Approaches: An Interdisciplinary Journal of Music Therapy
17 (4) 2025
ISSN: 2459-3338
https://doi.org/10.56883/aijmt.2025.637

ARTICLE

Understanding the silences, not just the sounds: An exploration into music therapists' meaning making of silence in improvisational music therapy

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ABSTRACT

Silence is a common experience in music therapy, potentially rich in meaning, however there is limited literature available about silence within improvisational music therapy. This article draws connections between musicological, psychological, phenomenological, and music therapy literature on: typologies of silence, silence as an intersubjective phenomenon, and silence as a space for reflection and processing. The importance of meaning making and silence in improvisational music therapy is explored through semi-structured interview data and Interpretative Phenomenological Analysis (IPA). The IPA interview analysis produced three superordinate themes, developed by the primary author and reviewed by the secondary author, comprised of ten subordinate themes: Anxiety and Tension In, and After, Silence; Silence as a Space; and Clinical Considerations of Silence. Connections are made between the analysis of participant interviews and existing phenomenological, musicological, psychotherapeutic and music therapy literature on silence. The discussion finds that the therapist's perceived strength of the therapeutic relationship is key to the experience of silence in the therapy environment. It also outlines silence as a space of reflection and self-actualisation, and as a facilitative aspect of clients experiencing empowerment and authenticity. This paper also presents a theory, based on the interview data gathered, providing a grounded theory angle. The theory offers a model of the continuation and cyclical recontextualisation of meaning from the musical, into silence, and beyond. The study identifies implications for practice and further opportunities to solidify existing theory and develop concepts unique to silence within music therapy.

KEYWORDS

improvisational music therapy,
silence,
phenomenological analysis,
meaning making

Publication history:
Submitted: 24 Jun 2024
Accepted: 15 Aug 2025
First published: 20 Oct 2025

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Publisher: Queen Margaret University Edinburgh | Centre for Person-centred Practice Research

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INTRODUCTION

During Garrick's training, he experienced many instances of silence that were therapeutically informative to the clinical work with his clients. These moments raised unique questions, anxieties and experiences that were not present in individual musicking or during musical parts of sessions.

Vignette

> I'm sitting on the floor in the lounge area of an inpatient adult mental health ward. Across from me is the only patient that has attended the open group. He sits opposite, holding an ocean drum. I think: "he has managed to make an ocean drum perfectly silent." I think: "perhaps I should break the silence, maybe he's waiting for me to take the lead?" I feel tense. "What does the patient think and feel right now? Is this anxiety mine? Am I feeling some sort of countertransference? What would a 'real music therapist' do?"

In the vignette, the first author cannot understand the meaning of the client's silence. However, the client is not the only person in silence. The author is as accountable for the silence in the space as the client. Some of the thoughts in the vignette point to why they engage in, and perhaps perpetuate, this silence. Silence is a common experience in music therapy, one that can be rich in meaning. Within improvisational music therapy literature there is limited writing on the meaning and use of silence within sessions (Sutton, 2002, 2005, 2006, 2023; Sutton & De Backer, 2009); this study explores music therapists' experiences of silence and forwards theory on some of the functions and uses of silence in clinical work. Literature on silence, its roles and uses, across fields related to clinical music therapy practice were reviewed. The following sections discuss silence from phenomenological, musicological, psychotherapeutic and musico-therapeutic perspectives, drawing connections between the different disciplines. We begin with how silence has been categorised across different disciplines.

Typologies of silence

Conceptualisations and categorisations of silence as a heterogenous phenomenon exist in phenomenology, musicology, and psychotherapy. Dauenhauer's phenomenological analysis of silence (1980) describes three typologies of silence that exist within discourse between two or more individuals. These categories: *Intervening silence, Fore and After silence,* and *Deep silence*, describe silence as an active, communicative, phenomenon between the self and others.

- Intervening silence: Periods of silence between units of sound to distinguish one from another.

- Fore and after silences frame a sounded expression that is a self-contained unit of information.
- Deep silence is uniquely unbound to any specific utterance and yet still exists in contrast to utterances.

Within music, Clifton posits that silence "participates in time, space, and gesture" (1976, p. 163), imbuing emotion and meaning into music.

- Temporal silences affect the listeners perception of time; perceived as a clear distinction between sound and non-sound, this silence can be as simple as all musicians 'playing': a rest simultaneously.
- Spatial silence is the (dis)use of voices across registers; Clifton likens this to "empty spaces in the sculpture" and refers to this silence in the context of the form of the music (p. 171).
- "Silences in motion" (p.178) impart the sensation of musical motion happening within the rests and silences of the music.

As above, Clifton and Dauenhauer both describe types and functions of silence in their respective works on the subject. In psychotherapeutic theory, Levitt (2001a) identified the tendency for silence to be treated as a homogenous phenomenon. Through an exploration of clients' experiences of silence within talking therapies, Levitt (2001a, 2001b, 2002) forwards an inventory of seven categories of silence grouped under three highest order categories:

- Productive silences
- Neutral silences
- Obstructive silences

Levitt argues that silence is a heterogeneous experience for clients in psychotherapy, challenging simple or homogenous understandings of silence in therapy. Across phenomenological analysis, musicological theory, and explorations into psychotherapy clients' experiences of silence, there is a consistent ability to separate silences into discrete categories. The phenomenological and psychotherapeutic categories described by Dauenhauer and Levitt are primarily separated by the experience of silence, with the theory of its function being based upon the affective experience. Clifton's analytical approach towards musicological silences is informed by Heidegger (1962) and Gusdorf (1965). Whilst the paper is primarily interested in describing and exploring the musical theory of each of his typologies, Clifton uses sensory descriptions of silences to introduce the reader to each concept, relying on an affective recognition within the reader to draw them into the mechanics of the music. Each set of typologies explored relate to silence as a phenomenon within their respective fields and each author draws upon the reader's experiences of silence(s) and their affective shapes to describe its forms and functions. The authors cited throughout use these shared experiences of silence(s) to communicate with the reader, exposing silence as an intersubjective phenomenon that is both implicit in the description of the typologies and explicitly described in within music therapy, psychotherapy, phenomenology and musicology.

Silence as an intersubjective phenomenon

Using Conversation Analysis, Sutton (2023) notes that silences threaten the stability of discourse in spoken conversation but act as a feature that maintains the attention of the listener in music, providing cohesion to the intersubjective experience. Dauenhauer (1980) privileges music as being one of few modalities that can maintain a stable *sense* of communication with two or more people engaging in simultaneous discourse. He positions emotional or psychological security as an antecedent to codiscourse, requiring the individual to relinquish complete autonomy to enter into an intersubjective relationship. Trevarthen (1980) defines intersubjectivity as the knowledge of and interaction with another's internal state, while Stern (2000) theorises that this capability develops in children between seven and nine months. Stern (2010) proposes that we create implicit relational knowledge through dynamic forms of vitality, multimodal expressions of the dynamic contours of inner states. For example, an emotion such as anger might manifest through various vitality affects. It might "explode," "ooze out," "sneak up" or "be cold" (p. 28). Meyer (1961, p. 35) conceptualises that music contains affective contours which manifest emotions in the audience through "embodied musical meaning." Meyer and Clifton (1976) describe the role of silence in these affective contours in manipulating anticipation, anxiety, and tension, suggesting that musical silences not only contribute to the experienced musical meaning but also contain information that is vital to the structure of music's affective contours.

Music therapy improvisation carries potential for intersubjectivity to manifest between client and therapist using music as a mode of expression; the therapist can interpret music and experience to infer the client's experience of themselves in the world (Pavlicevic, 1997). Sutton (2006) cites Flower's (2001) assertion that silence in music therapy is an informative phenomenon that may describe something about the connection between therapist and client. Analysing improvisational music with conversational analysis tools, Sutton (2002) proposes that musical silence overlaps with conversational silence for the purpose of modulating tension and emotional affect. Within talking therapies, Lane et al. (2002) identify silence as a key communicative factor between the client and therapist, describing it as a space in which clients impart emotional messages through transferential and countertransferential processes. They also discuss the ways in which the therapist's silence may be interpreted by the client; suggesting the impacts of silence in therapy can be helpful and harmful to the client's therapeutic journey, mirroring the findings of Ladany et al. (2004) and Levitt (2001a, 2001b, 2002).

Sutton, Clifton, and Meyer describe musical silence as a phenomenon that modulates the listener's affective experience. Through the lens of Stern's dynamic forms of vitality, it is possible to understand how these affective contours communicate information between individuals. Where silence plays a part in the affective structure of music, a connection can be made to Lane et al.'s (2002) findings of silence imparting emotional messages between the therapist and client. Silence is shown to have an active function in the intersubjective experience between people in music making and conversation.

Considering the myriad typologies of silence described in the previous section it is possible to infer that the active phenomenon of silence fulfils many communicative functions in the intersubjective relationship and experiences between individuals, as found by Ladany et al. (2004)

and Levitt et al. (2001a, 2001b, 2002). An exhaustive description of the affective experiences and functions of silence would be far outside the scope of this paper. However, a function of silence that is pertinent is the role it plays in affective processing, cognition, and reflection.

Silence as a space for reflection and processing

As referred to in Dauenhauer's (1980) three typologies, After-silence is a space for processing and reflection. In music, Potter (2017) suggests that silences can be communicative; communicative silence relies on timing and a balancing of predictive and reflective implications from the performer. Silence invites the listener to process what has happened in the music and creatively reconstruct the performers' meaning from the audience's subjective experiences. Potter's listener holds the music in their mind, reconstructs the sounds and affective contours, and engages in meaning making; this is a space in which affective experience meets cognition, developing insight through reflection.

Psychotherapy also positions after-silence as a space of reflection. Ladany et al. (2004) found that, in a study of 12 therapists, all participants used silence for client-focused reasons, such as the facilitation of a reflective state for clients. Elson (2001) writes that when client and therapist are in a state of silent attunement there is opportunity for both to reflect. The silence after the therapist offers their interpretation is a space in which clients may reflect and begin to engage in therapeutic processes self-observation, self-determination, and transformation. We liken the interpretation of Elson's therapist to the musical material that is offered by Potter's (2017) performer. Both are taken in by the 'audience' whose members then engage in a process of reflection and reconstruction of that material, resulting in a more complex and cognitive understanding of their experiences. Within the context of music therapy, Sutton (2023) states that silence opens a space for thought and reflection in both analyst and patient.

Across the three disciplines of musicology, psychotherapy and music therapy there is a convergence in how silence is conceptualised as a "space" that is used for affective processing and reflection. All the authors above describe a process in which an intersubjective relationship transitions from sound to silence. Affective experiences relating to the audible (and, perhaps, inaudible) material in the relationship continue for the individuals throughout this silence, drawing a line back to the way Clifton (1976) describes "Silences in Motion." Clifton describes a "Silence in Motion" as a lack of sound in music (silence), which is bridged through the experiencing body of the listener. Clifton cites a common example of this as music that is easily danced to, highlighting the bodily movement of the listener as the bridge that provides the continuation of motion in the music. Clifton (p. 178) cites Mahler's Fifth Symphony as containing a silence in which there is not only motion that is bridged by the listener, but the listener experiences the motion as changing direction. These silences impart real, and sometimes complex, affective experiences to the listener that allows a continuation of motion, a carrying forward, through into the next audible moment. Potter (2017) and Elson (2001) describe an affective experience at a point where there is no motion in the discourse. The literature illustrates an important aspect of the function of silence in reflection and affective processing by highlighting that as the discourse transitions from sound to silence, the affective experience also makes this transition with the individuals. In this way silence is not thought of as an "absence of," but as a continuation of the intersubjective relationship.

A common theme between Elson, Dauenhauer and Potter's work is the chronological placement of a reflective silence; it being at the end of an intersubjective experience. There is an implication in their works that reflective meaning-making cannot occur during an experience. van Manen (2016) supports this from a phenomenological perspective, positing that if one tries to reflect on the emotional experience in the moment then one fundamentally changes or dissipates the feeling that is being focused on. Therefore, any meaning-making of an experience must be retrospective at the point of cognition; even if one is still "in the music," one is no longer in the same experience of the music.

From the literature discussed, there is overlap in musicological, phenomenological, and psychotherapeutic interpretations of the roles and functions of silence, providing areas which may inform music therapists' interactions and interpretations within clinical work. Due to the multi-faceted conceptualisations of silence as a component of intersubjective communication, a "space" for reflection, and as an active choice by individuals, it is pertinent to explore the different ways in which silence interacts with the therapeutic process. Due to the comparatively limited literature in the area, it is valuable to expand the understanding of silence within the music therapy space. By engaging with therapist's experiences of silence in clinical work it is possible to build a more comprehensive view of the functions and roles that silence plays in music therapy.

RESEARCH QUESTION

We aim to explore the following question: How do music therapists understand their experiences of silence within improvisational music therapy sessions?

METHODOLOGY

This research took place between 2021-2022 as part of the first author's MA Music Therapy degree. Garrick Wareham is the first author and the primary investigator. Luke Annesley the second author, acted as supervisor during the degree and reviewer on completion of the first author's degree.

Study design

A qualitative study design based on interview data was chosen to explore the personal experience and meanings of silence that therapists has experienced during clinical work. Due to time limitations, other data gathering methods such as Interpersonal Process Recall using recordings of clinical work was not used, with the acknowledgement that this would provide additional rich data. Data was gathered through semi-structured interviews, which were transcribed and analysed using Interpretative Phenomenological Analysis (IPA) to develop and explore the data. IPA uses participant experience, which is then interpreted (Smith & Osborn, 2015). IPA's idiographic approach determines selection of participants, prioritising the homogeneity of participant experience and richness of depth of the data over sample size (Smith et al., 2009). IPA's data analysis utilises the hermeneutic cycle (Smith et al., 2022), deriving meanings from the data by moving between contexts, focusing on specific parts (words, sentences, paragraphs) and then focusing on the whole (full transcript) and

back again (Montague et al., 2020; Smith et al., 2022). Applying this cycle allows for an inductive approach, beginning with a subject of study and allowing data to inform understanding.

Sample size and recruitment

Recruitment criteria for participants required them to be currently practising or to have practiced improvisational music therapy as a Health and Care Professions Council (HCPC) registered music therapist within the last two years, with no minimum amount of practice required. The HCPC is the regulating body for 15 health and care professions in the United Kingdom; "arts therapists" are one of the professions under the purview of the HCPC, with "music therapist" being one modality within arts therapies (HCPC, 2020).

Calls for participants and digital posters were distributed through personal social media channels and emails were sent to gatekeeper organisations, such as the British Association for Music Therapists, with the request to disseminate calls for participants. Music therapists with publicly available email addresses or known through personal contacts were also approached; 'snowball sampling' through personal contacts was also used. A total of three participants were recruited through calls to action and personal outreach, all experienced professionals (5+ years active clinical work) across a range of client groups including forensic music therapy, child palliative, older adults and Autism Spectrum Condition (ASC) clients. All participants interviewed trained as music therapists in the UK; P1 described their work as integrative but strongly psychodynamic, P2 as integrative between psychodynamic and humanistic, and P3 as psychoanalytically informed music therapy. Interviews were between 45 minutes and one hour in duration.

Interviews and transcription

The first author conducted semi-structured interviews in the Spring of 2022; Microsoft Teams was used for interviews to include the geographical range of participants, enable use of auto-transcription services (Balushi, 2018), and allow participant safety concerns regarding COVID-19 in the United Kingdom to be respected. Participants consented to video and audio recording for the purposes of transcription as well as the use of the Teams text transcription function. The interview schedule contained nine open-ended questions, along with follow-up questions and prompts to encourage participants to expand freely on their initial answers. Interview schedule development was guided by Braun & Clarke (2013) and Smith et al. (2022).

Verbatim transcriptions from Microsoft Teams were checked against the video recording of the interview. Pauses, gestures and laughter that added contextual information or seemed important were noted in the transcriptions (Smith et al., 2022). Some "urms" and "ahhs" were removed from final transcriptions to provide more legible quotes to be identified as units of meaning for coding.

Coding and themes

Transcripts were separated into discrete units of meaning and imported into a Microsoft Excel spreadsheet, allocating each a general timecode and quote number. Notes, reflective links to theory,

expanded interpretations, and experiential statements were created alongside each unit. Experiential statements from all interviews were collated into a single sheet from which superordinate and subordinate themes were developed. During the process of theme development, the transcripts were repeatedly consulted, allowing for reconsideration of initially discarded data as part of the hermeneutic cycle as described by Smith et al. (2022). In summary, the analysis followed these steps (ibid):

- Transcription & Checking
- Several (minimum of three) reads of transcripts
- Import into Microsoft Excel & initial separation into units of meaning
- Exploratory notes on transcripts
- Construction of experiential statements
- Clustering experiential statements into subordinate themes
- Collation of subordinate themes from all interviews
- Development of Superordinate Themes

Reflexivity

It is important to acknowledge the author's role as the researcher in an interpretive process of data collection and analysis; the experiences and understanding of the subject inform the construction and specification of the interview schedule. The interpretation of the data provided by participants is understood through the context of preconceptions based on personal experience and understanding of theory of the authors. The first author identifies as white, middle class and male. He has a musical background in classical, jazz, and experimental electronic music. Through his undergraduate degree in music technology he was exposed to experimental compositions and sound installations which have contributed to a subjective understanding of the use of silence and ambient sounds as parts of music. Space was made for reflective notes as well as use of the hermeneutic cycle and the secondary author's own review to hold interpretations accountable to the context of the interview data.

Ethics

This research was approved as low-risk by the Psychology Ethics Committee, University of the West of England (UWE). Recollection and discussion of potentially distressing experiences was considered the prevalent risk, mitigated by provision of support options for participants and research supervision for the first author. Information sheets, consent forms and demographic questionnaires were sent to interviewees via Qualtrics before time of interview. Demographic questionnaires collected basic information on the participants to maintain records of age, race, gender, disability, number of years of clinical practice and music therapy approach, to provide relevant context to the experiences described by participants. During the coding process, names were anonymised and other data, including pronouns, were removed or replaced with gender-neutral choices unless considered contextually relevant. Data for client groups that the participants work with was not

collected; participants provided client group information based on the experience they described. Some interviews covered a range of experiences with different client groups.

FINDINGS

Three superordinate themes, comprised of ten subordinate themes, were developed from data provided by three participants: Anxiety and Tension In, and After, Silence; Silence as a Space; and Clinical Considerations of Silence.

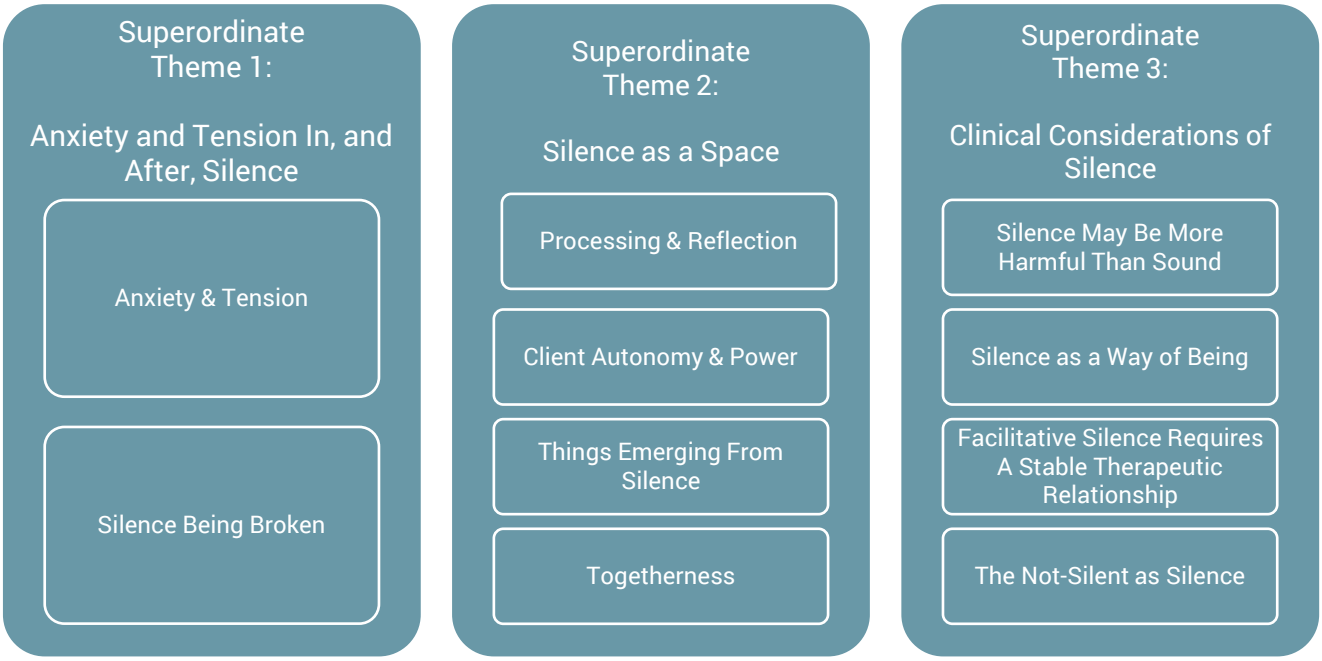

Figure 1: Superordinate and subordinate themes

Theme 1: Anxiety and tension in, and after, silence

Recounting moments of silence, participants described feelings of anticipation, excitement, physical sensations of anxiety, and active thoughts that questioned their choices in the session were common. Another common anxiety was the perception of outside observers; their judgement that silence meant that nothing was happening.

A series of thoughts described by Participant 1 (P1) demonstrates internally focussed anxiety:

> […] 'how long should I wait?' The other [question] I think would have been, 'Should I move the drums to their hand so they don't have to move quite so far?' You know, 'Is it rude for me to expect them to move their arm from here all the way down to there?' Or 'if I had the drum up here, it would be so much easier,' So I suppose I was thinking '… have I made an error here, and have I committed to something that's actually not entirely helpful for them?' (P1)

Participants only mentioned experiences of anxiety when in silence. Although the interview questions were specific to experiences of silence in clinical work, participants freely brought their musical experiences preceding silence into the discussion, no comparisons to experiences of anxiety when musicking were made. Participants also described anxieties that were externally focussed on the client's wellbeing and present experiences of the silence; the client's ability, or perhaps the capacity for the relationship, to "survive" the silence. Despite anxious impulses, participants described clinical scenarios where they resisted breaking the silence:

> […] but I just thought on that occasion that it could be clumsy, it could be that I wouldn't find the right words, or they wouldn't ring true for them... and then speaking, having words, and thinking 'no, I'm not going to say that'… (P3)

Even when P3 found words, they make an active choice to stay in silence and anxiety, commenting that it was important for the client to have the experience of silence in the way they needed to. P3 described that, in their experience, some therapists may stay silent because they do not have anything to express, or don't wish to put "their music" ahead of the client's.

> When clients did break the silences, participants described sensations of tension and relief. Anxiety was alleviated when client's broke silent moments. "… a sort of sense of relief, because I knew then that they would be alright, but in the silence I hadn't been so sure…" (P3)

P3 described anticipation, waiting on tenterhooks, and a fear for the client in their moment of silence. This anxiety was alleviated in their new experience of certainty that the client would be alright.

Theme 2: Silence as a space

Participants commonly used silence to process the content of the musical experience: **"**I was thinking about the music and reflecting on that, thinking 'oh what just happened?' and hearing it back in my head" (P3)**.** Silence after musicking with a client was described as providing therapists with an opportunity to reevaluate the music within the context of the whole performance. Participants noted that this provided further insight and could help contextualise their countertransference. Similarly, participants believe clients also use silence to process and reflect: "[…] often it's the silence bit which is where people get the insight and the perception of what might have changed or what they might have experienced in music." (P1). The participants considered silence after musicking as a time that clients can feel changes and experiences. Participants made no obvious distinction between their own and their clients' use of silence as a space for reflection.

Participants recounted their experiences of silences seeming to provide space for clients to experience autonomy and control, making their own decisions with as little coercion or expectation as possible:

> […] that's sort of invading the silence if you're inviting someone, or asking if somebody wants to play something… And if you break the silence by perhaps asking them again or asking something else, or moving… anything that you do is potentially invading the silence that they need in order to make that decision and in order to work out what to do next. (P1)

The use of "invading" as an action that someone other than the client might do suggests that some silences facilitate a sense of ownership. Here, invasion implies a removal of autonomy, power, and resources against the will of the occupant. P1 described the silence as needed "in order to make that decision," implying that the silence is owned by the client. P3 described a similar intention:

> I think the silence part in the context [of the work with the client] is about also trying to communicate something about how, despite all the feelings of abandonment, and not being heard, and everything, that actually they can make things happen. (P3)

Use of "abandonment" and the isolation of "not being heard" evoke an impression of the client's powerlessness. P3 considered that allowing the client the experience of making things happen in an uninterrupted way was the most important thing at the time. Events were often described as "emerging" from silence, with attention drawn to non-musical events such as speech and action. Participants described that new ideas and statements from clients appeared after silences. "I just was quiet, and I feel out of that they were able to articulate some things not said before." (P3).

Participants believed that silence gave the client room to share experiences that had not been previously made explicit within therapy:

> […] what's emerging from it is coloured and is shaped by what's happened in that silence, whether it's a physical thing, whether it's an emotional thing, whether it's an anxious silence, and a kind of waiting and a nervous energy, or a kind of peaceful silence... (P1)

P1 implied that there is something meaningful about the connection between experiences during silence and things that emerge after these silences.

Silences regarded as therapeutically meaningful during sessions tended to contain a sense of togetherness between the client and therapist. In the work recounted by P2, which revolved around developing a tolerance for silence, this seemed to be crucial to the therapeutic process:

> […] being in that moment where you are quiet together, but it's a safe quiet, and it's a quiet that feels OK and safe, and then it's broken, and that's still safe; that sense of containment and safety still remains. (P2)

The transfer from a togetherness in sound, to togetherness in silence and back to togetherness in sound seemed to be a key aspect of the experience. P2 suggested that they thought the emotional state of the client being transferred from sound to silence allowed the client to experience a way of being, feeling contained and supported by the therapist, which would have otherwise be intolerable.

Theme 3: Clinical considerations of silence

Participants regularly expressed that they perceived clients as distressed or overwhelmed by experiences of silence. These experiences were considered to not have any beneficial therapeutic effects. Participant's also discussed clients using silence as a way to isolate themselves from others, **"**[silence] can be the safe space or the frightening space, and often when people use it for the safe space… the whole purpose is to draw them out of that silence and that isolation and retreating from others" (P2). P2 observed that in moments of client self-isolation a part of the therapeutic process would be to encourage relationship with the therapist. P3 described that sometimes the therapist's silence could exacerbate the client's isolation: "[…] there could be that point where it could be so helpful to help someone make music, if it's music therapy and that they need that trigger, you could offer that…". Musicking can facilitate a therapeutic relationship where silence cannot. As client groups and pathologies vary, P3 made a strong case that when considering any approach or tool it is always necessary to refer to the client's reason for being in therapy.

A stable therapeutic alliance was regarded as foundational to a sense of 'togetherness' in silence. P2 summarised, "too much silence and no alliance, if there's too much silence, there's no alliance…". P2 considered too much silence within early therapy sessions or where the therapeutic alliance was not stable enough as a to hinderance to the therapeutic alliance, or a feeling of togetherness. The experiences described by participants were predominantly within the context of longer-term therapeutic work where a reasonably strong therapeutic foundation had been established, "[…] silence feels like something that should be a shared and agreed experience in some ways after a sense of safety and trust is built." (P2)

A therapeutic relationship that contains trust and safety for the client, as well as empowerment to negotiate boundaries with the therapist, was seen as crucial for clients to be able to engage in silence where therapeutic processes can happen. This foundation is key in facilitating clients' use of the silence for processing, introspection, and their ability to 'survive' silence.

Creating an ability for inner stillness, or the tolerance of internalised silence, could be considered a goal for therapists and clients to work towards. Developing an internal silence was important for P2's work with the client; the capacity to experience silence was seen as important for this client as an opportunity for introspection and reflection:

> […] there was more of a silence within, like a calm, a stillness that came across… but I guess in terms of what that meant for him, it was massive because there was an ability for him to sit with himself which allowed for more clarity of thought and the ability to reflect... that allowed for more space and more introspection and time to really think about what was going on. (P2)

Participants also described how pathologies that are physically or cognitively restrictive may result in silences that are not self-actualising or benevolent. P3 related that a therapist may be able to respectfully acknowledge these ways of being through their own silence:

> […] patients might be silent for all sorts of reasons… someone could have locked in syndrome, a form of brain damage or form of dementia, or had a stroke and that could be a really important part of the therapists' silence, somehow to acknowledge. I think if you're with someone who can't speak or who can't make sound it's respectful also to be silent… (P3)

P1 poses a concept of "relative" silence, reasoning that no environment can ever be truly silent within the human experience; there will always be sound. P1 elaborated how music may qualify as silence in this way:

> And then the new relative silence is this little texture that you're providing as a music therapist… something to bring into it that, that's not too defined by what I'm playing? So, like open fifths or something? So, you're not choosing major or minor. You're not putting a rhythm in… I would say that you could say that's a type of silence. (P1)

This outline suggests that music from the therapist that is perceived as containing little, or holds no, meaning creates an emergent space for the client. This music provides a grounding/masking function of blocking out environmental sound, focussing attention inwards to the contact between the therapist and the client. The aim is that the client will not draw meaning from and play off the music, but use it as a "silent" space to go forth in. One of the qualities P1 described was a minimisation of coercive elements that allows for client autonomy and power to still occur, "[…] I think for me to bring in that very gentle grounding type sound was almost saying, 'this is OK, this is in your own time,' rather than the abstract silence without there being any music at all". This statement makes explicit the intent of removing coercive implications from the relative silence. It suggests that some silences in music therapy can be experienced as 'expectant' or that clients may experience pressure within silence to do something. The participant suggested that the relative silence can mediate this pressure on the client. "Relative" silence, then, is a way of creating a space that is Other to the space outside of the therapy room, one that the music therapist can invite the client to be together in without demanding or coercing anything from the client.

DISCUSSION

This study, seeking to explore how music therapists understand their experiences of silence in improvisational approaches resulted in three categories developed from interviews with three music therapists. This section will explore individual experiential statements and bring them together from different categories to propose a richer concept of the functions and roles of silence.

Surviving the transition

Participants suggested that a stable therapeutic alliance (Flückiger, 2018) is foundational to feelings of togetherness between client and therapist in silence. Dauenhauer (1980) requires both participants to have psychological security to be able to enter the state of intersubjective relatedness that he and Stern (2004) describe. Dauenhauer's (1980) codiscourse and deindividualised silence parallel the silence at the end of musicking between therapist and client. The sense of intersubjective relatedness and togetherness transfers from the shared musicking between therapist and client into the silence beyond the sounds. Participants framed this continuation as an essential aspect of silence that clients needed to survive and allow therapeutic processes to begin. The transition into silence is an event that challenges the strength of the therapeutic alliance. If the therapeutic alliance is strong enough to survive this transition, then the sense of togetherness, safety, and containment remains. If the therapeutic alliance is not strong enough to withstand these initial moments of silence then it is possible that a separation between client and therapist occurs, instilling a sense of loss or isolation in both members of the dyad. In this way, silence is a trial of the dyad's relationship; one that both must be able to pass through together.

Reconstruction, reflection and self-actualisation

All participants described silence in clinical work as an opportunity to reconstruct and explore the meaning of the music that they had taken part in as well as speculating that clients found silence to be an important space to be able to process their own experiences. Potter (2017) suggests that silence invokes the listener to creatively reconstruct the performer's meaning. In these examples, both the therapist and client simultaneously occupy the positions of audience and performer, reconstructing and exploring the meaning of the other's music within the context of their own intentional performance.

Participants differentiated the way in which they believe the silent space was utilised by the therapist and clients. Participants implied that the therapist split their attention between internal (therapist focussed) and external (client focussed) anxieties in silence, whereas client attention was generally implied to be internally focussed. This mirrors Sutton's (2023) suggestion that therapists actively make space for considering how the silence evolves from the client's music making, and what the silence may mean for the client.

It was expressed that clients internalising experiences of silence from therapy sessions may be a helpful goal. This internalised silence was considered beneficial for clients in allowing them to engage in reflection and introspection. This therapeutic aim is reminiscent of the existential and humanistic goal of self-actualisation for the client (Maslow, 1954; Rogers, 1951, 1961; Yalom, 2002). Rogers (1959) posits that we want to feel and behave in ways which are consistent with our self-image. Through authentic reflection of actions and experiences, clients are able to be empowered and move closer to an ideal-self. Participants seem to consider internalised silence to be an enabler of this critical reflection and self-actualisation.

Being authentic

Participants recounted moments of silence where the intention was to enable the client to experience power and autonomy. Dauenhauer (1980) considers silence both as an active performance (an action that is chosen over all other possibilities by the individual) as well as a non-determinate (an action that allows for an infinite array of possible subsequent actions). Potter (2017) and Sutton (2006) consider the silence at the end of music as a moment of power shifting from performer to audience.

If "control" of silence can be given, received, and acted upon by the client, then an interesting concept of silence begins to form: a space that engenders client autonomy and power, which clients can authentically exist in, and in which they are empowered to define limits.

THROUGH-LINES OF MEANING

Silence is a space of uncertainty, whether it is framed as Dauenhauer's (1980) non-determinate, or Clifton's (1976) tension; participants reflect this in their experiences of anxiety. Both therapist and client enter a space in which the client is empowered and able to choose to end the experience. As a space for previously unexplored client material to emerge from, it is possible to consider the action of the client breaking the silence as an authentic, powerful act.

Linking the ideas discussed, it is possible to create a through-line of meaning from before the silence to afterwards:

(1) Togetherness in musicking is transferred into the silence along with power transferred to the client.

(2) The client and therapist continue the musical process through creative reconstruction and meaning making.

(3) A space of empowerment and autonomy for the client is created in the silence in which they can experience a new way of being.

(4) The intersubjective connection between client and therapist persists.

(5) Experiences and meaning making are integrated by the client and therapist during the silence.

(6) The silence is broken by an authentic act by the client.

(7) After the silence the experiences of musicking and the processing of that reconstructed meaning in silence shape the actions that follow (further musicking, discussion of experiences, the client's new understandings of situations, etc).

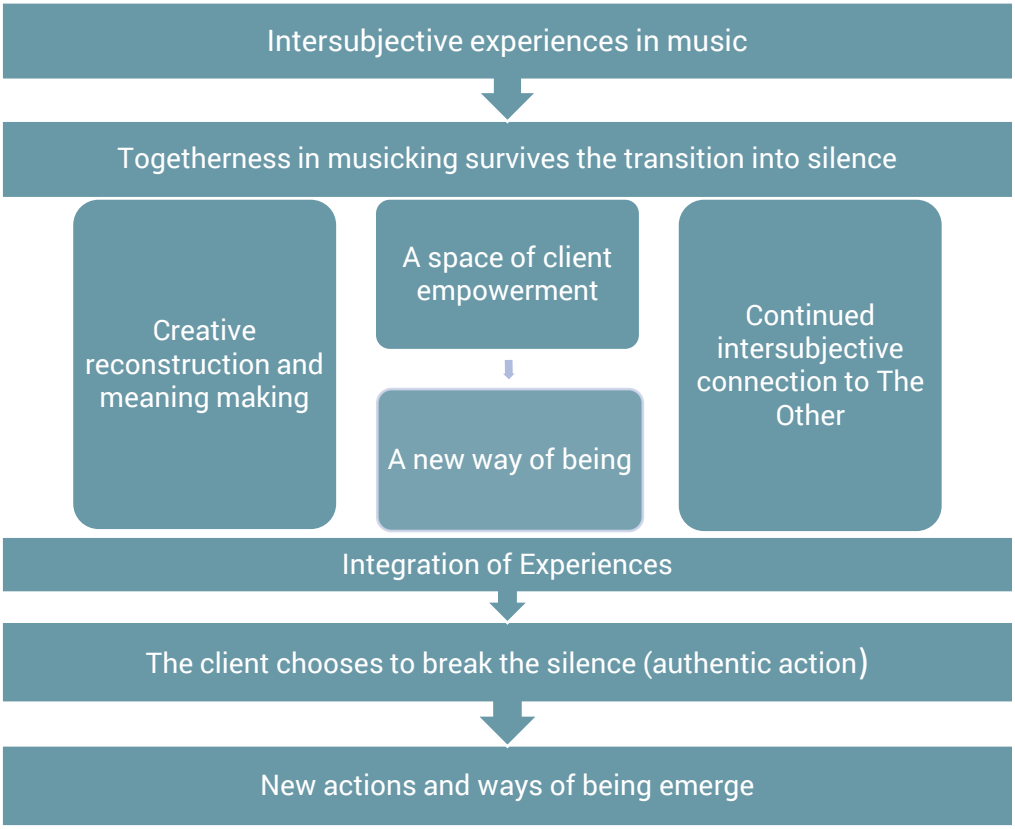

Figure 2: Through-lines of meaning concept

This chain of events is not a prescription, nor is it a static series; actions and processing may happen in different orders or concurrently. It is intended to be illustrative of how silence could be conceptualised as a space in which through-lines of meaning are maintained from one series of audible actions to the next, including silences within a single piece of music, several series of music making with silence between, or in silence after music that leads to something else. This theory reflects participants' observations that the things that happen after silence are shaped by the context of the silence experienced. Dauenhauer (1980) describes a model in which meaning is transferred from one moment to the next but is changed and contextualised with each transfer, using moments of silence to carry meaning forwards in time through processes of reflection, reconstruction and recontextualisation. Further research may provide opportunity to refine this theory, lending itself to a Grounded Theory approach; for now, it may serve as a starting point for that research and for clinicians interested in the therapeutic effects that silence may provide in session.

Limitations

The study presents the following limitations about the data gathers and the insights able to be made into the subject area. Firstly, participant clinical fields are not homogenous. There is potential for unique meaning making and ways of being for music therapists working with specific client populations that may not be represented in this study due to the breadth of client groups that the participants drew their experiences from. A more focused inquiry into the experiences of music

therapists working with X client group may provide richer and nuanced insight into specific kinds of meaning making about silence.

Secondly, the researchers and all participants identify as "White". This leaves a gap in which unique perspectives and meaning making experiences with different cultural and ethnic groups may not be described. Exploring experiences of music therapists that do not identify as "White," may offer richer and more heterogeneous experiences that were not described here.

Finally, the study only engages with the perceptions of therapy from the therapist's perspective; further research into client's perception and meaning making of silence will deepen our understanding regarding implications for clinical practice.

Implications for future research

Participants in this study described silence as having effects and enabling experiences and processes for clients. The above limitations suggest potential future research that is worth pursuing for reasons of developing specific and nuanced understandings of silence in music therapy, as well as general statements that may inform adaptations in clinical practice. Exploration into clients' experiences of silence within music therapy that engage with the inferences presented in this study may begin developing a more complete picture, offering insight into the therapeutic and intersubjective qualities of silence.

CONCLUSION

Using participant data from semi-structured interviews with three music therapists, silence has been illustrated as a multitudinous phenomenon within therapy. Although silence can be anxiety inducing and overwhelming, it may also be a space in which powerful meaning making, experiences, and therapeutic processes can be facilitated for clients. The implications for practice are direct, framing the strength of therapeutic relationship as an antecedent to beneficial therapeutic experiences in silence. The study outlines the need for further research into how silence is conceptualised in music therapy.

Disclosure statement and participant consent

The authors report no conflict of interest. Participants have consented to participation and publication of this research.

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Ελληνική περίληψη | Greek abstract

Κατανοώντας τις σιωπές, όχι μόνο τους ήχους: Μια διερεύνηση της νοηματοδότησης της σιωπής από μουσικοθεραπευτές στη διαδικασία της αυτοσχεδιαστικής μουσικοθεραπείας

Garrick Wareham | Luke Annesley

ΠΕΡΙΛΗΨΗ

Η σιωπή αποτελεί μια κοινή εμπειρία στη μουσικοθεραπεία, με ενδεχομένως πλούσιο νοηματικό περιεχόμενο· ωστόσο, η διαθέσιμη βιβλιογραφία σχετικά με τη σιωπή στην αυτοσχεδιαστική μουσικοθεραπεία παραμένει περιορισμένη. Το παρόν άρθρο αναδεικνύει συνδέσεις ανάμεσα στη μουσικολογική, ψυχολογική, φαινομενολογική και μουσικοθεραπευτική βιβλιογραφία που αφορούν: τυπολογίες της σιωπής, τη σιωπή ως διυποκειμενικό φαινόμενο, και τη σιωπή ως χώρο για αναστοχασμό και επεξεργασία. Η σημασία της νοηματοδότησης και της σιωπής στην αυτοσχεδιαστική μουσικοθεραπεία διερευνάται μέσα από δεδομένα ημιδομημένων συνεντεύξεων και με τη χρήση Ερμηνευτικής Φαινομενολογικής Ανάλυσης (Interpretative Phenomenological Analysis, IPA). Η ανάλυση των συνεντεύξεων μέσω της Ερμηνευτικής Φαινομενολογικής Ανάλυσης (IPA) ανέδειξε τρία υπερκείμενα θέματα, τα οποία αναπτύχθηκαν από τον κύριο συγγραφέα και ελέγχθηκαν από τον δεύτερο συγγραφέα, και τα οποία περιλαμβάνουν δέκα υποκείμενα θέματα: “Άγχος και ένταση κατά τη διάρκεια και μετά τη σιωπή”, “Η σιωπή ως χώρος” και “Κλινικές παράμετροι της σιωπής”. Γίνονται συνδέσεις ανάμεσα στην ανάλυση των συνεντεύξεων των συμμετεχόντων και στην υπάρχουσα φαινομενολογική, μουσικολογική, ψυχοθεραπευτική και μουσικοθεραπευτική βιβλιογραφία για τη σιωπή. Η συζήτηση καταλήγει ότι η αντιλαμβανόμενη ισχύς της θεραπευτικής σχέσης από τον θεραπευτή αποτελεί καθοριστικό παράγοντα για την εμπειρία της σιωπής στο θεραπευτικό πλαίσιο. Το άρθρο σκιαγραφεί επίσης τη σιωπή ως χώρο αναστοχασμού και αυτοπραγμάτωσης, καθώς και ως διευκολυντικό παράγοντα στην εμπειρία ενδυνάμωσης και αυθεντικότητας των πελατών. Επίσης, παρουσιάζεται μια θεωρία, βασισμένη στα δεδομένα των συνεντεύξεων, η οποία προσφέρει μια σκοπιά θεμελιωμένης θεωρίας. Η θεωρία αυτή προτείνει ένα μοντέλο συνέχειας και κυκλικής αναπλαισίωσης του νοήματος από το μουσικό στο σιωπηλό και πέραν αυτού. Η μελέτη προσδιορίζει τις επιπτώσεις στην πρακτική και αναδεικνύει περαιτέρω ευκαιρίες για την εδραίωση της υπάρχουσας θεωρίας και την ανάπτυξη εννοιών που είναι μοναδικές για τη σιωπή στη μουσικοθεραπεία.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

αυτοσχεδιαστική μουσικοθεραπεία, σιωπή, φαινομενολογική ανάλυση, νοηματοδότηση