How to do things with questions: The role of patients' questions in Short Term Psychoanalytic Psychotherapy (STPP) with depressed adolescents

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Abstract

The role of patients' questions in psychoanalytic psychotherapy is a neglected topic in the clinical and research literature. This qualitative study aims to bridge this gap by exploring the role of patients' questions in short-term psychoanalytic psychotherapy (STPP) with adolescents suffering from depression. This is a single case study, focusing on the interaction between the patient and his therapist when questions were asked by the patient, using conversation analysis methodology. Data were provided from a randomised controlled trial (RCT), known as the IMPACT study, in which all sessions were audio-recorded. The findings identify some typical ways in which the therapist responded to the patient's questions, and show that 'surprising behaviours' that seem associated with heightened affect appeared when the patient asked a question, leading to an enlivening of the therapeutic interaction. The study examines the significance of these findings within the context of the therapeutic relationship and discusses the implication of these findings for technique.

Introduction

In the 1930s, British psychoanalyst Edward Glover circulated a questionnaire among psychoanalysts in Britain with the intention of establishing their actual working practices. Of the sixty-three items on the questionnaire, analysts reached complete agreement on only six. One of these was the abstention from answering questions raised by a patient (Glover, 1954).

It is not entirely clear how such a consensus emerged. Sharpe (1930) attributes the origins of the 'rule' to Freud. Kelner (2009) suggests that Sharpe based her claim on Freud's response to his patient known as the Rat Man, where Freud suggested that 'whenever anyone asked a question like that, he was already prepared with an answer; he needed only to be encouraged to go on talking'. (Freud, 1909, p. 181). While this is a technique that Freud recommended in this case, it is hard to conclude that Freud meant this as a general rule, especially since he himself answered many of his patients' questions, as indicated by Thomä and Kächele (1987). Thomä and Kächele claim that the origin of the 'rule' should be attributed to Ferenczi, who in 1919 developed a counter-question technique, in which he 'made it a rule, whenever a patient asks me a question or requests some information, to reply with a counter interrogation of how he came to hit on that question' (Ferenczi, 1950 [1919], p. 183). He went on to explain that he did this because he was interested in exploring the impulse from which the question sprang and wished to direct the patient back to the 'sources of his curiosity'. Whether the root of the rule is attributed to Freud or to Ferenczi, these quotations indicate that both Freud and Ferenczi thought that withholding an answer might generate therapeutic insights. Freud focused on the unconscious content of the questions, whilst Ferenczi was preoccupied with the impulses behind the question.

Klein (1961) accepted the 'rule', claiming that questions should not be answered, only analysed. However she argues that children's questions should be treated differently. Re-reading her notes from her analysis of Richard, a 10-year-old boy, Klein noticed that she answered many of her patient's questions about her personal life. According to Klein, answering Richard's questions directly offered reassurance for his anxiety about the analysis coming to an end. Klein explained that the child's questions are different from the adult's because the 'child's curiosity expresses itself in a much more impetuous way, and they also expect as a much more natural thing, to know, for instance, whether the analyst has a husband or children or what her house is like' (Klein, 1961, p. 325). While she makes that distinction between children's and adult's questions, in a few points throughout her book she does wonder whether withholding answers from Richard might have actually been more helpful for his analysis.

Little exploration has been carried out into the practice of contemporary psychoanalytic clinicians. Sousa, Pinheiro and Silva (2003), however, claim that this 'strange recommendation' persists, suggesting that analysts are advised to refrain from answering patients' questions, even though there are hardly any written documents about this recommendation. Following an exhaustive search in electronic databases, Sousa et al. (2003) conclude that questions in psychoanalysis are a neglected issue, suggesting that the recommendation to refrain from answering patients' questions is something akin to a 'taboo', transmitted orally from generation to generation.

Commented [EE1]: Tense here ? You've got 'Freud suggested...' previously but now 'Klein accepts...'

Commented [EE2]: I'd delete 'question' here

Thomä and Kächele (1987) are also interested in the act of questioning, arguing that asking questions involves the analyst in a different way. While classical psychoanalysis aims for free association, from a relational perspective, a patient's questions may be understood as an attempt to move into a dialogue. Ogden (1992) suggests that this wish to form a dialogue with the analyst is typical of patients who feel that their own internal contents are worthless, and who therefore wish to pass their 'turn' to the therapist. Ogden also speculates that some patients who ask many questions feel it is too dangerous to wait and see how the relationship between them and their therapist unfolds, and so they seek immediate answers. Whereas Ogden emphasises the anxiety manifested in the use of questions, Parsons (1999) emphasises the playful aspect of patients' questions, showing how his patient's questions elicited playful interactions between them.

The idea that questions in psychoanalytic psychotherapy should be analysed as part of the frame of an ongoing 'interactional' structure (Jones, 2000) suggests that the methodology of Conversation Analysis (CA) might be appropriate in examining the role of questions in psychotherapy. CA is an approach that first developed in the field of sociology, but has been used widely as a way of exploring the specific ways in which dialogue takes place in a range of different settings, from phone conversations to conversations in the consulting room (Sidnell & Stivers, 2014). According to Peräkylä, Antaki, Vehvilaninen and Leudar (2008), the contribution of CA to the study of psychotherapy is through the concept of 'sequentiality', that is, the understanding that in social interactions, everything being said should be understood in relation to what has been said previously. When the patient and the therapist

speak, they present their understanding of what their co-participant has just said to them (Schegloff, 2007).

CA has been used to examine the therapeutic process by studying turn-by-turn interactions (Peräkylä, 2014), but patients' questions have had little attention in CA studies.   Although there is no CA research that aims specifically to focus on the use of patients' questions in psychoanalytic psychotherapy, some studies reveal patients' questions in their transcriptions. For example, in a single case study, Knox and Lepper (2014) show how an adult patient's question subverted a therapist's intended direction and controlled the conversational agenda.

In research looking at how conversations take place in non-therapeutic settings, many CA studies emphasise a link between questions and control. According to Heritage (2003), questions control interactions by imposing certain constraints on the answerers, the most important being setting agendas; a question is a demand to discuss a certain topic and it is impossible to neglect this agenda without interactional consequences. Hayano (2014) explains that questions project a preferred response. The basic preferred response that applies to all questions is that the responder should answer the question (an answer is preferred over a non-answer). There are certain actions, such as questions or greetings, which force a specific action in the next turn. These actions are referred to as 'adjacency pairs' by conversation analysts as there is an intuitive and reflexive link between the two turns, produced by two different speakers. It is unusual for the second item (an answer) to be missing following the first item (a question) (Stivers, 2014). When an answer is missing, it is treated as an indicator of disengagement rather than a non-

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answer. Therefore, people usually try to provide an answer even if they do not know the answer or they do not want to answer (Hayano, 2014). This may raise issues pertaining to the general recommendation in psychoanalysis to refrain from answering patients' questions, avoiding a 'preferred response', and the impact of this clinical decision on the patient–therapist relationship.

Studies using CA in medical (Gill and Roberts, 2014) and legal (Komter, 2014) settings reach the conclusion that within a professional relationship, it is the professional participant (e.g., a doctor) who asks the questions, whilst the lay participant (e.g., a patient) generally avoids asking questions. One study (Beresford and Sloper, 2003) explores conversations between adolescent patients and their doctors in a medical setting, demonstrating that adolescent patients are particularly reluctant to ask their doctors questions as they are worried about revealing their poor adherence to health recommendations. According to Shakespeare (1996), children and adolescents are assumed to have 'less-than-full membership' in social interactions. Full members 'are those with a shared stock of common-sense knowledge about the social world and a common competence in applying that knowledge' (Payne, 1976, p. 330), and it is assumed by society that children are in the process of learning those social rules and developing these competences, enabling them to become 'full members' in social interactions when they reach adulthood (Shakespeare, 1996). Perhaps adolescents are even more reluctant to ask questions than adult patients, as their 'lower status' derives from their position as the lay participant within a professional relationship, combined with society's perception of them as 'less-than-full members'.

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Hutchby and O'Reilly's (2010) study suggest that the child's or adolescent's 'less-than-half membership' status is not simply a feature of their status position within the hierarchical structure of society, but is also constructed through turn-taking and sequence-organisation in discussions between family members and professionals. They suggest that, in their study of children in family therapy sessions, the child's access to the conversational floor is often denied, while the adults are 'fighting' over their right to question and to control the agenda of the conversation. The child, in these interactions, does not get a chance to answer questions, and does not ask any questions.

Whilst patients' questions are under-researched in CA studies (Hayano, 2014) and neglected in the psychoanalytic literature (Sousa et al., 2003), the above literature suggests that patients' questions, and specifically adolescent patients' questions, may raise theoretical and technical challenges for clinicians. The current study attempts to bridge these gaps and to explore these technical and theoretical issues by examining the interaction between a depressed adolescent patient and a therapist in Short Term Psychoanalytic Psychotherapy (STPP) around the patient's questions. Specifically, it focuses on questions that aim to set the conversational agenda, aiming to examine the interactions these questions elicit.

Methodology

The current research is a qualitative single case study, offering a secondary analysis of existing data using CA to examine the way in which an adolescent's questions were engaged with in a case of short-term psychoanalytic psychotherapy (STPP).

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Setting

The data used in this study were recorded as part of the IMPACT study, a randomised controlled trial (RCT) that compared the effectiveness of STPP with cognitive behaviour therapy (CBT) and a brief psychosocial intervention for adolescents suffering from moderate-severe depression (Goodyer et al., 2017). The study was based in the United Kingdom and involved 465 young people aged 11–17 with a diagnosis of depression. All three treatments were manualised, and sessions were audio-recorded. The current study focuses on STPP, a model comprising twenty-eight sessions described in detail by Cregeen et al. (2017) in the treatment manual. In the manual, therapists are advised to use questions to assist their patients in elaborating or clarifying their speech (see Cregeen et al., 2017, p. 66), but there is no mention of patients' questions or how therapists should respond to such questions.

Families taking part in the IMPACT study were also invited to take part in a qualitative study, called IMPACT-My Experience (Midgley, Ansaldo, & Target, 2014). IMPACT-ME collected semi-structured interviews with young people and their families, and aimed at exploring their experience of STPP. These interviews took place at three different points: before treatment began, at the end of treatment, and at the one-year follow-up. At the end of therapy, the therapists were also interviewed. The interviews were also transcribed.

Data used for this study

The current study used twenty-five audio-recorded sessions of a single case from the STPP arm of the IMPACT RCT. After analysis of the audiotapes was completed, the findings were consulted and further data added to provide contextual information. These data included:

- Demographic and baseline information about the selected case collected during the IMPACT trial: gender, age, and presenting problems.
- Transcription of interviews with the patient and the therapist at the end of treatment, carried out as part of IMPACT-ME

Case selection

The case was purposively selected based on the following inclusion criteria:

1. An adolescent who had been randomised to the STPP arm of the study.
2. Audio-recordings available for at least six sessions.
3. The participant had taken part in the IMPACT-ME sub-study (which only covered cases seen in London).

Ten cases were identified which met these criteria, and from these, one was randomly selected in order to allow for an in-depth exploration.

Clinical introduction – selected case

The selected case comprised a female therapist and a 16-year-old adolescent male patient, named Sam (this is a pseudonym, assigned for the purpose of this study). Like all IMPACT patients, Sam had a diagnosis of depression and at the point of referral, he also reported that he was self-harming and had suicidal ideation. Sam had an exceptionally good attendance record of twenty-five sessions, and by the end

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of treatment Sam no longer met diagnostic criteria for depression, although he still showed quite high levels of depressive symptoms. These changes were maintained at the one year follow up assessment, at which point his depression levels had reduced further. (The research team did not have access to the therapist's clinical notes or assessment formulation, and no further details are given about the background to the case to preserve anonymity).

Based on listening to the audio-recordings of all the sessions, there were long periods when Sam appeared too depressed to engage in conversation, and most of the interactions between the therapist and Sam seemed quiet, flat and somewhat dead. Sam's self-harming behaviour was a significant focus throughout the therapy. The therapist appeared to understand Sam's self-harm as a form of self-punishment, claiming he directed his aggression inwards. According to their IMPACT-ME interviews, generally speaking, both Sam and his therapist experienced Sam's therapy as helpful. Neither Sam nor the therapist mentioned the topic of questions in their interviews.

Identification of the patient's questions

All twenty-five recorded sessions were reviewed by the first author to identify all patient questions. To be considered a question, speech needed to meet the following criteria:

1. The first author concluded that the therapist understood the utterance as a question demanding an answer, based on a turn-by-turn interaction. Rhetorical questions were not considered as questions as they do not demand an answer.

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2. The question was either grammatically a question or had rising intonation.

3. The question was not a clarifying question.[1] The rationale for the omission of clarifying questions was based on the focus of the research on how patients' questions control the conversation by setting the topic. Although clarifying questions do demand that the respondent discuss a certain topic, they do not set a new topic for discussion, but merely encourage the respondent to elaborate on the topic discussed in their previous utterance.

Once identified, the verification of text as a question was independently checked for reliability by a peer researcher, who listened to the audio-recorded sessions and confirmed that the questions identified by the first author met the above criteria.

Transcriptions

Using a transcription methodology created by Jefferson (2004) which constitutes the basis of CA, the author transcribed in detail the interaction around each of the patient's questions – a few seconds before the question and then the interaction that followed directly afterwards. For reasons of practicality, it was decided to keep the interaction transcribed to approximately 3 minutes in total for each question. The transcription methodology attempts to capture sequences as heard through the audio-recording, including pauses, overlapping speech, or changes in volume, reflecting how the utterances were made.

Data analysis

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[1] This refers to questions that demand that the therapist elaborate on her previous utterance, without adding any new interpretations/ideas. Questions such as, 'What do you mean?' were omitted from this research, but questions such as, 'Did you mean that I was depressed?' were not omitted. Whilst the former question solely asked for clarification, the latter added the idea of depression.

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Commented [EE7]: Not any old peer !

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Once the CA symbols were applied to the transcriptions and their credibility verified, analysis of the data extracts was undertaken, starting with an examination of the responses between therapist and patient and how they took turns (Peräkylä, 2014), and attempting to identify a pattern occurring within the patient–therapist interaction centred on the patient's questions. As with verification of CA symbol use, the credibility of the analysis was again independently checked by a peer researcher who reviewed the process. Finally, based on the CA findings, the first author offered her own clinical reflection on the transcriptions, drawing on her psychoanalytic perspective. This clinical reflection was included to allow for a dialogue between CA and a clinical/psychoanalytic perspective to take place in how the data could be understood.

Ethics

All therapists and young people in the IMPACT study agreed to their sessions being tape recorded for the primary purpose of assessing treatment fidelity, and additionally for examining the process of psychotherapy (Goodyer et al., 2017). The IMPACT study protocol was approved by Cambridgeshire 2 Research Ethics Committee, Addenbrookes Hospital Cambridge, UK (REC Ref: 09/H0308/137), and informed written consent was obtained from all participants in the study. To protect the confidentiality of the participants in the current study, identifiable details, such as the names of people/places, have been disguised.

Results

Across the 25 sessions of Sam's therapy, fifty-three patient questions were identified, but twenty-four of these did not meet the above criteria Sixteen were

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categorised as rhetorical questions and eight were categorised as clarifying questions, and therefore did not meet the criterion (see *Identification of patients' question* in the methodology section). Therefore, this study is based on the analysis of the remaining twenty-nine patient questions. Interestingly, none of these appeared in the first seven sessions, suggesting that the therapeutic relationship needed to be established before Sam felt able to ask questions. From the eighth session, the twenty-nine questions appeared in different sessions.

Analysing the turn-by-turn interaction in the transcribed sequences led to the following findings: in all the sequences, following the patient's question and the therapist's response, 'surprising behaviours' (Goffman, 1961) appeared, performed verbally by at least one of the participants - usually the patient. These 'surprising behaviours' included a particularly long turn, a change in volume, interruptions, swearing, or a change in pace. Goffman (1961) argues that 'surprising behaviours', when one of the participants takes the freedom not to meet the demands of the conversation, are indicative of strong emotions, particularly anger. Although Sam was withdrawn throughout most of the treatment, his questions were associated with affective experience and expression.

The appearance of 'surprising behaviours' and the eruption of strong emotions are demonstrated in the following examples. These examples also illustrate how the absence of a direct answer, namely the therapist's 'non-preferred' response, facilitated the expression of strong affect. The questions asked by the patient are highlighted in bold.

First example: This interaction, taken from the eighth session, is representative of many of those across the therapy. Following the patient's question and the lack of a preferred-response from the therapist, anger was expressed through the patient's 'surprising behaviours' (in this instance, swearing, shouting and taking a particularly long turn). These 'surprising behaviours' could be understood as a rupture in the patient–therapist interaction, which was repaired within the 3-minute sequence. Ruptures and repairs are recognised as universal features of conversational interactions and are identified at the level of the turn (Sacks, 1992; Schegloff, 1992, 2006). According to Knox and Lepper (2014), ruptures in a conversation occur when there is a clash in participants' perspectives. When a rupture occurs, the participants often work to restore the turn-taking order to enable the conversation to continue. The methodology of CA may detect conversational micro-ruptures and repairs of which the participants may only be vaguely aware.

1. P: I (.) ah yeah

2. T: still it must be a bit, a bit unsettling, as if you don't know where you belong, do you <u>belong</u> upstairs do you belong downstairs↑

3. : °I go upstairs and then I come here°=

4. T: =mmm

5. **P: °I don't know why ah that work (.) I can always just come here?,° ↑**

6. T: you don't know why you can't come directly here?

7. P: yeah

8. T: you don't like to have having to sort of register in somewhere (2) What don't you like about that?↑

9. P: It's all right ((Noise)) I don't like being told what to do °too much° (.) This is very (xxxxx) I just don't like it

10. T: so in a way last week when you were a bit late ummm <You quite perhaps liked the challenge of finding your way to the room and just coming in↑>

11. P: mmm pretty much (-) I mean there's there's this like this not being told what to do thing like I'm supposed to be one of my friends he's quite like an (.) what's the word (.) I don't use the word posh but that's the only word I can think of he said for his birthday he's invited me and his friends to go to dinner at someplace and you'll have to ((Noise)) And I don't know what he said it's something like everyone else got it, I didn't get it I didn't get it, it's like you have to wear I don't know it's like casual-smart or something like that something too it's like oxymoron one thing is completely different to the other and said <I don't know what that is> and he's like well everyone knows what it is. And I'm like <WELL I DON'T> and he says wear this and I was like why would I go like a <u>party</u> or something wearing what I'm wearing to school (.) it's like it's like these are the only smart trousers I've got I never had to dress smart for anything else I don't want to (.) And I just don't like being told I have to dress the same as other people (.) Cause it's like why do everyone have to wear the same clothes?↑ IT'S STUPID and it's like if you like don't wear those clothes people will judge you it's like fuck off (.) you don't judge someone by the fact (.) or you do

You can judge someone by the fact that they think they can judge you because they think you are not wearing the right clothes it's like with school uniform you have to wear it but a party or something if everyone has to wear the same clothes well what's the point it's boring, °isn't it°? Boring to have to wear the same shirt and everyone wearing black trousers (.) so what I'm gonna' do I'm gonna' (.) basically get a pair of black skinny jeans wear them I don't have any smart shoes so I'll wear these or something even less smart something black but but it wouldn't fit with something else, wouldn't it? And really really brightly colour [shirt

12. T: /(laughs)]

13. P: /and they'll be like well I've got the shirt on (.) I've got black trousers on so what's the problem? (laughs) (.) see what people think cause it's like it just pisses me off everyone saying you have to wear this (.) and if you are not you are obviously an idiot or you are obviously (xxxxx) not confirming to the stupid rule you just decided to (xxxxx) (1)

14. T: you clearly don't like being told where to go (.) and wait (.) and maybe you also don't [like

15. P: it's so stupid] just sitting and [waiting

In the above interaction, Sam asks the therapist why he had to wait in the waiting area (turn 5). The therapist does not answer the patient's question directly, but instead acknowledges his dissatisfaction, 'you don't like to have having to sort of register in somewhere' (turn 8). This acknowledgement is, in fact, an indirect question, as the therapist is seeking more information. In other words, instead of

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answering the question directly, the therapist indirectly refers an indirect question to the patient. Sam's failure to provide an answer creates a pause in their interaction (2 seconds of silence). Following the therapist's refusal to answer a direct question, Sam responds similarly with a non-preferred response. This can be understood as a 'micro-rupture' in their interaction.

After the silence, the therapist re-phrases her questions, asking the patient directly 'what don't you like about it?' (turn 8). Sam then takes a particularly long turn, which includes raising his voice and swear words. Through these 'surprising behaviours', he demonstrates the freedom of not meeting the demands of the conversation, expressing the anger that triggered his question about the waiting area initially. The therapist enables the patient to take this long turn and to express his angry feelings in this way. At some point, however, she laughs (turn 12), putting a boundary to the patient's long turn, and then Sam also laughs (turn 13). The patient's laughter mirrors the therapist's laughter, indicating a collaboration between them. Their laughter is a micro-repair.

Following this micro-repair, they are back on track, meeting the demands of the conversation: each taking their turn, yet also enabling the other to contribute (turn 12–15). The therapist can then return to the initiating topic, that is, the patient's question in turn 5, sharing her observation about the patient's underlying feelings about waiting for the session in the waiting area (turn 14), and then getting his agreement (turn 15). Whilst there is an agreement in turn 15, Sam also behaves 'surprisingly' again by interrupting the therapist (turn 15). The sequential order has

been repaired, but the patient may have needed to let his therapist know that he still feels angry or frustrated.

Clinical/psychoanalytic commentary: Sam's question, and the therapist's non-preferred response, create a micro-rupture in their interaction. Following this rupture, in turn 11, Sam's speech is aggressive and somewhat chaotic, resembling a toddler's tantrum. The therapist responds to the 'tantrum' by enabling him to express his aggression (allowing him to shout, swear and take a particularly long turn), but she then puts a limit to it by 'surprisingly' interrupting him. Akin to the good-enough mother's response to her toddler's tantrum, the therapist is 'open' to his communications but also puts a boundary in place, protecting Sam from his own emotions. It is possible that, consciously or unconsciously, the question that elicited this interaction was aimed at creating this type of mother–child interaction. Sam's question may have been consciously or unconsciously motivated by his concern about the therapist's capacity to tolerate and contain his aggression. Despite the therapist not replying to the content of Sam's question, she seems to understand Sam's need to express his anger, and her non-preferred response enables this to happen. Answering the question directly may have shut down the anger that triggered the question about the waiting area, denying Sam the opportunity to feel he could express his anger and that his anger could be contained.

Second example: in the first example, Sam's question and the therapist's response initiated a micro-rupture in the patient–therapist interaction, allowing angry feelings to erupt. In the following extract, taken from the fifteenth session, 'surprising behaviours' (a particularly slow and quiet voice) also feature after Sam's question,

expressing more depressive feelings. In this example, it was both the patient and the therapist who were speaking particularly slowly using a quiet voice. The following extract illuminates how the therapist responded to many of Sam's questions as 'transference-material', and avoided a direct answer. The therapist's interpretation of the transferential dynamics, and the slow, quiet voice she adopted, allowed the expression of Sam's depressive feelings, and an intimate exchange between the two of them. The following sequence took place after Sam shared his worry about not having friends at university.

1. **P: °why would you want to be with someone that is just depressed?°**
2. T: I think it's hard for you to <u>really really</u> believe that the reason why we have 28 sessions is because that's what the project is (.) when you are in that kind of state and you think no one including me would want to be with you you think that <u>really</u> I just divided it in half as if I can't bear to be with you for the whole (.) someway you must know that's not true (.) but that's what it feels like (2)
3. P: ummm (6)
4. T: <I think you do realise that it is very important to keep coming here>
5. P: yeah (xxxx) (5)
6. T: <well there are still some sessions to go (.) and you can choose to (.) have them>=
7. P: =yeah
8. T: <ok and we had our extra time we need to stop for today>
9. P: alright

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In turn 1, the patient, speaking very quietly, asks a question, expressing his worry about his depression pushing people away. His quiet tone of voice tallies with the depressive feelings to which he is referring. By using a question, he demands a response from the therapist. The therapist, then, responds to Sam's question by taking a relatively long turn, which includes many silences and pauses, and talks about the patient's fear. The therapist reframes the question about making friends at university as a 'transference question', related to their relationship.

In turn 3, the patient appears to agree with the therapist ('ummm'), and thereafter, there is a particularly long pause (6 seconds). The therapist then takes her turn, speaking surprisingly slowly (turn 6), responding to Sam's fear about not being wanted by saying: <I think you do realise that it is very important to keep coming here>. In that way, the therapist shows the patient that he is wanted: she wants him to come. The surprising slow voice adds affect to her words, as she sounds warm and soothing. In turn 5, the therapist obtains the patient's agreement, and then there is another long silence. The therapist then responds in turn 6 by speaking particularly slowly, encouraging the patient that there are still sessions to go, addressing his worry about being abandoned. Sam, in turn 7, responds straight away, by saying: 'yeah'. The lack of gaps between their turns conveys that the patient was attuned to the therapist's speech, enabling the therapist to end the session in turn 8: 'ok and we had our extra time we need to stop for today'. The therapist employs the same slow, soothing voice in that turn, making the ending feel smooth. Without the previous collaboration between them, the ending of the session might have felt abrupt. In turn 9, the patient responds by saying 'alright'. Perhaps, despite the depressive feelings, there is something 'right' in the interaction between them.

Clinical commentary: A few minutes before the end of the session, Sam asks a question, expressing his anxiety about abandonment. From that moment, the therapist adopts a slow, soothing voice in attunement with Sam's low mood. Throughout this interaction, Sam remains mostly quiet. This exchange resembles an interaction between a mother and her baby before bedtime, as if the therapist is helping Sam relax and fall asleep. The therapist understands that Sam needs to be reminded that she is there for him. Namely, without directly answering his question, the therapist responds to Sam's question by showing him that she is not abandoning him. The therapist's maternal presence and reassurance facilitate their smooth separation at the end of the session. Perhaps Sam's question was aimed at creating this intimate interaction, and the therapist understands that and responds accordingly.

Third example: the following sequence, taken from the twenty-third session, provides an example of an interaction in which the patient asked multiple questions, and the therapist responded to all these questions with a non-preferred response (lack of direct answers). The appearance of the patient's questions one after the other was typical of many of the sequences. In the following sequence, the 'surprising behaviours' included overlaps and abrupt changes in volume.

1. P: English literature ruins the enjoyment of the book I read not because I had to revise but because I just said well I'll read and without thinking about any of the stuff I worked on at school I enjoyed it because it is a good book and it means quite a lot of things (.) **have you read it?** ↑ Yeah it's quite good

Commented [EE12]: Another full stop.

2. T: you really wanted to know if I passed my GCSEs and A levels↑ [what have I read and done↑

3. P: **I guess] I guess you did °did you do GCSEs?° ↑Did they have GCSEs?↑ °I don't know if they had GCSEs°**

4. T: well maybe you want to know what kind of things I'm interested in ummm that might that might have some connection with your interest you quite often ask me about music or (.) literature (.) trying to find a way of connecting up with someone that is a lot older than you mmm (2)

5. **P: °ummm what did you do for A levels ?↑°**

6. T: °you are quite curious now to know° [how did I

7. P: /I think]

8. T: /manage my exams

9. **P: I think you already told me but I can't remember did you do Spanish?** ↑ You said something something about Spanish or maybe that somehow

10. T: maybe your memory is maybe perhaps you do remember that ummm when you were reading when you were telling me about your Spanish (.) you wanted to know if I understood it or not

11. P: yeah that's what I was thinking

12. T: so maybe somewhere in your mind you were thinking I must have studied Spanish at one point in my life

13. P: **did you?↑**

14. T: well I think you might also really be sort of much more interested in what °you know° what have I studied to be able to do what I'm doing now it's not so much understanding Spanish to be the issue but it's understanding <u>can</u> can I

understand (.) you and your some of your emotional ups and downs it's a

different kind of language

15. P: yeah

16. T: that seems to be much more

17. P: =well I'm guessing it's much more difficult than understanding Spanish but I

guess there are things that people do °when something is going on when

specific things happened to them° like there are specific behaviours that

indicate something

In the above interaction, the patient asks five questions. In turn 1, Sam takes a

relatively long turn, ending with a question. He wants to know whether the therapist

has read the book he has been studying at school. In turn 2, the therapist does not

provide a direct answer, but refers to other things the patient wants to know about

her, such as whether she passed her GCSEs. Sam then interrupts the therapist's

speech in turn 3, rephrasing the topic the therapist raised as a direct question to the

therapist: 'I guess] I guess you did °did you do GCSEs?° ↑Did they have GCSEs?↑ °I

don't know if they had GCSEs°'. The 'surprising behaviour' of overlapping the

therapist's speech in turn 3 may be linked to his anger towards his therapist for not

providing him with a direct answer. The overlap could be indicative of a 'micro-

rupture' in their interaction due to the therapist's failure to provide an answer. In this

turn, the patient also lowers the volume of his speech, then raises the volume and

lowers it again. The abrupt changes in volume may be the result of his feelings of

confusion and anger about the therapist's failure to answer his questions directly. In

turn 4, the therapist responds again without answering the question directly. She

takes a relatively long turn, re-framing his questions as 'transference-material', linking it to his curiosity about their common interests.

In turn 5, despite not getting his preferred response, Sam asks another question pertaining to the therapist's personal life, giving the therapist another chance to 'please' or 'disappoint' him – 'repairing' their interaction or deepening the 'rupture'. He does so by speaking particularly quietly.

In turn 6, the therapist responds again without providing a direct answer, reflecting on the adolescent's curiosity. The therapist speaks particularly quietly in that turn, which may be a reaction to Sam's constant demands. The patient, then, surprisingly, in turn 7, interrupts the therapist's speech, making it clear that he wants an answer to his question. In turn 8, the therapist finishes the point she started in turn 6, letting Sam know that despite his insistence, she refuses to give him what he wants. In turn 9, despite her refusal to answer, Sam asks another question. In turn 10, the therapist does not offer a direct answer, but links the patient's question to a previous conversation they had. Whilst the patient wants to know about his therapist's past, the therapist links the question to a previous exchange between them. The patient confirms, in turn 11, that he shares the same memory. This is a moment of micro-repair, in which they both refer to a shared experience.

Following the micro-repair, in turn 13, Sam again asks a direct question, pushing the therapist into a corner, insisting on getting what he wants. The therapist then relies on the micro-repair in turns 11 and 12 and offers her understanding of the dynamics between them. According to the therapist, Sam's questions have to do with his worry about being misunderstood. This enables the patient and the therapist to think about

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this worry in turns 15–17, and Sam drops his insistence on a direct answer. It is the therapist's avoidance of preferred responses that enables them to explore Sam's underlying worry, and when this worry is acknowledged, the questioning stops.

In this interaction, the therapist avoids providing direct answer to any of Sam's five questions. In classic psychoanalysis, it is the therapist who learns about her patient's personal life and not the other way around. When the therapist refuses to answer Sam's questions by providing personal information about herself, Sam makes another attempt, making it clear that he refuses to conform with the 'rules'. By refusing to answer the patient's questions, the therapist upholds the 'rules' of the professional encounter, but this leads to a micro-rupture in their interaction.

Clinical commentary: In this interaction, Sam may be using questions as a means to engage the therapist in a verbal-intercourse, attempting to 'penetrate' into her mind. Sam's transference towards his therapist appears to have a sexual nature. He may be using questions to establish his self-assertion and masculinity. Although the therapist refuses to answer his questions (refuses to be intruded upon), she does acknowledge his wish to be known (remembered and understood), and it is this acknowledgement that ends his questioning. The questions, in this interaction, can be understood to have a developmental function, enabling Sam to explore his sense of control and his potency.

Discussion

In his book *How to do Things with Words*, Austin (1961) coined the term 'speech act', suggesting that 'by saying something, we *do* something' (p. 1). He was referring both

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to the action taken by the speaker through his utterance and to the utterance's effect on the listener's actions. Whilst the twenty-nine questions identified in this study differed in terms of content, they all elicited similar 'actions' as the participants behaved 'surprisingly', either expressing strong anger or depressive feelings. In other words, the questions 'did' something in the interaction, and perhaps the role of the questions was to prompt a certain interaction.

Through the use of CA, this study has identified a specific pattern in relation to questions and answers: following the adolescent's questions and the therapist's 'non-preferred' responses, the patient and the therapist found themselves in a 'lively' interaction in which strong feelings erupted. These interactions were unique within the context of this treatment, as the therapist described Sam as withdrawn. Thus, it can be argued that the function of the questions was to fight the 'deadness', changing the nature of the interaction by eliciting a lively dialogue. The therapist's non-preferred response facilitated the expression of these feelings and their containment. Through the questions, Sam appeared to demand care and requested special attention, and the therapist's response could be understood as maternal.

Understanding questions as a request for special attention is interesting in relation to Freud's (1909) response to a question asked by the Rat Man, in which the Rat Man asked for a prognosis and Freud reassured him that the situation looked very favourable. Here, Freud answered the Rat Man's question directly, and also added some reassuring compliments: 'In this connection I said a word or two upon the good opinion I had formed of him, and this gave him visible pleasure' (1909, p. 178). Whilst Freud in 1909 and the therapist in the current study responded very differently

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to their patients' questions (Freud answered this question directly, and the therapist in this study mostly avoided direct answers), the patients' question, in both cases, invited a parental response and an intimate exchange. Whereas Freud offered direct reassurance to the Rat Man through his preferred response (direct answer) and additional compliments, the therapist in this study offered subtler reassurance, which could best be understood by the way in which the interaction played out following the question/non-answer interaction.

This research contributes to psychoanalytic exploration of patients' conscious and unconscious motivation in using questions. Although Ogden (1992) speculates that patients ask questions to pass their turn to their therapist in an attempt to avoid feelings of uncertainty and emptiness, this study suggests that questions may be used by adolescents as a means of connecting, and as an attempt to elicit a meaningful interaction which may be facilitated by the therapist's response. This research suggests that it might be beneficial for therapists to pay detailed attention to whether and when their patients ask questions, and to consider what function these questions and responses are serving in their interactions.

This study also suggests that there is a link between the patient's questions and aggression, as many of his questions elicited interactions in which angry/aggressive feelings were expressed. This link is particularly interesting given the patient's diagnosis of depression, as psychoanalytic formulations of depression often associate depression and aggression. According to Parsons (2007), during puberty, adolescents are besieged with increasing sexual and aggressive forces as their bodies change. As a result of this abrupt change, they are often scared of their own

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aggression, specifically its potential to harm their objects, and may therefore direct their aggression inwards. This deflection prevents the development of healthy aggression, which is essential for psychic growth, enabling the adolescent to separate, individuate, and develop mature sexuality. When healthy aggression does not develop properly, the adolescent may experience depression and might self-harm. According to this study, questions in psychotherapy may be an opportunity for the patient to direct his/her aggression outwards in a safe space. The therapist's response to the patient's questions is important in enabling this to happen, and for this process to feel safe for the patient. In this study, the therapist's clear boundaries and sensitivity, expressed through her tone of voice (soft, slow, quiet, laughter), contributed to feelings of warmth and safety, whilst the non-preferred responses encouraged the expression and exploration of aggression.

According to Winnicott (1963), adolescents in the process of healthy development need to 'prod' society and to question the adult world. Winnicott argues that 'antagonism' is essential for the adolescent's healthy maturation process and that it is the role of those in his/her immediate environment to contain such oppositional behaviour, although this is easier said than done. Therapy may provide a safe space for the adolescent in which s/he gains the opportunity to provoke an adult, and questioning may be a way of doing so.

In his paper about play, Parsons (1999) refers to interactions with an adult patient, who asked many questions about Parsons' personal life. Parsons describes many of his interactions with this patient as a 'playful battle', comparing these interactions to a karate lesson in which the participants pretend that they wish to hurt each other. It

is interesting to think about the idea of a 'playful battle' in relation to the conversational ruptures and repairs identified using CA in this study. These ruptures and repairs, following the patient's questions, did not lead to a breakdown, but were fixed within seconds. According to Safran, Muran and Eubanks-Carter (2011), the presence of rupture–repair episodes is associated with a good therapeutic alliance, whereas failure to resolve alliance ruptures is seen as predictive of dropout. The link between ruptures in the alliance and conversational ruptures, as studied by CA, has not yet been fully examined. It may be the 'playful' quality of these 'battles', however, that enables the conversational rupture to be repaired quickly, preventing the rupture from intensifying.

There are a number of limitations to this study, which mean that the findings should be treated with caution. This was a single case study, so it cannot be concluded, based on this research, that all adolescents ask questions during therapy, and if they do, that all adolescents use questions in the way demonstrated by this young person. A unique characteristic of the young person was that he was an exceptionally good attender who engaged well in the therapy process. Comparisons with other cases of depressed adolescents, or adolescents with other reasons for attending therapy, or younger children, would enable an examination of whether there is a link between patients' questions and the particular characteristics of each young person and their developmental stage.

Conclusion and implications for clinical practice

This was a single case study, exploring the role of an adolescent patient's questions in STPP using CA methodology combined with a clinical psychoanalytic

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commentary. The study found that 'surprising behaviours' that seemed connected with strong emotions appeared when the patient asked a question that potentially aimed at setting the conversational agenda. These questions, and their responses, elicited a 'lively' interaction between the patient and the therapist, often leading to episodes of conversational rupture and repair. The findings of this study suggest that clinicians should be mindful of what questions 'do' in an interaction with a patient, considering the interactions elicited by questions as an important clinical dynamic that may potentially be therapeutic. This study suggests that it might be helpful for clinicians to reflect on their patients' questions (or their lack of questions) in supervision and for supervisors to be aware of this too. It also suggests that training school might consider covering the topic of patients' questions as part of their curriculum. Further research on patients' questions, and different types of questions, may expand our understanding of their role within the unique relationships between patients and therapists and assist us to think about questions in a more nuanced way.

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