3.2 (.84)
Associative	01(33)	02(67)	00(00)	00(00)	03	2.7 (.58)
Mnemonic	09(56)	04(25)	03(19)	00(00)	29	2.7 (.81)

Expressive pauses were associated with the highest ratings of Experiencing (mean of 3.2), followed by Feeling pauses (mean of 3.0). Level 3 Experiencing indicates that although emotions are not the focus of the client's speech (Level 4), that they are being

referenced throughout the discourse. The means of the other pauses were clustered more closely together (Reflective pauses, 2.8; Disengaged pauses, 2.8; Associational pauses, 2.7; Mnemonic pauses, 2.7;) with Interactional pauses having the lowest in Experiencing modal ratings (2.4). Level 2 Experiencing indicates that emotions are not referred to by the client, although the client has not disconnected from the discourse (Level 1).

Overall, the level 5 on the Experiencing Scale was most strongly associated with Reflective pauses (comprising 75% of the pauses at level 5). This high level suggests that the posing of emotionally-referenced questions for exploration may be associated with Reflective pauses. Level 4 on the Experiencing Scale was most strongly associated with Reflective, Expressive and Feeling pauses (comprising 31%, 28% and 25% of the pauses at level 4, respectively). This finding suggests that the focus on emotional and experiential content in session may be associated with these pause types.

Chart 8



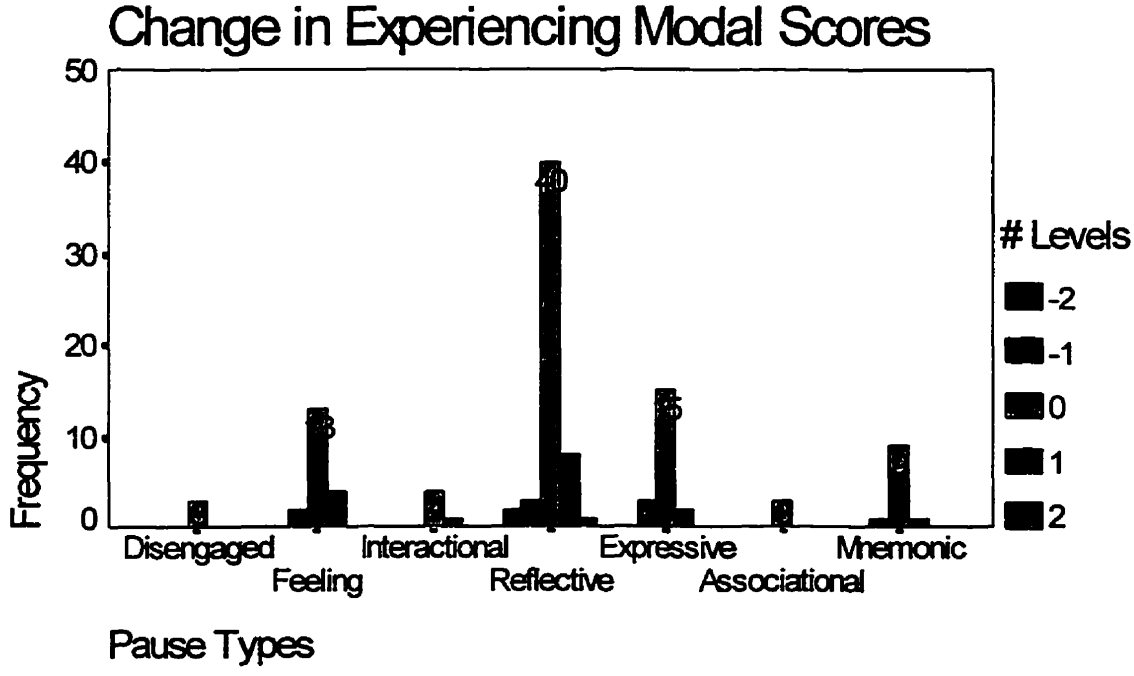
Because the Experiencing Scale which was used in this study rates client speech alone, Chart 8 presents the modal ratings of the speaker patterns in which client speech preceded pauses (either Client-Client or Client-Therapist speaker patterns) and does not include those pauses that were preceded by therapist speech. However, as a large majority of the Interactional pauses (76%) were found within speaker patterns in which the therapist speaks before the pause (either therapist-therapist or therapist-client speaker patterns), pauses preceded by therapist speech were examined for this pause type. In this instance, the Experiencing ratings of the client speech prior to that therapist speech were examined. Although the therapist speech which did occur between the client speech and the pause could confound the trends found between the client Experiencing and the type of pause, it seemed that as these speaker patterns were more representative of these pause types that it would be useful to present these data in this exploratory study. For the Interactional pauses, these ratings occurred mainly at level 2 (62%) with some ratings at levels 3 (31%) and 4 (8%). It appears that for Interactional pauses, these Experiencing ratings were approximately the same as those for client speech immediately preceding an Interactional pause (mean of 2.5 versus mean of 2.4).

In order to investigate the patterns of change in client Experiencing modes associated with specific pausing types, Experiencing modal change scores were calculated which represented the Experiencing modal score which followed each pause subtracted from the Experiencing modal score which preceded the pause. As the Experiencing Scale

rates client speech independently of therapist speech, this analysis focused on the relatively few pauses within client speech (Client-Client patterning; 28/118) which underwent a change in Experiencing modal scores after a pause (see Chart 9).

Although Experiencing modal ratings generally remained stable (77.7%), 14.4% of all the CC-speech pattern ratings increased by one level after a pause while 0.5% of the ratings increased by two levels. In contrast 5.3% of the Experiencing ratings dropped one level, 1.6% dropped two Experiencing levels and 0.5% dropped 3 levels. Chart 9 presents these modal rating changes in terms of Pause Type. The findings from this analysis seem to suggest that, in these therapy sessions, Experiencing Scale scores did not shift in a meaningful fashion after a pausing event.

Chart 9



Pause Types and Client Vocal Quality Scale Ratings

In order to explore the relationship between the different pause types and Client Vocal Quality, the vocal quality of clients' speech immediately before and after each pause was rated (including Client-Client and Client-Therapist speech-patterns). Units of rating were defined by changes in the CVQ ratings, the speech turn immediately before and after a pause being kept as one rating unit until a change in vocal quality occurred. All of the pauses types were found to occur most frequently following speech coded in the External vocal quality (Disengaged, 65%; Feeling, 59%; Interactional, 75%; Reflective, 61%; Expressive 85%; Associational, 67%; Mnemonic 88%). Pausing types which were most associated with Focused vocal quality included the Reflective pauses (of which 17% were found within this vocal quality) and the Feeling pauses (8%). Feeling pauses were the only type of pause to have any instances located within speech classified as Emotional voice (3%). A complete listing of these findings is presented in Table 10 below.

Table 10

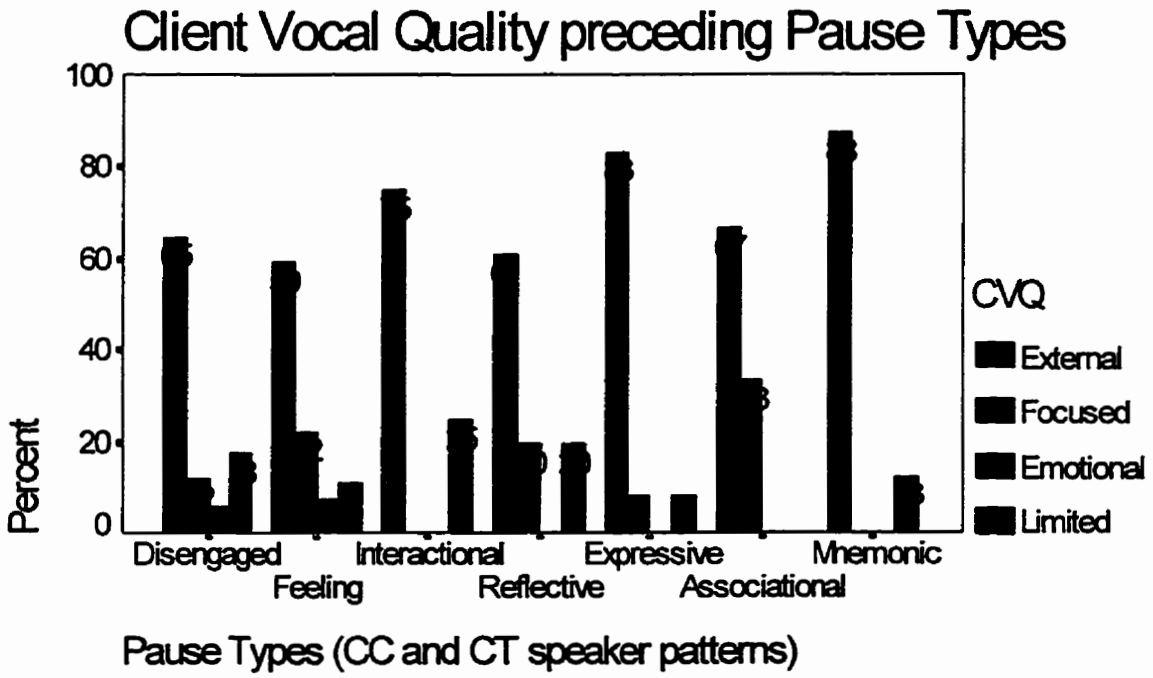
Client Vocal Quality Levels preceding Pause Types

	N(%) CVQ Distribution				
Pause	External	Focused	Emotional	Limited	#Pauses
Disengaged	11(65)	02(12)	01(5.9)	03(12)	17
Feeling	16(59)	06(22)	02(07)	03(11)	27
Interactional	06(75)	00(00)	00(00)	02(25)	08
Reflective	53(61)	17(20)	00(00)	17(20)	87
Expressive	20(83)	02(08)	00(00)	02(08)	24
Associative	02(100)	00(00)	00(00)	00(00)	03
Mnemonic	14(88)	00(00)	00(00)	02(12)	16

As with the Experiencing Scale used in this study, the Client Vocal Quality Scale only focused on client speech. Consequently, Chart 10 presents the modal ratings of the speaker patterns in which client speech preceded pauses (either Client-Client or Client-Therapist speaker patterns) and does not include those pauses that were preceded by therapist speech. Most of the pause types have a considerable proportion of pauses which are preceded by client speech (ranging from 49%-100%). However, as a large proportion

of the Interactional pauses (76%) were found within speaker patterns in which the therapist speaks before the pause (either therapist-therapist or therapist-client speaker patterns), the Interactional pauses preceded by therapist speech were also were examined. In these instances, the CVQ ratings of the client speech before the therapist speech prior to these pauses were examined. Although the therapist speech which did occur between the client speech and the pause could act as a confounding factor between the CVQ and the type of pause, it appeared that, as these speaker patterns were more representative of these pause types, it would be useful to examine these data in this study.

Chart 10



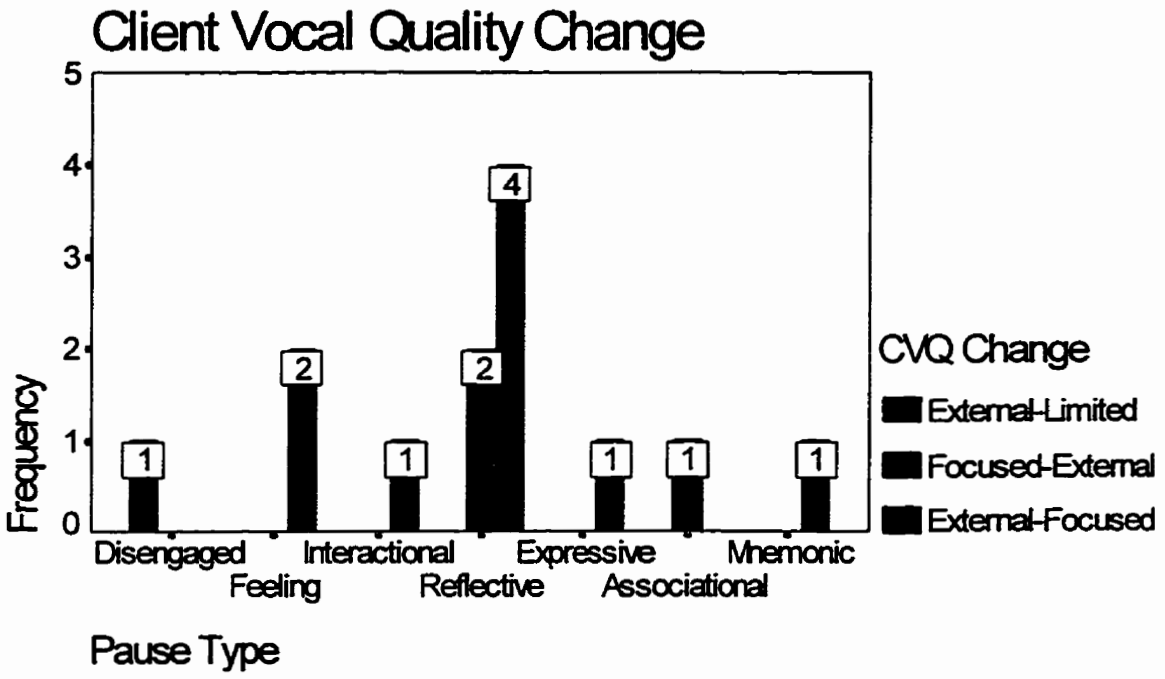
For the Interactional pauses, the client speech prior to the therapist speech preceding pauses were found within the limited vocal quality (69%) and the external vocal quality (31%). These ratings illustrated much higher limited vocal quality ratings than was indicated in Chart 10. When all types of speaker patterns were examined together, 59% of the Interactional pauses still occurred within the limited vocal quality pattern, more than of any other pause type. As the clients most often engage in Interactional pauses after a therapist speech, it can be useful to know that the limited vocal quality appears to be a useful marker of these pauses.

Overall, it appears that the limited vocal quality was most strongly associated with Interactional pauses, the Emotional vocal quality was most strongly associated with Feeling pauses (66% of pauses in Emotional vocal quality) and the Focused vocal quality was most strongly associated with Reflective pauses (63% of pauses in Focused vocal quality). The External vocal quality was dominant across all pause types, with the exception of the Interactional pauses when all pauses were considered.

To examine shifts in CVQ levels, the pauses which were embedded within client speech (Client-Client speech pattern) were examined. It was found that there was no change in Client Vocal Quality for 88.1% of C-C pauses assessed. Of the CVQ shifts which did occur (n = 14), nine were changes from External voice into Focused voice. These changes occurred after 2 Feeling pauses, 1 Interactional pause, 4 Reflective pauses, 1 Expressive pause and 1 Mnemonic pause. Three shifts entailed change from Focused

voice to External voice (two shifts occurred after moments of Reflective pauses and one after an Associational pause) and one shift from External to Limited vocal quality (after a Disengaged pause). Chart 11 depicts these findings. It appears that there was little change in CVQ after pause events within the sessions examined for the analysis.

Chart 11



Discussion

If language were liquid it would be rushing in.

Instead, here we are in a silence more eloquent than any words could ever be.

These words are too solid. They don't move fast enough to catch to blur in the brain that flies by and is gone.

And is gone, and is gone, gone, gone, gone. And is gone.

- Suzanne Vega (1987)

This chapter will first discuss the strengths and limitations of this study, followed by a consideration of the qualitative and quantitative findings in turn. Although these two sections will be presented in turn, an effort has been made to integrate findings from both analyses when commonalities have emerged from the research findings. The place of silence in psychotherapy will be discussed next followed by some suggested guidelines for clinical practice. Finally, I will present a section concluding this study and offering directions for future research on silence in psychotherapy.

Strengths and Limitations of the Study

This project combined quantitative and qualitative methodologies, creating challenges which shaped this project. One of the primary procedural differences between the two methodological approaches is the recommended methods of subject selection. A grounded theory analysis requires participants who are as different as possible as regards to the phenomenon being studied so that the theory which is developed can be as encompassing as possible. As such, the therapists who participated in my study are of

different ages, genders, levels of experience, and therapeutic orientations. The clients who participated are of different genders, ages, vocational status, socio-economic status, race and suffer from different degrees of depression. Although this is a strength in a qualitative analysis, it is detrimental when viewed from a quantitative experimental framework.

Although 2 clients were able to be interviewed from 3 of my therapists, it still is difficult to differentiate client-effect from therapeutic orientation-effect and it is impossible to differentiate therapist-effect from therapeutic-orientation effect as there was only one therapist practicing each orientation. As it can take a long time to find participants for a qualitative project of this sort, it was not possible to find the number of participants required to make this project conclusive in both designs. As well, it is difficult to conduct a qualitative analysis on a large number of subjects as the analysis is very labour intensive. Instead, the quantitative results must be viewed as exploratory and be interpreted cautiously given the limited sample size included in this analysis. However, as there has been no empirical research conducted on silences in psychotherapy as a heterogeneous phenomena, the findings from this study remain a significant contribution to the psychotherapy research literature.

The adaptations of grounded theory methodology allowed this study to best address the study objectives put forth. By leaving the pauses in category clusters instead of creating a higher-order core category, the findings help to elucidate the pluralistic

nature of pausing experiences. The sorting of the data into categories which emphasized psychotherapy process over content allowed for the creation of a data set which was appropriate for the research question at hand. The translation of these IPR interview results into a Pausing Inventory Categorization System was useful in order to explore the psychotherapy sessions and to develop theories for clinical practice and for future psychotherapy research.

This study makes a contribution to the growing body of research on the subjective track of the client (e.g., Angus & Rennie, 1989; Elliott, 1986; Rennie, 1994a; Rennie, 1994b) and continues to use the research findings to new ends. It has implemented the methods of Interpersonal Process Recall and of interviewing clients on their experience both which have been found in this literature to be particularly suited for the study of that which is unexpressed or covert within the therapy session and of the ways in which clients may exercise agency to negotiate the focus and depth of the therapeutic dialogue.

These methods of inquiry have been used to differentiate specific types of subjective experience in this qualitative analysis and this study continues on to relate the findings to session discourse characteristics. The connections found between the subjective processes and the discourse characteristics make it possible to conduct larger quantitative psychotherapy transcript analyses in the future, using the Pausing Inventory Categorization System Manual, and to bridge the two methodologies with more conclusive quantitative findings than this foundational project allowed. The

development of a process measure from a qualitative analysis may allow for the integration of processes associated with clients' internal track into research which otherwise could not consider the clients' experience. As well, this project illustrates the development of a process measure which originated in the empirical findings of client in-session experience. This is a novel derivation which contrasts with the theoretical foundations of previous therapy process measures (e.g., the Experiencing Scale, the CVQ) and is a methodological contribution to psychotherapy process measure research.

Qualitative Analysis

The most significant finding of this part of the study was the identification of different categories of pausing processes. This study provides empirical support for the view of pausing as a heterogeneous phenomenon, challenging the early notions of silence as a homogeneous sign of resistance. The grounding of pausing experiences is an improvement on typologies generated from therapists' assessment of their client pausing experiences (e.g., Benjamin, 1981). This differentiated perspective on silence in psychotherapy can be used to improve therapists' sensitivity to silences in their session and can be used to identify different pausing processes for research purposes.

Disengaged Pauses. Disengaged pauses occurred when clients engaged in the avoidance of difficult emotions or in shutting themselves down emotionally when exploration in the therapy session became too difficult. These pauses occurred often when clients felt uncomfortable with further disclosure in the therapy session.

There has been some previous research on client's reported experiences of defensiveness. In order to avoid threatening areas of discussion, clients described using stories to distance them from their emotions changing the subject to a more innocuous topic and withholding thoughts from the therapist (e.g., Rennie, 1994c; 1994b). As well, there is a large body of psychoanalytic and psychodynamic theoretical literature which focuses on silences as markers of defensiveness in sessions (e.g., Ferenczi, 1916/1964, Marshall, 1972; Zeligs, 1961). This study adds to this literature by offering empirical evidence of the link between a certain type of silence and client's experiences of disengagement, as well as identifying these Disengaged pauses as potential in-session markers for therapists to engage in inquiries about client defensive patterns.

Disengaging was identified as a main reason for pausing in 2 of the interviews. One client, who would use her silences to think of humorous ways to deflect her therapist away from focusing on her emotions, was able to identify that it was feeling uncomfortable discussing difficult subjects which caused her to be flippant. This client would use these pauses to exercise agency in determining the direction of the dialogue with the motive of maintaining a comfortable level of exploration.

The other client who used disengaged pauses frequently, felt that she avoided entering into feeling states in order to avoid sliding into a deeper state of depression. For this client, pauses seemed to happen spontaneously: when the emotional pain became too great during the session she felt her mind and body scrambled her thoughts in order to

halt her thinking about sensitive topics and to protect her from experiencing the pain.

This experience fell into the "shutting down" sub-category. There was a passive quality to this experience in contrast to the Avoiding category of disengaged pauses. There was a sense of loss of control over her process which the other clients did not seem to experience. These disengaged pauses seemed to be related to her feeling that it was not acceptable to be vulnerable. This was marked by her calling herself "*pathetic*" in the IPR interview when she listened to her own expressed sadness in the audiotaped therapy session and by her insight at the end of the IPR that she seems to blame herself for feeling depressed. Future research may focus upon whether there is a link between self-punitiveness around feeling negative emotions and deeper depressions. In this study it was found that strong negative reactions to sadness were expressed by the two clients who "disengaged" most often when they are confronted with emotional topics.

None of the clients described the process of disengagement in pauses in the theoretical terms which many psychoanalytic theorists utilize when discussing silence in psychotherapy (e.g., Arlow, 1968; Loomie, 1961; Nacht, 1964). They did not discuss their silences as regressions to infantile states, as connected with anal or oral eroticism and restriction, as states of indifferentiation from the therapist, or as a technique used either for self-punishing purposes or used to express aggression towards parents or the therapist. As this literature focuses on the origin and the interpretation of the client's experience rather than on the substance of the in-session experience, client's

interpretations of silences on this level were not the focus of this IPR study. It may be that clients in long-term psychoanalysis would have interpreted their experiences using these frameworks, but it may also be that the IPR setting is not conducive for interpretations of this type which can be both very personally disclosing and very intellectually abstract.

It seemed clear, however, that although clients experienced some silences as having defensive quality that most silences did not fall into this category at all. This study provides empirical evidence which supports the more modern psychoanalytic theorists who argue that all silences do not indicate resistance and regression but indeed are more varied in their meaning (e.g., Mertens, 1990). Additionally, as the psychoanalytic and psychodynamic literature on silence tends to focus on analysands who are unusually silent, this literature itself may not be representative of the origins of Disengaged pauses for most clients.

Clinically, the disengaging sub-categories, Avoiding emotion and Shutting down, can be quite difficult for therapists to distinguish from one another. It therefore may be important for therapists to ask clients about what they are experiencing in these pause moments in order to develop a detailed understanding of the intra-psychic processes by which clients disengage from focusing on threatening subjects. The analysis of disengaged processes, the emotions that motivate them, and the ways they serve the client may help a client to develop the ability to tolerate experiencing negative emotions.

Therapists may sense that clients are experiencing difficulty in these moments. This is the only type of pause which is dominant in the speaker-pattern in which the clients speaks, a pause occurs and the therapist continues (40%), so perhaps therapists are able to sense that their clients may require support to deal with a difficult emotion. This sense can be a useful in-session marker of these pauses.

Although these pauses are the most supportive of the traditional psychoanalytic perspective of silence as a resistance phenomenon (e.g., Freud 1912) and can provide the opportunity for the analysis of resistance in psychoanalysis, these moments can be very fruitful across different psychotherapeutic orientations as well. Humanistic therapies might invite clients to explore the ways they negotiate emotion in disengaged pauses so that they can be articulated and fully understood (e.g., see Greenberg, Rice & Elliott, 1996 on self-interruptive processes). Alternatively, cognitive therapists might find disengaged pauses to be rich sources of client critical self talk, perhaps directed at clients' own internal experience of emotion or pain. An analysis of these dynamics seems to be congruent with many therapeutic orientations.

Feeling Pauses. Feeling pauses were moments in which clients either experienced emotions or moved deeper into an emotional state. The very experience of being encouraged to attend to emotions was described as a positive experience and clients described the feeling pauses themselves as very powerful moments.

As clients reported having a sense of "something deeper" allowing them the time

to orient themselves in relation to this can be fruitful and may lead in directions difficult for a therapist to predict. This sense is thus highly similar to, if not identical with, the "felt sense" that clients use to guide their inner exploration in Gendlin's (1978) Focusing technique. The present study focuses on moments throughout therapy in which clients are so deeply emersed in emotional experience that they need to break off the dialogue with their therapist, regardless of whether a Focusing task has been initiated. This can allow for the studying of moments of emotional intensity across various therapeutic tasks and orientations.

As clients appeared to find these pauses so beneficial, it appears important for therapists to allow clients to have these moments without interruption. In the sessions analyzed in the present study, these pauses tended to occur most often after client speech (75%) and usually are followed by client speech (53%). In teaching fourth year undergraduate students therapy skills, however, I found that "tolerating silence" was experienced as one of the most difficult tasks for beginning therapists. During pauses therapists may need to cope with the anxiety of losing contact with the client as well as the anxiety rooted in a need to rescue clients from negative emotion. Consequently, it was reassuring that the participants in this study expressed very favourable reactions to these silences regardless of whether they were experiencing positive or negative emotions in Feeling Pauses. This finding can be used in training to reassure novice therapists who may feel uncomfortable focussing clients on difficult emotional experiences.

Interactional Pauses. Moments in which clients focused upon the demands of communicating with their therapists, tried to understand a therapist task or comment and tried to manage their impression or emotions to safeguard the therapeutic alliance were classified as Interactional Pauses. The Interactional pause type appeared to be most supportive of the representations of pausing experiences in the theoretical literature of group therapists (e.g., Strayhorn, 1979; Lewis, 1977) which emphasizes the interactional nature of pauses in psychotherapy and the reactions clients may have to therapist or group processes.

In terms of Rennie's (1994c) article on clients' accounts of resistance, Interactional pauses would correspond to "external upsets," which occurred when the therapist activity was disjunctive from a client's experiences, as opposed to "internal upsets" which occurred when clients experienced distressing thoughts or emotions. In the Pausing Inventory, internal upsets would tend to correspond with Disengaged pausing experiences. Rennie (in conversation, July 1998) noted that these moments in therapy sessions often appeared to be marked by moments of silence.

These pauses, when the clients are thinking about their interaction with their therapists, are among the most difficult in therapy. Clients often described them as uncomfortable and awkward moments. The most worrisome of these pauses appeared when therapist tasks were unclear or when clients were upset about their therapist's comment. The client and therapist experiences could become completely incongruent.

At times the client was found to misrepresent personal experience in order to avoid threatening the alliance by questioning the therapist's direction. Rennie's (1994b) article on client deference in psychotherapy supports the finding in this study that clients are very reluctant to question or oppose their therapists. In his analysis of the experience of an hour of psychotherapy, the clients interviewed said that they were reluctant to question or challenge their therapists. Instead, clients would try to make allowances for their therapists, complying with them and trying to understand their perspectives, even when they conflicted with their own experience. Similar findings were found in research on clients' experiences of disjunction in problematic reaction resolution tasks (Watson & Rennie, 1994). Clients would tend to allow their therapists to set the focus despite feeling that the therapists' line of inquiry was impeding the exploration. Metacommunicative probes into the client experience are recommended in the literature as ways to explore these moments in therapy, however, a positive alliance appears to be crucial in order to create an environment in which clients will feel comfortable disclosing discomfort in response to these probes (Rennie, 1992; Rennie, 1994b; Rennie, 1994c; Watson & Rennie, 1994).

This study adds to this literature by suggesting that Interactional pauses may function as markers of these experiences and by suggesting discourse characteristics which can aid in the recognition of these pauses. Since they may be the only cues that a client is not understanding a task, or is being deferential in providing what appears to be

the "correct response," these pauses may be important for therapists to learn to recognize. It may be particularly important to check with clients about pauses after therapeutic interventions which are task focused. Interactional pauses can act as markers to indicate that the client either is having difficulty understanding the task instructions or is having difficulty because the therapist is not attuned to the client's experience. As indicated by the high correlation between the number of interactional pauses and the number of questions asked by the therapist in a session ($r = .90$), this can be particularly difficult for clients of therapists who are following a step-by-step process or exercise protocol who may soon learn what next step or answer is supposed to follow each question.

Although these pauses are difficult, they can be managed well and may in fact become very fruitful parts of therapy. One such pause occurred in a session where the therapist made an interpretation that the client didn't like and the client immediately told the therapist that she felt uncomfortable with the interpretation. The therapist and client then were able to discuss the issue and resolve it successfully, not only maintaining a strong alliance but explicitly developing a shared understanding of the role of interpretations in therapy. It has been suggested that clients experience the therapeutic alliance as an important factor in whether the client is comfortable discussing and resolving misunderstandings (Rhodes, Hill, Thompson & Elliott, 1994). Clients who did not experience a positive relationship with their therapist tended to withhold their concerns or criticisms and so misunderstandings were often not resolved within the

session.

As well, these results indicated that clients can often be uncomfortable with therapist silences which feel unstructured, disapproving or ambiguous. This supports theorists such as Spinal (1984) and Lewis (1977) who described types of therapist silences as being very anxiety provoking for clients. As well, it supports Stone, Karterud and Stones' (1994) concern that therapists' silence may provoke strong negative feelings in clients, written in response to the Rutan and Alonso's (1994) article which suggested that therapists remain silent in session as a method of dealing with their countertransference reactions.

If clients are given explicit permission to discuss their reactions to therapist comments and request, they may be more likely to decide to share their reactions with their therapists. Clients appear to need to be encouraged throughout therapy to express their feelings about their therapists, particularly after Interactional pauses, as even in the context of very strong alliances this can be experienced as very threatening. If the experience of a moment of disjuncture is shared, the ensuing discussion could address issues such as task formulation and the purpose of therapy. As well, in psychoanalytic or psychodynamic therapy orientations, therapist inquiry into these moments can provide useful material for transference analyses and for discussion about clients' interpersonal responses to conflict.

The long duration of these pauses is a distinguishing feature which can aid

therapists in their identification (mean of 11 seconds). These pauses most often occurred after the therapist said something which was experienced as unsettling or unclear (50%), were followed by a long silence and then, as the client was confused or lost in trying to contemplate an appropriate response, were followed by the therapist again. The sense of having to clarify responses or of having to "save" clients after a pause could be a useful marker that an Interactional pauses may be occurring and the therapist may wish to inquire about the client's experience of those moments.

When clients' concerns were addressed, they were able to go deeper into the nuances of an issue and to begin to identify the ways they held themselves back from exploration or growth. On the other hand, when therapists simply continued to push clients in an uncomfortable direction, clients at times ended up falsifying their experiences or half-heartedly supplying the "correct" responses. This could become a very dangerous threat to the therapeutic alliance and sense of purpose in therapy. It seemed that interactional pauses could be either detrimental to the therapy or highly productive, depending on how they were managed by the therapist. The issues of communication and alliance appear to be key.

Reflective Pauses. Pauses which were characterized by clients engaging in activities such as questioning, developing an awareness of an issue, making connections between ideas and reaching realizations were classified as reflective pauses. The processes which occur in Reflective pauses mirror those processes which occur within the

Reflexive narrative process in the Narrative Process Coding System (Angus, Hardtke & Levitt, 1996). These pauses also appear to be the pause type which best corresponds with the cognitive/information processing model understanding of pauses as moments of meaning-making requiring attention (e.g., Perfetti & Papi, 1985).

Reflective pauses appeared as the most frequent type of pause in all but one of the therapy sessions which I examined. This finding supports Rennie's (1992) designation of "client's reflexivity" as the core category in his grounded theory study on client's experiences of a psychotherapy session. Although this core category encompasses many processes and observations which would fall outside of those within the reflective pausing category, the designation of reflexivity as the major characteristic of the psychotherapy experience is supported by this higher order cluster of categories; similarly is his description of reflexivity as a covert process which may remain unexpressed in the session (Rennie, 1998a). The present study adds to this literature by focusing on those moments within the discourse in which clients' attention is so deeply engaged in a reflexive process that the clients disengage from the therapeutic dialogue in order to fully attend to their thoughts and by distinguishing these moments from other silent processes. The identification of these pausing moments can allow one to track the more intense moments of reflexivity within the session.

As clients described these moments as being very productive, it seems best for therapists to allow clients to enter into reflective silences and to encourage them to enter

into these moments when they do not do so spontaneously. An important marker of clients' reflective engagement may be the lack of eye contact with the therapist. The Focused Voice from the Client Vocal Quality Scale (Client Vocal Quality Manual, Rice, Koke, Greenberg & Wagstaff, 1967), is described as "eyes turned inward" capturing the sense of the reflective pauses, which were the pause type most associated with the Focused voice.

Although these pauses most frequently occurred as breaks within client discourse (35%), indicating that spontaneous reflection often occurs, therapists may want to reassure clients explicitly that they should take their time if moments of reflection appear to be cut short. One client described feeling uncomfortable when she made her therapist wait while engaged in a Reflective pause. She was unsure whether or not it was reasonable to expect her therapist to wait for her to contemplate an issue and so reported ending a Reflective pause before she was ready. Encouraging clients to take their time in looking inward, to find what feels important about an issue, or to see what comes to mind when they are thinking of an issue can be important processes which give clients permission to explore an issue at their own pace. As much as this may be suggested by the therapeutic style of the therapist, it still may be best if made explicit at critical points of reflection within the session.

Expressive Pauses. Expressive pauses occurred when clients took time to attempt to articulate experiences or ideas more clearly or when attempting to name a feelings.

Both the category "speech acts" in the Watson and Rennie (1994) analysis of clients' experiences of resolving problematic reactions and the Focusing step, finding a "handle," described by Gendlin (1996), describe similar expressive processes. In each of these processes, clients try to find words or phrases which can best symbolize their felt experience.

In these dyads, the process-experiential sessions were found to have the highest percentages of Expressive pauses (22% & 23%), the therapy which is most influenced by Gendlin's experiential method of Focusing. The findings of this study suggest that there may be something about the therapist acting within this therapeutic modality which encouraged a higher frequency of these pauses as they were not as common in the other therapists' sessions, although the therapist and therapeutic modality cannot be distinguished in this study.

This study also identified different discourse characteristics of these pauses. They largely occurred within client speech (77%), and appeared to be marked by the client's initial articulation of an experience, a pause and then either a change of wording to capture the experience more accurately or an expression of failure to better represent the experience. In the main, Expressive pauses largely seemed to have a productive impact upon clients' exploration. When carefully evaluating the words they chose to describe their experience in sessions, clients found ways to represent their experience more accurately to their therapists as well as to themselves. For instance, one client described a

pause in which she was about to represent herself negatively but then reassessed her choice of words and found a more positive way to describe herself.

There may, however, be somewhat of a self-critical or anxious component behind some Expressive pauses, as represented by the clients' need to evaluate the words they choose. Although this use of Expressive pauses did not seem to predominate in any of the clients' therapy discourse included in this study, there were some pauses which seemed to result from an anxious self-scrutiny in which clients felt concerned that they were losing control when they could not find the right words with which to express their experience.

In a pilot project for this study, an analysis was undertaken of silences in one good and one poor short-term process experiential dyad (Levitt, 1996). Using a precursor to the Pausing Inventory Categorization System, Expressive pauses in psychotherapy session transcripts were identified by means of markers similar to those listed in this study. The client in the poor-outcome therapy was found to have a predominance of Expressive pauses. This client appeared to have a style of second-guessing himself, focusing on his self-presentation and editing his speech as he spoke throughout his therapy sessions. The findings from this pilot study may indicate that an individual's expressive style or level of anxiety may influence the number of Expressive pauses. There were no reliability estimates on the ratings from this pilot project so these suggestions can not be considered conclusive. Future research may explore, however,

whether there is an optimal level of Expressive pauses beyond which these pauses are more indicative of anxiety than clients' attempts to experientially guide their discourse.

If a client seems to be self-monitoring to an excessive degree, the therapist might wish to check to see if self-monitoring is an issue that the client feels merits further examination in therapy. If the client is engaged in the more productive form of this process, the process of searching for the best label for a felt experience, it may be beneficial for the therapist to encourage such an exploration, or even to model it by helping to search for the label slowly with reference to their own internal processes. As in a Focusing exercise (Gendlin, 1996), it can be important to allow clients the time they need to locate the symbol which best represents their experience. If clients have difficulty with this process, therapists may wish to engage in a more intensive Focusing exercise and assist clients to explore their bodily sensations and mental imagery to locate a suitable experiential label.

Associational Pauses. Associational pauses occurred when clients would change from one topic to a different topic within the therapy session (n=3). There were only a few of these pauses in the sessions analyzed. As such it is hard to comment on their function in therapy. They may indicate that a client is finding it difficult to continue discussing one topic for long enough to develop a deeper exploratory process. Rasmussen and Angus (1996; 1997) examined the therapy sessions of Borderline clients and found that, as compared with neurotic clients, they tended to switch topic abruptly

during sessions. A string of Associational Pauses would characterize this type of process.

Although pauses often are located at topic segment shifts, which occur when a new topic or new facet of a topic is introduced (as indicated by the Narrative Process Coding System), these pauses are usually not Associational Pauses. Generally these pauses would be classified as Reflective pauses which result from going deeper or making connections between issues.

A difficulty in classifying Associational pauses is that although raters can identify them, clients have difficulty describing these moments in IPR interviews. If a client stopped discussing a topic such as "Mother's operation", paused, then proceeded to the topic "Brother-in-law's casserole," it was unlikely that the client would describe the process of "switching gears" - the quality of the pause. Instead the clients were more likely to say that in the pause they thought of the casserole and how they enjoyed it, without referencing the switch. The process of "switching" is a subtle process that is either not seen as being evident in the discourse and not worthy of comment, or is not recognized by the clients as a process in which they are engaged. When processes of shifting from the initial topic were recognized, they were acknowledged by sentences which indicated a dismissal of the old topic. Then the client would go on to discuss the new topic.

The Associational pause category was included in this version of the Pausing Inventory Categorization System in order to be as inclusive as possible. In the future,

however, it may be best to remove this category from the Pausing Inventory Categorization System. As clients were not able to describe explicitly the process of switching topics and only rarely described the process of new ideas emerging, this pausing process did not appear to be very salient in the clients' experience.

Under further examination, this category may become a sub-category of Mnemonic or Disengaged Pauses. Associational pauses, from a psychodynamic perspective, can be seen as switches from one topic to another which are motivated by avoidance. Alternatively, however, they may also been seen as moments in which clients suddenly remember something important that they wanted to discuss. As clients did not overtly discuss avoidance when discussing these pauses, as they did when discussing the disengaged pauses, these pauses would seem to best fit under the rubric of Mnemonic pauses. The idea of an emerging idea may best be thought of as a memory process (e.g., a client remembering a new topic she wanted to discuss in session).

Mnemonic Pauses. The experience of clients trying to recollect events or details has been addressed in a few studies of clients' in-session experience. Watson and Rennie (1994) describe recollection as a process which helps clients examine situations and check their feelings. Rennie (1994a) describes client recollection of telling stories in therapy as a process which can allow clients to re-experience events while avoiding the potential threat of expression. This study focuses on silent moments of recollection and articulates some of the discourse characteristics which distinguish Mnemonic processes

from other types of pausing.

Mnemonic pauses were most common in one of the therapy sessions of the IPT therapist (31%). It may be that her orientation -- focusing on finding interpersonal patterns may call for these types of pauses in searches of past interactions. These pauses have a clear purpose: clients required time to retrieve details about events, memories or other information.

Occasionally mnemonic pauses may be caused by defensive forgetting. For instance, one client, who had difficulty discussing emotion, forgot what she was talking about after her therapist made an incisive interpretation. Generally, however, it seemed that clients would relay what they recalled and there was little need for therapists to inquire after these silences in the session. Instead, these were usually moments in response to therapists' inquiries for information (45%) in which clients engaged in strategies to attempt to recall details or events which were then promptly conveyed. In cases where mnemonic silence seems to be generated by anxiety about emotion, or if there are many such silences, therapists may want to note whether there are patterns in the content or context of this forgetting and then draw their clients attention to this process.

Process Measure Analysis

Duration of Pauses in the Therapy Dyads

The length of pauses in each session was found to be vary substantially, in accordance with the different therapists acting within their preferred therapy orientations.

The average duration of the silences was highest in the cognitive therapists' sessions (9.01 seconds). These silences were much longer than those found within any other sessions examined (range 2.4-6.7 seconds), although this study cannot differentiate whether this may be more likely due to the effects of therapist or therapy orientation. Contributing to this result was the large number of interactional pauses (the type of pause with the longest mean duration), occurring most frequently in the two cognitive dyads.

Another factor which may have increased the length of a few of the silences in the second session was the therapist's request that the client record thoughts in a thought record during the session. Writing-silences were removed from the analysis, however it is possible that there could have been a few "writing" pauses which were not discernable in the sessions. Since the other cognitive session, which did not have any "writing" pauses, was also characterized by pauses which were quite long (mean of 8.4 seconds), it is likely that the effects of any over-inclusion that may have occurred were minimal. As this study only examines one therapist from each therapeutic orientation, it is important to remind the reader that therapist and therapeutic orientations are inseparable in this study, so interpretations should be made cautiously.

The tasks in the cognitive therapy sessions seemed to require more lengthy reflection from clients than the "tasks" in the client-centred, interpersonal or process-experiential sessions. It may be that the more formulaic nature of the tasks in this therapy gave clients cause for longer pauses, whereas in the other therapy sessions, clients were

asked to make sense of their immediate experience or to explicate internally felt emotion. In the cognitive therapy sessions, clients were asked to engage in tasks which required them to move beyond their immediate experiences in order to evaluate and reflect on the meaning of those experiences using a cognitive model. For instance, a task completing a thought record may take longer to complete as it requires the clients to shift away from their immediate experience in order to formulate their experiences into equation-like understandings. In the other therapy sessions, clients tended to work with their immediate experience and their sessions had briefer and fewer interactional pauses.

The findings of this study did not support previous research which has suggested that silence in psychotherapy is associated with the beginnings of sessions (Becker, Harrow, Astrachan, Detre & Miller, 1968; Wepfer, 1996). These two studies examined silence in group and psychoanalytic psychotherapies respectively. In this study, a positive correlation of .40 was found between pause length and the ordinal number of the pause within that session, indicating that longer pauses tended to occur later in the session. Research will be required to indicate whether the different findings are products of different therapeutic orientations.

Number of Pauses in the Therapy Dyads

There was great variance in the number of pauses across the therapy sessions evaluated in this study. The client-centred session had many more pauses than the process-experiential sessions, the other humanistic therapy. It had almost as many pauses

(79) as the cognitive sessions (81 and 88), although their mean length (5.9s) was briefer than those in the cognitive sessions (8.4s and 9.9s), being within the range of the pauses in the other therapies. As one might expect in this type of therapy, the therapist in this session had a reflective intervention style and often moved the client to focus on emotion. As well, this client was the most profoundly depressed client included in this study and had the slowest response style, being likely to become tearful or sad during the therapy discourse. These two variables might have interacted to produce the high frequency of pauses within this session.

Pausing Processes in the Therapy Dyads

It is striking how the frequency of Reflective pauses is higher than any other type of pause across all but one of the sessions (an IPT session) included in this study. As Reflective pauses are characterized by reflexive processes, this finding supports the idea that reflexivity is the key or central task in therapy (see Rennie, 1992; 1998a). An interesting future study could compare these results with an analysis of the types of pauses which tend to occur in conversation to see whether reflexivity is the central task of pauses in colloquial discourse as well.

Both therapists who had two clients who participated in this study had one client with a high proportion of Disengaged pauses and one with a low proportion of Disengaged pauses. The frequency of disengaged pauses in sessions therefore appears to be a client characteristic (see Chart X). This finding is not surprising, as individual

clients enter therapy with very different ways of dealing with anxious or stressful experience. In future studies, it could be useful to examine disengaged pausing in clients suffering from different types of clinical disorders, to see how different types of clients deal with difficult emotional moments in therapy and how therapists manage to successfully deal with disengaging processes.

Other pauses seem to be more of a therapist or therapy characteristic, such as Expressive, Feeling, and Mnemonic pauses. Expressive pauses in this study seemed to be most common in the therapy of the PE therapist (22% and 23%). These pauses seem to occur most frequently when clients are being asked to articulate novel experiential information. The use of PE chairing exercises, in which clients speak as different parts of themselves, pulls for clients to express themselves in novel fashions, and they often need to pause to find the words that best fit the new voice they are expressing.

Mnemonic pauses occurred most commonly in one of the interpersonal therapy sessions (31%), which has a psychodynamic influence and asks clients about the connection between their current experience and their past history.

Interactional pauses seemed to occur most often within the cognitive therapists' psychotherapies (12% and 22%). This may be due to the task-focused nature of this therapy and the question-answer style of the therapist in which clients described feeling that there were correct solutions to tasks that they were meant to understand and provide. Although the PE modality is task focused and the therapist in the dyads examined here

engaged clients in tasks as well, the element of expectation of success was not discussed in the same way by the PE clients. This may be due to the fact that PE tasks are embedded within a client-centered style of interaction, so that the tasks are motivated by clients' emotional concerns instead of by the therapy goal of teaching specific interventions to the client. The relevance of the PE tasks to the client's immediate experience, may be responsible for the absence of interactional pauses in the PE therapy sessions in spite of a task driven therapeutic orientation.

Pause Type and Pause Duration

The pause types appeared to be associated with different durations of silence. Interactional Pauses were the longest types (11 seconds) with the other pauses ranging between 5 and 8 seconds. It may be that these pauses are so lengthy because they can call for the client to make judgements about whether they are willing to disclose their thoughts about the therapist to the therapist. Wepfer's (1996) finding that longer silences often follow interpretations may be suggestive of interactional pauses where clients are trying to negotiate remaining congruent to their experience without threatening the therapeutic relationship.

Another process that occurs is that clients can begin to become self-conscious of the silence they are engaged in. One client described a cycle in which she becomes increasingly concerned with her difficulty articulating her experience which raises her self-consciousness to the point that anything which was previously formulated begins to

disintegrate. This immobilization would freeze this client when a pause went beyond a certain duration, similar to the long group therapy pauses described earlier (see Lewis, 1967).

As clients often attempted to protect the therapeutic alliance, it was difficult for them to express themselves when their thoughts towards their therapist were antagonistic. Clients would often describe checking themselves to see if negative feelings that they felt were indeed directed to the therapist or should be directed towards themselves. It seemed very threatening for clients to describe negative feelings about their therapists' interventions and clients would often analyze them internally, or just contain them, rather than risk harming the alliance through their expression.

Clients may continue with a series of tasks, being resistant the entire way through. Two clients described still being undecided on whether or not they wanted to engage in tasks well after these tasks had been initiated. The processes of analyzing and deciding how to deal with thoughts about the therapist can be lengthy and recurrent; indeed the pauses which they generate appeared to be marked by their duration and persistence throughout a task.

Speaker Patterns

Speaker patterns can be particularly useful for identifying different pauses for future transcript ratings. These patterns reflect the speaker before each pause and the speaker after each pause. Associative shifts are by definition Client-Client (CC)

patterned pauses, as these are pauses in which clients suddenly shift from one content area to an unrelated other content area. The next strongest pattern found was Expressive shifts, which also tended to be pauses within client speech (CC; 77%). Feeling and Reflective pauses also tended to be CC pauses (53% and 35%, respectively). These three types of pauses, most often found in CC monologue, are the ones which were considered to be the most productive types of pauses in psychotherapy. Therefore much pausing within CC speech may be seen as suggestive of the productive use of silence in a session.

Disengaged pauses were most often found within Client-Therapist patterns of speech (40%). These pauses were followed by therapist speech more than any other type of pause (66%). It would seem that clients begin approaching difficult subjects and stop as their anxiety peaks. It may be that the therapists then note that the client is pausing due to a heightened level of anxiety and then intervene in order to provide direction or support to the client.

Mnemonic pauses were most frequent within Therapist-Client speech patterns (45%). These typically occurred when the therapist asked the client to recall an event or a detail and then the client would need to pause to retrieve the information. They were generally found to be followed by client speech (83%), even if the pause was stimulated by the client.

Interactional pauses occurred most often following therapist speech (76%) and followed by therapist speech (50%). Often this occurs when a therapist explains a task,

and then waits for the client to respond. If the client does not understand the task, does not agree with the task or has a conflictual reaction to the therapist, the client does not respond and instead silently tries to decide how to best respond. The therapist then would try again to explain the task, to engage the client, or to find out what is happening. If the client speaks first then a TC pattern would result, which is the next most common type of speech pattern for this pause (26%). The therapist appears to be the stimulus for this type of pause in either case, which corresponds to the nature of these pause as being one in which the client considers the therapist or their interaction with the therapist.

Pause Types and NPCS Sequence Types

The pauses identified in these sessions are all most frequent in Reflexive narrative sequences, with the exception of Mnemonic pauses. As it is when clients are describing an event or a story that details are likely to be recalled, these pauses are most common in External narrative sequences (48%). This association may be a useful marker for the identification of Mnemonic pauses, which comprise 21% of the pauses in the External narrative sequence types, although, as the Reflective pauses were most frequent in all narrative sequence types (47% of the pauses in the External narrative sequence type, 36% of pauses in the Internal narrative sequence type and 53% of pauses in the Reflexive narrative sequence type), it by no means should be considered a certain indicator.

The pause types which appear to be most strongly associated with the Internal narrative sequences are the Expressive and Feeling pauses, both of which are located

within this sequence type approximately one third of the time (31% & 31%). Both pause types require the client to look inward, one to find a symbol and the other to experience a feeling.

As 90.1% of the NPCS codes which preceded a pause tended to continue past it, a pattern of stability in NPCS sequence type appeared to be associated with the pauses rather than a pattern of change. This finding is consistent with a view of pauses as moments in which an internal process becomes so powerful that a client has to briefly withdraw from interaction. For instance, if Feeling pauses are the moments of deepest emotional experience, it is likely that these powerful moments would evolve from within the context of an emotional dialogue. Similarly, if this is the case, one would expect these pauses to lead to a continuation of the dialogue in order to integrate or make sense of this deep experience. As a result, it is more likely that pauses would occur embedded within one narrative sequence process if pausing is seen as the height of processing.

Pauses appeared to have an association with shifts in Topic Segments and Narrative Sequences, occurring at approximately one quarter and one fifth of the shifts in the narrative discourse respectively. This finding provides some support for the use of these pauses as markers for shifts in Sequences and Segments as outlined in the NPCS manual (Angus, Hardtke & Levitt, 1996). Although most pauses are not associated with shifts, many shifts which occur seem to happen near pauses.

Pause Types and Experiencing Scale Ratings

Mnemonic Pauses and Disengaged Pauses were found to be predominantly rated at Experiencing modal level 2 (56% & 47% respectively), which is a level of discourse in which clients are speaking on intellectual or behavioural terms about their experience. This is a more superficial level of discourse and indicates that these pauses generally are not associated with high levels of processing.

Interactional pauses and Reflective pauses were most frequently found at level 3 (75% & 41% respectively). Level three scores often represent the discussion of emotion in behavioural terms or as a symptom. Although the topic of emotion may have been introduced into the discourse, the emotion was not focused upon or experienced. In the transcripts where Interactional pauses were experienced after discourse which was rated at level 3 it was frequently found that emotion was addressed on quite a superficial level. For instance, the following transcript segment would receive a level 3 Experiencing Scale rating.

C: My feeling is that I can't do that
T: That's a thought right?
C: That's a thought
T: So does that generate any feelings like hopelessness, or pessimism, or discouragement, or depletion,
C: I'd say discouragement,
T: anxiety (p:04) And the thought is, I can't...
C: I can't work full time.
T: Ok, any other thoughts that go on?

Because the client's emotion has been invited and then misunderstood, the client may be at more risk of feeling frustrated at the therapist, causing Interactional pauses which may be more likely to occur at these moments and hence be associated with an Experiencing level of 3.

Feeling and Expressive pauses seem to be almost evenly divided between levels 2, 3 & 4 indicating that these pauses may reflect greater client emotional involvement in the therapy discourse. Level 4, which indicates a shift from a focus on stories or thoughts to a more concentrated focus on emotions, was most strongly associated with Reflective, Expressive and Feeling pauses (comprising 31%, 28% and 25% of the pauses at these levels, respectively). It appears that dialogue about emotion tends to elicit pausing processes of these types, wherein clients either symbolize, reflect upon or experience emotional states. This association supports the clients' descriptions of these moments as powerful and important in their therapies.

Level 5 is the level at which clients move from focusing on an emotional state to questioning the meaning, evolution or purpose of that state. Reflective Pauses were most strongly associated with this level (comprising 75% of the pauses at level 5). During these moments clients would try to explore experientially-referenced questions. This level is the beginning of "high" Experiencing and it is from this questioning that clients move towards integration and insight, so although it did not occur very often, the appearance of this level marks an important transition in this model. In terms of future research, it

might be of interest to examine changes in high-Experiencing Disengaged pauses, the one disengaged pause that followed discourse rated at a level 5 in this sample was immediately followed by discourse rated at level 2, perhaps providing evidence of the process of disengaging from a threatening topic.

As with the NPCS results, it seems that after a pause Experiencing levels tend to remain as they were or similar to the way they were before the pause. As with the NPCS, this supports the idea that pauses tend to occur within the middle of a process. As well, it would be of interest to conduct a study with a larger number of Associational Pauses to see if these would be associated with a greater number of shifts in processing.

Pause Types and Client Vocal Quality Ratings

External vocal quality was found to be the dominant vocal quality across all pause types (with the exception the Interactional pauses if all speaker patterns are considered). This vocal quality has the very regular and even pace which characterizes story-telling (e.g., "I went to the beach yesterday. I ran outside and played volleyball with my friends."). There is evidence that an Externalizing voice is associated with relatively unproductive therapy (Butler, Rice & Wagstaff, 1962; Rice & Wagstaff, 1967). It appears that, as this vocal quality is the norm in the sessions examined, the productivity of pauses may be best associated with the degree of deviation from the External vocal quality.

In terms of Client Vocal Quality, it is the Client Focused voice category which

has been associated with favourable outcome in psychotherapy (Butler, Rice & Wagstaff, 1962; Rice & Wagstaff, 1967). Focused vocal quality communicates a sense of introspection by its dysrhythmic and uneven pace with pauses in unexpected places (e.g., "I think - - - that this might - - - it might feel different"). In this study, Focused vocal quality was found to occur most frequently in relation to Reflective Pauses (63%) and Feeling pauses (22%). Future research may examine whether these pause types are associated with productive therapy outcome, as is Focused vocal quality.

Emotional vocal quality was most strongly associated with Feeling pauses as well (66% of pauses in the Emotional vocal quality). The Emotional client vocal quality may be a useful marker to indicate Feeling pauses, although if there is a sudden change in vocal quality after the pause, the pause may indicate a Disengaged pause in which the client was experiencing emotion, but then used the pause to moved away from this experience. The one disengaged pause that followed Emotional vocal quality speech in this sample was immediately followed by discourse rated as having Focused vocal quality, perhaps indicative of the process of moving away from difficult emotion. It might be of interest, in future research, to examine changes in vocal quality after Disengaged pauses.

In this examination of Interactional Pauses in Client-Client and Client-Therapist speech patterns, these pauses appeared to be most associated with External vocal quality (75%). As these pauses were found to generally follow therapist speech, however, the

examination of this pause type was extended to consider Therapist initiation pauses. When pauses were examined in relation to all speech patterns, Interactional pauses were the only pause types which were not strongly associated with External vocal quality but were found predominantly in the Limited vocal quality (59%). This vocal quality is characterized by a lack of energy and tends to sound as if the speaker has a constricted voice, with a reedy or nervous quality. As this pause type indicates "uncertainty" over tasks, or puzzlement over therapist actions or meaning, it is not surprising that this uncertainty is reflected in the clients' vocal quality. The clients experiencing interactional pauses described being insecure about their interaction with their therapist and the Limited vocal quality category appears to be sensitive to this state. Limited vocal quality client speech, followed by a therapist speech and then a pause, may be a useful marker of Interactional pauses.

In terms of the session analyses, it was found that the occcurence of shifts in CVQ categories are not frequent (88.1% of CVQ ratings remained constant after a pause). As with the other process measures, this constancy may be due to the tendency for pauses to occur when clients are in the middle of (or at the height of) expressing, contemplating, or feeling and need a moment for a deeper level of processing.

A Summary of the Process Measure Findings

When considering the combined results of the three process measures, pauses which appeared to be less associated with productive psychotherapy processes included

Disengaged pauses and Interactional pauses. Interactional pauses were associated with the Reflexive narrative sequence type, with Limited vocal quality, which has been linked to poor therapy outcome (Rice & Wagstaff, 1967), and with the lowest levels of Experiencing of the different pause types. Disengaged pauses were associated with External vocal quality and low Experiencing Scale scores and with NPCS shifting (23%), suggesting that these may not be occurring at a deep level of any one type of processing.

Mnemonic and Associational pauses appeared to be more neutral, although it is difficult to interpret the process measure ratings of the Associational pauses as these pauses occurred so rarely in this analysis. Mnemonic pauses appeared to be associated with low Experiencing Scale scores, with External vocal quality and were most frequently found within the External narrative sequence type.

Across the three psychotherapy process measures, it appeared that the Feeling, Reflective and Expressive pauses were indicators of high processing or emotionally referenced processing. Reflective pauses were most associated with Reflexive narrative sequences, levels 4 and 5 on the Experiencing Scale, and Focused client vocal quality which has been linked to positive therapeutic outcome (Rice & Wagstaff, 1967). Feeling pauses were associated with Internal narrative sequences, level 4 on the Experiencing Scale, and Emotional and Focused client vocal quality. Expressive pauses were associated with Internal narrative sequences and level 4 on the Experiencing Scale. These results endorse the view of these three pausing types as productive processes

within psychotherapy.

These process measure findings presented empirical evidence for the conceptualizations of distinct pausing experiences as derived from the qualitative analysis. The findings supported the clients' experiences of the Reflective, Expressive and Feeling types of pauses as important moments in their therapies. As well, the associations made between pause types and process measures can be used to assist in the recognition of session discourse markers of the various pausing types in order to aid in their identification for future research projects.

The Place of Silence in Psychotherapy

Based upon the IPR interview and therapy session analysis results, it would appear that three types of silences, Feeling, Expressive, and Reflective pauses, may be associated with highly generative moments in psychotherapy. They are moments in which clients described achieving profound emotional experiences, symbolizing those experiences, and proceeding to make meaning of their experiences. In an idealized framework, they may be viewed as occurring within a cyclical pattern wherein the client moves from a Feeling Pause to an Expressive Pause to a Reflective Pause and then onto a new Feeling Pause again, learning to experience, articulate and then understand one issue after another. In psychotherapy, however, clients would be expected to move back and forth between these pauses in order to overcome their anxiety and the blocks that prevent each next pausing experience.

If we envision psychotherapy as a journey into the depths of the client, and we view the psychotherapy narrative as the path upon which the client and therapist travel, it seems that certain types of silences (Feeling, Expressive, Reflective pauses) are staircases along this path, which move a client to contact deeper levels within themselves. The psychotherapy narrative then continues the client's movement along until they reach the next set of stairs and delve deeper into themselves yet again. The stairs require the narrative structure in order to exist, after all a staircase suspended in air is no longer a staircase as it comes from nothing and leads to nowhere. By the same token, the narrative without the moments of silence is a flat and often circular path. Although the clients may continue to move along the surface layer, they are unlikely to achieve meaningful change or new understanding of self and others in the world. Both aspects of psychotherapy, the spoken and the unspoken, are needed for productive change. Both need to be recognized and explored in order to develop an appreciation of the process of psychotherapy.

Prior to therapy, clients may not be able to realize when they need to enter a period of inward contemplation. They may be too anxious to enter into focused reflection or may not have learned to recognize when it is called for. The process of therapy can be seen as a process of learning to become comfortable with pausing and with attending to one's internal experience in a sustained fashion. Once clients learn to recognize when they need to focus on their emotions,on finding symbols or on finding connections, it should become less difficult to navigate their narratives and to develop the ability to

make necessary adjustments. The following guidelines are presented to suggest ways in which therapists may be able to assist clients to become more comfortable with processes of productive pausing in psychotherapy.

Guidelines for Clinical Practice

Although the following guidelines must be considered tentative at this stage of the line of inquiry opened up by this study, the returns from this study have provided a number of recommendations for clinical practice. These suggestions are based upon my study of the clients' reported experiences during pauses, upon readings of silent moments in therapy sessions, and upon the process measure ratings of different types of silences. They indicate general attitudes and interventions with regards to silence in psychotherapy which may be productive in light of the understandings derived from the present study.

1. Therapists may find it useful to be alert to the different processes that may be occurring within pauses and to their importance. Often silent processes in therapy go unrecognized and undiscussed. As they can be more subtle indicators, they can be more challenging for therapists to address. The sensitive therapist can recognize moments of silence as active moments in therapy instead of viewing them simply as moments in which discourse is absent.

2. Observing the patterns of pausing in which clients engage might assist therapists in prescribing appropriate interventions. Clients may be found to engage in the same types of pauses repeatedly, or may not pause at all. Therapists can then decide what strategy to

take to help clients reach optimal moments of sustained inward exploration.

3. It appears to be productive to allow for and to encourage Reflective, Feeling or Expressive pauses in the therapy discourse. Clients expressed very favourable reactions to experiencing both positive and negative emotions in silences. As a therapist it may be important not only to suggest and encourage these moments of silence but to support and guide clients to stay in these silences without leaving them prematurely as their anxiety builds.

4. Asking clients what is happening for them when pauses occur which are awkward or unclear may allow the therapist access into the client's internal track during moments of possible disjuncture. In this study clients often disclosed processes when asked directly about them. The content of these moments can be impossible to access in any other fashion. For instance, a client may disengage consciously or may disengage automatically when something feels overwhelming. Asking "What is happening for you now?" can feel like a very direct question, but may be the only way to distinguish between the two, and to learn more about the client's methods of coping with anxiety or difficult emotion.

5. Explicitly encouraging clients to give feedback may be necessary to create an environment in which clients can question the therapist. Otherwise, clients may act with deference to please the therapist or to safeguard the therapeutic alliance. The clients in this study were apprehensive about expressing anything critical towards their therapist.

Clients would describe checking themselves to see if negative feelings that they feel should indeed be directed towards the therapist or should be directed towards themselves. The therapist's authority was often placed above their own (see Rennie, 1994b) and at times, instead of challenging the alliance, clients would compromise their own experience. It may be particularly important to invite feedback from clients when awkward or "empty" silences occur while there is a task-focus within the psychotherapy session.

6. If, when threatening or emotional issues are discussed, clients seem to pause and then "shut down", make joking remarks, or change to a less threatening topic, it may be important to discuss their reactions to the expression of emotions, particularly vulnerable or anxious emotions. For instance, learning that clients feel angry at themselves for feeling sad, and sorting through this issue might be important for clients to eventually feel comfortable sustaining sad Feeling pauses (see Greenberg, Rice & Elliott, 1996 on self-interruptive processes). Depending upon the therapeutic orientation being used, these moments may allow for the initiation of an analysis of the client's defensive processes, patterns of negative self-talk or self-interruptive processes.

7. When clients are unsure of what they would like to discuss initially in the session or if they have too many topics they want to discuss, explicitly asking them to take a moment or two to decide what feels most important for them can be helpful both to help them decide on a topic and to encourage reflective pausing at the onset of a session.

8. It may be useful to model productive pausing for the client during the session. By illustrating slow and thoughtful processes, a therapist may implicitly give the client permission to take their time in explorations and may set a therapeutic pace of exchange with a client. Research conducted on interviews suggests that interviewers modelling silences can influence their clients' speech patterns to mirror their own (Matarazzo & Wiens, 1967; Matarazzo, Wiens & Saslow, 1965), so therapists may wish to become conscious of their own pace of speech and use of silence within the therapy session.

Conclusion and Future Directions

In the next stage of this research, silence in psychotherapy needs to be examined in relation to therapeutic outcome in order to further examine the treatment suggestions which have been derived from this study. As well, it would be interesting to explore the therapist experience of silences, both to study how both internal tracks interact and to study how conflicts of understanding and direction are resolved at the level of discourse.

Also, pauses could be examined in relation to different client populations. Specifically, readings of the literature on pausing raise questions about whether Schizophrenic and Borderline clients might use silence quite differently within their sessions. Also, as there is some evidence that silence is interpreted differently within certain cultures (e.g., Loveday, 1982; Nakajima, 1967; Nakane, 1972; Yamaguchi, 1986), it would be interesting to compare the results from this projects with clients from different cultural origins. The author's research programme involves movement in these

different directions.

As well, a study of the experience of "control of time" in therapy is being conducted. It was interesting that when confusion or conflicts arose in pauses some clients seemed to express a sense of control over their time, while others seemed to feel that the therapist controlled the time in the session. For instance, one client described a conflict over time in a manner which suggested that she assumed ownership of the therapy time. She felt it was her decision whether or not she would take a long or a short time to deliberate on an issue. In contrast, another client described her use of therapy time by making a distinction between her pauses and "therapist-pauses". Therapist-pauses were experienced by this client as awkward moments in which she felt unsure of the therapist's expectations of her. It appeared that the control over the time in the session and the silences is linked to client agency. Clients who felt they have the right to take the time to centre themselves emotionally seemed to feel more certain of what they chose to discuss in the session and of their right to dictate the direction the session should take. Without this sense, clients can be left feeling that they are or that they should be dependent on the therapist for guidance through each step of their process.

If we look at therapy as a place where client and therapist are attempting to engage in an interpersonal quest towards the restructuring of the client's life narrative, then the structuring of optimal silences does seem important. As therapists, in recognizing our own personal preferences and comfort levels with different types of

silence, we can become more aware of the ways in which we may limit or influence our clients' engagement in different processes. An attunement to the type of silence a client is experiencing can be important in maintaining the alliance as well as providing an environment which encourages the client to continually reference their discourse with inward checks to their emotional experience.

In summary, an often unrecognized goal in therapy may be to teach a process which allows clients to learn to feel comfortable enough to experience disturbing emotions and contemplate troubling thoughts in a focused and sustained fashion. Having another person who can structure these silences, easing and increasing anxiety as needed to maintain this focus, can be a necessary step for clients. The understanding of this process, this delicate therapeutic choreography, provides an important framework from which therapeutic productivity and personal development can be understood.

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Appendix A

Study Description

I am a graduate student in Clinical Psychology in the York PhD programme. Currently I am working on my dissertation, the focus of which is the process of psychotherapy. In this project, I am looking to interview clients on their experience of an hour (or 50 minutes) of psychotherapy. As such, I am asking therapists if they have any clients who might be willing to participate in this study.

Participation would entail the taping of a session (audio or videotape, I would arrange for either) and then I would meet with the client soon after the session (the same day or the following day) and would ask the client about their experience of different moments in the therapy session after listening to short segments of the tape with them. The main question in the interview is "How did you experience that moment?" The interview will take approximately 1.5-2 hours and I will pay clients 30$ to recompense them for their time. All information will be held as strictly confidential.

The advantages of participation include a time to review the therapy experience. Clients often report that these interviews are helpful and provide insight into their own process. In addition clients can receive a summary of the findings of the study and can request a copy of the interview. This study will contribute to developing an understanding of the way clients experience psychotherapy and will help to develop efficacious approaches to clinical treatment.

I am interested in any type of individual psychotherapy and am not interested in any one type of treatment or client. I will not require details about the client's history for this project. Also this study is not assessing therapist variables and does not require an interview with the therapist.

If you have a client (or are a client) who would be interested in participating in this research, please contact me through York University's Psychology Department 736-5290 or through my e-mail, levitt@yorku.ca.

Appendix B

Summary of Therapist Questionnaires

Individual Dyads can be tracked by numbers.
For the purposes of confidentiality, dyads are not listed in any order and are not identified by therapy orientation.

Please reflect back on your client as your answer this questionnaire. "X" the answers that describe the way you feel about your therapy experience with your client. Please work quickly, as I am interested in your first impressions. Thank you for your cooperation.

1. Your rating on the outcome of the therapy (or if the therapy is ongoing, "outcome considering the stage you are at")

____	__6__	____	__5,7__	_1,2,3,4___
Unsuccessful	Slightly successful	Some success	Moderately successful	Highly successful

2. How much more therapy do you feel your client needs now?

____	_1,2,7___	_3,4,5___	__6__	____
No need at all	Slight need	Could use more	Considerable need	Very great need

3. If you are terminating with this client now, what determined this choice?

____	____	_1,2___	_3,4,5,6,7___
Client's decision	Therapist's decision	Mutual agreement	External factors

4. How much has your client benefitted from therapy?

_1,3,5___	_2,4,7___	____	____	____
A great deal	A fair amount	To some extent	Very little	Not at all

5. Everything considered, how satisfied are you with the results of his/her psychotherapy experience?

____ Extremely dissatisfied
__6_ Moderately dissatisfied
____ Fairly dissatisfied
____ Fairly satisfied
_2,4,7 Moderately satisfied
_1,2,5 Highly satisfied
____ Extremely satisfied

6. As a therapist how would you describe yourself?

____ Extremely inexperienced
____ Rather inexperienced
_5__ Somewhat inexperienced
3,4,6,7 Fairly experienced
_1,2 Highly experienced
____ Exceptionally experienced

7. At the beginning of therapy how well did you feel your client was getting along?

____	__4__	_____	_2,3,5,7___	_1___	_____
Very well	Fairly well	Neither well nor poorly	Fairly poorly	Very poorly	Extremely poorly

8. How severely disturbed was your client at the beginning of therapy?

____ Extremely disturbed
_5,6 Very much disturbed
_7,1,4 Moderately disturbed
__2__ Somewhat disturbed
____ Very slightly disturbed
____ Not at all disturbed

9. How much anxiety did your client experience at the beginning of therapy?

__5__	_1,6,7___	_2,3___	__4__	_____
A tremendous amount	A great deal	A fair amount	Very little	None at all

10. How much internal "pressure" did your client experience about these problems when he/she entered psychotherapy?

__5__	_1___	_2,3,7___	__4__	_____	_____
Extremely great	Very great	Fairly great	Relatively small	Very small	Extremely small

11. How much do you feel your client has changed as a result of therapy?

_1___	_2,3,4,5,7	_____	__6__	_____
A great deal	A fair amount	Somewhat	Very little	Not at all

12. How much of this change do you feel has been apparent to others?

A) People closest to your client (husband, wife, etc.)

____	_2,3,4_	_1,5,7	__6_	_____
A great deal	A fair amount	Somewhat	Very little	Not at all

B) Close friends

_3__	_2,4,5_	_1,7_	_____	_____
A great deal	A fair amount	Somewhat	Very little	Not at all

C) Co-workers, acquaintances, etc.

__4_	_3,5,7_	_____	_____	_____
A great deal	A fair amount	Somewhat	Very little	Not at all

13. On the whole, how well do you feel your client is getting along now?

_2,3__	_1,4,5,7	_____	_____	__6_	_____
Very well	Fairly well	Neither well nor poorly	Fairly poorly	Very poorly	Extremely poorly

14. How adequately do you feel your client is dealing with any present problems (or problems at the termination of therapy?)

_2_____ Very adequately
_1,3,4,5,7 Fairly adequately
_____ Neither adequately nor inadequately
_____ Somewhat inadequately
_____ Very inadequately

15. To what extent has the complaints or symptoms that brought your client to therapy changed as a result of treatment?

_2__ Completely disappeared
_1,3,4 Very greatly improved
_7,5_ Considerably improved
____ Somewhat improved
_6__ Not at all improved
____ Got worse

16. How soon after entering therapy did you feel that marked changes had taken place in your client?

____ sessions (approximately)
1-20, 2-80, 3-6, 4-6, 5-10, 6-NA, 7-NA

(* see Table X in Method Section for results)

17. My client and I agree about the steps to be taken to improve his/her situation + TASK

_1___ __2__ _3___ _4___ _5___ _6___ _7___
Never Rarely Occasionally Sometimes Often Very often Always

18. My client and I both feel confident about the usefulness of our current activity in therapy. + TASK

_1___ __2__ _3___ _4___ _5___ _6___ _7____
Never Rarely Occasionally Sometimes Often Very often Always

19. I believe my client likes me + BOND

_1___ __2__ _3___ _4___ _5___ _6___ _7____
Never Rarely Occasionally Sometimes Often Very often Always

20. I have doubts about what we are trying to accomplish in therapy - GOAL

_1___ __2__ _3___ _4___ _5___ _6___ _7____
Never Rarely Occasionally Sometimes Often Very often Always

21 . I am confident in my ability to help my client + BOND

_1___ __2__ _3___ _4___ _5___ _6___ _7____
Never Rarely Occasionally Sometimes Often Very often Always

22. We are working towards mutually defined goals + GOAL

_1___ __2__ _3___ _4___ _5___ _6___ _7____
Never Rarely Occasionally Sometimes Often Very often Always

23. I appreciate my client as a person + BOND

_1___ __2__ _3___ _4___ _5___ _6___ _7____
Never Rarely Occasionally Sometimes Often Very often Always

24. We agree on what is important for my client to work on + TASK

_1___ __2__ _3___ _4___ _5___ _6___ _7____
Never Rarely Occasionally Sometimes Often Very often Always

25. My client and I have built a mutual trust + BOND

_1___ __2__ _3___ _4___ _5___ _6___ _7____
Never Rarely Occasionally Sometimes Often Very often Always

26. My client and I have different ideas on what his/her real problems are - GOAL

_1___ __2__ _3___ _4___ _5___ _6___ _7____
Never Rarely Occasionally Sometimes Often Very often Always

27. We have established a good understanding between us of the kind of changes that would be good for my client + GOAL

_1___ __2__ _3___ _4___ _5___ _6___ _7____
Never Rarely Occasionally Sometimes Often Very often Always

28. My client believes the way we are working with his/her problem is correct. + TASK

_1___ __2__ _3___ _4___ _5___ _6___ _7____
Never Rarely Occasionally Sometimes Often Very often Always

Appendix C

Pausing Inventory Classification System Manual

This manual was developed for the purpose of training raters for this study. It was based upon the analysis of interviews with clients on their experiences of pausing in psychotherapy. A new manual will be developed to integrate findings from the current study.

I. Disengaged Pauses

Definition: Client is disengaged from emotion or is avoiding emotion

Sub-Categories:
1. Avoiding Anxiety/Feelings:
A. Avoiding hurt, angst, fear
B. Regrouping/Composing self
C. Trying to lighten therapist focus (i.e., make jokes, change topic)
2. Shutting down:
D. Withdrawing
E. Stopped

Cues:
- To differentiate: Defensive pauses these tend to be more often C-T pauses while Interactional Pauses are more often T-T pauses
- client is trying to distract therapist away from emotional discussion
- denial of feeling inherent in topic
- client seems uncomfortable with further disclosure and resistant to further analysis
- client seems to have shut down and withdrawn from process
- process seems to be finished and client processing has stopped

Type 1:
Before the pause: Client disengaged before the pause
- Question-answer modes pull for this
- Therapist inquiry about a painful topic or therapist focusing client on emotion
- Client follows an emotional statement or disclosure with a joke or summary/distractor response

During Pause:
- Client tends to look at therapist, or look outwardly, silence feels "stopped" and non-productive
- Feeling of "That's all. I have nothing else to say" from client

After the pause:
- Client continues in new line of discussion, often less emotional, or diminishes the emotional importance of previous topic
- Therapist either acknowledges that something has happened internally for the client or continues along in the new line of discussion

Type 2
Before the pause: Client disengages during the pause
- Therapist inquiry about a painful topic or therapist focusing client on emotion
- Client is moving into an increasingly emotional state or has just revealed disclosing content

During Pause:
- Client seems to be inwardly focused and then seems to stop abruptly or prematurely

After the pause:
- Client jokes
- Client gives quick answer, a joke or summary that cuts off further exploration or discussion (e.g., "That's all." or "It's just something I have to do.")
- Therapist tries to focus client on emotion or content again

Examples:

Example 1: (Disengages during pause)
C: I'll still have residual feelings for this person, but I'll allow myself to have feelings for other people as well. Do you know what I mean? (Right) So my caring for him won't be a problem in future relationships
T: It won't be a problem
C: Yeah, I hope to reach that point
T: What do you think will help get you there? What do you think you need at this point to help get you there?
C: I don't know (laughs)
T: You'd say, I need
C: - - - - a million dollars, no (laughs)

Example 2. (Disengaged before pause)
C: So I finally did talk to him and I told him how I felt and he was ok with it all. It was good. It went well.
T: So really you're reaching out
C: And all kinds of stuff fell into place. - -
T: That's really great, yeah and - - - - - yeah yeah, that's really great and I'm not sure where this leaves you

Example 3: (Disengaged before pause)
C: Last session after I went home I felt a lot of anger
T: And what happened to it?
C: well, I drove home and parked the car and just sat and thought about things, sort of feeling immobilized, so many different kind of feelings
T: ok (p:06) immobilized - like you couldn't do anything
C: It was an extreme effort to get out of the car
T: ok - what do you want to work on today?

Example 4. [discussing how she got herself fired from work] (Disengaged before pause)
C: What I did, in the end, was I fired myself from that job. Somehow that figures in here, the direct connection I'm not sure about
T: So the sense that it's tied in, but not clear
C: Not clear. (p:22)
T: I'm wondering if there are 2 things that were shaken after the accident, one the accident will shatter your view of what the world will deal you...

II. Feeling Pauses

Definition: Clients are feeling emotion, re-experiencing emotion, or in the process of moving into an emotional state

Cues:
Before the pause:
- emotional content (e.g., "I felt so sad. I just am so forelorn")
- non-emotional content that is very emotionally-laden (e.g., "I haven't seen my daughter for 5 years now. I can't understand what is happening with my life.")
- repetition of phrases (e.g., it's probably, it's probably going to be, real, real hard)
- voice sounds shakey, tearful, shouting,

During the pause:
- Expression of emotion (e.g., crying, tearfulness, sobbing)

After the pause:
- emotional content (e.g., "I felt so sad. I just am so forelorn")
- non-emotional content that is very emotionally-laden (e.g., "I haven't seen my daughter for 5 years now. I can't understand what is happening with my life.")
- voice sounds shakey, tearful, shouting

Sub-Categories:
1. Moving deeper into feeling state:
A. Moving deeper
B. Flood of feelings

2. Feelings:
A. Fear, vulnerability, uncertainty, tension
B. Sadness, pain, despair
C. Anger, frustration
D. Other feelings

Examples:
Example 1. (Conflict with being caring vs asserting self with other)
T: Try feeding him and then saying what you need. They are two very different states. One is feeding him, the other is saying what you need.
C: (crying) I don't know if I can do it. - - - - - It's such a mind shift, it's not the same thing. I don't know (crying)
T: When you feed him you

Example 2.
C: Cause it's too much pressure to put me in the middle (yeah yeah) and I haven't heard from him since then either cause he knew I was mad (p:11) I talked to her parents, I told her parents I didn't want anything to do with the situation

Example 3.
C: I wish I had my daughter with me still. I haven't seen her since she was adopted. I put an advertisement in the paper once, but never did hear anything. I haven't seen her for 5 years (p:05) I don't know her anymore. (Note: emotional words are not used, but emotion is obvious in the context of the speech)

IV. Interactional Pauses

Definition: Pauses due to client reaction to therapist and expected or perceived therapist reaction. Clients shift from thinking about their issues to thinking about the therapist or their interaction with the therapist.

Sub-Categories:
1. Seeking Therapist Approval
A. Impression Management
2. Uncertainty Regarding Therapist Task or Comment
A. Uncertainty re:task fulfillment
B. Demands of communicating with therapist
3. Safeguarding the Therapeutic Alliance
A. Emotional reaction to Therapist

Cues:
- These tend to happen more frequently in therapies which have question-answer styles of interaction.
- Seems as though client feels uncertain of therapist reaction (imagined or actual),
- Clients seem uncomfortable with further disclosure, and are resistant to further analysis **but** this is because they are thinking about the therapist,
- Clients seem to be altering information in order to present it in a certain light in order to gain therapist approval
- To differentiate: Interactional Pauses are more often T-T pauses while Defensive pauses tend to be more often C-T pauses; also Defensive ones occur when clients avoid difficult emotion due to their own reluctance to engage in these emotions whereas Interactional Pauses occur when the therapist (or imagined therapist) becomes the focus due to concern for the relationship.

Before the pause:
- Therapist says something awkward or obvious
- Therapist sets task that client doesn't understand or seems constrained by
- Therapist asks a complicated question
- Client seems to seek the approval of the therapist

During the pause:
- There seems to be an uncomfortable tension at times, or a feeling of confusion
- Client seems to be waiting for more explanation from therapist
- Sometimes eye contact with therapist, indicating client waiting or seeking support

After the pause:
- Client asks for clarification on task
- These are often pauses within therapist speech as therapists will often try to provide spontaneous explanation if the client appears puzzled during a pause.
- Client responds in way that indicates that they haven't understood the therapist statement (e.g., repeating the statement or repeating their last assertion, sometimes with more qualifiers such as "well, I just think I felt unsettled in that situation for some reason")
- questions are often asked after pause to "break" the silence
- clients indicate that they were not thinking

Examples:

Example 1. [discussing concern re: anxiety about being rejected at work]
T: All right. Do you want to do this in the form of a thought record of that? (Mm) Alright, what do you put in the first column
C: Situation?
T: mhm
C: (p:24) the concrete situation is this is where is work at
T: The concrete situation is pondering your ability to work - is that right? (Mhm) it doesn't need to be concrete-concrete.

Example 2. C: you know, that were the accomplishments whatever they are, we're talking in rather vague terms at this stage
T: So what would a little accomplishment look like (p:07)
C: Well, I don't know, I don't know exactly what we're talking about, I mean.
T: I guess what we're suggesting if we just had little ones but saw that they were growing that that might constitute an increase in motivation (mhm, yeah, probably) so the thing is what do we count or what would we track or what

Example 3. (Second pause) T: [it seems like we have a long enough list in this column against the negative thought..] Maybe it's time to summarize what you've got and come up with a balanced thought. How would you put that all together? (p:66) Are you telling yourself you can't do it?
C: That is what I'm telling myself
T: Isn't that interesting (p:11) Does that impair you
C: I think it does
T: So it's a pretty potent thought isn't it.

IV. Reflective Pauses

Definition: Client is questioning idea, heightening awareness, making connections or insights

Sub-Categories:
A. Questioning
B. Increasing awareness of issue
C. Connection making
D. Insight/Realization

Cues:
- Client is deliberating, comparing, questioning, planning exploring
- Like Reflexive Process in Narrative Process Coding System (Angus, Hartdke & Levitt, 1996)

Before the pause:
- Expression of wondering, analyzing, judging, assessing, questioning
- Examining alternatives, evaluating options
- Making connections or insights
- Client in focused CVQ voice

During the pause:
- Client seems to be focused in their heads

After the pause:
- Expression of insight, or continued wondering, analyzing, judging, assessing
- Connections made or continued to be sought

Example:
Example 1. C: So here I was having a conversation about someone else who's depressed and I'm wondering if I was projecting, you know, Um, One of the things my boss said to me about the conversation, maybe I was //?at fault? maybe I wasn't owning my defenses or something, I can't even remember what it was now, But it was really funny because I thought we were talking about her (laughs). I can remember what the issue was but Like it was "oh actually this could be interesting - - - and maybe this is a pattern there.

Example 2.
C: I don't know how to right where I am
T: you're not sure where you are? (P:11) where do you think you are?
C: some days it's like everythings so lousy

Expressive Pauses

Definition: Clients are having trouble finding the correct-feeling word or phrase to express themselves

Sub-Categories:
A. Articulation of ideas
B. Naming/identifying feelings

Cues:
- Concern re: therapist evaluation, self monitoring/correcting, concern with precision
- Focusing inward on forming a symbol or finding a word that seems to fit best experientially
- To differentiate from Reflective pauses, in Expressive pauses clients seem to be trying to locate a word to express meaning rather than engaging in a process of meaning-making itself (i.e., thinking about a word vs thinking about meaning).
- There tends to be a word or phrase change after the pause (e.g., "I felt angry (p:03), sort of tied up in knots") or some indication that a word was not successfully found (e.g., "It wasn't sadness, it was more (p:05) I don't know something like sadness").

Before the pause:
- Clients stutter (e.g., "But you know I'm I'm I'm (p:03) there's a good way to put it (p:03) I'm, I admire beauty too much"
- Clients say something awkward or vague (e.g., "I felt it had to do with all kinds of work things like (p:03) not being ambitious")

During the pause:
- Clients seem to be seeking the correct word, may begin to try on words to themselves

After the pause:
- Clients find an expression or symbol of their experience
- Clients indicate that they have failed or come up with an awkward phrase (e.g., "I was able to uh (p:05) make it go back to how it used to be before.")
- client continues along same line of thought, sentence continues in same structure.
- stammering

Example:

Example 1.

T: I get a sense of that shattered, my world view is shattered. and the pieces are all lying around and I have to reconstruct reality
C: And I have to give up almost the um - - - almost the illusions that I used to have,

Example 2.

C: I could have if I wanted to. I realized later that's what he was looking to me for. I could have smoothed it over in a nanosecond, actually, but I know I'm I'm - - I know there's a lovely positive way to put this but I don't I'm I'm - - - - I'm too much, I favour truth and justice

VI. Associational Pauses

Definition: The process of emergence of a new idea - often a leap to a different topic.

Cues:
- These are largely CC pauses
- Client changes topic suddenly after a pause
- Client exploration invokes a new idea
- Infrequent, most topic changes are smoother
- If happens too often, it seems may seem like client is avoiding getting too deep into any one topic

Examples:
Example 1.
C: I used to say "I don't do anger", I mean I did do anger, but I wasn't aware and I've been aware recently, which is good, being angry with someone is better than being depressed - - - (sigh) so back to the bigger bruhaha

Example 2.
C: So that was the story of the funeral I went to this week. It wouldn't have been so bad if it wasn't raining so terribly (p:03). The other thing that happened this week was that I got a raise at work. That made me feel really good...

VII. Mnemonic Pauses

Definition: Pauses due to client requiring time for recall

Cues:
Before the pause:
- Therapists often ask for information (e.g., "When did you decide that you wanted to pursue that career?")
- Clients seem to be struggling with details (e.g., "Was it Wednesday or Friday? (P:03) It was Friday.")

During the pause:
- Clients seem to be inwardly focused, or mentally "picturing" events

After the pause:
- Clients have retrieved the information they were seeking
- Clients signal that they have failed in trying to recall (I went to a movie (P:03) I never remember what movies are called.)
- Client continues along same line of thought

- Client changes preceding comment to be more accurate or more detailed

Examples:
Example 1: [re: anger from last session]
T: And what happened to it?
C: (p:04) well, I drove home and parked the car and just sat and thought about things, sort of feeling immobilized, so many different kind of feelings
T: ok
Example 2:
C: I went to the fair on Monday, or no, (p:04) it was Wednesday

Please see the following page for Pausing Category System Cue Sheets which may assist as a reference while rating.

PAUSING CATEGORY SYSTEM - Cue Sheets

I. DEFENSIVE PAUSES

Definition: Client is disengaged from emotion or is avoiding emotion

Cues: (Client can disengage before or after the pause)

- Question-answer modes pull for this
- Therapist inquiry about a painful topic or therapist focusing client on emotion
- Client follows an emotional statement or disclosure with a joke or summary/distractor response
- Client tends to look at therapist, or look outwardly, silence feels "stopped" and non-productive
- Client seems to be inwardly focused and then seems to stop abruptly or prematurely
- Feeling of "That's all. I have nothing else to say" from client
- Client continues in new line of discussion, often less emotional, or diminishes the emotional importance of previous topic
- Therapist either acknowledges that something has happened internally for the client or continues along in the new line of discussion or "saves" client
- Client gives quick answer, a joke or summary that cuts off further exploration or discussion (e.g., "That's all." or "It's just something I have to do.")

II. FEELING PAUSES

Definition: Clients are feeling emotion or in the process of moving into an emotional state

Cues:

- emotional content (e.g., "I felt so sad. I just am so forelorn")
- non-emotional content that is very emotionally-laden (e.g., "I haven't seen my daughter for 5 years now. I can't understand what is happening with my life.")
- repetition of phrases (e.g., it's probably, it's probably going to be, real, real hard)
- voice sounds shakey, tearful, shouting,
- Expression of emotion (e.g., crying, tearfulness, sobbing)
- emotional content (e.g., "I felt so sad. I just am so forelorn")
- voice sounds shakey, tearful, shouting

III. INTERACTION PAUSES

Definition: Pauses due to client reaction to therapist and expected or perceived therapist reaction

Cues:

- To differentiate: Interactional Pauses are more often T-T pauses while Defensive pauses more often C-T pauses
- Therapist says something awkward or obvious
- Therapist sets task that client doesn't understand or seems constrained by or asks a complicated question
- Client seems to seek the approval of the therapist
- There seems to be an uncomfortable tension at times, or a feeling of confusion
- Client seems to be waiting for more explanation from therapist
- Sometimes eye contact with therapist, indicating client waiting or seeking support
- These are often pauses within therapist speech as therapists will often try to provide spontaneous explanation if the client appears puzzled during a pause.
- Client responds in way that indicates that they haven't understood the therapist statement (e.g., repeating the statement or repeating their last assertion, sometimes with more qualifiers such as "well, I just think I felt unsettled in that situation for some reason")
- questions are often asked after pause to "break" the silence

IV. REFLECTIVE PAUSES

Definition: Client is questioning idea, heightening awareness, making connections or insights

Cues:

- Expression of wondering, analyzing, judging, assessing, questioning
- Examining alternatives, evaluating options
- Making connections or insights
- Client in focused CVQ voice
- Client seems to be focused in their heads
- Expression of insight, or continued wondering, analyzing, judging, assessing
- Connections made or continued to be sought

V. EXPRESSIVE PAUSES

Definition: Clients are having trouble finding the correct-feeling word or phrase to express themselves

Cues:

- Clients stutter (e.g., "But you know I'm I'm I'm (p:03) there's a good way to put it (p:03) I'm, I admire beauty too much"
- Clients say something awkward or vague (e.g., "I felt it had to do with all kinds of work things like (p:03) not being ambitious")
- Clients seem to be seeking the correct word, may begin to try on words to themselves
- Clients find an expression or symbol of their experience
- Clients indicate that they have failed or come up with an awkward phrase (e.g., "I was able to uh (p:05) make it go back to how it used to be before.")
- client continues along same line of thought, sentence continues in same structure.

VI. ASSOCIATIONAL PAUSES

Definition: The process of emergence of a new idea

Cues:

- These are largely CC pauses
- Client changes topic <u>suddenly</u> after a pause
- Client exploration invokes a new idea
- Infrequent, most topic changes are smoother

VII. MNEMONIC PAUSES

Definition: Pauses due to client requiring time for recall

Cues:

- Therapists often ask for information (e.g., "When did you decide to pursue that career?")
- Clients seem to be struggling with details (e.g., "Was it Wednesday (P:03) It was Friday.")
- Clients seem to be inwardly focused, or mentally "picturing" events
- Clients have retrieved the information they were seeking
- Clients signal that they have failed in trying to recall (I went to a movie (P:03) I never remember what movies are called.)
- Client continues along same line of thought
- Client changes preceding comment to be more accurate ot more detailed

Appendix D

List of Primary Categories from Qualitative Analysis*

Legend: MUs = Meaning units

I. Disengaged Pauses - 48 MUs

1. Avoiding Anxiety/Feelings: 29 MUs

A. Avoiding hurt, angst, fear - 20 MUs (Dyads 2, 3, 4, 6 & 7)
- Swallowing feeling - 4 MUs
- Fear about exploring feeling - 4 MUs
- Avoiding feelings - 20 MUs

B. Regrouping/Composing self - 5 MUs (Dyads 3 & 4)
- Focusing on part of the room to calm down - 2 MUs
- Regrouping/Pulling self together - 3 MUs

C. Trying to lighten therapist focus - 4 MUs (Dyads 3 & 4)
- Making glib remarks - 2 MUs
- Keeping it light - 3 MUs

2. Shutting down: 19 MUs

D. Withdrawing - 5 MUs (Dyads 2, 4 & 7)

E. Stopped - 14 MUs (Dyads 1, 2 & 7)
- Stopped thinking - 5 MUs
- Run out of things to say - 3 MUs
- Waiting - 3 MUs
- Tension stopped thought - 3 MUs

II. Feeling Pauses - Getting in Touch with Emotion - 61MUs

1. Moving deeper into feeling state: 18 MUs

A. Indefinite feelings - 12 MUs (Dyads 1, 2, 3, 4, 6 & 7)
- Trying to go deeper - 2 MUs
- Can't identify feeling - 8 MUs
- A feeling begins - 2 MUs

B. Flood of feelings - 6 MUs (Dyads 1 & 4)

2. Feelings: 43 MUs

A. Fear, vulnerability, uncertainty, tension - 14 MUs (Dyads 1, 2, 3 & 5)
- Fear - 6 MUs
- Vulnerability - 6 MUs
- Uncertainty - 2 MUs
- Tension - 2 MUs

B. Sadness, pain, despair - 8 MUs (Dyads 4 & 5)
- Sadness/Despair - 4 MUs
- Pain - 5 MUs

C. Anger, frustration - 11 MUs (Dyads 4 & 5)
- Anger - 4 MUs
- Frustration - 6 MUs
- Disapproving - 3 MUs

D. Other feelings - 10 MUs (Dyads 2, 4, 5 & 6)
- Surprise - 2 MUs
- Relief - 1 MU
- Lost - 1 MU
- Pressured - 1 MU
- Confused - 1 MU
- Drained -1 MU
- Shame -1 MU
- Exposed -1 MU
- Pity - 1 MU

III. Effects of Interaction with Therapist - 65 MUs

1. Demands of Communication with Therapist: 22 MUs

A. Awareness of therapist's experience - 19 MUs (Dyads 1, 2, 3, 4, 5 & 7)
- Awareness re: therapist presence - 18 MUs
- Waiting for therapist response - 2 MUs
- Concern re: therapist comfort - 8 MUs
- Feels therapist want to explore issue more/differently than client - 6 MUs
- Awareness of changes in therapist mood - 3 MUs

B. Pulling away from feelings in order to articulate them - 3 MUs (Dyad 2)

2. Uncertainty Regarding Therapist Task or Comment: 24 MUs

C. Uncertainty re: task fulfilment - 24 MUs (Dyads 1, 2, 3, 6 & 7)
- Unsure about time passing during task - 4 MUs
- Unsure re: right answer - 5 MUs
- Unsure re: task selection - 12 MUs
- Unsure re: therapist comment - 4 MUs

3. Safeguarding the Therapeutic Alliance: 19 MUs

D. Approval Seeking/Impression Management - 9 MUs (Dyads 1, 4, 5 & 6)
- Concern with therapist judgement - 5 MUs
- Deciding what to reveal/how to reveal information - 6 MUs

E. Managing Emotional Reaction to Therapist - 10 MUs (Dyads 6 & 7)
- Frustrated with therapist - 7 MUs
- Exasperated with therapist - 2 MUs
- Preference to figure something out by self - 1 MU

IV. Reflection Processes - 79 MUs
1. Questioning - 21 MUs (All dyads)
- Questioning motivations - 3 MUs
- Questioning idea/general - 8 MUs
- Questioning feelings - 6 MUs
- Questioning incident - 5 MUs
2. Increasing awareness of issue - 8 MUs (Dyads 1, 2, 4 & 5)
3. Connection making - 40 MUs (Dyads 2, 3, 4, 5, 6 & 7)
- Searching for connections/patterns - 17 MUs
- Connecting past and present experience - 9 MUs
- Comparing ideas - 9 MUs
- Process of connecting ideas - 15 MUs
4. Insight/Realization - 10 MUs (Dyads 2, 4, 5 & 6)

V. Expressive Processes - 23 MUs
1. Articulation of ideas - 11 MUs (Dyads 1, 2, 4, 5 & 7)
- Searching for right words - 4 MUs
- Deciding for right way to express idea - 7 MUs
2. Naming feelings - 12 MUs (Dyads 2, 3, 4, 5 & 7)

VI. Associational Pauses - 9 MUs (Dyads 1, 2, 4, 6 & 7)
- Topic ending - 3 MUs
- Topic switching - 2 MUs
- Trying to switch topic/perspective/context - 4

VII. Mnemonic Pauses - 25 MUs (All dyads)
- Recall event/item - 15 MUs
- Reconstruct/order story - 2 MUs
- Searching through past history - 5 MUs
- Using mnemonics - 1 MU

* Note: The numbers of primary category meaning units do not necessarily add up to the number of sub-category meaning units as each meaning unit found in a sub-category (a higher order category) may have been sorted into more than one primary category as a procedure of open-categorization was applied to the analysis.

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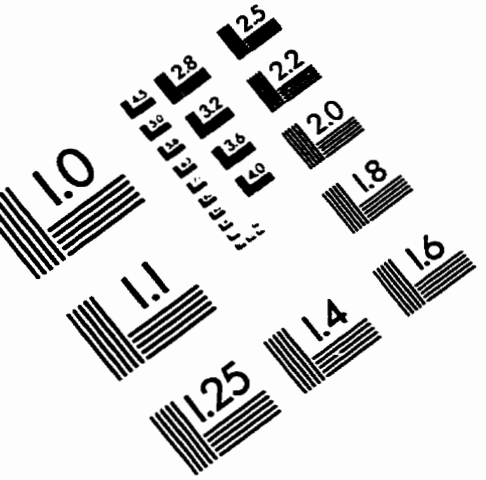
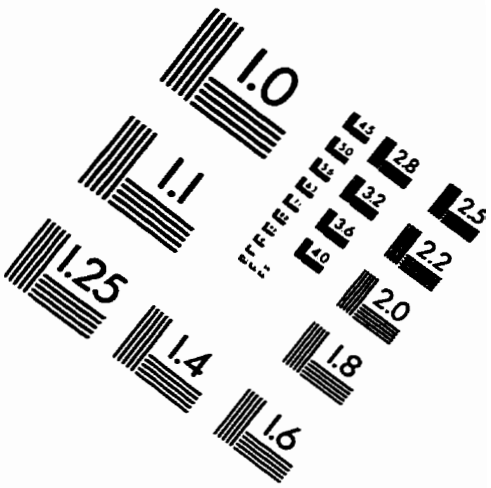
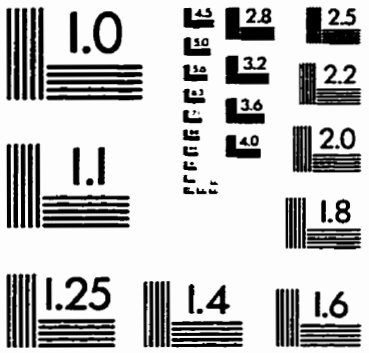
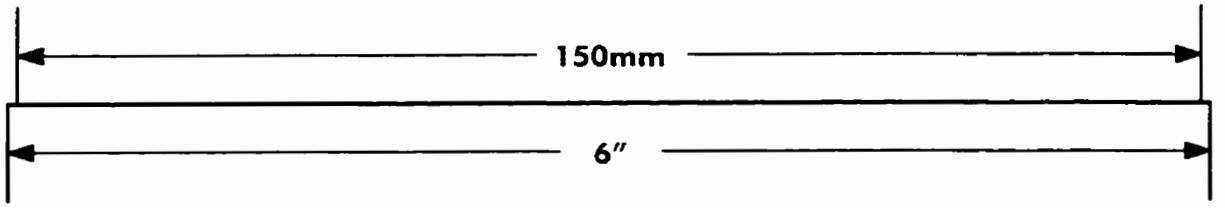
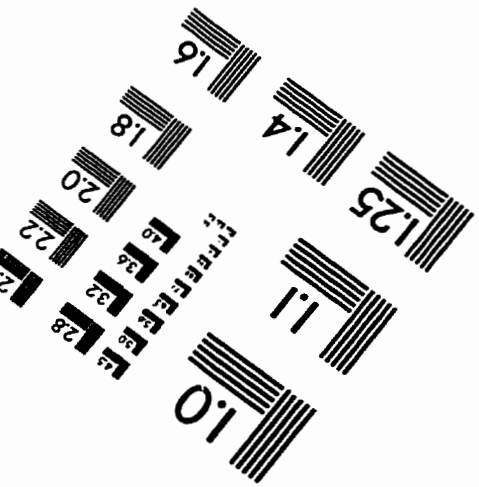
TEST TARGET (QA-3)

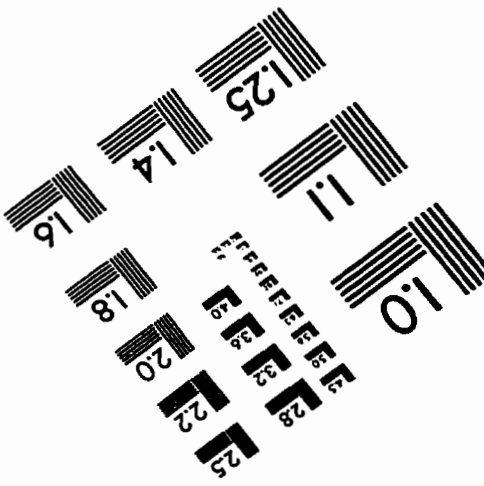












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