Silent about Silence

The ethical importance of 'non-talk' in qualitative health research.

Paul K. Miller & Tom Grimwood

Qualitative Research: Silence as a Problem?

- Ethically robust qualitative health research aims to preserve a speaker's original *meaning*; avoiding misrepresentation or decontextualisation.
- *Silence* challenges many of our existing conceptual frameworks.
- Part 1: Placing silence in a wider intellectual context.
- Part 2: Empirical case studies.

Conceptual Frameworks

- J.L. Austin (1961):
  - *How To Do Things With Words*.
  - Austin: concerned with theorising non-propositional language
    - (Propositional language = statements that are either true or false)
  - Speech acts can be 'brought off **non-verbally**'
  - So long as they are '**conventionally** non-verbal.'
    - BUT: Convention based on repetition
    - Absence of speech **substituted** with physical gesture
    - Suggests a wider intellectual context that perceptions of silence are framed within

Conceptual Frameworks

- Helen Steward, (1997):
  - *The Ontology of Mind*.
- 'Events' are not always and only 'changes'.
  - Events can also be changeless, such as 'the saying of nothing'.
  - 'Sometimes, as it were, we use our language to carve out events from a part of space and time where things remain unaltered. **Usually**, there is nothing to command our attention in such **dreary** scenes, but from time to time, an aspect of an unchanging situation can have significance which warrants the use of the language of events.' (p.71)

Conceptual Frameworks

- Observations:
  - 1. Dismisses significance and accentuates marginality;
    - But silence communicates regularly (see Jaworski 1992; Davidson 1984; Tannen 1989)
  - 2. Hypothetical example (as with Austin) leads to abstraction.
  - 3. Both (1) and (2) confirm a pre-existing order of meaning.
    - Implicit hierarchy rooted in western discourses: speech over non-speech.
    - Relationship of speech to power.

Conceptual Frameworks

- Both Austin and Steward employ a notion of context and convention.
- The ambiguity of silence leads both to turn to intentionality, or substitutions;
  - This tacitly accepts the priority of speech over non-speech
  - Silence loses its formative quality **as** silence
  - ...All **before** we have engaged with any actual data.
- In short: determining what silence **means** without allowing for what silence **does**.

In the World…

- Empirical sections framed within qualitative health research (own background), but wider applicability.
- One cannot 'not communicate' – *anything* is potentially meaningful.
  - A phone 'not ringing' it is not simply a 'nothing'.
    - Waiting for outcomes of a job interview?
      - Initially, because they've not decided?
      - Later, because they've spoken to the successful candidate first?
- The 'nothing' here may have a variety of meanings for an individual according to their expectations of what might/should/will happen, or 'usually' happens in their experience.
- *This meaning will impact substantially upon their behaviour.*

Parkinson's Disease.

- Illes, Metter, Hanson & Iritani (1988) / Harré & Gillett (1995).
- Speech in advanced Parkinson's characterised (among a range of characteristics) by:
  - Increased *number* of silent hesitations/minute.
  - Increased *duration* of silent hesitations.
- Raises problems <u>for those interacting</u> over what is a 'just a pause' and what is an actual 'silence' in talk.

Normative Expectations.

- Many studies reveal a normative expectation of VERY short silence durations in everyday conversations (approx 1.5 seconds, though variable by context).
- People tend to find silences of any greater length unusual, difficult or embarrassing – or at the very least evidence that the speaker has 'finished' unless 'umms' used.
- Research into Parkinson's revealed a tendency by co-interlocutors to 'jump in' after about one or two seconds of 'dead air'.
  - Interpret extended 'hesitation' as having finished'; start talking again.
  - Jumping-in creates new, challenging context for sufferer – shifts the interaction to new topic when last one not 'finished'. Highly confusing, never lets them finish what they are trying to say.
  - Understanding the problem helps with the solution – moral obligation to treat apparent 'silence' as 'extended contemplation time' even if it means leaving silences that are uncomfortably long in generic terms.

Qualitative Research.

- Same problem of interpreting meaning of silence can occur in health research as in health practice.
- Difference is that in practice it is usually understood that silence <u>is</u> significant:
  - Patient not answering questions in a consultation.
  - Therapy sessions often loaded with 'pregnant pauses'.
- In qualitative research, we often dismiss it outright.
- General conventions for effective transcription of interview data, for example, always geared towards correct representation of what is <u>said</u>:
  - Tidy-up 'ums' and 'ahs' for ease of reading.
  - Do not 'misrepresent' or 'de-contextualise'.
- BUT: Silence both part of action AND context, and we largely just delete that.

Conversation Analysis.

- Well-trodden theme in CA (see Sacks, 1992).
- Exclusive focus on form and structure of turn-by-turn interaction.
  - Essentially different mission to qualitative content-oriented analyses, e.g. Grounded Theory or IPA.
- Uses elaborate transcription system. Shows how people interpret actions (including silences) *in situ;* can often tell *how* by what they subsequently do.
  - 'Proof procedure'.
- For example:

Suicide Risk Assessment (Miller, 2004).

<u>[D-P/22/DP] <DEPRESSION/DEFERRED></u>

1.	Doctor:	well (.) ahm [PATIENT'S NAME] i:n any case where we diagnose depression (.5)
2.		the rules are that *((coughs))* well (.) before we talk about treatments we are
3.		supp<u>o</u>sed to check that it's not a <u>bad</u> case by ma:king sure you've never had
4.		any (.) a:hm how should I say? (.) self destructive thoughts?
5.		**(1.0)**
6.		you know (.) thoughts about hurt[ing↓
7.	Patient:	[ah god <u>no</u> *((laughs))* nah never (.) not
8.		with the kids and (.) tha (.) ah mean (.) it's hard sometimes (.) but (.) no
9.		(.5.) no (.) ah haven't thought about that at all ah (.) ah don't have t<u>i</u>:me
10.		to be <u>kill</u>in mahself *((laughs))*=
11.	Doctor:	=*((laughs))* that <u>is</u> good *((continues))*

However…

- Highly technical method often impenetrable to specialists.
- Certain zealotry among CA practitioners – all or nothing.
  - However! Don't need to be doing CA to take on board its sophisticated understanding of the import of silences.
- For example:

Depression in Primary Care (Miller, 2004).

- Doctor: Yes, well [patient's name], it strikes me that you have depression. Not severe, but it's just as well you came in. I know there are some misperceptions about depression, it's not an uncommon illness though and we can sort out treatment now. And in a minor case like this, there should be no problem, it's not a big deal at all.
- Patient: Well, you're the doctor!

Depression in Primary Care (Miller, 2004).

EXTRACT 1 [D-P/33/DP] <DEPRESSION/DEFERRED>

1.	Doctor:	ye:s (.2) well [PATIENT'S NAME] it strikes me that you (.) have depression (.) not severe↓ but it's just as well [you came in
2.		**(1.0)**
3.	Doctor:	I know there are some (.) misperceptions about depression (.5) it's not an uncommon illness though (.) and we can sort out treatment now↑
4.		**(1.5)**
5.	Doctor:	and in a minor case like this (.) there should be no problem
6.		**(1.0)**
7.	Doctor:	it's not a big deal at all
8.		**(.5)**
9.	Patient:	well (.) you're the doctor↓

Ethics and Power.

- First transcript shows exactly what was said.
- But! By deleting key silences, misses the fact that the patient is withholding agreement with the diagnosis over a series of interactional turns; is basically not happy with it.
  - Something the GP himself inferred when trying to downgrade the impact of diagnosis in response to each silence.
- *Tantamount to misrepresentation.*
- Methodological disempowering of the patient? Patient uses silence to indicate discontent. Shouldn't be ignored.

Conclusions.

- Silence is not aberrant, but an integral part of interactions.
- Instinctively understood by people when interacting, but often ignored when doing qualitative research.
- Both a methodological and ethical case for taking better account of the role of silence in qualitative content-oriented health research.

And That's That!

- All questions welcome!

Tom Answers!

Reflexivity.

- **Reflexive** framing between silence, words, physical actions and situations.
- All actions (including 'not talking') do not just happen 'in contexts', but are parts of the contexts they inhabit and ongoingly transform them, which informs future actions (Garfinkel, 1967).
  - Your question not getting an answer might = 'not heard' or 'ignoring you'; either way, you'll probably repeat it. The non-action creates a new trajectory of action.
- To ignore/delete the role of any of the features of a situation is to risk altering the import of what is going on.