2001

Solitude, Silence, and the Training of Psychotherapists: A Preliminary Study

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SOLITUDE, SILENCE, AND THE TRAINING OF PSYCHOTHERAPISTS: A PRELIMINARY STUDY

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The spiritual disciplines of silence and solitude have long been practiced within the contemplative Christian tradition as a means of character transformation and experiencing God. Do these disciplines affect the use of silence in psychotherapy for Christian clinicians in a graduate training program? Nineteen graduate students in clinical psychology were assigned to a wait-list control condition or a training program involving the disciplines of solitude and silence, and the groups were reversed after the first cohort completed the spiritual disciplines training. One group, which was coincidentally comprised of more introverted individuals, demonstrated a striking increase in the number of silent periods and total duration of silence during simulated psychotherapy sessions during the period of training. The other group, more extraverted in nature, did not show significant changes in therapeutic silence during the training. These results cause us to pose research questions regarding the interaction of personality characteristics and spiritual disciplines in training Christian psychotherapists.

To what extent do the characteristics of the therapist, or the match between therapist and patient, affect the outcome of psychotherapy? These questions have been studied over the past 40 years (e.g., Ricks, 1974; Orlinsky & Howard, 1980; Najavits & Strupp, 1994; Lafferty, Beutler, & Crago, 1991; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Strupp, 1980a, 1980b, 1980c, 1980d; Lieberman, Yalom & Miles, 1973). Therapist variables scrutinized in previous studies include age, gender, ethnicity, socioeconomic status, personality patterns such as dominance and authoritarianism, coping patterns, intellectual values, sexual and religious values, whether the therapist has had personal therapy, professional affiliation and training, theoretical orientation, level of experience, rate of speech, questioning style, sentence length, activity level, confidence, and a host of other variables (Lambert, 1989; Beutler, Machado, & Neufeldt, 1994). The goal behind much of

this research has been to uncover what characteristics of a therapist differentiate successful and unsuccessful therapists.

A set of therapist characteristics that pertains to spiritual beliefs and practices has potential influence on client treatment outcome. The spiritual life of a therapist could conceivably affect therapist characteristics and thereby change the interactions between the patient and therapist. Unfortunately, there is a paucity of empirical research investigating the spirituality of a therapist and its effect on the process or outcome of therapy. What little research that has been reported is focused more on the interventions used by religious therapists than on the therapist characteristics (e.g., Jones, Watson, and Wolfram, 1992). For example, Adams (1993) found a positive relationship between clinicians' personal practice of the historic spiritual disciplines and the extent to which they employ the spiritual disciplines in therapy. These previous studies provide information regarding techniques used in religiously oriented therapies, but do not directly address issues of therapist characteristics. To what extent does the personal practice of the classical spiritual disciplines change the therapist? Do these changes affect the therapeutic relationship in any meaningful way?

SOLITUDE AND SILENCE

Historically, Christianity has advocated the practice of spiritual disciplines as indispensable in developing Christian character (Foster, 1988; Willard, 1988). Two of these disciplines are solitude and silence.

Outward solitude is "choosing to be *alone* and to dwell on our experience of isolation from other human beings" (Willard, 1988, p. 160, emphasis his). As a person practices outward solitude, internal forces and conflicts that are muted or masked by the noise of routine interaction with others must be confronted. The facade presented to the outside world, which is so carefully developed over one's lifetime, begins to crack and break. According to Foster (1988), as a person is able to look past that facade to the authentic self, an inner solitude develops. The fear of being alone, or being with others, dissipates. Being alone no longer means loneliness, and being with others no longer means being controlled by them for fear of being rejected. According to Matthew, there were many instances throughout Jesus' ministry in which he took time in solitude: before choosing the disciples (Luke 6:12), after John the Baptist's death (Matt. 14:13), after miracles and healings (Matt. 14:23, Mark 1:35, Luke 5:16), and the night before his arrest and crucifixion (Matt. 26:36- 46) (Foster, 1988). In fact, Jesus began his ministry by spending forty days alone in the desert (Matt. 4:1-11).

Spiritual silence is not merely refraining from speech; it involves listening to God (Foster, 1988). In silence, people learn to hear what God would have them do. Like solitude, silence produces fear. Words are a way to manage and control others; and many people believe that if they don't speak, they will lose control of the situation or their image. The need to manage how others perceive us is strong, and the discipline of silence stops our efforts at self-justification. We no longer need to worry about defending our motives or actions. Instead, we can learn to trust God with our reputation (Foster, 1988). It is "only when we learn to be truly silent are we able to speak the word that is needed *when* it is needed" (Foster, p. 102, emphasis his).

Beginning therapists often struggle in their efforts to "speak the word that is needed when it is needed." Sometimes they speak words too soon, when silence is the best response

(Levenson, 1995). Kron and Friedman (1994) describe a therapy session in which an angry client fell silent after a few moments and remained so until the end of the hour. As she was terminating therapy the client described that time as the most meaningful hour of therapy she had experienced. Of course discernment must be used to determine whether silence is appropriate in a given situation, as it can have negative or positive effects (Cook, 1964; Hargrove, 1974; Lennard & Bernstein, 1960; Lief, 1962; Kron and Friedman, 1994; Matarazzo & Wiens, 1967; Wiens, Saslow, & Matarazzo, 1966). In this article, we are interested in knowing if the spiritual disciplines of solitude and silence affect beginning therapists capacity to sit silently in a simulated therapy experience.

METHOD

Participants

Participants were volunteers recruited from an incoming class of Master of Arts students in clinical psychology at Wheaton College. Extra credit in a person-centered therapy course and a free book were offered for participation. In the class, students were organized into groups of three, known as triads. These triads allowed the students to practice therapy techniques and interventions on one another. Each student played three roles during the triads: therapist, client, and observer. The instructor and teaching assistant of the course videotaped the triads on a weekly basis for review. All participants signed a release so the research team could review the videotapes of the triads.

Fifteen women and four men ranging in age from 22 to 53 years were the volunteers for this study. Seventeen were Caucasian, one was Asian-American, and one was Asian. Nine students chose to not participate due to scheduling conflicts.

Instruments

Preference for Solitude Scale. Participants completed the Preference for Solitude Scale, a 12-item test, developed by Burger (1995). Each of the items provides a choice of two options, one reflecting a preference for solitude and the other a preference for being with other people. According to Burger (1995), the scale was found to be internally consistent (K-R 20 = 0.70 to 0.73) and adequately valid for measuring a person's preference for solitude. Further examination of the scale by Cramer and Lake (1998) found similar internal reliability estimates (KR 20 = 0.74 to 0.75) and a test-retest correlation (r = 0.76) for a 6 to 8 week testing interval.

Faith Maturity Scale. All participants were given the Faith Maturity Scale (Benson, Donahue, & Erickson, 1993), a thirty-eight item questionnaire in which participants are asked to indicate their agreement with statements measuring "the degree to which a person embodies the priorities, commitments, and perspectives characteristic of vibrant and life-transforming faith, as they have been understood in 'mainline' Protestant traditions" (p. 3). The responses are measured using a 7-point Likert scale ranging from 1(never true) to 7 (always true). Participants must rate the extent to which the statements are in line with their beliefs and practices. Reliability estimates range from 0.84 to 0.89; and validity has been

demonstrated in several ways, including expert raters, comparison to known groups, its relation to age, and relation to other measures (Benson et al., 1993).

Introversing-Extraversing Scale. The Millon Index of Personality Styles (MIPS) Introversing-Extraversing scale is a measure of an individual's disposition toward looking outward versus inward in seeking information, inspiration, and guidance (Millon, 1994). Participants were given only the items pertaining to the Extroversing and Introversing scales. Research in the development of this scale indicates good internal-consistency reliability with estimated coefficient alphas of .82 and .77 for Extraversing and Introversing, respectively. Retest reliability was reported at .90 for both subtests.

Measure of silence. All triads were videotaped three times. The number of discrete silence periods was tallied and the length of each discrete silence period was measured in seconds. To qualify as a discrete silence period, the silence was required to be at least 2.5 seconds in length. Additional information was collected regarding whether the therapist or the client spoke last, as well as which individual interrupted the silence. Non-words (e.g., Mmm-Hmm, Uh, Umm, etc.) were considered to have broken the silence while "involuntary" noises such as sighing and coughing were not. Two separate individuals scored the videotapes to determine the length and number of silences, and a third person, who did not view the tapes, tallied the results. One rater was blind to the members of each group; the second rater was not. Interrater reliability was tested using Spearman's rho and ranged from $r = .89$ to $r = .98$. Because the correlations were strong, only the blind rater's scores were used for data analysis.

Design

A waiting list control group design was used. Participants self-selected their triads, and then triads were randomly assigned to training in spiritual disciplines (Group 1) or to the control group condition (Group 2). After the first experimental group (Group 1) completed the training and underwent an evaluation, the second group received the training in spiritual disciplines and the training for Group 1 was discontinued. All participants received an identification number so they remained anonymous from the data collection and analysis group.

Procedure

A baseline measure of all participants' use of silence was taken from a videotaping of the triads in their first meeting. The videotapes of the triads were examined measuring the frequency and duration of silence. Participants were asked after the videotaping to complete the instruments described above. At this point, Group 1 began the training process. The training consisted of two components, an instructional/accountability component and an experiential component. The instructional component consisted of an initial two-hour meeting to introduce the experimental group to the disciplines of solitude and silence. Information based on the work of Foster (1988), Willard (1988), and classical writers was provided. A graduate student familiar with these works and the spiritual disciplines provided the instruction and accountability. This individual did not participate in data collection or analysis. Copies of Foster's (1988) book, *Celebration of Discipline* were provided to all

participants. After the initial session, three follow-up sessions were required, one per week. These meetings lasted 60 minutes and provided additional training and guidance, recommendations for solitude and silence, recommended readings to be carried out over the following week, discussion of the participant's experiences from the previous week, and practice as a group with solitude and silence. The meetings were also used to provide some accountability for the progress of the participants in their practice of the disciplines and to note any other spiritual disciplines they may be doing on their own. A tracking sheet was used for the participants to self-report their activities.

The experiential component was also based on the writings of Foster (1988), Willard (1988), and classical writers. Participants started with small experiences of the discipline such as taking two or three minutes per day in solitude, or stillness, and silence. Each week, this was increased until, at the end of the training, the participants were encouraged to take thirty minutes of silence and solitude per day in preparation for a four-hour retreat at a nearby retreat center. The time commitment for participants was five hours in training and follow-up, a four-hour silent retreat, and the time spent weekly practicing the disciplines.

The second group (Group 2) also received some attention during this time. There was an initial two-hour meeting consisting of a seminar on how to write papers in APA format and graduate level expectations. The same graduate student performed this instruction to eliminate instructor variation. There were no follow-up meetings for Group 2 at this time. No assignments were given nor did they take the four-hour retreat. They were, however, asked to keep a log of the spiritual disciplines they were performing on their own. The time commitment for Group 2 was two hours plus the daily tracking sheets.

After Group 1's silent retreat, videotapes of both groups in their triads were reviewed for incidences and length of silences. All participants also completed the measures mentioned above. After completing these measures, the groups switched with Group 2 receiving training in the spiritual disciplines and Group 1 serving as a pseudo-control, thus allowing all students to receive the same training. Again, after the completion of this phase of the project, participants' videotapes of the triads were reviewed and the measures were administered. The total time commitment was approximately 12 hours per participant, plus the time spent practicing silence and solitude.

RESULTS

The two groups were compared prior to training as well as at the end of each training phase on the average number and the average length of silence periods during therapy simulations. Scale scores on the therapist's faith maturity, preference for solitude, and tendency toward introversion were analyzed at the end of each phase as well. Descriptive statistics for each of these variables are summarized in Table 1. Each hypothesis test was analyzed using a split plot analysis of variance (ANOVA).

Measurements of Silence

The first analysis revealed a significant between-subjects effect on the total length of the silences measured in seconds during the simulated therapy sessions, $F(1,17) = 11.24, p < .01$.

A within-subjects effect over time for the length of the silence variable was observed, F (1,17) = 17.78, $p < .01$. The analysis also reveals an interaction effect for group and time, F (1,17) = 11.99, $p < .01$. Finally, an examination of the within-subjects contrasts reveals that there was no significant difference within the participants on the length of silence between the baseline measure and phase 1, F (1,17) = 3.85, $p = .067$, but a significant difference between phase 1 and phase 2, F (1,17) = 14.80, $p < .01$. When the interaction effect with the group is examined, there is no significant interaction between the baseline and phase 1, F (1,17) = 1.38, $p = .26$, although there is a significant interaction between phase 1 and phase 2, F (1,17) = 11.05, $p < .01$. The results are presented graphically in Figure 1. These results pertain to the *total length* of silence observed during a simulated psychotherapy session, and an identical pattern of significant differences was observed when the *total number* of discrete silence periods was used as the dependent variable.

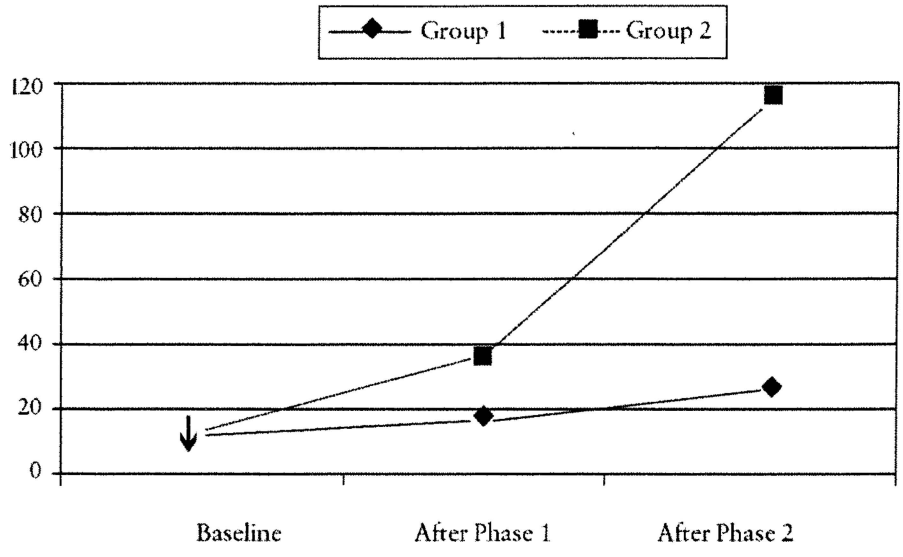

Figure 1. Duration of silence (in seconds) during simulated therapy sessions for Group 1 and Group 2. Group 1 received training in the spiritual disciplines of solitude and silence during Phase 1. Group 2 received training during Phase 2.

Therapist Characteristics

Split plot ANOVAS were also used to evaluate therapist characteristics. The first analysis was the therapist's preference for solitude, revealing a significant between-subjects effect, F (1,17) = 8.60, $p < .01$, with Group 2 scoring higher than Group 1. There was no within-subjects effect, F (2,34) = .314, $p = .73$. No interaction effect was observed, F (2,34) = .195, $p = .82$. A significant between-subjects effect was also observed on the introversion scale, F (1,17) = 10.74, $p < .01$, with Group 2 scoring higher than Group 1. There was no within-subjects effect, F (2,34) = .336, $p = .72$, nor an interaction effect, F (2,34) = .987, $p = .383$. With regard to faith maturity, no significant differences were observed between, F (1,17) = .351, $p = .562$, or within subjects, F (2,34) = .071, $p = .93$, nor was there an interaction effect, F (2,34) = .079, $p = .92$.

DISCUSSION

Neither group changed throughout the study with regard to introversion, preference for solitude, or faith maturity. Given that the experiment was of a short duration, it is unlikely that traits developed over a lifetime would be changed in a few short weeks. Therefore, it is not surprising that tendency toward introversion, preference for solitude and faith maturity did not change. Spiritual disciplines are not rapid behavior-change techniques. They work primarily through character formation, which only indirectly leads to changes in values and behaviors, presumably including behaviors emitted in the therapy office.

Table 1 Means and Standard Deviations of Dependent Variables

			Baseline		After Phase 1		After Phase 2	
Variable	Group	*N*	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev
Length of	1	10	11.6	12.6	16.6	17.4	22.3	32.2
Silence	2	9	14.9	12.2	34.6	45.5	112.9	59.2
Number of	1	10	3.3	3.3	4.6	4.1	4.9	6.1
Silences	2	9	4.1	3.5	7.6	8.7	22.8	8.7
Preference for	1	10	5.9	2.3	5.8	3.0	5.2	3.7
Solitude	2	9	9.6	2.3	9.0	3.8	9.2	3.6
Introversion	1	10	5.5	5.4	5.3	4.8	3.7	2.9
	2	9	13.7	5.9	12.9	8.5	13.9	8.6
Faith Maturity	1	10	4.9	0.3	4.9	0.4	4.9	0.4
	2	9	4.8	0.4	4.9	0.5	4.8	0.5

Note. Group 1 received training in the spiritual disciplines of solitude and silence during Phase 1. Group 2 received the training during Phase 2.

But is it possible that the disciplines of solitude and silence may also have some direct behavioral effect in promoting silence among beginning therapists? The expectation when this study began was that training new therapists in spiritual disciplines, specifically the disciplines of solitude and silence, would result in increased use of silence by the therapist with clients in a simulated therapy session. In fact, one of the two groups showed the expected changes in therapeutic silence after engaging in the spiritual disciplines of solitude and silence (The other group did not). Coincidentally, the group that changed in response to personal training in solitude and silence was comprised of individuals with greater preference for introversion and solitude than those in the other group. Perhaps those individuals who have a propensity toward solitude and introversion are the ones most immediately affected by a specific program in the practice of the spiritual disciplines of solitude and silence.

These results lend credence to the tentative conclusion that certain spiritual disciplines may promote particular therapeutic behaviors. However, these disciplines appear to interact with the personality characteristics of the trainee. Because the faith maturity measure did not change significantly during the experiment, nor was there a difference between the groups, the behavioral differences observed appear to be related more to personality than to depth of faith experience.

CONCLUSION

This is a preliminary study with distinct limitations (e.g., small sample size, short duration of intervention, simulated therapy sessions, limited to beginning therapists); thus, it is unwise to draw definite conclusions or make generalizations. Nevertheless, the findings are intriguing and somewhat unexpected, causing us to pose the following research questions to the broader community of scholars interested in the relationship of spiritual practices and therapeutic behavior:

1. Which spiritual practices interact with which personality traits in changing specific therapeutic behaviors?
2. Does the long-term practice of certain spiritual disciplines change the underlying characteristics (e.g., traits) of the therapist in addition to changing therapeutic behaviors? If so, can these character changes be predicted by the personality traits of the therapist prior to their training in spiritual disciplines?
3. Can spiritual disciplines be used to remediate particular weaknesses for students in training or clinicians in practice?

In proposing these research questions, we are mindful that the purpose of the spiritual disciplines has never been to produce competent psychotherapists, and we have some trepidation about trying to measure the effects of the spiritual disciplines with the techniques and instruments of science. This mixing of historic spiritual disciplines with Enlightenment epistemology produces discomfort. Can we effectively measure the work of God's transforming presence with pencil-and-paper self-report instruments or scientifically observable behaviors in the psychotherapy office? Despite these discomforts, and in full awareness that scientific study will probably never fully explain the therapeutic process or the mystery of spiritual disciplines, we believe this line of research may ultimately have something to offer the Christian clinician.

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