Dissertation Volume 2

Literature Review

Empirical Research Project

Reflective Commentary

Candidate Number: [redacted]

University College London

Submitted in partial requirement for the Doctorate in Psychotherapy (Child

and

Adolescent)

DECLARATION

I declare that the material submitted for examination is my own work. The ideas and findings of others have been referenced in accordance with the guidelines provided and any work by others has been acknowledged.

I understand that anti-plagiarism software may be used to check for appropriate use of referencing.

Candidate Number: [redacted]

Date: 11.08.2022

Signature: Alice Dehl

Table of Contents

Acknowledgements

I would like to thank my research supervisors Elizabeth Edgington, Georgia Lepper, and Nick Midgley, for their support and guidance as I have undertaken this research.

Part 1: Literature Review

Title: **The Therapist's Use of Questions in Psychoanalytic and Other Therapies: a Literature Review.**

Candidate Number: [redacted]

Word Count: 7891

Abstract

This paper reviews the literature on the therapist's use of questions in psychoanalytic and other therapies. It starts by reviewing the function of questions in everyday conversation before going on to briefly review the history of questions in psychoanalytic practice. Finally, following a systematic search of the literature, the existing empirical studies focused on the therapist's use of questions are reviewed, showing that there is a gap in the literature with regard to empirical studies of questions in psychotherapy generally, and in particular in psychoanalytic literature. This paper argues that this is an important gap to address, as questions have been shown to be a key element of psychoanalytic technique which raises broader issues about the role of the therapist in psychoanalytic psychotherapy, and clinical technique. Possible reasons for this gap are also discussed.

Introduction

This paper presents the findings of a review of the literature around the therapist's use of questions in psychoanalytic and other therapies. How psychoanalytic psychotherapists use questions has been a neglected issue, both in the psychoanalytic literature historically, as well as in the contemporary empirical literature. It is also an important area with consequences for clinical technique and for our broader understanding of the

role and aims of psychoanalytic psychotherapy. Questions are an integral aspect of therapeutic work and of the interaction between patient and therapist, but they are utilised variably in different forms of therapy. In solution focused therapy for example, there would likely be a high proportion of direct questions from therapist to patient (Macmartin, 2008). Questions might be used by some therapists to encourage their clients to speak more during sessions (Muntigl & Zabala, 2008). Others consider questions as therapeutic interventions in their own right (e.g. McGee, Del Vento, & Bavelas, 2005). Therapies using high numbers of questions, as with solution focused or cognitive behavioural types of therapy, have been described as 'question driven', compared with 'response driven' therapies such as psychoanalysis and psychoanalytic psychotherapy, in which the therapist conveys their understanding of the patient's experience, in response to the patient's verbalisations (Peräkylä & Vehviläinen, 2007).

This paper will begin by giving a more general introduction to the literature on questions, and considers questions as part of different types of conversation. The second section of this paper considers the role of therapists' questions in psychoanalysis. Questions are shown to be generally neglected in the historical psychoanalytic literature, and it is only more recently that researchers are beginning to address this gap in the literature. The third section of this paper comprises a systematic, narrative review of the empirical literature on therapists' questions in psychotherapy. This is not limited to psychoanalysis for two reasons: firstly, because of the paucity of empirical papers in this area; secondly, in order to understand more generally how

research has examined the way that therapists use questions in psychotherapy, to provide a context for considering how psychoanalysis might develop empirical research in this field.

This paper argues that empirical approaches to examining how therapists use questions in the psychotherapy field, and especially within psychoanalysis, are still at an early stage of development, and that further research is desirable in order to shed more light on an important part of therapeutic technique, which has been neglected in the empirical and the theoretical literature.

Questions in conversation

In order to better understand the use of questions in psychotherapy, it is helpful to consider questions more widely as an element of conversation. It is accepted that there are three main types of question in English (Biber et al, 1999). These include polar questions (requiring a yes/no answer), content questions (preceded by interrogative words including who/ what/ where /when /why /how (many)), and alternative questions (proposing two possible answers, such as ‘do you want tea or coffee?’ (Stivers, 2010). Questions are an integral part of conversation across cultures and languages, but what constitutes a question is not always easy to ascertain.

Hayano (2013) notes that there are several ways of identifying a question, including rising intonation, and grammatical structure, but that these features on their own are not sufficient to identify whether an utterance is a question. Geluykens (1988) challenges the assumption that a polar question (requiring a ‘yes’ or ‘no’ response) is usually accompanied by a rise in intonation. He suggests that the best way of identifying a question is to look at the response it generates, which should demonstrate whether the hearer identifies the utterance as a question or not. Following this view, Hayano (2013) suggests that a key indicator of when a question has been asked is the epistemic gradient of the conversation. This refers to who knows what, so that if one speaker makes a statement which refers to something the recipient is expected to know about, this statement should be considered a question. In this view, questions presuppose knowledge. All this suggests that what constitutes a question depends on the specific context of the speakers having the conversation. There is no simple way of identifying a question in English, and the process of working out whether an utterance is asking a question often seems to rely on the epistemic status of the speakers (Heritage, 2013). This refers to the levels of asymmetry between the speakers, or to who has access to knowledge and who is seeking knowledge. Pomerantz (1980) divides knowledge held by various speakers in a conversation into two types. Type 1 is knowledge or ‘knowables’ that the speaker has in virtue of being the subject actor of this knowledge, for example their name, how they feel; Type 2 is knowledge that the speaker has ‘by virtue of the knowings being occasioned’, for example what their friend did yesterday (Pomerantz 1980, p.

187). This allows the author to identify direct and indirect means of questioning that speakers may employ to elicit information based on these epistemic divisions. It thus points to a more reliable way of identifying questions in conversation.

The form and function of questions within various types of naturally occurring as well as institutional kinds of interaction has been widely explored. Stivers (2010) analysed naturally occurring spontaneous conversations between adults, to understand the different types of questions asked and the distribution of these different types. A substantial majority of the questions asked in these samples of naturally occurring conversation were polar (yes/no) questions. Notably, in response to polar questions, confirmations were more common than disconfirmations. The study also showed that although a main function of the questions asked was to obtain information, questions also functioned to enable other social actions such as initiating repair or securing agreement - ways of keeping the conversation and the interaction between participants going. Responses that were fitted to the question asked were more common, and this was understood as a 'bias across interaction towards cooperative response' (Stivers, 2010, p. 2780). This follows a general rule or 'preference principle' in conversation, that confirmations are preferred to disconfirmations (Pomerantz and Heritage, 2013). Participants in conversation tend to orient themselves through social norms, and this also applies to the use of questions in conversation. Participants may also depart from these preference principles at times. As

might be expected, children's use of questions and answers has been shown to be less in line with social norms than that of adults. Van Hekken and Roelofson's (1987) study demonstrated that younger children are more likely not to answer questions, thereby breaking the conversational 'rule' mostly adhered to by adults. Stivers, Sidnell & Bergen (2018), coded questions and responses and showed that children between the ages of four and eight did not reliably distinguish between norm-following and norm-departing responses to questions.

Another important aspect of the function of questions in general conversation is to convey the speaker's presuppositions, or beliefs (Heritage, 2003). Questions also set the agenda of the conversation by presenting topics. Although the recipient may choose not to follow the agenda set by a question, the usual preference is for it to be followed. Clearly, questions have many implications for the speakers using them, and are much more than simple requests for information.

The phrasing of questions has consequences for the interaction and can often inform us about the social context and about the relationship between the speakers. Curl & Drew (2008) analysed questions in telephone calls between family and friends and compared these with questions occurring as part of out of hours calls to a doctor. They posited that speakers are more likely to ask a question in the milder form of 'I wonder if', in situations when they are more aware of the contingency surrounding the recipient's ability to grant the

request. This links to the speaker's perceived entitlement for the request to be granted. Institutional practices can also be observed through the study of questions. For example, Heritage and Robinson (2006) used conversation analysis (CA) to develop a typology of questions that doctors ask their patients in order to find out about patients' problems. They also tested the effect of these various types of questions on the patients' presentation of their problems. The study found that 'Type 1' or open-ended questions prompted longer presentations of a problem or situation, compared with 'Type 2' confirmation questions which seemed to be aimed more at confirming a discrete symptom or problem. Studies which explore conversations in the medical field seem particularly relevant to thinking about the therapist-patient interaction, due to the inevitable power dynamic which is a factor in both types of conversation. Questions may also be used in unusual ways in particular social interactions. Seuren (2019) analysed American courtroom interactions and found that attorneys used particular tag questions (such as 'is that correct?') that are not often found in ordinary interactions.

Overall, questions have been shown to take a variety of forms and functions in both everyday and more institutional types of conversation. Questions have been shown to be complicated aspects of conversation, which do much more than simply requesting information from the recipient. Questions reveal presuppositions, set the agenda of the conversation, and reveal important information about the social context of the conversation, and the epistemic gradient between the speakers.

Questions in psychoanalysis

Psychoanalysis is a culturally specific conversation, within which questions are used in particular ways. Some might hold the view that the psychoanalyst or psychoanalytic therapist should refrain from asking too many questions; rather, responding to or interpreting what the patient brings would be advocated (Lemma, 2003). Whether this is true in practice, either now or in the past, is another matter. The notion that a psychoanalyst should not ask questions is not clearly stated in the psychoanalytic literature, however it seems to have persisted in the field as an orally transmitted taboo (Sousa, Pinheiro, & Silva, 2003). The idea of not asking questions perhaps stems from the psychoanalytic concept of analytic neutrality or abstinence (Freud, 1915; Hoffer, 1985). The idea of analytic neutrality has shifted in meaning over time, and continues to generate debate amongst psychoanalytic thinkers (Shill, 2004). The concept covers distinct but related dimensions, including the analyst's attempt to refrain from self disclosure and moral judgements, to maintain an understanding of the complexity of a patient's feelings and expression, and to listen patiently in a way that attends to how much more is going on psychically than is manifestly obvious (Adler & Bachant, 1996).

In the literature on clinical technique in psychoanalysis, attention is drawn to the imperative inherent in analytic neutrality not to 'dictate the sequence or timing of issues' (Adler & Bachant 1996, p. 1034), and to take up themes as

the patient presents them - the analytic principle of free association. Thus, asking questions would be seen to detract from the patient's ability to present themes. Similarly, Busch (2014) highlights the danger that an analyst asking too many questions is moving away from the psychoanalytic principle of free association. Therapists would then need to be aware of the danger of asking too many questions, particularly those driven by personal interest, in case of diverting the patient from their train of thought. In these terms, questions are not prohibited, but knowing how and why questions are being used is crucial. It is also important to note the general shift from a strictly classical understanding of psychoanalysis as allowing psychic change by making the unconscious conscious through interpretation (Strachey, 1934), to a more relational approach which takes into account developmental factors and the importance of the relationship between analyst and patient (Stern et al., 1998; Safran & Muran, 2000). Following this general shift, it is possible to view the use of questions in psychoanalysis differently, as more emphasis is placed on the interaction between patient and therapist, and questions, an important part of conversation, could also be viewed as an important part of psychotherapy. It also allows for the possibility that the knowledge generated in psychoanalysis is shared or co-constructed, rather than being knowledge that one participant has and the other seeks.

Perhaps linked to the lack of theorising regarding the use of questions in psychoanalysis or psychoanalytic psychotherapy (Busch, 2014), there is also no classification of the types of questions used in the psychoanalytic

literature. Olinick (1954) suggested that questions are so much an integral part of the analytic encounter that they are difficult to conceptualise, although questions asked by the analyst were suggested to be helpful as they define a situation in a tentative manner, inviting a collaborative response. Questions could also, in an unhelpful manner, be an example of an unresolved anxiety in the analyst. He posited that systematic questioning of a patient can be helpful for certain patient groups, for example a patient in an anxiety state. Margolis (1994) proposed that a specific type of question, the object oriented question, could be helpful for pre-oedipal patients, in orienting them more towards the external world and towards reality, and thus promoting their psychological development. Questions asked by an analyst have been classified as 'non interpretive interventions', designed to pave the way for interpretation (Loewenstein, 1948). Elsewhere in the psychoanalytic literature, questions have been discussed as being interpretations in their own right (Discussion following Dr. Holt's address, 1948), or conversely, it has been suggested that all interpretations are questions which would be confirmed by the patient's response (Skolnikoff, 1989). Clearly, it is not easy to separate questions from other aspects of psychoanalytic technique.

In our general understanding of questions, a question is designed to elicit a response. Within psychoanalysis and psychoanalytic psychotherapy, this is not straightforwardly the case. Almond (1995) suggested that although part of psychoanalytic technique is to understand questions, many of these are 'not couched in an interrogative form, but may be expressed through silence or the

reflection of words or phrases' (Almond, 1995, p. 475). A question might also appear to be unanswered in a psychoanalytic session, as psychoanalysis does not always follow a strict question-response format in the way that some other therapies do (Lemma, 2003). Psychoanalysis might allow the patient a long turn, sometimes with significant gaps or silences and the opportunity to extrapolate or change topic, before a response from the therapist is felt to be needed. Within the context of psychoanalytic psychotherapy therefore, questions are complicated. Since psychoanalytic psychotherapy presupposes the existence of an unconscious and therefore of 'knowledge' of which the patient is not conscious, the usual epistemic gradient presupposed when a question is asked could be said to be reversed. In asking a question, a therapist might be hinting at or encouraging their patient towards something they feel they see in the patient, but that the patient has not yet seen. This could be described as an example of the therapist presenting their epistemic stance as being lower than their epistemic status - in other words, although they know something the patient does not know, they are talking to the patient as though the patient is the one who knows. As discussed above, although participants in conversation usually aim to preserve congruence between the epistemic stance they present and the epistemic status they occupy relative to a topic, speakers can also be motivated to appear more or less knowledgeable than they really are, and this may lead to a divergence between epistemic stance and epistemic status (Heritage, 2013).

Overall, there have been several descriptive attempts to approach how analysts might make use of questions from a technical perspective, and many questions have been raised about the potential usefulness, as well as the potential risks, of asking questions during analysis (Appelbaum, 2010; Sousa, 2005), but these topics have been largely neglected in the empirical literature. Boesky (1989) suggested it does not make sense to consider the analyst's use of questions as either 'good' or 'bad' for the analysis (although they may be helpful in communicating the analyst's benign curiosity to the patient), but that they are to be understood as being as complex as any other aspect of interaction in psychoanalysis. Due to this, he stated it is not possible to systematically classify questions in the clinical psychoanalytic situation. Whilst it seems sensible to avoid a reductionist approach to classifying the use of questions in psychoanalytic psychotherapy, it also seems that it would be both possible and beneficial to design research in order to learn more about the ways in which psychoanalysts and psychoanalytic psychotherapists ordinarily use questions, and the varying effects these questions might have.

Empirical studies exploring therapist's questions in psychotherapy

This final section of this paper is a systematic search of the empirical literature on therapists' questions in psychotherapy. As set out above, given that the empirical research on therapist's questions in psychoanalytic psychotherapy is likely to be very minimal, this section reviews empirical studies of therapist's

questions in psychotherapy more broadly. Databases PsycArticles and PsycINFO were searched, with the following search term combinations:

‘therapist* questions’ AND ‘psychoanalysis’

‘Questions’ AND ‘psychoanalysis’

‘therapist* questions’ AND ‘psychoanalytic psychotherapy’

‘Questions’ AND ‘psychoanalytic psychotherapy’

‘therapist* questions’ AND ‘psychodynamic psychotherapy’

‘Questions’ AND ‘psychodynamic psychotherapy’

‘therapist* questions’ AND ‘psychotherapy’

‘Questions’ AND ‘psychotherapy’

Searches were restricted to the title and abstract, in order to identify papers which considered questions as an element of therapeutic technique, even if this was not mentioned in the title. Papers were included if they were empirical studies which explored (at least in part) questions asked by the therapist as an aspect of therapeutic technique. Due to the small number of empirical papers on psychoanalysis and psychoanalytic psychotherapy found in initial searches, papers that were identified in the searches on other types of psychotherapy were included, to give a broader understanding of the way empirical studies have examined how questions have been used by therapists.

The searches returned large numbers of papers (215 from PsycArticles and 5592 from PsycINFO, with several papers being found in both databases). However, after reviewing, most of these were excluded due to either not being empirical, or not exploring questions as therapeutic technique. This left 27 papers.

Eight of these papers explored questions asked by a therapist in psychoanalysis or psychoanalytic/ psychodynamic psychotherapy. These papers all explored psychotherapy with adults. Importantly, questions asked by the therapist were not the main focus in any of these studies, but were one aspect explored in the paper, for example as one of a range of therapist interventions studied.

A further 19 studies were included which focussed on questions asked by a therapist in other types of therapy, including solution focussed therapy, family therapy, individual cognitive behavioural therapy, person/ client centred therapy, dialectical behaviour therapy, trauma focused therapy, group therapy, and constructivist therapy. Most of these studies were about therapy with adults, five studies focused on therapy with children or adolescents. Eight studies focussed specifically on questions asked by the therapist as an element of therapeutic technique. In the remaining eleven studies, questions asked by the therapist were not the main focus of the study, but were one aspect explored in the paper.

These 27 studies included were reviewed and a narrative report compiled, organised around six key themes from the studies. In what follows, a narrative

review sets out each of these themes, with examples of studies that were the basis for each theme.

Questions are a therapeutic intervention or facilitating technique, one of several which can be employed by the therapist when the interaction has stalled or there has been a rupture in the interaction

Questions are therapeutic interventions in their own right (McGee, Del Vento, & Bavelas, 2005). This study offers a microanalysis of questions as therapeutic interventions, meaning a close examination of the verbal interaction structures (here, question and answer sequences), with particular emphasis on how these sequences function in the interaction. The authors selected data from videotapes and transcripts from a family therapy training programme, using theoretical sampling to select and analyse questions which exemplified clinical techniques. The question and answer sequences presented are used by the authors to support and extend the notion of questions as interventions, as well as presenting a method for analysing how they work in therapy. Examples illustrate ten main points about how family therapists use questions as a therapeutic technique. In particular, it is interesting to see how therapists in these examples 'correct' their questions or offer them in a different form, when the patient does not answer a question, thus avoiding a potential rupture in the interaction.

Vegas et al. (2015) categorised questions asked by an analyst as 'linking' interventions, aimed at making matters conscious for the patient. This mixed qualitative and quantitative single case study aimed to illustrate the interplay

between the analyst's interventions (coded as explorations, linking interventions, or interpretations) and the patient's linguistic productivity (including use of repetition, level of symbolization and emotional engagement). The authors found that the analyst was more likely to use a linking intervention when the patient was at their baseline level of functioning, rather than in a more symbolic mode. Exploratory interventions, felt to be more disorganising for the patient, were usually saved for when the patient was in a higher mode of symbolic functioning. These results suggest that the analyst's interventions, including use of questions, are carefully tailored to the emotional state of the patient in sessions. The authors also microanalysed particular sections of the transcriptions, focussing on the language used and how things were said, in order to illustrate their quantitative data. Questions are not the main focus of this study, however there is an extended discussion of a particular question asked by the analyst, which creates a link between past and present for the patient. This is related to the content of the question, which encourages the patient to think about an earlier time in her life (talking about an operation her mother had).

Questions can be employed by the therapist as a therapeutic intervention when the interaction has stalled. In one paper about Dialectical Behaviour Therapy with adolescents (Jager et al., 2016), questions asked by a therapist are identified as responses to an 'I don't know' ('IDK') response to a previous question from the therapist. The IDK responses are analysed using conversation analysis (CA) in order to focus on the patterns of speech in the sessions and the next turn responses from therapist and patient. 'IDK'

responses are typically considered a non-cooperative response to a question as they avoid answering the questions, and thus entail a rupture in the interaction. Two of the therapists' further strategies observed in this study include redoing the question already asked, and proposing a candidate (yes-no) answer. This paper demonstrates that questions asked by a therapist might close down the conversation, as well as having the potential to re-start the interaction following a rupture.

Overall, these studies have been able to make useful and interesting links between the therapist's use of questions and the patient's responses. As these studies focus on different types of therapy and the use of questions was not always a main focus, it is difficult to generalise. However, several of the studies had in common a finding that therapists will modify their questions, in response to the patient's reaction.

The therapist's use of questions reveals the presuppositions embedded within their particular theoretical orientation, and how therapists actually work in the consulting room

Hardy and Shapiro's (1985) comparative study of types of therapist response across different types of therapy showed that questions are used most frequently in cognitive behavioural types of therapy, compared with more exploratory types of psychotherapy. This seems in line with the common assumption that questions are not a psychoanalytic technique. Tomori and Bavelas (2007) compared solution focused therapy and client centred therapy,

by identifying the first 50 therapist utterances of sessions, and categorising these as either questions or formulations, then as positive, negative, or neutral. They found that client centred therapists used formulations almost exclusively, whereas solution focused therapists used both formulations and questions commonly, suggesting they were more likely to initiate contributions as well as responding to the client. Solution focused therapists' formulations and questions were mostly positive, whereas the client centred therapists' questions were primarily negative and rarely neutral or positive.

Macmartin (2008) explored questions asked within solution focussed therapy and narrative therapy, specifically 'optimistic questions', designed to prefer answers from clients that affirmed their agency, competence, or other abilities. The paper uses Conversation Analysis (CA) to illustrate in detail points in therapy where clients disaffiliated from these questions, and how they did so. This is suggested to be important because the optimistic questions asked reveal the implicit or explicit goal of solution focussed therapy, and many other forms of psychotherapy, as being to transform the patient's past or current experiences, so at these points the patient also appears to be disaffiliating from the goals of therapy. The paper thus has consequences for other forms of therapy than those mentioned.

Renger (2021) asked the views of six Person Centered Therapists about their use of questions, and analysed the interviews using thematic analysis. The therapists interviewed described asking direct questions to be a significant part of their approach. This was surprising, as asking questions is not a

defined and accepted technique in the original conception of person centred therapy, linking to the supposition that this type of therapy is non-directive. The study also reviews and summarises the questions used in therapy sessions from two person centred therapists, finding that questions were in fact used extensively for a range of purposes, including clarifying issues, challenging the client, to facilitate progress, and out of curiosity. Here, studying the ways questions are actually used by therapists generates surprising and interesting results which challenge presuppositions about what constitutes a particular type of therapy.

Neimeyer et al. (2016), present the technique of ‘questioning our questions’, an existing technique used in constructivist supervision, which aims to deepen the therapist’s reflection on the therapy process. This technique is illustrated with material from a therapist in training, who analysed a series of six question and answer cycles pertaining to their client. Questions were asked about the question, designed to understand the therapist’s state of mind, their understanding of the client, and their reasons for asking the question. The therapist’s written responses are provided, as well as written supervisory feedback and suggestions. The authors propose that this method of ‘questioning our questions’ should be used more widely in constructivist therapy. The implication of this study is that questions are a powerful tool in therapy and one that has many subtle implications for the therapeutic process. This study is focused on the process for the therapist and patient,

and a next step might be to complement this with quantitative analysis of what types of questions, and how many, are asked at different points in sessions.

Collectively, these studies illustrate therapeutic processes by analysing in detail the verbal utterances that took place in sessions. Studying the therapist's use of questions in different types of therapy is able to show both the technical differences between therapies as they actually happen in the consulting room, as well as the presuppositions housed within particular theoretical orientations. Renger's (2020) study shows how the use of questions within person centred therapy can be quite different from expectations. It would be useful to know whether this is also true within psychoanalytic sessions.

The presuppositions housed within questions asked by a therapist may shape the patient's view of themself in important ways

Healing and Bavelas (2011) sought to analyse whether questions which had particular presuppositions embedded in them would have an effect on the client's viewpoint or even behaviour. They conducted a lab based study using forms of questions drawn from psychotherapy, interviewing undergraduate volunteers with two sets of contrasting types of questions. The findings showed that the presuppositions housed within the question asked had a significant impact on the client's view of how they performed in a task - for example, asking the question 'what kept you from succeeding at the task?' focusses the interviewee on external events, and conveys the questioner's presupposition that the reason for the interviewee not succeeding at the task

was because of an external cause, rather than personal agency. This has important relevance for questions in a therapeutic dialogue, as it demonstrates both how questions can constrain a patient to a particular focus or topic, as well as revealing the psychological impact of the questions on how the patient perceives themself.

In psychodynamic psychotherapy, therapists may also use questions to modify the client's view of themself and their past. Friedlander et al. (2012) explored a single case of successful short term dynamic psychotherapy (STDP). The case was selected from a larger study, which used thematic analysis to analyse post-termination interviews and post-session questionnaires to gauge the patients' experience. The study aimed to find out whether and how a corrective experience occurred in this successful case of STDP. Extracts of sessions are explored in detail through the use of Conversation Analysis (CA), focussing on what was said, and the next turn response. Questions are identified as one verbal intervention used by the therapist to address the client's resistance to exploring painful relationships with her parents, with the result that the client did seem to have had a corrective experience. The client described how the therapist's '"gentle shove" of questions [...] made me see what I have been trying to avoid since childhood' (p. 354). The CA extracts also illustrate and explore a particular type of question used in this case, the candidate answers strategy (Pomerantz, 1988), which directs the respondent to provide particular kinds of answers or information. These yes/no (polar) questions are identified as being used by the therapist to promote their agenda of exploring and overcoming

resistance. Questions are clearly an important part of the findings of this study, but they are not the main focus, and it would have been helpful to learn more about how they are used and whether any clearer link could be made to the success of the therapy or the notion of a corrective experience in therapy.

Anderson et al. (2012) explored the effects of interpersonal hostility on speech acts in 62 cases of time limited psychodynamic psychotherapy. Cases were categorised as low or moderate interpersonal hostility based on ratings of interpersonal process using Structural Analysis of Social Behaviour (Benjamin, 1996). Speech acts were then coded and compared across low and moderate hostility episodes. The study found that therapists in 'moderate hostility' episodes of therapy asked fewer questions, compared with lower hostility episodes. The authors suggest this is part of the therapists' tendency to *tell* rather than *listen* during 'moderate hostility' episodes. Here, questions are identified as an aspect of listening - perhaps in demonstrating the therapist's curiosity, or of opening up the conversation for the patient's view. Although asking questions is often viewed as an attempt by the therapist to control or direct the therapeutic conversation, a different view of questions is also evident.

Overall, these studies show how questions asked by a therapist can have important, even transformative effects on a patient, and in a way which affects them outside of the therapy room and in their relationships. The studies show how questions can constrain the patient to particular kinds of answer, but may also be used to create room for the patient's view. Clearly, there is no one way

of looking at questions asked by a therapist, and much depends on context. Given this, the use of Conversation Analysis seems particularly helpful as a methodology, as it allows for a close observation of the verbal utterances in therapy, and when put together with other contextual information about the case presented, makes a fuller view of the therapeutic process possible.

Particular types of questions are relevant for particular clinical populations, including trauma presentations and suicidal ideation

Melidonis and Bry (1995) explored a particular type of question, called exceptions questions, asked by therapists during behavioural family therapy interventions for four families attending a crisis unit. The therapists for these families started to respond to families' blaming statements by asking for an exception to the problem. The study identified blaming statements and positive statements, and the frequency of these, from session transcripts. The results showed that when therapists used these exception questions, positive statements made by the families increased. This is felt to be important because within the specific context of distressed families, one of the problems is felt to be that the family members are struggling to shift from negative or blaming communications to the more supportive verbal interactions necessary to reduce conflict. The therapists' exception questions would then be a therapeutic intervention specifically tailored to this problem.

One study (Orf, 2014) sought to assess factors that inhibit or promote disclosure of suicidal behaviour in psychotherapy sessions, through developing a questionnaire which assessed attitudes and behaviours

regarding suicidal ideation during therapy. This was issued online to a sample of 85 participants involved in psychotherapy. The study used a hierarchical linear regression to identify which factors linked to disclosure of suicidal ideation, and found that the therapist asking specific questions (interpersonal theory of suicide questions) significantly predicted disclosure of suicidal ideation. This is extremely important clinically, as if the patient is able to talk about their suicidal thoughts, the clinician then has the chance to help them with this and potentially reduce the risk of a suicide attempt.

In one study focussing on therapy as a treatment for trauma, (Howells, 2013), asking multiple questions at once was felt to be an unhelpful therapeutic technique as it undermined the client's emotional engagement with traumatic material.

Muller (2009) proposed that questions related to the particular theme of protecting others can be helpful when offering psychodynamic psychotherapy to patients who have experienced intrafamilial trauma, and have a primarily dismissing (avoidant) attachment. In this study, these are termed 'activating questions', proposed to have the function of activating the patient's capacity to think about attachment, first with regard to others in their life, then with regard to their own early experiences. This study also indirectly explored the presuppositions housed within the therapist's questions, as these 'activating questions' seem to contain a presupposition that the patient did in fact have meaningful attachments in their life, but that these are being avoided because of something too painful to face. This way of working clinically also involves

the presupposition that part of the patient's problem is their defensive tendency to downplay their relationships. Thus this specific type of question used with these patients directly challenges the patient's defensive strategies. This is explained with a descriptive case example, however the paper would benefit from some specific examples of the questions asked being listed.

Overall, it is clear that questions have an important therapeutic role in treating different clinical presentations. Studying the therapist's use of questions with different clinical populations also reveals the therapist's ways of working and attempts to attend to the patient' presenting difficulties. These papers also point to the need for therapists of various theoretical orientations to have training on different clinical presentations and of appropriate techniques for working with these.

Therapist's questions have an effect on the patient's contribution to the therapeutic dialogue, as well as the patient's opinion of the therapy and therapist

Schectman (2004) explored questions as one type of intervention by therapists working in individual and group bibliotherapy with fifty one aggressive boys. Therapist helping skills and the patient's verbal responses were coded, then analysed quantitatively to find any possible correlations. Questions asked by the therapist are listed as a 'therapist helping skill', used frequently in both individual and group therapy. In individual treatment, questions were related to reduced resistance and increased cognitive and affective exploration, but were unrelated to insight or change. Here, questions

seem to have a positive effect on the patient's ability to contribute to the dialogue in a thoughtful way. This was also the case in Anvari et al's (2022) study which explored 'open questions for thoughts' and 'open questions for feelings' as two examples of therapists' skills in psychodynamic psychotherapy sessions. This was a large scale project comprising 36 cases of psychodynamic psychotherapy. Open questions for feelings were found to be linked to an increase in the patient's cognitive-behavioural exploration, explained as the process of the patient coming to understand their thoughts and behaviours. The paper also found that therapist's questions were tailored in response to the patient's presentation immediately prior to the question being asked - for example, therapists focussed more on affect (including asking open questions for feelings) when patients were already focussing on feelings. Within a positive psychology therapy framework, Bacher (2009) coded client responses to therapist questions, and found that open-ended questions from the therapist led to more cognitive emotional processing than more direct or closed-ended questions.

Brull (2009) examined seven sessions of adolescent psychotherapy and observed links between the therapist verbal response modes (TVRMs) and in session 'good moments' and the therapeutic alliance. One of the TVRMs was open or closed ended questions asked by the therapist. A negative correlation was found between the therapist's use of open ended questions and the therapeutic alliance. In two of the sessions studied, use of open ended questions resulted in the highest percentage of 'good moments' in sessions. The study found no correlation between these 'good moments' and the

therapeutic alliance in the individual sessions studied. This study raises several interesting questions, however it is difficult to generalise as the findings may relate to specific interactions between this adolescent/ therapist couple.

Asking questions has also been suggested to have more negative consequences for the therapeutic process. As early as 1962, Frank and Sweetland transcribed psychoanalytic interviews and categorised the patients' responses, finding that direct questions asked by the therapist resulted in an increase in statements about problems, and a decrease in understanding and insight. In this case, direct questions asked by a therapist were viewed as unhelpful to therapeutic progress, as they seemed to hinder the patient's self exploration and understanding. Therapist's questions in short term dynamic psychotherapy have also been demonstrated to be an intervention related to lower levels of patient affect (Town et al., 2012). The authors of this study coded therapist interventions, one of which was questions, and coded the immediate patient response in terms of the levels of affect demonstrated. This is felt to be important because of the emphasis in time limited dynamic psychotherapy on the therapeutic role of patient experienced affect, and thus in this case, therapist's questions seem to link to reduced therapeutic effectiveness. However, it could be argued that some of the therapist interventions categorised in this study as 'confontations' and linked with higher levels of patient affect are also questions, for example 'can we look at what might have stirred up inside you' (p. 215). Again, the crossover between questions and other interventions in psychoanalytic psychotherapy is raised,

and thus the difficulty of distinguishing questions from these other interventions, and making a clear statement about the therapeutic impact of questions asked by the therapist.

Questions asked by a therapist also affect the patient's view of the therapist and the therapy. Wang's (2011) study found a negative relationship between questions and ratings of therapist empathy from Asian American students accessing counselling via their college. In another study (Bishop, 1998), both psychology trainees and non-therapist undergraduates gave higher ratings to solution-focused questioning styles, compared with diagnostic interviewing (straightforward requests for information) and rational emotive therapy questioning. This seemed to be because solution-focussed questioning was perceived to be more collaborative, and to promote more creativity on the part of the patient, than other styles. Therapists' questioning styles have also been shown to influence perceived therapy effectiveness. Nishina (2013) sought to determine whether closed ended questions would be preferred by Japanese clients, but found that both Japanese and American participants gave higher ratings to a therapist who used an open questioning style. These papers do not make any claims about the actual rated effectiveness of the therapies studied, or make any links to therapeutic alliance.

Collectively, these papers highlight many effects on the patient of questions asked by the therapist. Some of the papers distinguish between different kinds of questioning (open or closed questioning), and this is helpful as it

allows for a more nuanced understanding about what it was about the particular question used that brought about the patient's response.

Questions can be viewed as part of the therapy-as-interaction, and thus as part of the co-construction of meaning in therapy

De Jong et al. (2013) considered questions in psychotherapy as a therapeutic technique which is part of the co-construction of meaning in therapy - following a post modern understanding of therapy, whereby the meaning made is a product of both the therapist and the patient, rather than a positivistic truth. Questions are noted as being one way in which therapists contribute to, and influence, the therapeutic dialogue, and this is illustrated by the inclusion of transcribed and analysed extracts, which demonstrate co-construction taking place. The patient is shown to cooperate with a question asked by the therapist, and the presuppositions housed within it, without questioning these.

Knox and Lepper (2014) present a detailed analysis of an exchange between a psychotherapist and client engaged in short term dynamic psychotherapy, aiming to show how observational methods can be used to approach the dynamics of intersubjectivity in the clinical process. Questions were not the main focus of this single case study, but questions asked by the therapist were explored in detail through the use of conversation analysis (CA). CA allowed the authors to look in detail at what was actually said during the session with the use of transcripts, how it was said, and how this impacted the therapeutic interaction. In the therapeutic exchange presented, questions

were observed to be used by both patient and therapist to direct the flow of the conversation, and one effect of questions employed by the therapist was to open up the patient's narrative. The authors also raise the interesting question 'how often is an interpretation a question in declarative form?' (Knox & Lepper, 2014, p. 47) This perhaps goes some way to explaining why there has been little focus on the specific topic of questions asked by therapists in psychoanalytic psychotherapy, as it can often be difficult to distinguish questions from interpretations, making attempts at categorising the verbal interventions of the therapist complicated.

Notably, both these papers use a form of microanalysis as methodology, in the case of Knox and Lepper's (2014) study, this is specifically CA, but both papers use transcribed material from therapy sessions and pay careful attention to how things are said by patient and therapist, and the next turn responses. This close attention to detail is helpful as it illustrates exactly how questions are used as one therapeutic intervention which is a key part of the therapist's contribution to the session.

Summary and Conclusion

This literature review has explored the role of questions in conversation more generally, as well as the historical development of thinking concerning how questions are asked by a therapist in psychoanalytic psychotherapy. It then went on to systematically review how empirical studies have examined the ways therapists use questions in therapy more generally. The final part of this literature review comprised a search of the empirical research completed on

questions asked by a therapist, and stepped out from the narrower focus of psychoanalytic psychotherapy to looking at how questions are used by therapists in other types of therapy.

In the final, systematic review section, a small body of empirical studies was found which sheds light on the ways questions are used by therapists in different types of psychotherapy. In most of the studies included, questions were considered to be an established therapeutic intervention, which has important consequences for the therapeutic interaction. However, questions are used quite differently in different types of therapy, being a main type of intervention in some therapies including solution focused and cognitive behavioural therapy. Questions were shown to have an impact on the therapeutic interaction, and on the patient, that could be either positive or negative, and this depended on the specific context of the therapist and patient and type of therapy, as well as the clinical presentation of the patient. This points to a limitation of this literature review, which is that different types of therapies were included, which categorised questions differently, and so it is difficult to make general statements. The literature review does, however, point to an important gap in the literature with regard to the empirical study of questions in psychoanalytic psychotherapy. Although some empirical papers explored this area as part of a wider exploration of therapeutic interventions, no papers were found which focussed specifically on the therapist's questions, and questions asked by the therapist in psychoanalytic psychotherapy remains a largely neglected topic. The topic of questions

asked by a therapist was also shown to be neglected in the psychoanalytic theoretical literature.

It is important to consider why there might be less of a focus on questions in psychoanalytic psychotherapy. This could be partly to do with a historical prejudice against the use of questions in psychoanalysis, which came up repeatedly in the middle section of this literature review. Perhaps there has been less of a focus on questions in psychoanalysis and psychoanalytic psychotherapy because of the difficulty, also noted in some of the studies included, in distinguishing questions in psychoanalytic psychotherapy from interpretations and other therapeutic interventions. There is also the possibility that psychoanalytic researchers have shied away from researching therapists' questions, stemming from a reluctance in making simplistic statements about what happens in psychoanalytic psychotherapy. This might point to the specific nature of psychoanalytic psychotherapy, which has not often been presented as a manualised treatment, and instead relies on the training, skills, and theoretical background of the therapist, and the relationship developed with the patient. This was addressed by some of the studies included, which presented a microanalysis of the therapeutic interaction, sometimes using a conversation analytic approach, which could take into account the specificity of the therapeutic situation being studied. This allowed for a nuanced examination of the relationship and process between patient and therapist through observing what they said to each other, and how.

Arguably, there are ways of conducting research on the use and effects of therapists' questions that are not out of line with the aims and principles of psychoanalytic psychotherapy. Further research is indicated in order to shed light on the topic of therapist's questions in psychoanalytic psychotherapy, which has important consequences for our understanding of the role of the therapist, the function of psychoanalytic psychotherapy, as well as the effect on the therapeutic interaction, and on the patient.

References

Adler, E., & Bachant, J. L. (1996). Free Association and Analytic Neutrality: The Basic Structure of the Psychoanalytic Situation. *Journal of the American Psychoanalytic Association*, 44(4), 1021–1046. https://doi.org/10.1177/000306519604400403

Almond, R. (1995). The Analytic Role: A Mediating Influence In The Interplay Of Transference And Countertransference. *Journal of the American Psychoanalytic Association*, 43, 469-494.

Anderson, T., Knobloch-Fedders, L. M., Stiles, W. B., Ordonez, T., & Heckman, B. D. (2012). The power of subtle interpersonal hostility in

psychodynamic psychotherapy: A speech acts analysis. *Psychotherapy Research*, 22, 348-362. https://doi.org/10.1080/10503307.2012.658097

Anvari, M., Dua, V., Lima-Rosas, J., Hill, C. & Kivlighan, D. (2022). Facilitating Exploration in Psychodynamic Psychotherapy: Therapist Skills and Client Attachment Style. *Journal of Counseling Psychology*, Advance on-line publication. https://doi.org/10.1037/cou0000582

Appelbaum, D. (2010). On Learning to Inquire: Revisiting the Detailed Inquiry. *American Journal of Psychoanalysis*, 70(1), 78-85.

Bacher, A. D. (2009). A qualitative analysis of client expressions of meaning in psychotherapy. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 70(11-B) , 7197. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc6&NEWS=N&AN=2010-99100-412.

Benjamin, L. S. (1996). Introduction to the special section on structural analysis of social behavior. *Journal of Consulting and Clinical Psychology, 64*(6), 1203–1212. https://doi.org/10.1037/0022-006X.64.6.1203

Biber, D., Hohansson, S., Leech, G., Conrad, S., Finegan, E. (1999). *Longman Grammar of Spoken and Written English*. Longman, London.

Bishop, W. (1998). Questions as interventions: Big five personality factors and perceptions of socratic, solution-focused, and diagnostic questioning styles. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 59(1-B) , 0410. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc3&NEWS=N&AN=1998-95014-053.

Boesky, D. (1989). The Questions and Curiosity of the Psychoanalyst. *Journal of the American Psychoanalytic Association*, *37*(3), 579–603. https://doi.org/10.1177/000306518903700301

Brull, J. V. (2009). Therapist verbal response modes, the therapeutic alliance, and in-session client good moments. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 69(12-B) , 7803. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc6&NEWS=N&AN=2009-99120-084.

Busch, F. (2014). *Creating a Psychoanalytic Mind: a psychoanalytic method and inquiry.* East Sussex and New York: Routledge.

Curl, T. & Drew, P. (2008.) Contingency and Action: a comparison of two forms of requesting. *Research on Language and Social Interaction*, 41(2), 129-153.

De Jong, P., Bavelas, J. B. & Korman, H. (2013). An introduction to using microanalysis to observe co-construction in psychotherapy. *Journal of Systemic Therapies*, 32, 17-30. https://doi.org/10.1521/jsyt.2013.32.3.17

Discussion Following Dr. Holt's Address. (1984). *Modern Psychoanalysis*, 9(1), 53-62.

Frank, G. & Sweetland, A.. (1962). A study of the process of psychotherapy: The verbal interaction. Journal of Consulting Psychology, 26(2), 135-138. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=paovfta&NEWS=N&AN=00004731-196204000-00006.

Freud, S. (1915). Observations on transference-love, in J. Strachey (Ed.) *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XII (1911-1913): The Case of Schreber, Papers on Technique, and other works* (pp. 159–171). London: Hogarth Press.

Friedlander, M., Sutherland, O., Sandler, S., Kortz, L., Bernardi, S., Lee, H., et al. (2012). Exploring Corrective Experiences in a Successful Case of

Short-Term Dynamic Psychotherapy. *Psychotherapy*, 49, 349-363. https://doi.org/10.1037/a0023447

Geluykens, R. (1988). On the Myth of Rising Intonation in Polar Questions. *Journal of Pragmatics*, 12, 467-485.

Hardy, G. E. & Shapiro, D. A. (1985). Therapist response modes in prescriptive vs. exploratory psychotherapy. *British Journal of Clinical Psychology*, 24, 235-245. https://doi.org/10.1111/j.2044-8260.1985.tb00656.x

Hayano, K. (2013). Question Design in Conversation. In J. Sidnell and T. Stivers (Eds.) *The Handbook of Conversation Analysis* (pp. 395-414). Blackwell publishing: West Sussex.

Healing, S. & Bavelas, J. B. (2011). Can questions lead to change? An analogue experiment. Journal of Systemic Therapies, 30, 30-47. https://doi.org/10.1521/jsyt.2011.30.4.30

Heritage, J. (2013). Epistemics in Conversation. In J. Sidnell and T. Stivers (Eds.) *The Handbook of Conversation Analysis* (pp.370-394). Blackwell publishing: West Sussex.

Heritage, J. (2003). Designing questions and setting agendas in the news interview . In P. Glenn , C. LeBaron & J. Mandelbaum (Eds.), *Studies in language and social interaction* (pp. 57 – 90). Mahwah, NJ : Lawrence Erlbaum .

Heritage, J., & Robinson, J. (2006). The Structure of Patient's Presenting Concerns: Physicians' Opening Questions. *Health Communication*, 19(2), 89-102.

Hoffer, A. (1985). Toward a Definition of Psychoanalytic Neutrality. *Journal of the American Psychoanalytic Association*, *33*(4), 771–795. https://doi.org/10.1177/000306518503300402

Howells, Christopher J. (2013). Examining trainee therapists' responses to client discussions trauma in psychotherapy: A qualitative analysis. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 74(1-B(E)) , No Pagination Specified.

Jager, M., Huiskes, M., Metselaar, J., Knorth, E. J., De Winter, A. F. & Reijneveld, S. A. (2016). Therapists' continuations following I don't know-responses of adolescents in psychotherapy. *Patient Education and Counseling*, 99, 1778-1784. https://doi.org/10.1016/j.pec.2016.05.016

Knox, J. & Georgia Lepper, G. (2014) Intersubjectivity in therapeutic interaction: a pragmatic analysis, *Psychoanalytic Psychotherapy*, 28(1), 33-51, DOI: 10.1080/02668734.2013.840331

Lemma, A. (2003). *Introduction to the Practice of Psychoanalytic Psychotherapy*. West Sussex: John Wiley and Sons Ltd.

Loewenstein, R. M. (1948). The Problem of Interpretation, paper presented at the meeting of the New York Psychoanalytic Society, summarised in Proceedings of Local Societies (1948). *Bulletin of the American Psychoanalytic Association*, 4B(2), 29-36.

MacMartin, C. (2008). Resisting optimistic questions in narrative and solution-focused therapies. In A. Peräkylä, C. Antaki, S. Vehvilainen, I. Leudar (Eds.), *Conversation analysis and psychotherapy*. New York, NY, US: Cambridge University Press, US; pp. 80-99 https://doi.org/10.1017/CBO9780511490002.006.

Margolis, B. D. (1983) The Object-Oriented Question: A Contribution to Treatment Technique. *Modern Psychoanalysis* 8:35-46

McGee, D, Del Vento, A., & Bavelas, J. B. (2005). An Interactional Model of Questions as Therapeutic Interventions. *Journal of Marital and Family Therapy*, 31, 371-384. https://doi.org/10.1111/j.1752-0606.2005.tb01577.

Melidonis, Greer & Bry, Brenna. (1995). Effects of Therapist Exceptions Questions on Blaming and Positive Statements in Families With Adolescent Behavior Problems. *Journal of Family Psychology*, 9, 451-457. https://doi.org/10.1037/0893-3200.9.4.451

Muller, R. (2009). Trauma and dismissing (avoidant) attachment: intervention strategies in individual psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 46, 68-81. https://doi.org/10.1037/a0015135

Muntigl, P., & Zabala, L. (2008). Expandable Responses: How Clients Get Prompted to Say More During Psychotherapy. *Research on Language and Social Interaction*, 41(2), 187-226.

Neimeyer, R. A., Woodward, M., Pickover, A. & Smigelsky, M. (2016). Questioning our questions: A constructivist technique for clinical supervision. *Journal of Constructivist Psychology*, 29, 100-111. https://doi.org/10.1080/10720537.2015.1038406

Nishina, S. (2013). The influence of therapists' questioning styles on Japanese and American individuals' perceived therapy effectiveness. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 73(7-B(E)) , No Pagination Specified. Retrieved from

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc10&NEWS=N&AN=2013-99020-416.

Olinick, S. L. (1954). Some Considerations Of The Use Of Questioning As A Psychoanalytic Technique. *Journal of the American Psychoanalytic Association*, *2*(1), 57–66. https://doi.org/10.1177/000306515400200102

Orf, R. (2015). Factors that promote and inhibit client disclosure of suicidal ideation. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 76(6-B(E)) , No Pagination Specified. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc12&NEWS=N&AN=2015-99240-180.

Peräkylä, A., & Vehviläinen, S. (2007). Conversational practices of psychotherapy: An overview. Paper presented at the IV Conference on Conversation Analysis & Psychotherapy, Bologna, Italy.

Pomerantz, A. (1980). Telling My Side: “Limited Access” as a “Fishing” Device’. *Sociological Enquiry*, 50(3-4), 186-198.

Pomerantz, A. (1988). Offering a Candidate Answer: An information seeking strategy. *Communication Monographs, 55*(4), 360–373. https://doi.org/10.1080/03637758809376177

Pomerantz, A. and Heritage, J. (2013). Preference. In J. Sidnell and T. Stivers (Eds.) *The Handbook of Conversation Analysis* (pp. 395-414). Blackwell publishing: West Sussex.

Renger, S. (2021) Therapists' views on the use of questions in person-centred therapy, *British Journal of Guidance & Counselling*, DOI: 10.1080/03069885.2021.1900536

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York, NY: Guilford Press.

Seuren, L. M. (2019). Questioning in court: The construction of direct examinations. *Discourse Studies*, *21*(3), 340–357.

Shechtman, Z. (2004). Client Behavior and Therapist Helping Skills in Individual and Group Treatment of Aggressive Boys. *Journal of Counseling Psychology*, 51, 463-472. https://doi.org/10.1037/0022-0167.51.4.463

Shill, M. A. (2004). Analytic Neutrality, Anonymity, Abstinence, and Elective Self-Disclosure. *Journal of the American Psychoanalytic Association*, *52*(1), 151–187. https://doi.org/10.1177/00030651040520012101

Skolnikoff, A. (1989). Countertransference and analytic process in five clinical hours, paper presented at the Meeting of the Psychoanalytic Institute of New England, East, *Psychoanalytic Quarterly*, 58, 181.

Sousa, P.L. (2005). In Progress … I Hope. *Psychoanalytic Inquiry.*, 25(5), 580-601.

Sousa, P.L., Pinheiro, R.T. and Silva, R.A. (2003). Questions about questions. *International Journal of Psycho-Analysis*, 84(4), 865-878.

Stern, D.N., Sander, L.W., Nahum, J.P., Harrison, A.M., Lyons-Ruth, K., Morgan, A.C., Bruschweiler-Stern, N., Tronick, E.Z (1998). Non-interpretive mechanisms in psychoanalytic therapy. The 'something more' than interpretation. The Process of Change Study Group. *International Journal of Psychoanalysis*, 79(5), 903-921.

Stivers, T. (2010). An overview of the question-response system in American English conversation. *Journal of Pragmatics*, 42(10), 2772-2781.

Stivers, T. (2010). An overview of the question-response system in American English conversation. *Journal of Pragmatics*, 42(10), 2772-2781.

Stivers, T., Sidnell, J., & Bergen, C. (2018). Children's responses to questions in peer interaction: A window into the ontogenesis of interactional competence. *Journal of Pragmatics*, 124, 14-30.

Strachey, J. (1934). The nature of the therapeutic action of psychoanalysis. *The International Journal of Psychoanalysis, 15,* 127–159.

Tomori, C. & Bavelas, J. B. (2007). Using microanalysis of communication to compare solution-focused and client-centered therapies. *Journal of Family Psychotherapy*, 18, 25-43. https://doi.org/10.1300/J085v18n03_03

Town, J. M., Hardy, G. E., McCullough, L. & Stride, C. (2012). Patient affect experiencing following therapist interventions in short-term dynamic psychotherapy. *Psychotherapy Research*, 22, 208-219. https://doi.org/10.1080/10503307.2011.637243

Van Hekken, S. M. J., & Roelofson, W. (1982). More questions than answers: A study of question-answer sequences in a naturalistic setting. *Journal of Child Language*, 9(2), 445-460.

Vegas, M., Halfon, S., Cavdar, A. & Kaya, H. (2015). When interventions make an impact: An empirical investigation of analyst's communications and patient's productivity. *Psychoanalytic Psychology*, 32, 580-607. https://doi.org/10.1037/a0039020

Wang, S. (2011). Cultural empathy: Therapist verbal interventions and Asian American client ratings. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 72(1-B) , 576. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc8&NEWS=N&AN=2011-99140-105.

Part 2: Empirical Research Project

Title: **Therapists' Questions in Short Term Psychoanalytic Psychotherapy with Depressed Adolescents**

Candidate number: [redacted]

Word count: 8390

Keywords: adolescent depression, psychoanalytic psychotherapy, conversation analysis, negative transference

Abstract

Background

Questions are an integral part of therapeutic exchanges, but little empirical work has been done on how questions are used within psychoanalytic psychotherapy sessions.

Aim

This study explores how therapists use questions in short term psychoanalytic psychotherapy (STPP) sessions with depressed adolescents.

Method

Three STPP cases were selected and questions asked by the therapist were identified, transcribed, and analysed in terms of type and function. A specific type of question (considered as 'performative') was noted as being of interest. These questions and the responses were analysed using Conversation Analysis (CA).

Results

A high number of questions was asked across all cases, with type and function generally comparable to findings from non-therapeutic conversational settings. The specific questions identified as 'performative' were used by the therapist to verbalise the patient's unspoken negative thoughts and feelings towards the therapist. A high proportion of avoidant responses to these questions was found.

Conclusion

These results have consequences for refining clinical technique and the training of psychotherapists doing short term psychoanalytic psychotherapy with depressed adolescents, with particular reference to addressing the negative transference.

Impact Statement

This paper has implications for both further research and clinical practice. In the field of research, the paper addresses an important gap in the literature in terms of process research in the field of child and adolescent psychoanalytic psychotherapy. It builds on the existing literature to address the specific area of questions asked by a therapist in psychoanalytic psychotherapy with adolescents. The paper demonstrates the value of the methodology used (Conversation Analysis) and its applicability to the field of child and adolescent psychotherapy process research. Several areas for further research are identified, which could include larger studies linking outcome data to the processes taking place during psychotherapy with adolescents.

In terms of clinical practice, this paper has important implications for benefiting service users. A central finding of the study was that one aspect of psychoanalytic psychotherapy practice, addressing the negative transference, can have a particular effect when working with adolescents. The use of this technique is discussed, with reference to making difficult conversations as manageable as possible for adolescents suffering from depression. Conducting research of this kind thus has an ethical implication, as it allows for the possibility of improving the levels of care for young people accessing mental health services, and potentially increasing levels of engagement and thus access to services.

The paper also has implications which can benefit therapists offering short term psychoanalytic psychotherapy sessions. As the paper identifies and

explores techniques used by psychoanalytic psychotherapists, the results could be integrated into the continuing professional development and training of clinicians, and used to refine clinical technique.

This links to another implication, which is that of increasing the knowledge base with regard to the wider field of psychotherapy with young people. If the process of psychoanalytic psychotherapy is better understood, this may be of interest not only for psychoanalytic psychotherapists, but also to mental health practitioners from other training modalities, who may be able to make use of the findings in their own work and training. This paper thus promotes the possibility of encouraging dialogue between different professionals, and the possibility of sharing knowledge, with the overall aim of improving the quality of care for young people accessing mental health services.

Introduction

Questions are a universal feature of language (Stivers et al., 2009); they are also an integral part of therapeutic work (McGee, Del Vento, & Bavelas, 2005), but are utilised in varying ways in different forms of therapy (Macmartin, 2008; Muntigl & Zabala, 2008). There are three main types of question in English (Biber et al., 1999). These include polar questions (requiring a yes/no answer), content questions (preceded by interrogative words including who/ what/ where /when /why /how (many)), and alternative

questions (proposing two possible answers, such as ‘do you want tea or coffee?’ (Stivers, 2010). Polar questions are the most common question type in the English language (Stivers, 2010) . What constitutes a question in English is not straightforward to ascertain. Hayano (2013) notes that questions can be identified in many ways (rising intonation, grammatical structure), but these features on their own are not sufficient to identify questions. Whether a statement can be said to be a question often relies on the ‘epistemic status’ (Heritage, 2013, p. 376) of the speakers - a concept which refers to the degree of knowledge that a speaker has. Someone with more knowledge may be said to have a higher epistemic status than someone with less, inferring an ‘epistemic gradient’ (Heritage, 2013, p. 378) between the speakers. This follows Pomerantz’s (1980) division of knowledge into type 1 knowables, those that ‘subject actors *as subject actors* have rights and obligations to know’ (Pomerantz, 1980, p. 187) and type 2 knowables, ‘those that subject actors are assumed to have access to by virtue of the knowings being occasioned’ (Pomerantz*,* 1980, p. 187). There have been many studies exploring questions as part of everyday conversation as well as various institutional types of conversation (Curl & Drew, 2008; Stivers, 2010; Heritage & Robinson, 2006; Stivers, Sidnell, & Bergen, 2018). These studies show how questions have many functions in conversation, including setting agendas, revealing presuppositions, seeking information, and revealing the epistemic gradient between participants.

When it comes to the therapeutic setting, a certain amount has already been written about what role they may play. Questions may be used by therapists to address ruptures in the therapeutic interaction (McGee, del Vento, & Bavelas, 2005; Jager et al., 2016), to increase cognitive and affective exploration from the patient (Schectman, 2004), to affect the patient's view of themselves and their relationships (Friedlander et al., 2012) or even their behaviour (Healing & Bavelas, 2011). Although there has been an ongoing debate in the psychoanalytic literature regarding how analysts use questions (Adler & Bachant, 1996; Boesky 1989), an attempt to theorise and categorise the use of of questions in psychoanalysis and psychoanalytic psychotherapy has been largely neglected (Busch, 2014), and an assumption persists that psychoanalytic psychotherapists should not ask questions (Sousa, Pinheiro, & Silva, 2003). With the exception of a few recent papers (Anvari et al., 2022), the use of questions by therapists is also a neglected topic in the empirical literature on psychoanalytic psychotherapy. The current study aims to address this gap in the literature, by exploring how psychoanalytic psychotherapists use questions, in the particular context of short term psychoanalytic psychotherapy (STPP) sessions with adolescents.

Psychoanalytic psychotherapy can be used to ameliorate a number of difficulties including depression, anxiety, relationship or interpersonal problems, as well as for personal development. Psychoanalytic treatments have considerable empirical support (Shedler, 2011), including in the area of psychoanalytic psychotherapy for children and adolescents (Midgley &

Kennedy, 2011; Midgley, O'Keefe, French, & Kennedy, 2017). There is now a large body of outcome research demonstrating the effectiveness of psychodynamic psychotherapy for adults, children, and adolescents, and research addressing the question of 'what works for whom?' (Fonagy, Target, Cottrell, Phillips, & Kurtz, 2002), but it is still not always clear why particular types of therapeutic intervention work, and how to identify the particular ingredients of these treatments which help to bring about therapeutic change. There is thus an indication for complementary process research, to help us understand more about the therapeutic processes occurring during treatment.

Process research aims to increase our understanding of what happens in therapy, and how it happens. Process research allows for the possibility of improving treatments by refining the techniques used by clinicians. It is important in improving our understanding of how to help patients who do not recover, or drop out, from a treatment that has been shown to be effective (Rhodes, 2011), by aiming to illustrate the processes underlying therapeutic change in individual treatment modalities. Process research can also challenge a common view of psychoanalysis and psychoanalytic psychotherapy as being an insular or esoteric profession, by making psychoanalytic data and observations available to practitioners from other disciplines (Safran, Muran, & Shaker, 2014).

A range of process research studies exist which explore processes taking place in adult psychoanalysis and psychoanalytic psychotherapy (Waldron,

Gazillo, & Stukenberg, 2015). Studies have used various methodologies, often borrowed from the field of social sciences, including content analysis (Pole & Jones, 1998; Salvatore et al, 2017), discourse analysis (Avdi & Georgaca, 2007; Madill & Barkham, 1997), narrative analysis (Boothe, Grimm, Hermann, & Luder, 2010; McLeod & Balamaoutsou, 1996), thematic analysis (Bell, 2017; Meier & Boivin, 2000), and conversation analysis (Peräkylä, 2004, 2008). Process research has shed light on key aspects of the psychoanalytic process, including the psychoanalytic concepts of transference (Levy & Scala, 2012; Luborsky, 1990; Luborsky, Popp, Luborsky, & Mark, 1994), and the therapeutic or working alliance (Safran, Muran, & Shaker, 2014). Waldron et al. (2004) demonstrated that the quality of an analyst's intervention is more important than the type of intervention for promoting patient productivity.

Fewer studies exist which explore the processes taking place in psychoanalytic psychotherapy with children and adolescents. Researchers have successfully designed standardised measures which address particular aspects of the child and adolescent psychotherapy process, such as the Children's Play Therapy Instrument (CPTI, Kernberg, Chazan, & Normandin, 1998). Recent process research studies have also begun to reduce the gaps in our understanding of the processes taking place during psychotherapy with adolescents, including adolescents' expectations of the therapy (Midgley, Holmes, Parkinson, Stapley, Eatough, & Target, 2016; Stewart, Steele, & Roberts, 2014), and how adolescents responded to interpretations about

ending therapy (Della Rosa and Midgley, 2017). These studies can help us understand the process of psychoanalytic psychotherapy, with a particular emphasis on which kinds of therapeutic technique are manageable and helpful for the patient. The results of these studies can also be used to help clinicians refine or modify their existing technique.

Process research has been important in order for us to better understand several aspects of psychoanalytic psychotherapy, however questions asked by a psychoanalytic psychotherapist remain largely neglected as a topic explored by process research. How questions are used, their impact on the therapeutic interaction, on the patient, and on the progress of therapy, remains largely unknown. This paper thus proposes that process research addressing how questions are used by therapists is indicated, in order to shed light on an important therapeutic technique. The paper seeks to explore how psychoanalytic psychotherapists use questions in short term psychoanalytic psychotherapy (STPP) with depressed adolescents. The paper has three more specific aims:

1) To explore how many questions, of what type, and with what function, are asked by therapists in short term psychoanalytic psychotherapy sessions with depressed adolescents;
2) To explore whether there is something specific about the ways in which psychoanalytic practitioners use questions in this therapeutic context;

3) To explore how patients respond to a specific type of question asked by the therapist (as identified in the first steps above), and to examine the impact of these questions on the therapeutic interaction.

Through addressing these aims, this paper seeks to illustrate the process of short term psychoanalytic psychotherapy with depressed adolescents, and to take a first step towards identifying particular interventions within psychoanalytic psychotherapy which may be one of the mechanisms of change that contribute to therapeutic progress.

Method

Design

This is a mixed-methods, exploratory study. As explained below, the design also evolved as the study progressed, in response to initial findings.

The data for this study were existing audio recordings of Short Term Psychoanalytic Psychotherapy (STPP) sessions with adolescents with a DSM-IV diagnosis of major depressive disorder, taken from the STPP arm of

the IMPACT study (Goodyer et al., 2017). The IMPACT study was a randomised clinical trial which took place at 15 National Health Service Child and Adolescent Mental Health Services (CAMHS) in England. The IMPACT study sought to compare STPP, Cognitive Behavioural Therapy (CBT), and a brief psychosocial intervention, as treatments for depression in adolescents. The Mood and Feelings Questionnaire (MFQ, Daviss et al., 2006) was the main outcome measure, identifying self-reported depression scores at follow up. The results of the IMPACT study showed that all three treatments were equally successful in ameliorating depression in adolescents, based on improvement in the MFQ scores.

STPP as used in the IMPACT study is a 28 session treatment model which makes use of the existing principles of psychoanalytic work with children and adolescents, including the focus on putting feelings into words, the relationship between therapist and patient, use of transference and counter-transference feelings, and an emphasis on conflicts, particularly those thought to be of an unconscious nature (Cregeen, Hughes, Midgley, Rhode, & Rustin, 2017). Therapists offering STPP were CAMHS clinicians with Association of Child Psychotherapy (ACP) recognised training in child and adolescent psychoanalytic psychotherapy.

Sampling and selection of participants

This study was conducted as part of a research group within which students were looking at various elements of the STPP process and using Conversation Analysis (CA) to analyse these. Across the research group, STPP cases were selected from an anonymised spreadsheet of all the STPP cases from one of the IMPACT geographical locations. Cases were selected on the basis that the young person had attended the median number of therapy sessions (11 - Goodyer et al., 2017), or as close to this number as possible. This aimed to ensure some similarity between selected cases, and avoid outlying cases where there were only a few sessions, or an unusually high number. Five cases met this criteria. From these five, three cases were selected for study by the larger research group. Three cases were considered appropriate as this would make possible a broader view of therapist's questions than a single case study would allow, whilst not choosing too many cases, and removing the possibility of a detailed analysis of the interaction, as required by CA. The cases were:

Case 1: 15 year old boy, seen by a female therapist. This boy's attendance was sporadic (14 sessions attended, out of 28 offered) but he continued therapy until the planned ending. Main themes of the psychotherapy were his difficulties in trusting his own feelings, in expressing strong or difficult feelings, and difficulties imagining that others will understand him and care about him.

Case 2: 18 year old girl, seen by a female therapist. She attended therapy sporadically (12 sessions attended, out of 27 offered) and dropped out before the planned ending. She had previous experience of therapy. Main themes of the psychotherapy were family relationships, her ability to communicate

emotions (particularly negative emotions), and her tendency to focus on the difficulties of others, rather than those of her own.

Case 3: 17 year old girl, seen by a male therapist. Her attendance was sporadic (13 sessions attended, out of 23 offered) and she dropped out before the planned ending. She had previous experience of therapy. Main themes of the psychotherapy were her difficulty in letting others know about difficult emotions, how this affected her family relationships, and the nature of the therapeutic relationship.

Criteria for selecting sessions. From these three cases, the second, median, and penultimate sessions were identified, giving nine sessions altogether. This was in order to analyse interactions taking place across the course of the therapy. First and last sessions were avoided on the basis that according to psychoanalytic theory (e.g. Cregeen et al., 2017; Schlesinger, 2014) these are expected to contain specific features in virtue of their position, which was not the main focus of this study.

Data analysis

All sessions were listened to three times, divided into three minute segments, and important features of the interaction noted, including whether questions were asked. This allowed for an overview of the important themes and features of the sessions. To address the first aim of this study, each question asked by the therapist was noted, transcribed, and identified with a number. Questions were included in the data if they contained formal indications of

being a question, including lexical markers (who, what, when, where, why, how), syntactic markers (question can be identified by word order, e.g. ‘did you go to town?’), or prosodic markers (raised intonation). Questions which did not contain such markers, but which clearly functioned as questions in terms of being designed to elicit a response, were also included. The questions were analysed quantitatively in terms of type (polar, content, or alternative questions). They were then analysed by function using Stivers and Enfield’s (2010) categorisation of questions. In this categorisation system, the function of a question is identified from a list which has been shown to capture the main social actions performed by questions in American English: ‘request for information’, ‘other initiation of repair’, ‘request for confirmation’, ‘assessment’, ‘suggestion/offer/request’, ‘rhetorical’, ‘other’ (Stivers & Enfield, 2010, p.4. -please see Appendix A for descriptions of each function and examples).

To address the second aim of this study, a specific type of question was identified as being of interest (see findings, below, for justification of this focus). These questions were listed separately and studied to find any themes or similarities. To address the third aim of this study, these selected questions and the patient responses (immediate next turns in the interaction) were transcribed. In response to the data, these responses were categorised as:
-agreement – ‘yeah’/ ‘yes’/ ‘I guess so’/ ‘mmm’;
-disagreement – ‘no’ or a reformulation of the statement to say that it is not the case;

-avoidance – not answering the question, represented by pause/ silence, laughter, ‘I dunno’/ ‘hadn’t thought about it’, or unclear utterance containing two or more different types of response, for example agreement followed by disagreement or uncertainty).

The frequency of different types of response was analysed, to quantify the types of responses that these questions prompted.

To explore the patients’ responses and the consequences for the therapeutic interaction in closer detail, detailed transcription of 6 out of 18 of these interactions was completed. Cases 1 and 2 each contained two performative questions for transcription. Case 3 had a higher number of performative questions, so two were randomly selected, to include the same number of examples from each case. Excerpts were analysed using Conversation Analysis (CA). CA (Sacks, 1992) is a social science research method which enables the study of naturally occurring and institutional conversation. It assumes that conversation follows a set of rules and procedures for interaction. Analysing these conversations in close detail can allow us to learn about these rules, as well as what might be specific about particular kinds of interaction. CA focuses on the way utterances are structured and how they follow on from each other according to conversational ‘turns’ (Sacks, Schegloff, & Jefferson, 1974). Researchers doing CA usually use videotaped or audiotaped records of interactions, which are then transcribed in a particular way so as to allow the syntactical and prosodic features of utterances to be identified. This is usually using a transcription system

developed by Jefferson (2004). Importantly, CA focuses on the turn-by-turn interactions of a conversation, and how one turn responds to the previous turn as well as prompting the turn of the next speaker.

For the current study, transcription utilised selected CA transcription conventions (Jefferson, 2004), agreed within the supervision group with peers also using CA. This allowed for conversational features to be identified, and for a close observation of the interactional features surrounding these questions, without going into excessive detail and obscuring the overarching themes of the extracts. (Please see Appendix B for a full list of the transcription notation used). One minute before and one minute after the question was transcribed, taking into account natural breaks in the conversation. This aimed to capture enough of the interaction to keep the questions in the context of the session, whilst avoiding an artificial cut off.

The selected excerpts were analysed in detail following CA conventions, with close attention paid to the conversational features present and the patterns of turn taking in the interactions. Excerpts were also analysed in terms of the clinical implications with links made to the context of the therapeutic session. Three excerpts were chosen for presentation, to illustrate the range of patients' responses to the selected questions (avoidance, agreement, disagreement).

Ethics

The IMPACT study was approved by Cambridgeshire 2 Research Ethics Committee, Addenbrookes Hospital, Cambridge, UK (Goodyer et al., 2011). Participants in the IMPACT study gave their consent for data to be used in additional studies exploring the process of psychotherapy such as this. The audio-recorded data was accessed via a secure system. During transcription, all patient identifying information was changed or removed to ensure anonymity of participants. Typed transcriptions were stored with password protection.

Reliability of analysis

Reliability checking was completed on 5% of the questions, in terms of the inclusion of the questions within the data, on the categorisation of the particular type of question identified, and on the transcription of two of the excerpts and the CA of these. This was done by a peer familiar with the question categorisation system and the CA transcription conventions used. Disagreements were resolved by recourse to a third party during group supervision. My academic supervisors also read and commented on the CA of the presented excerpts.

Results

Number, type, and function of questions identified

A high number of questions (618 in total) was asked by the therapists across the nine sessions selected from the three cases. Table 1 shows the breakdown of the number of questions asked by therapists per case, across the three sessions selected:

Table 1

Number of questions asked per case

Case	Number of questions asked by therapist
1	207
2	165
3	246

Of the three types of question coded, polar questions were the most common type of question asked by therapists, followed by content questions. Alternative questions played a very small part.

This was true for all three therapists, although there is some variation between the distribution of question types, which seems likely to reflect therapists' individual styles –the therapist in Case 1 asked more content word questions than in Cases 2 or 3 (37% compared with 12% and 23% respectively). Table 2 shows the breakdown of questions by type, overall and in each case.

Table 2

Types of questions asked by therapists

Question type	Overall	Case 1	Case 2	Case 3
Polar	73%, n=454	61%, n=128	84%, n=139	76%, n=187
Content	25%, n=152	37%, n=77	12%, n=19	23%, n=56
Alternative	2%, n=12	1%, n=2	4%, n=7	1%, n=3

The most common function of the questions was a request for confirmation (45%, n=278) followed by requests for information (30%, n=183), and suggestion/ offer/ request (22%, n=136). The remaining 3% of questions were divided between ‘other’, other initiations of repair, assessment, and rhetorical questions, and there were no instances of questions that served as ‘outloud’. Table 3 shows the breakdown of questions by function, across all 3 cases.

Table 3

Function performed by questions

Function of question	Frequency
Request for information	30%, n=183
Other initiation of repair	1%, n=4
Request for confirmation	45%, n=278
Assessment	Less than 1%, n=1
Suggestion/ offer/ request	22%, n=136
Rhetorical	Less than 1%, n=1
Outloud	0%, n=0

Other	2%, n=15

Identification of a specific type of question asked in STPP sessions

During the breakdown of questions by function, particular questions were identified, which were difficult to categorise in terms of the social action they performed, but occurred relatively frequently in the STPP sessions studied. These were polar (yes/no) questions, posed declaratively, which seemed to be characterised by the therapist attempting to verbalise or 'perform' something they thought the patient was thinking, but not saying. No existing category from the categorisation scheme used seemed to adequately capture the specificity of the function of these questions, which contained elements of requests for confirmation, suggestions, rhetorical questions, and 'outloud' questions. These questions were therefore designated the new category of 'performative' due to their identified purpose of performing an utterance relating to a thought or feeling attributed to the patient, but spoken by the therapist. Below are three examples:

From Case 1, session 2, minutes 21-24:

'you might be thinking well (.) does she really care...'

From Case 2, session 11, minutes 21-24:

‘you know the week that your grandfather’s funeral is (.) you might think well (.) you know (.) bloody hell why aren’t you there (.) You know I this is I need a session this week you know don’t you know what’s going ↑on↑ in my life’

From Case 3, session 2, minutes 9-12:
‘and I was thinking maybe (.) you know (.) you thought (.) now has he bothered to remember (.) what I was going on about (.) you know has he really listened (.) has he really paid attention (.) he can’t even seem to get the names right I’ve just said’

46 performative questions were identified in total across the nine sessions coded. (Please see Appendix C for the full list of performative questions). The need for this new category of performative questions suggested to the researcher that these questions might exemplify a type of questioning that is particular to psychoanalytic discourse, at least as it has been explored here with depressed adolescents. A link between some of these questions was noted, as several were observed to address a specific theme of the patient’s unspoken negative feelings towards the therapist. 18 questions addressing this theme were identified.
These questions were dubitatively posed, containing markers of uncertainty for example ‘might’ or ‘maybe’. They were also posed as statements, and often lacked the formal markers used to identify questions. A range of themes was identified with regard to the content of the questions, including inferred annoyance about breaks or endings of sessions; about the therapist not

understanding (or not making enough effort to understand), not being available when needed, or not caring about the patient; about the therapist not being able to hold intense feelings that might come up, or the therapist having too much power in the therapeutic relationship. As will be discussed later, these performative questions could be described as a particular way of constructing the negative transference with the young person. Cases 1 and 2 each had two of this type of question, whilst Case 3 had 14 questions of this type - a markedly higher number, suggesting a difference in style between therapists. It could not be ascertained from the data used in this study whether this was due to the specifics of the patient's presentation in Case 3, the therapist's theoretical orientation and style, or other factors.

Patient responses to performative questions

The most frequent response to this type of question was avoidance (50%), suggesting that adolescent patients generally found these types of questions difficult to answer. Disagreement was the least common response. This could have many possible meanings, but brings into play the power imbalance between adolescent patient and therapist, and the possibility that patients did not feel comfortable disagreeing with their therapist. Table 4 shows the different types of responses and the number of instances of each response.

Table 4

Type and frequency of patient responses to performative questions

Type of response	Agreement	Disagreement	Avoidance
Number of instances of this response	33% (n=6)	17% (n=3)	50% (n=9)

Conversation Analysis of a selection of session excerpts containing performative questions and patient responses

Avoidant responses. Below is a transcribed and analysed example of an avoidant response, taken from Case 1, session 3, as session 2 not recorded (male, 15 years, seen by a female therapist). Therapist and patient are discussing the patient's view that it is 'weird' to consider whether other people keep him in mind:

01 T: what is (.) what is weird about ↑it↑

02 P: Sort of (.) that I (.) sort of the fact that I've never really actually

03 thought about it (.) and (.) the way (.) that you don't really know

04 if someone (.) if anyone's thinking about you (.) so it's not really

a one (.) so that you don't get someone sort of someone coming

up to you and going oh I was thinking about you earlier

T: °mm°

P: so I wouldn't really know if anyone has (2s) and it's sort of a strange question to ask someone

T: °yes° (.) but then (3s) erm (3s) and then it (.) I suppose it just (.) brings me back to the therapy as well because (.) you might be thinking you know (.) does she really care (.) you know when you tell me all these (.) about these messy feelings (.) does she really care you know (.) the session is going to end (.) after 50 minutes (2s) whats (.) what that a (.) what's the therapy about

(3s)

P: I dunno (2s) hadn't really thought about that either [(laughs softly)] (1s) mm not sure really (1s) I've never sort of sat there

T: [mmm]

P: and gone (.) does someone actually care (.) I've just always ju I think I've always jumped to the conclusion that they're just there (2s) I've sort of never (.) let a person in properly (.) I've always sort of just told em (.) well everyone knows

T: yeah=

P: =that I wouldn't there's never really been a person when I've sat

26 down >apart from now actually< that I've really sort of told em
27 about my emotions in the sense (.) like I've told em maybe (.)
28 this has happened in my life that sometimes I get a bit upset
29 (.) but I've never sort of sat there and really expla:ined (2s) what
30 how I feel

At the start of this extract, the patient is hesitatingly explaining what he finds 'weird' about the idea that somebody might wonder how he is doing (a topic set by the therapist). He gives a range of reasons across two turns. The therapist then directs the topic of the conversation from the general (the patient's thoughts about 'people') to the particular (his thoughts about his therapist). This is done with her use of a performative question (ll. 11-15) which, through its design, sounds particularly hesitant, with several pauses and repetitions. The patient's mixed response resists the agenda of the question. There is an initial 3 second pause, followed by the patient's statement that he doesn't know, then another pause (two seconds). He continues, saying he hasn't thought about it, then laughs, followed by re-stating that he isn't sure. The therapist's overlap with the patient at this point ' mmm ' (l. 19) demonstrates her agreement that he doesn't appear to have thought about this, and perhaps also encourages him to go on thinking about it. Her tone here has a humorous edge, perhaps to match the patient's laughter. The patient continues with the conversation set up in these terms, explaining why he hasn't thought of this before.

Clinically, the therapist's performative question infers that the patient might assume she doesn't care about him. In particular, she draws the patient's attention to the limitations of the therapy: 'the session is going to end after 50 minutes'. It might be that one of the underlying dynamics of this patient's depression is his lack of capacity to hold important people in mind and in turn to expect that he will be kept in mind by them. His somewhat contradictory response suggests he is very ambivalent about his therapist's question and will not allow himself to either disagree or agree with her – he remains in a neutral position. In one sense, the patient's claim that he has 'never really thought about it' rings true, as his halting utterances have the feel of somebody thinking aloud. In this way, the performative question asked by the therapist, although it seems to cause some discomfort, also prompts helpful reflection from the patient and thus development in the therapy. The patient realises that he doesn't usually let people know about himself in an emotional sense: 'I've sort of never let a person in properly', and that this is different with his current therapy, where he is invited to talk about the quality of his experience, not only the content.

Agreement responses. Overall, there were more agreement responses (33%) than disagreement responses (17%), suggesting that although performative questions might be awkward for patients, they are not necessarily rejected. Some of these questions might be awkward for patients

precisely because they are experiencing the negative feelings the therapist suggests, or because they are not ordinary topics of conversation, so might feel unfamiliar.

Below is a transcribed example of an agreement response in a section during which patient and therapist discuss the patient's response to attending therapy, taken from Case 3, session 2 (female, 17 years, seen by a male therapist):

01 T: >so it sounds like you< you feel like you know like you can have
02 these relationships and you can have quite a (.) ° powerful
03 response° to these things and (.) it quite worries you
04 P: mm-hmm
05 T: how much you can react
05 P: yeah
06 T: and feel out of control (.) erm (.) and I don't know I was thinking
07 maybe (.) maybe there is something about erm (.) thinking about
08 what's this going to be like coming here (.) and (.) whether
09 you're going to have a bit of a reaction to it
10 P: °mm hmm°
11 T: maybe you (.) already have (.) I don't know (.) but maybe you've
12 sort of wondered about (.) what's this going to do to you
13 P: °mmm°

14 T: and how are you going to feel

15 P: °mmm°

16 T: and am I gonna upset you

17 P: yeah

18 T: and are you gonna feel vulnerable

19 P: °mmm°

20 T: and are you gonna feel all of those things are you gonna feel

21 cross and (.)would you really want to

22 P: yeah (.) yeah like that was kind of the first thing that came into my

23 head when like they suggested erm (.) like >any kind of therapy<

24 T: °right°

25 P: >just that talking about things brings up a lot (.) and just makes

26 you feel like<more things (.) and it does kind of make me feel

27 like (.) icky (laughs/exhales)

The therapist's performative question begins here in l. 6 and is an extended question in which he verbalises his idea of the patient's worries about negative aspects of therapy and being with the therapist that might be experienced – that the interaction might be upsetting, the patient might feel vulnerable, might not want to experience these intense feelings. This topic has been prepared by the therapist's introduction of the 'conversational floor'

(Lepper, 2009) earlier in the interaction, with his previous question, ‘so it sounds like you...can have quite a powerful response to these things and it quite worries you’. This polar question defines the topic of the conversation as well as defining the patient’s next turn as a yes or no answer, which the patient accordingly follows, although with a somewhat non-committal ‘mm-hmm’. This allows the therapist to continue in his next turn to qualify the terms of his question slightly, ‘how much you can react’. The patient then offers a stronger token of agreement: ‘yeah’, staying within the terms of the conversation, but not adding much. These turns pave the way for the therapist’s following question which moves from the general topic of feelings generated by the therapy, ‘what’s this going to be like coming here’, to the specific topic of her feelings about the therapist, ‘am I gonna upset you’. He subsequently increases the distance between himself and the patient again by moving to the question of the patient’s wish (or not) to engage with these feelings in therapy: ‘would you really want to’. There is a marked degree of hesitation in his question, with frequent pauses, repetitions, and evidentiality devices including ‘I don’t know’ and ‘maybe’, all of which serve to reduce his commitment to the statement.

In the next turn (l. 22), the patient follows quickly, acknowledging her agreement with the therapist’s suggestions by adding to the exchange, ‘like that was the first thing that came into my head’. The patient also creates distance between herself and the therapist through a move to the general ‘any kind of therapy’ (l. 23). The therapist offers a quiet ‘right’, which allows the

patient to stay with this general stance. Accordingly, the patient begins her next turn with an utterance about things more generally, ‘talking about things’, rather than the specifics of the relationship between them. She speaks quickly and repeats the general term ‘things’, proceeding to shift the pronouns from the general ‘makes you feel’ to the personal ‘makes me feel’, followed by a quiet laugh.

Clinically, this appears to be quite an emotional interaction. The therapist’s performative question appears to identify a key worry the patient has, about whether the therapeutic interaction will be uncomfortable or even upsetting. The quietness with which the patient speaks initially and the speed of her speech later both suggest her heightened emotional state. Through the therapist’s performative question, which allows for discussion of the general as well as the specific (the therapeutic transference relationship), the therapist is able to generate agreement, as well as creating room for the patient to speak about her personal experience and fears about coming to therapy. She is able to put words to this feeling which is described as ‘icky’. Her laugh or exhalation at the end of her utterance also conveys anxiety. The therapist phrases his question very tentatively, and places the personal element of it ‘am I gonna upset you’ in the middle, immediately preceded and followed by more general statements. This seems to make the suggestion manageable for the patient. Although the patient agrees, and talks about her own feelings, she moves away from the personal relationship between patient and therapist, and shifts the worry onto how things will feel more generally in therapy.

Disagreement responses. Disagreement was the rarest response to a performative question (17% of responses). Below is a transcribed example of a disagreement response, taken from Case 2, session 7 (female, 18 years, seen by a female therapist). Patient and therapist are discussing the patient's dislike of the counsellor she was seeing previously:

01 P: yeah (.) I guess so (1 s) and (.) I don't think she really understood

02 it and I think she like (.) she sort of focussed too much on how my

03 dad (.) never lived with me when (.) that isn't really that (.) big a

04 problem (.) in my life

05 T: mmm

06 P: she wasn't focussing on the right things

07 T: right

08 (1 s)

09 P: erm (2 s) and she used to write things down and that really used

10 to annoy me (.)

11 T: right

12 P: When she was talking to me

13 (3 s)

14 T: we've got just under 5 minutes by the way

15 P: mmm (5 s) like that's (.) why I don't like (.) the (therapy centre)

16 (12 s)

17 T: and perhaps (.) perhaps you feel that sometimes here too that I

18 don't understand or say (.) don't focus on the right things or (.)

19 don't get the right (.) er end of the stick

20 P: I think you do (.) I think (.) I don't I just (.) that other woman I just

21 didn't (3 s) she'd really come out with the wrong things (.) [I think

22 T: [Right]

23 P: I] felt and if I tried to explain to her that I didn't think it was right

24 (.) she didn't get it

25 T: right=

26 P: =or she wouldn't really understand or (.) yeah (3 s) I dunno

27 (2 s)

28 T: so it felt it made things worse

29 P: yeah

30 T: but I guess talking (.) when it's difficult (.) anyway (.) and you

kind

31 of manage to do it but then you feel its not heard (.) it's not a (.)

32 very helpful or (.) it's quite a [painful] experience

33 P: [yeah]

34 P: mm (.) yeah (.) it wasn't very (.) nice (.) I just remember it as

35: being really cold but that's because it was winter

Initially in this extract, the patient's list of reasons for why she didn't like her previous therapist are punctuated by understated acknowledgement tokens from the therapist ('mm'; 'yeah'). There are several pauses of two seconds and three seconds in the following lines, followed by the therapist's utterance regarding the time remaining. The patient does not take this up but shifts the topic back to her dislike of the previous therapist, now phrased in relation to the place where that therapy took place. An extended pause follows, which the therapist chooses to break with a performative question (ll. 17-19), repeating some of the patient's phrasing in a clear attempt to link the patient's complaints to the current experience with this therapist. The patient disagrees in the next turn by reformulating the statement to the contrary, 'I think you do,' and returns immediately to the complaint about the previous counsellor. This response resists the terms of the question, which is a polar question which should be answered with 'yes' or 'no'. Her response is also hesitant and unclear, appearing to start four times before a phrase is completed. In this way, the patient refuses to pick up on the topic shift introduced by the therapist. The patient's response also controls the conversation by maintaining ownership over the conversational floor. The therapist acknowledges the patient's repeated explanations of why she didn't like the previous therapist, until there is a two second pause (l. 27), at which point the conversation seems to have reached a sort of impasse or rupture. The therapist then offers a reformulation, this time following the conversational floor set up by the patient. In the lack of personal pronouns, this is very general: 'it felt it made things worse', with which the patient agrees. The

therapist's next utterance stays within the terms set up by the patient, so rather than mentioning herself or the previous therapist, the predicament is formulated in terms of the emotional experience, 'it's not very helpful or (.) it's quite a painful experience'. The patient agrees, notably overlapping with the therapist, perhaps showing her relief at being able to agree again. She adds the physical feeling of being 'cold'.

Clinically, the therapist's linking of the patient's statements to negative feelings that the young person might be having about the therapist is clearly uncomfortable for the patient. The patient lets the therapist know that she is not about to start discussing her feelings about her current therapist, especially any negative ones. This is significant for this patient as the initial segmenting of sessions showed that she also struggled to express any negative feelings towards other important people in her life. Following the disagreement, the therapist gets the conversation moving again by exploring the negative feelings as they are attached to the previous counsellor so that the patient seems to feel heard. The therapist here respects the patient's wish to keep the focus within the domain of difficulties experienced in the previous relationship, and attempts to articulate the emotional experience of this. The patient's mention of physical coldness possibly links to the emotional coldness at which the therapist hinted. Later in the session, the therapist suggests the patient's hope that this time, in this therapy, things might be different.

Discussion

This study aimed to identify and explore questions asked by therapists during STPP sessions with depressed adolescents. After exploring the type, number, and function of therapist questions asked across a sample of nine sessions from three STPP cases, a specific type of question, termed performative, was identified as being a particular way in which therapists appeared to use questions in these sessions. The impact of these performative questions, addressing what the therapist considered to be unspoken negative feelings about the therapist, was explored through analysis of the patients' next turn responses. Analysis of the procedural aspects of the interactions containing these questions was completed using CA.

A high number of questions asked by therapists was identified overall. Based on the assumption often made about psychoanalytic psychotherapy that therapists do not ask a lot of questions (Sousa, Pinheiro, & Silva, 2003), the number of questions was higher than might be expected in a psychoanalytic exchange. This study therefore challenges this assumption, as well as emphasising the interactional or relational aspect of psychoanalytic psychotherapy (highlighted by e.g. Stern, 1985). In the sessions studied, the therapists' use of questions showed them to be very active participants in the conversation.

One hypothesis regarding the high number of questions asked by the therapists relates to the diagnosis of the patients. Young people diagnosed with depression might be expected to be low in mood, and thus to need their therapists to take a more active role in the therapy. The active role of the therapists perhaps also takes into account the short term nature of this work, within which there might be a need for more direction from the therapist to ensure that important themes are not avoided.

The results of the analysis of question types by distribution is in keeping with the findings of other studies (Stivers, 2010) which analysed the distribution of question types in naturally occurring interactions in American English. The same three primary question types of polar, content, and alternative questions, were represented, and in similar proportions to the study by Stivers (2010). Additionally, the breakdown of questions by social action showed that questions were used for a variety of functions in addition to simply requesting information. The highest frequency of questions in these sessions served as requests for confirmation, which is slightly higher than has been shown to be evident in naturally occurring conversation (Stivers, 2010). This may be evidence of therapists testing their intuitions about the patient before moving on to further interpretative statements.

As well as following many of the rules and procedures of ordinary conversation, psychoanalytic psychotherapists working with depressed adolescents were also shown to use questions in more specific and unusual

ways. This study identified the therapists' use of performative questions, which were employed to draw attention to negative thoughts and feelings patients might have about them. CA analysis of the selected excerpts showed that performative questions were one example of a specialised conversational device used by therapists to challenge their patients, and make room for discussion of purported difficult feelings, which the therapist felt were pertinent to their patient's depressed presentation.

In psychoanalytic terminology, these performative questions would be described as examples of interpreting the negative transference (Freud, 1912) – addressing the patient's inferred negative feelings about the therapist, in the hope that these can be understood and worked through. The negative transference interpretations phrased as performative questions in this study use something the young person brings about an aspect of their life, and pull this into the arena of the therapy by linking it to the therapist themself. One psychoanalytic understanding of depression is as the result of unexpressed aggression that is turned around on the self (Freud, 1917; Busch, Rudden, & Shapiro, 2004). Helping patients to experience and express their negative or aggressive feelings towards others, rather than directing these feelings towards themselves, would thus help them to recover. Addressing the negative transference would be expected to be a key part of the therapy of the depressed young people included in this study, for whom the struggle to put difficult feelings into words was a main feature of their presentation.

Posing interpretations as questions, particularly dubitatively posed questions, allows therapists to present their epistemic stance as being lower than their epistemic status (Heritage, 2013). In the case of psychoanalytic psychotherapy, the epistemic gradient between patient and therapist is complicated. The patient's feelings about their therapist could be described as type-1 knowables (Pomerantz, 1980) - knowledge that the patient has in virtue of it being knowledge about their subjective experience. This would afford the patient a higher epistemic status than the therapist, who arguably doesn't have knowledge of these things. Within psychoanalytic psychotherapy though, one of the therapist's aims is to bring alive for the patient things of which they are not consciously aware. From this perspective, the therapist has the higher epistemic status, even though they are discussing the patient's experience. This has the potential to feel uncomfortable for the patient, which is one reason that therapists might choose to present a low epistemic stance in phrasing their negative transference interpretations more tentatively, as performative questions.

Posing interpretations as questions also leaves the patient with the option to disagree. Nonetheless, disagreement was the rarest kind of response to these questions. Perhaps patients found it difficult to disagree openly with their therapists, which again poses questions about the relative status of patient and therapist and, more widely, the dynamics of power within the therapeutic relationship, especially with adolescents.

This study also aimed to examine how young people responded to therapists' performative questions addressing negative feelings about the therapist. These questions were followed by a high frequency of avoidant responses. Patients broke conversational rules in these responses, as the questions were all formulated as polar questions, which conversational rules dictate should be answered with 'yes' or 'no' (Raymond, 2003). This suggests that these patients often found questions that addressed their negative feelings about the therapist awkward or difficult to answer. The detailed CA of excerpts added to this analysis, illustrating how the young people in this study tended to work hard to keep any suggestion of negative feelings out of the relationship with the therapist. They found it more palatable to discuss negative feelings if they related to another domain – a previous relationship or another aspect of their life, or if they were otherwise generalised. This supports established advice offered to therapists in the need for tactful handling when approaching the negative transference, and making use of interpretations in displacement (Trowell, Rhode, & Hall, 2010) when working with depressed adolescents. The therapist's use of performative questions, as identified in this study, demonstrates one way in which therapists might address the negative transference in a tactful manner. Performative questions addressing negative transference issues were also shown to lead to moments of mutual understanding between patient and therapist. In this way, performative questions were one way in which therapists kept their patients engaged in the process of therapy, whilst difficult subjects were addressed.

Clinical, theoretical, and methodological implications

In terms of theory, this study has identified a particular type of transference interpretation which, to the author's knowledge, has not previously been identified. Although further work is needed in order to generalise the results of this study, the term 'performative questions' might be usefully added to psychoanalytic terminology, to allow us to better identify and describe what happens in psychoanalytic sessions. The findings of this study have implications for refining clinical technique, as it is suggested that the use of performative questions is one way in which therapists might aim to make negative transference interpretations more manageable than if they were posed as statements with a higher degree of certainty. The data presented in this paper could provide material for training seminars for psychoanalytic psychotherapy, or could perhaps be incorporated into the manual for STPP.

Methodologically, this study builds on existing studies (Peräkylä, 2004; Knox & Lepper, 2014) which have used CA to explore in detail the process of psychoanalytic psychotherapy. The use of CA allowed for phenomena occurring in psychoanalytic psychotherapy sessions to be observed, which could then be brought into dialogue with psychoanalytic concepts such as 'transference interpretation' and 'negative transference'. The presentation of session material also allowed for a view into the therapy room, to give a live understanding of the therapeutic process, which can also be accessible to practitioners from non-psychoanalytic trainings.

Strengths and limitations

This study addresses a gap in the literature with regard to how therapists use questions in short term psychoanalytic psychotherapy with depressed adolescents. The study sheds light on the frequent use of questions, as well as the specific use of performative questions, their effects on the therapeutic process, and implications for clinical technique. As there is so little already published in this area, this study is necessarily preliminary, but offers important observations which have implications for clinical practice.

The use of CA gives only a partial description of the therapeutic process with regard to questions asked by the therapist. CA enables a detailed understanding of the procedural aspects of a therapeutic conversation, but is, of course, limited – missing for example the important aspects of gaze and other non-verbal communications, including the feelings that were generated, which are another key aspect of psychoanalytic work.

Although appropriate for CA, this study also had a small sample size of three cases, so the extent to which the results can be generalised is limited, and links between process and outcome were not the aim of this study. It would be helpful to look at a larger number of cases, and cases covering different clinical populations, to confirm whether performative questions are also used by other therapists doing STPP. Links to outcome could be informed through

further research which analyses a larger sample of cases and looks for links between the number of performative questions addressing the negative transference, and clinical outcomes.

Conclusion

This study identified the large number of questions asked by therapists during STPP sessions with depressed adolescents, and demonstrated the active role taken by the therapists, which challenges certain preconceptions about psychoanalytic technique. The study also identified a particular type of question termed ‘performative’, which was a specialised conversational device used by therapists to address the negative transference. These performative questions were often met with avoidant responses from the young people, bringing up the important topic of whether, and how, it is helpful to address the negative transference with depressed adolescents. Detailed CA analysis of performative questions also demonstrated the high levels of sensitivity needed from therapists when addressing the negative transference with depressed adolescents.

References

Adler, E., & Bachant, J. L. (1996). Free Association and Analytic Neutrality: The Basic Structure of the Psychoanalytic Situation. *Journal of the American Psychoanalytic Association*, 44(4), 1021–1046. https://doi.org/10.1177/000306519604400403

Anvari, M., Dua, V., Lima-Rosas, J., Hill, C. & Kivlighan, D. (2022). Facilitating Exploration in Psychodynamic Psychotherapy: Therapist Skills and Client Attachment Style. *Journal of Counseling Psychology*, Advance on-line publication. https://doi.org/10.1037/cou0000582

Avdi, E., & Georgaca, E. (2007) Discourse analysis and psychotherapy: A critical review, *European Journal of Psychotherapy and Counselling*, 9(2), 157-176. https://doi.org/10.1080/13642530701363445

Bell, C. R. (2017). Psychotherapeutic subjectivities: A thematic analysis of experiences of change in psychoanalysis / psychodynamic psychotherapy and cognitive-behavioral therapy (Order No. 10640305). Available from *ProQuest Central; ProQuest Dissertations & Theses Global*. (2001239778). Retrieved from https://www.proquest.com/dissertations-theses/psychotherapeutic-subjectivities-thematic/docview/2001239778/se-2

Biber, D., Hohansson, S., Leech, G., Conrad, S., Finegan, E. 1999. *Longman Grammar of Spoken and Written English*. Longman, London.

Boesky, D. (1989). The Questions and Curiosity of the Psychoanalyst. *Journal of the American Psychoanalytic Association*, *37*(3), 579–603. https://doi.org/10.1177/000306518903700301

Boothe, B., Grimm, G., Hermann, M., & Luder, M. (2010) JAKOB narrative analysis: The psychodynamic conflict as a narrative model, *Psychotherapy Research*, 20:5, 511-525,https://doi.org/10.1080/10503307.2010.490244

Busch, F., Rudden, M. and Shapiro, T. (2004). *Psychodynamic Treatment of Depression*. Washington: American Psychiatric Publishing

Busch, F. (2014). *Creating a Psychoanalytic Mind: a psychoanalytic method and inquiry.* East Sussex and New York: Routledge

Curl, T. & Drew, P. (2008). Contingency and Action: a comparison of two forms of requesting. *Research on Language and Social Interaction*, 41(2), 129-153.

Cregeen, S., Hughes, C., Midgley, N., Rhode, M., & Rustin, M. (2017). *Short term psychoanalytic psychotherapy for adolescents with depression: a treatment manual*. London: Karnac Books

Daviss, W.B., Birmaher, B., Melhem, N.A., Axelson, D.A., Michaels, S.M., & Brent, D.A. (2006). Criterion validity of the Mood and Feelings Questionnaire

for depressive episodes in clinic and non-clinic subjects. *Journal of Child Psychology and Psychiatry*, 47, 927–34.

Della Rosa, E., & Midgley, N. (2017) Adolescent Patients' Responses to Interpretations Focused on Endings in Short-Term Psychoanalytic Psychotherapy. *Journal of Infant, Child, and Adolescent Psychotherapy*, 16(4), 279-290, https://doi.org/10.1080/15289168.2017.1378531

Fonagy, P., Target, M., Cottrell, D., Phillips, J., & Kurtz, Z. (2002). *What works for whom?: A critical review of treatments for children and adolescents.* New York: Guilford Press.

Freud, S. (1912). The Dynamics of Transference. *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XII (1911-1913): The Case of Schreber, Papers on Technique and Other Works* (pp. 97-108). Great Britain: The Hogarth Press.

Freud, S. (1917). Mourning and Melancholia, *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIV (1914-1916): On the History of the Psycho-Analytic Movement, Papers on Metapsychology and Other Works* (pp. 237-258). Great Britain: The Hogarth Press.

Friedlander, Myrna, Sutherland, Olga, Sandler, Steven, Kortz, Laura, Bernardi, Shaina, Lee, Hsin-Hua, et al. (2012). Exploring Corrective

Experiences in a Successful Case of Short-Term Dynamic Psychotherapy. *Psychotherapy*, 49, 349-363. https://doi.org/10.1037/a0023447

Goodyer, I., Reynolds, S., Barrett, B., Byford, S., Dubicka, B., Hill, J., Holland, F., Kelvin, R., Midgley, N., Roberts, C., Senior, R., Target, M., Widmer, B., Wilkinson, P., Fonagy, P., (2017) Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT): a multicentre, pragmatic, observer-blind randomised controlled superiority trial, *Lancet Psychiatry* 4(2), 109-119

Goodyer, I. M., Tsancheva, S., Byford, S., Dubicka, B., Hill, J., Kelvin, R., Reynolds, S., Roberts, C., Senior, R., Suckling, J., Wilkinson, P., Target, M., & Fonagy, P. (2011). Improving mood with psychoanalytic and cognitive therapies (IMPACT): a pragmatic effectiveness superiority trial to investigate whether specialised psychological treatment reduces the risk for relapse in adolescents with moderate to severe unipolar depression: study protocol for a randomised controlled trial. *Trials*, 12, 175.

Hayano, K. (2013). Question Design in Conversation, in J. Sidnell and T. Stivers (Eds.)*The Handbook of Conversation Analysis* (pp. 395-414). Blackwell publishing: West Sussex.

Healing, Sara & Bavelas, Janet Beavin. (2011). Can questions lead to change? An analogue experiment. *Journal of Systemic Therapies*, 30, 30-47. https://doi.org/10.1521/jsyt.2011.30.4.30

Heritage, J. (2013). Epistemics in Conversation, in J. Sidnell and T. Stivers (Eds.) *The Handbook of Conversation Analysis* (pp. 370-394). Blackwell publishing: West Sussex.

Heritage, J., & Robinson, J. (2006). The Structure of Patient's Presenting Concerns: Physicians' Opening Questions. *Health Communication*, 19(2), 89-102.

Jager, M., Huiskes, M., Metselaar, J., Knorth, E.J., De Winter, A.F., Reijneveld, S.A. (2016). Therapists' continuations following I don't know-responses of adolescents in psychotherapy. *Patient Education and Counselling*, 99(11),1778-1784. https://doi.org/10.1016/j.pec.2016.05.016

Jefferson, G. (2004). Glossary of Transcript Symbols with an Introduction, in G. H Lerner (Ed.) *Conversation Analysis: Studies from the First Generation* (pp. 13-31). Amsterdam: John Benjamin.

Kernberg, P. F., Chazan, S. E., & Normandin, L. (1998). The children's play therapy instrument (CPTI): Description, development, and reliability studies. *Journal of Psychotherapy Practice & Research*, 7 (3), 196-207.

Knox, J. & Lepper, G. (2014) Intersubjectivity in therapeutic interaction: a pragmatic analysis, *Psychoanalytic Psychotherapy*, 28:1, 33-51, DOI: 10.1080/02668734.2013.840331

Lepper, G. (2009). The Pragmatics of Therapeutic interaction: An Empirical Study. *International Journal of Psycho-Analysis*, 90(5), 1075-1094.

Levy, K., & Scala, J. (2012). Transference, Transference Interpretations, and Transference-Focused Psychotherapies. *Psychotherapy* 49(3), 391–403

Luborsky, L. , Popp, C., Luborsky, E., & Mark, D. (1994). The Core Conflictual Relationship Theme, *Psychotherapy Research*, 4(3-4), 172-183. https://doi.org/10.1080/10503309412331334012

Luborsky, L. (1990). The everyday clinical uses of the CCRT. In L. Luborsky & P. Crits-Christoph (Ed.), *Understanding transference: The CCRT method* (pp. 235-250). New York: Basic Books.

MacMartin, C. (2008). Resisting optimistic questions in narrative and solution-focussed therapies, in A. Perakyla, C. Antaki, S. Vehvilainen, & I. Leudar (Eds.) *Conversation Analysis and Psychotherapy* (pp. 80-99). Cambridge: Cambridge University Press.

Madill, A. and Barkham, M. (1997) ‘Discourse analysis of a theme in one successful case of brief psychodynamic-interpersonal psychotherapy’. *Journal of Counselling Psychology*, 44 (2), 232–44.

McGee, D., Del Vento, A., & Bavelas, J. (2005). An interactional model of questions as therapeutic interventions. *Journal of Marital and Family Therapy* 31, 371 - 384.

McLeod, J. and Balamaoutsou, S. (1996). Representing narrative process in therapy: qualitative analysis of a single case. *Counselling Psychology Quarterly*, 9, 61–76.

Meier, A., & Boivin, M. (2000). The achievement of greater selfhood: The application of theme-analysis to a case study. *Psychotherapy Research, 10*(1), 57-77.

Midgley, N., & Kennedy, E. (2011) Psychodynamic psychotherapy for children and adolescents: a critical review of the evidence base, *Journal of Child Psychotherapy*, 37(3), 232-260. https://doi.org/10.1080/0075417X.2011.614738

Midgley, N., O’Keefe, S., French, L., & Kennedy, E, (2017). Psychodynamic psychotherapy for children and adolescents: An updated

narrative review of the evidence base. *Journal of Child Psychotherapy*, 43(3), 307-329.

Midgley, N., Holmes, J., Parkinson, S., Stapley, E., Eatough, V., & Target, M. (2016). "Just like talking to someone about like shit in your life and stuff, and they help you": Hopes and expectations for therapy among depressed adolescents. *Psychotherapy Research, 26*(1), 11-21. https://doi.org/10.1080/10503307.2014.973922

Muntigl, P., & Zabala, L. (2008). Expandable Responses: How Clients Get Prompted to Say More During Psychotherapy. *Research on Language and Social Interaction*, 41(2), 187-226.

Peräkylä, A. (2004). ‘Making links in psychoanalytic interpretations: a conversation analytic perspective’. *Psychotherapy Research*, 14 (3), 289–308.

Peräkylä, A. (2008). Conversation Analysis and Psychoanalysis: interpretation, affect, and intersubjectivity, in A. Perkyla, C. Antaki, S. Vehvilainen, & I. Leudar, I. (Eds.) *Conversation Analysis and Psychotherapy* (pp. 100-119). Cambridge: Cambridge University Press.

Pole, N., & Jones, E. (1998). The talking cure revisited: content analyses of a two year psychodynamic psychotherapy. *Psychotherapy Research,* 8(2), 171-189.

Pomerantz, A. (1980). Telling my side: “limited access” as a “fishing” device. *Sociological Enquiry*, 50, 186-198.

Raymond, G. (2003). Grammar and social organization: Yes/No interrogatives and the structure of responding. *American Sociological Review*, 68, 939-967.

Rhodes, P. (2012). Why clinical psychology needs process research: An examination of four methodologies. *Clinical Child Psychology and Psychiatry*, 17(4), 495–504. https://doi.org/10.1177/1359104511421113

Sacks, H. (1992). *Lectures on Conversation*. Oxford: Blackwell

Sacks, H., Schegloff, E., & Jefferson, G. (1974). A Simplest Systematics for the Organization of Turn-Taking for Conversation. *Language*, 50(4), 696-735

Safran, J. Muran, C., & Shaker, A. (2014) Research on Therapeutic Impasses and Ruptures in the Therapeutic Alliance. *Contemporary Psychoanalysis*, 50(1-2), 211-232. https://doi.org/10.1080/00107530.2014.880318

Salvatore, S., Gelo, O.C., Gennaro, A., Metrangolo, R., Terrone, G., Pace, V., Venuleo, C., Venezia, A., & Ciavolino, E. (2017). An automated method of content analysis for psychotherapy research: A further validation, *Psychotherapy Research,* 27(1), 38-50. https://doi.org/10.1080/10503307.2015.1072282

Schlesinger, H. J. (2014). *Endings and beginnings: On terminating psychotherapy and psychoanalysis (2nd ed.).* New York: Routledge/ Taylor & Francis Group

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist,* 65 (2), 98 –109. https://doi.org/10.1037/a0018378

Shechtman, Z. (2004). Client Behavior and Therapist Helping Skills in Individual and Group Treatment of Aggressive Boys. Journal of Counseling Psychology, 51, 463-472. https://doi.org/10.1037/0022-0167.51.4.463

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist,* 65 (2), 98 –109. https://doi.org/10.1037/a0018378

Sousa, P.L., Pinheiro, R.T. and Silva, R.A. (2003). Questions about questions. *International Journal of Psycho-Analysis*, 84(4), 865-878.

Steiner, J. (1993). Psychic Retreats. New Library of Psychoanalysis: London/New York: Routledge. https://doi.org/10.1080/07351699409533994

Stern, D. (1985). *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology*. London: Karnac Books.

Stewart, P. K., Steele, M. M., & Roberts, M. C. (2014). What happens in therapy? Adolescents' expectations and perceptions of psychotherapy. *Journal of Child and Family Studies, 23*(1), 1-9. http://dx.doi.org.libproxy.ucl.ac.uk/10.1007/s10826-012-9680-3

Stivers, T. (2010). An overview of the question-response system in American English conversation, *Journal of Pragmatics*, 42(10), 2772-2781.

Stivers, T., and Enfield, N. J. (2010) A coding scheme for question–response sequences in conversation, *Journal of Pragmatics* 42 (2010) 2620–2626

Stivers, T., Enfield, N. J., Brown, P., Englert, C., Hayashi, M., Heinemann, T., Hoymann, G., Rossano, F., de Ruiter, J. P., Kyung-Eun Yoon, K., & Levinson, S. C (2009). Universals and cultural variation in turn-taking in conversation. *Proceedings of the National Academy of Sciences of the United States of America*, 106 (26), 10587-10592.

Stivers, T., Sidnell, J., & Bergen, C. (2018). Children's responses to questions in peer interaction: A window into the ontogenesis of interactional competence. *Journal of Pragmatics*, 124, 14-30.

Trowell, Judith and Rhode, Maria and Hall, Jackie (2010) What does a manual contribute? In *Assessing change in psychoanalytic psychotherapy of children and adolescents. Today's challenge*. (pp. 55-92) London: Karnac. Accessed at http://repository.tavistockandportman.ac.uk/407/1/What_does_a_manual_contribute.pdf

Waldron, S., Gazzillo, F., & Stukenberg, K. (2015). Do the Processes of Psychoanalytic Work Lead to Benefit? Studies by the APS Research Group and the Psychoanalytic Research Consortium, *Psychoanalytic Inquiry*, 35(1), 169-184. https://doi.org/10.1080/07351690.2015.987602

Waldron, S., Scharf, R., Crouse, J., Firestein, S., Burton, A., & Hurst, D. (2004). Saying the right thing at the right time: a view through the lens of the Analytic Process Scale (APC). *Psychoanalytic Quarterly*, 73, 1079-1125.

Appendix A: Coding scheme for categorising questions by social action (Stivers and Enfield, 2010, p. 4)

Questions are categorised as one of the following social actions:

-request for information (for example ‘what time did you leave?’)

-other initiation of repair (for example ‘huh’? or /’what?’ or partial repeat such as ‘he went where?’);

-request for confirmation (asserting a proposition for confirmation, such as ‘so you’re coming tomorrow night?’)

-assessment (stating evaluation; seeking agreement, for example ‘isn’t it beautiful out today’ or ‘she’s such a pretty girl isn’t she’)

-suggestion/ offer/request (questions which suggest, propose, or offer something to another, as well as questions that request something from another (e.g. ‘did you want some [about a breakfast cereal])

-rhetorical question (questions that may seek a response but not an answer, for instance asserting an opinion as in ‘it all comes out in the wash, doesn’t it?)

-outloud (delivered to noone in particular, do not appear to be designed to elicit a response, for example ‘now where are my keys?’ whilst looking in a bag)

-other (if the question did not fit any of these existing categories well). List, as specifically as possible, the social action that the question is being used for. If there is a sufficient number of ‘other’ cases, a new category can be generated.

Appendix B: List of symbols used for transcription

°words between degree signs° quiet speech

<u>underlined words</u> emphasis

WORDS IN CAPITALS loud speech

↑words between upwards arrows↑ raised intonation

↓words between downwards arrows↓ lowered intonation

(.) short pause - under a second

(2s) timed pause, 1s or longer

>words between inward facing chevrons< fast speech

<words between outward facing chevrons> slow speech

[words between square brackets] overlapping utterances

((sound)) something not represented in words/sound vocalisation such as cough/laugh

= latching (no interval between adjacent utterances)

(xxxx) unintelligible utterances. Words written in parentheses signify that the utterance is heard by the researcher but unclear.

words highlighted orange performative question indicated

Appendix C: full list of performative questions asked by therapists

Questions highlighted in blue - address something negative about the therapist

Case 1

Session 3

21-24

34. You might be thinking well, does she really care

35. What's the therapy about

27-30

40. It's almost as if you're saying 'look how messed up I am and 'I don't have one counsellor, I have two' you know 'what are you going to do about it'

30-33

41. So I think that one of the questions is do I really get how troubled you really feel at the moment

Session 11

27-30

106. But I had another thought which was well (2) what happens to (name) (.) when there is (.) when there is silence does he feel (.) someone needs to say something (.) even if it's just for the sake (.) of something (.) going (.) having something going

Session 20

3-6

143. Maybe what you're saying is that it's just too much

21-24

176. So perhaps you felt that I was going to wave my finger at you (.) and say (name) hasn't been coming (.) erm why (.) are you doing that

30-33

184. I think what you are saying is will you misuse that freedom (.) or will you be able (.) to use it in a way that helps you (.) enjoy life or will you use it in a way that is going to get you into trouble

Case 2

Session 2

36-39

263. But it's sort of you felt oh no this is happening again (1) sort of dreading the depression

Session 7

21-24

313. Perhaps you worry she's gonna (.) if she's got really bad (.) you're gonna get really bad again

24-27

316. But I think (.) you worry about her but you also worry about yourself what effect is it gonna have on you are you going to, how are you going to be affected by it (.) and what are you going to do about it (.) how are you gonna feel

33-36

319. And perhaps you're worried (.) that it's going to bring you down too (2) you really dread going back to that place that (.) you were in (1) that felt quite hopeless you lost your sense of future and motivation

39-42

326. And perhaps you feel that sometimes here too that I don't understand or don't focus on the right things or don't (.) or get the wrong end of the stick, or

Session 11

9-12

340. Well I think (.) I wonder if you sort of feel (.) erm (.) you know we've talked before about how you've come to you feel you know her so well (.) almost more than yourself and (.) and that actually (.) it can be easier to be worried about her than to be worried about yourself (.) erm and whether that's something that you think about you know or (.) am I sort of thinking about (friend's name) when actually I'm not feeling great or things aren't

21-24

348. I was thinking that in relation to (.) you know also coming here in relation to me cancelling last week's session and how you know (.) that might be (.) for you and you were very reasonable about it and you know yes that's fine wasn't a problem but it might also be annoying (.) you know the week that your grandfather's funeral is (.) you might think well (.) you know (.) bloody hell why aren't you there? You know this is I need a session this week and don't you know what's going on in my life (.) and you know and (.) equally with the pictures and the pictures up there and you not having a picture that that some people might think that that would be hurtful or annoying you might be annoyed with your mum well why if you have all these pictures why aren't our pictures up (interrupted)

Case 3

Session 2

3-6

377. Maybe you think you need to tell me a bit more details about them and (.) will I really remember

6-9

391. So (1) you were upset (.) and you felt like her response was just to get cross with you (.) so then what's the answer (.) Don't know, and I'm not gonna tell you anything (1) I'm not gonna bother (.) because I'm too upset to even listen

9-12

393. So it kind of (.) you know there's a kind of (2s) you know you sort of give it back to them (.) you felt kind of (.) I don't know shut down (.) shut out whatever (.) so you shut them out back (.) and I don't know I was just thinking maybe there's this sort of feeling (2s) about feeling a bit (1s) shut out somehow by your mum's response too (1s) I don't know (.) but I was also thinking (1s) I was thinking about coming here (.) the way you start today (.) and I was thinking maybe (.) you know (.) you thought (.) now has he bothered to remember (.) what I was going on about (.) you know has he really listened (.) has he really paid attention (.) he can't even seem to get the names right I've just said (.) sso I thought maybe (.)you know there's a kind of (.) concern that this thing would develop here too (.) that you would feel quite offended by (.) my behaviour in some way

394. But I wonder whether you thought you know did I remember (.) and what the hell was I doing if I ↑can't↑ (.) Isn't that my ↑job↑

396. But I wonder whether you would think it was my ↑fault↑

12-15

402. So am I playing some kind of difficult game (.) am I making it harder for you

403. You know I'm not saying (.) it's meant to be like that but whether you sort of feel a bit like that (.) you know (.) is this what psychotherapy's like

30-33

439. So it sounds like you feel like you know like you can have these relationships and you can have quite a (.) powerful response to these things and (.) it quite worries you (.) how much you can react (.) and feel out of control (.) and I don't know I was thinking maybe (.) maybe there's something about erm (.) thinking about what's this going to be like coming here (.) and (.) whether you're going to have a bit of a reaction to it (.) maybe you already have (.) I don't know (.) but maybe you've sort of wondered about (.) what's this going to do to you how are you going to feel (.) and am I gonna upset you (.) and are you gonna feel vulnerable (.) and are you gonna feel all of those things are you gonna feel cross and (.) would you really ↑want↑ to

33-36

443. I don't know whether you were sort of saying I don't know when you say you were like this with counselling (.) whether you're saying (.) you know that (.) you know that that's the kind of response you have to the counselling (.) and whether you sort of think oh well (.) this'll be the same kind of response (.) but I was thinking whether (.) in your kind of (.) you know when I had that counselling whether you're worried (.) that it's gonna be (.) worse (.) your response (.) that it's gonna be (.) harder (.) and if you're gonna feel more upset

444. But I suppose maybe you're worried that that's (.) erm (.) if you get really upset here (.) will I be able to take it?

36-39

448. But I was also thinking maybe you were also worrying that (.) you wouldn't stop (2) and that I wouldn't know how to stop you (.) from crying (.) so (.) you know (.) what would we ↑do↑

39-42

459. I guess I'm kind of thinking about you know about worrying about sort of being left in a state and I guess I was kind of thinking you know that erm (.) we're not gonna meet next week (.) or the week after (.) so it's going to be quite a long time (.) and maybe this is (.) you know your second session but (.) perhaps you are a bit worried about you know being a bit of a gap (.) before

the next meeting as well (.) and you know and will I have forgotten everything cos you know I'll be so busy with the rest of my life (1) where will you know where to start next time

460. So you're what you're saying in a way is that (.) erm having to think over Christmas would be a disaster

45-48

474. But I was thinking whether you're sort of saying something about being part of a group some how and feeling (1) erm (1) feeling quite lost (.) feeling like you don't really have that much of a place (.) that you'll just be kind of a (.) a number (.) nobody will remember you as important at all

Session 7

9-12

482. I don't know whether (.) (sigh) you know whether you (.) you want me to say well no(.) you know you had a row with your mum (.) she doesn't think this is a great idea (.) she thinks you're mad or something (.) better not come (.) you know it's almost as if (.) will I go along with that (.) sort of decision making (.) which you seemed to think was pretty mad (.) actually

12-15

486. So is that because of having a row that it came up is it because of coming to see me (1.5) did you actually go and do something (.) really which would tell them how it really is (.) have you actually just said (.) this is what it's like this is how I feel (.) I want you to know

491. It might not feel for the better (.) it might not make you feel good (.) might make you feel worried (.) you know you think that they'll they really↑mind↑ now they really ↑know↑ something they're gonna be you know (.) god why did I tell you know you might feel very cross and angry about that

15-18

494. Maybe you think am I gonna force you into coming to see me you know is this your free (.) free will and I was thinking maybe (.) also (.) you feel that when I talk (.) about things and I say this is how it is (.) you feel like I'm kind of imposing on your free that I'm going to (.) get you to think the way I am and actually you're not gonna have that (.) cos it's not on (.) and am I kind of exerting some kind of power over you (.) which you <u>don't</u> like

18-21

500. Maybe you're saying there was (.) an idea that (.) you know in some ways when you were little (.) that it wasn't just that you were (.) you know were being good (.) because that was the way you were (.) but whether

actually (.) somebody (.) couldn't manage you being upset (.) because they were too upset themselves

21-24

503. You know are you saying if I (.) tell her I'm upset then I'm worried that she'll get depressed

24-27

509. Maybe you sort of think (.) what what am I getting out of this this therapy

30-33

519. I mean maybe it would be easier if I were to give you some really neat answer (.) and that would be it (.) and that you wouldn't have to kind of struggle (.) struggle with knowing what to do or who you are or (.) or any of these things (.) and I don't seem to be being very helpful in that way (.) and maybe you feel I must have some answer somewhere and I'm just not supplying it (.) really and the other thing is (XXX)

33-36

520. But also you might feel that dunno (.) is this some kind of really ↑cruel↑ way is this psychotherapy (.) kind of ↑cruel↑ it makes you (.) you you know (.)

let down your kind of (.) your defences (.) in a way (.) how how can that be of any help (.) you know even if it is effective (.) is it effective in a really bad way

39-42

I suppose it's a question about what do you do about these things am I kind of (.) am I sort of encouraging you just to <wallow and cry> every time you come here to see me and you know that's all it's gonna be and it's gonna be endlessly crying again and again and again (1) or (.) am I helping you to kind of do something about these things (2) really do something (.) you know without necessarily resorting to punching somebody

Session 13

6-9

545. Well I was thinking whether you (.) thought that I might feel a bit pushed out about what why is she coming with (?) (name) should be here just to see me on her own (.) ⌈how would I feel (.) and (.) whether you know there was this question about whether I would be particularly possessive and feel (.) annoyed that you would be with somebody else

9-12

546. Well I suppose I was just kind of thinking about all of that and I was thinking (.) also about last week and I guess I was thinking one of the things

that I've talked to you about is erm (.) not seeing you for a couple of weeks (.) really and ↑I↑ (.) was thinking (.) well I suppose that you know erm (.) I wondered what that ↑meant↑ (.) to you really (.) and I wondered whether (.) you're telling me about a girl who can be quite possessive with people and feel (.) abandoned (.) feel cross (.) if they feel that somebody is (?) with other people (.) really (.) your friend (.) but I as thinking whether (.) cos one of the things that came up last week was about (.) you know not being rude I think you said (.) I thought ↑maybe↑ (.) you know you were telling me about the kind of girl who could be very possessive of somebody (.) who could really mind a great deal (.) you know there is an idea that (.) you know what is the reason that I'm not seeing you for those couple of weeks (.) what am I up to (.) what am I doing (.) you know (.) and thought maybe there was some feeling that well (.) he's going to do something else (.) what about me (.) and I'm not part of that.

547. I suppose I was thinking whether (1) whether that is also a part of you that you don't always know about (.) really (.) a part of you that might feel possessive and really might mind (.) might want somebody all for themselves cos I ↑think↑ what happened out in the waiting room was that I was to feel (.) you know to be the one who was a bit possessive of you (.) really that I would <u>mind</u> you know she's just here to see me ↑<u>what</u>↑ <u>the hell is that girl doing here</u>(.) you know (.) she should just be here on here own and if you say oh I'll just be a sec whether I'll feel you know oh (.) I'm just here for her con↑venience↑ so I thought whether (.) I don't know that gets a bit played out

really (.) you know whether you let me know something about other feelings of yours that you ↑could↑ feel possessive

45-48

610. Cos I suppose what I'm thinking was whether (.) you know when I talk about holiday break and what I'm saying is (.) you know you can't control what happens here (.) you know (.) this is the deal this is what's going on (.) your response is well this is when I'm going away whether that's about asserting something back you know who's in charge of the therapy here (.) Who makes the decisions here. Is it me is it you (.)How do we do this(.)

611. Why did we stop

613. But maybe you think why do I do that (.) Why do I say ok that's it stop (.) You're in the middle of something what the hell's going on.

616. I wonder whether you're saying you know its (XXX) but actually you could be a bit pissed off with me for saying it's time to stop (.) you could think we were having a conversation and we were getting somewhere and you've fucking stopped it and you've gone away for another week.

Part 3: Reflective Commentary

Title: **A reflective commentary on completing a piece of empirical research as part of a clinical doctorate in child and adolescent psychotherapy training**

Candidate number: [redacted]

Word Count: 4045

Introduction

This paper describes my experiences as a Child and Adolescent Psychotherapist in training conducting a piece of empirical research as part of the academic requirements of my training. I faced many resistances to undertaking this research, but found the task ultimately rewarding and worthwhile. I have found it helpful to consider these resistances in more detail,

as well as the process of overcoming them, in order to appreciate the beneficial links between research and clinical practice.

Freud (1925) considers the different types of resistances to psychoanalysis, exploring scepticism directed towards new scientific discoveries:

(...) this scepticism shows two unexpected features; it may be sharply directed against what is new while it spares what is familiar and accepted, and it may be content to reject things before it has examined them. But in behaving thus it reveals itself as a prolongation of the primitive reaction against what is new and as a cloak for the retention of that reaction. It is a matter of common knowledge how often in the history of scientific research it has happened that innovations have met with intense and stubborn resistance, while subsequent events have shown that the resistance was unjustified and that the novelty was valuable and important. What provoked the resistance was, as a rule, certain factors in the subject-matter of the novelty, while, on the other side, several factors must have combined to make the irruption of the primitive reaction possible.
(Freud, 1925, pp. 212-13)

In this paper I will consider my own resistances to conducting an empirical research project through the lens of Freud's two types of resistance - general resistance to the new, and specific resistance to the 'subject matter' of the project. I had to work through these resistances to be able to complete an

empirical project that I felt was worthwhile, and not to reject things before I had examined them. Nevertheless, keeping these resistances in mind helped me to maintain a healthy scepticism when considering the findings that could be drawn from my results, and to make clear links between my research findings and the implications for clinical technique, whilst being mindful of the limits of this kind of research. The process had three main stages:

1. Initial resistances, which corresponded to the early stages of the project - choosing a topic, methodological design, understanding my research method;
2. Overcoming the resistances and allowing interest to gather. This corresponded to accessing the data and beginning to analyse it;
3. Reaching a middle position - beginning to integrate my research findings with my clinical practice. This corresponded to the process of completing the data analysis, writing up the research, and drawing conclusions.

This is, of course, simplified, and feelings from the earlier stages persisted and fluctuated as the project progressed.

1. Initial resistances

My initial resistances to undertaking this research can be grouped firstly into resistances to the new, and secondly, into more ‘primitive’ emotional

resistances to the notion of undertaking empirical research in the realm of psychoanalytic practice. As an Arts graduate, I had a general resistance to empirical research as something ‘new’ with which I was unfamiliar. I found the idea of identifying a topic of research and methodology very daunting, feeling I lacked the necessary experience and expertise. This was ameliorated by the structure of my training programme, which included the opportunity to work as a research group with peers, and to have access to data from a recent Randomised Controlled Trial - the IMPACT study (Goodyer et al., 2017). I was initially relieved that the overwhelming choice of research topic was removed from the equation, and that the broad area, as well as the methodology (Conversation Analysis, CA (Sacks, 1992)) were already defined. I also felt ambivalent, as I felt my work would be such a small part of something that was already generating a lot of further study, and that the scope of the work was already defined and therefore lacking in creativity on my part.

I also feel I experienced the more emotional or ‘primitive’ resistances described by Freud (1925) to conducting empirical research on psychoanalytic psychotherapy processes. These was linked to my assumption that to participate in this kind of research would be to become part of something that I felt could actually hinder the progress and understanding of psychoanalytic psychotherapy for children and adolescents - reducing the process to something too strictly defined and compartmentalised, at the cost of understanding the nuance and value of psychoanalytic work. This is a long standing fear within psychoanalytic practice (Midgley, 2004). Linked to this, I

had an initial resistance to CA, the methodology identified by my supervisors as being appropriate to conducting process research on the IMPACT data. Through completing my literature review, I learned that CA is a social sciences research method that has been applied to many situations to analyse naturally occurring or institutional examples of conversations. CA focuses on the procedural aspect of conversation, and analyses the linguistic features evident in the different turns taken by participants. I worried that using CA could overlook the intuitive knowledge and experience in talking to children/ adolescents that are part of the selection process for and training of child psychotherapists. I was also concerned that applying CA to psychoanalytic session material would obscure one of the most important parts of the session from a psychoanalytic perspective, that of the countertransference, or feelings evoked in the session. I quickly realised, however, that this was a necessary limitation of this kind of research, but that this did not stop the research being valuable and bringing to light other aspects of psychoanalytic practice.

Additionally, I was ambivalent about being linked to the IMPACT study from which I was to take my data - although pleased that the study increased the evidence base for child psychotherapy, I felt the study reflected the increasing focus in many CAMHS teams on short term work, including short term psychoanalytic work.

As well as these concerns, in the early stages of the project, I felt anxious that the research was pulling me away in time and focus from clinical work. I felt

there was a lack of fit to my clinical learning, and struggled to balance the academic demands of setting up the research project, alongside my cases in the clinic, supervisions, analysis, and clinical papers that needed to be completed.

Despite these uncertainties, I did feel that early on in the project, I had a particular focus. As a supervision group of four students, we were encouraged to choose beginnings, endings, questions, or answers, as our topic. Being able to discuss the project with a small group of students using the same data and methodology made it easier to share concerns and work them out. I realised there was more flexibility in designing the study than I had imagined, and was immediately drawn to exploring questions asked by the therapist because I could identify a clear link to my clinical practice. As a trainee seeing children and adolescents for once weekly as well as intensive psychoanalytic psychotherapy in the CAMHS clinic where I worked, I was conscious of my own technique, whether it was considered ‘correct’, whether it was due to my personality and style, and whether other therapists would have used questions similarly. I also wondered about the impact of asking questions and how helpful they were. With the support of my research supervisors and colleagues, I was able to come to a rough research design which consisted of sampling sessions from the data available to us, and I decided I would focus on three cases, taking three sessions from each, to give a total of nine sessions. I wondered about the advantages and disadvantages of conducting a single case study instead, to be able to analyse the therapeutic processes in

more detail. In the end I decided against it, as I wanted to gain a more general overview of how questions were used in the sessions.

The anxiety and frustrations of the early stages of the project were compounded by practical difficulties, including difficulty accessing the audio data that I would need in order to transcribe sessions. It took time to gain remote access to the data, and following this, I was regularly locked out of the online system. Due to time constraints, accessing the data on-site was not an option. On reflection, these difficulties have links with the frustrations of setting up clinical psychotherapy work, particularly the intensive cases that trainees are required to see during their training. These can be difficult to set up practically, finding times that work for both the family and the trainee, ensuring that the same clinical room will be regularly available for the time slots, sometimes negotiating with schools, as well as endeavouring to fit around other commitments that the child and family may have. This is coupled with the task of finding a supervisor with whom the trainee feels they can work, and whom it is possible to see regularly, arranged around the supervisor's other commitments and the trainee's role as a clinician in a busy and demanding CAMHS clinic. This can often feel like so many practical tasks to get out of the way, to get to the 'real' business of the therapy work, rather than being seen as an essential part of the process of starting by holding a child in mind and creating a space for them and the trainee. This seemed reflected in the research process where I, as well as my peers in my research group, felt desperate at times to get access to the data and start analysing it. I

found it hard to see this setting up as part of the process, and as learning to work within the limits and frustrations of the data available, which is a likely part of any research project.

2. Middle phase: allowing interest to gather

The middle phase of the work consisted of trying my best to overcome the resistances discussed above and to start to work more freely. It was also the phase in which I started to get to grips with using CA. There was a lot to learn, and many of the CA papers I read seemed bewilderingly complicated, using a myriad of transcription symbols that seemed to me to be impossible to decode. In discussion with my research group, we decided it would be unhelpful to go into so much detail. We collectively identified a selection of conversational features that would give enough detail for us to comment on, but not so much as to become confusing. We practised transcribing and using symbols to represent conversational features in group supervision sessions and I came to realise how much time the transcription process would take - a painstaking and unfamiliar process, requiring listening repeatedly to the same short passages. The support of my peers was helpful at this point as we transcribed some sessions together, checking we were interpreting and using the transcription symbols in the same way.

Listening to the sessions when we were able to get access was eye opening and thought provoking, as we could finally listen to ‘live’ clinical material and

begin to think about it. Initially though, I found it difficult to step back and respond as a researcher, rather than as a clinician. It was difficult to put my more clinical, or emotional, response to one side and remember that I was supposed to be looking at the material with a different lens. I feel, however, that later in the project, my clinical experience helped me to notice aspects of the material that I may not have spotted otherwise. I also became increasingly aware that a research perspective was not necessarily so different from my clinical perspective on the data, both requiring careful attention to detail and a wish to learn more about the material with a view to improving treatments for young people. I found the presentation of the young people in the IMPACT study, who seemed to speak quite freely in conversation with their therapists, quite different to the presentations of the young people I worked with in a LAC clinic, who often communicated more on a non-verbal level. I wondered how I would be able to use the knowledge I was attempting to generate.

At this point, although I had identified an initial area of research - questions asked by the therapist - I had not decided what type of questions I would focus on. I needed to narrow the scope of the project, and in discussion with my research supervisors and peer group, tried to work out how best to begin. I initially felt I would focus on questions which had some reference to feelings, because of the focus in psychoanalytic work on feelings generated in response to an event or thought. I selected therapists' questions which pertained to feelings or emotions, and began to transcribe sections around these, but this did not turn out any kind of a pattern, and was in the end

unsatisfying. This is an example of one of the many false starts that occurred as part of the project, which were a necessary, if frustrating, part of the process. Alongside the help of my supervisors, group supervision and Research Workshops with my peers were further sources of support which ameliorated these frustrations and, over time, enabled me to further define and clarify my methodology.

My supervisors suggested that I find a way to give an overview of the questions asked in the sessions I chose. I decided to follow an existing method devised by Stivers and Enfield (2010), which had been used to analyse questions asked in a large sample of conversations. This was a huge amount of work, as I identified over 600 questions asked by the therapists in my nine sessions, and needed to code them in 11 ways. This was a painstaking process and took about four full days of work. Although it required perseverance to complete, and felt quite procedural, this was a crucial part of the process in getting me to look in more detail at the types of questions asked by the therapists. I was at the stage of having a ‘broad sweep’ of the data, but still felt lost as to how I might focus on a specific type of question. Doing this coding meant I ended up with a mixed methodology, which gave me some quantitative data. This was something I had never imagined doing, coming from an academic background in English Literature and Philosophy. However, I felt strongly that it was necessary to give the research a grounding in the overall use of questions in the therapy studied, and give the shorter, qualitatively analysed excerpts more context. It also helped me ‘step out’ from

the detailed attention given to specific extracts with which I was more familiar, in clinical work, for example, with a session vignette or full session write-up for supervision.

In the end, it was the process of coding the questions that allowed me to narrow the focus of my study and define my research question. I came across several questions which didn't seem to fit with the coding system. This was really the point where the work became exciting, as I felt I had identified something of interest and perhaps specific to psychoanalytic discourse. Following this, I was able to look in more detail at these questions, and again, as I was able to really focus on this particular aspect of the data, I became increasingly interested in the work. It started to feel less like it was something I had to do, and more like a project that might turn out some interesting results that could have implications for clinical theory and technique.

I was unsure what to do with these questions and ended up listing them all, then looking for further links. A clear link emerged as I noticed several of the questions addressed the patients' negative feelings towards their therapists. I found this interesting and was from this point able to connect my research more with clinical sessions and technique, as I feel the question of how helpful it might be to take up the negative transference with patients is an ongoing discussion within psychoanalytic practice. Working in a LAC service with very vulnerable young people who have often experienced multiple traumas and abuse, the question of how to approach negative transference in a way that

can be tolerated is often on my mind and discussed in clinical supervisions. I therefore found that I could begin to bring together my clinical thinking with this research project.

From this point, I was able to look for patterns in the identified questions, as well as in the responses of the patients, both of which I listed and coded. I was initially struck by how the patients seemed to find the questions difficult to answer, as well as how tentatively the clinicians posed the questions. It made me think more about the power dynamics present in a clinical session, and how difficult it might be for a patient to admit to their negative feelings about their therapist. I could also link this to my own experience of my training analysis.

3. Reaching a more integrated 'middle' position

In the final stages of my project, I was able to reach what I felt was a more integrated position between clinical work and research. My initial resistances to completing this work had not gone, but I think were replaced by a more balanced view. These initial resistances could then be integrated more as a healthy scepticism, which helped me not to be overly certain about any conclusions drawn from the project, or how far they might be generalised.

This part of the project felt rewarding as I had really got to the detail of the sessions and started to observe patterns. The biggest challenge at this point

was to select material for presentation in the final write up. I had a lot of data from the broad categorisation of the questions, and realised it would not be possible to present all of it. This was a difficult decision as I had spent such a long time categorising the questions, but it was necessary. It was also difficult to select extracts from the sessions to present in their transcribed form, with the corresponding analysis. In the end, I settled on three sections illustrating questions asked by a therapist, also showing the different types of response I had identified from the patients.

During the stages of writing up, I took advice from my research supervisors about separating the CA part of my analysis from the clinical thinking. I tried applying this when writing about my selected extracts, and found that it really helped me to see how the phenomena I had been able to identify by applying CA had additional clinical meaning. It meant I could make clinical sense of a therapeutic interaction from a different perspective from that which I may have been able to take otherwise. This is the point, quite close to the end of the project, at which I had the strongest sense of things moving forward and coming together. Keeping the clinical part of the material separate both helped to structure the analysis, and to free me up to focus on the turn by turn procedural aspects of the conversation, as required by CA. I also felt relieved that I had found a way to include my clinical thinking in a way that felt helpful and that could have meaning for clinical practice, which was an initial hope when I was first thinking about how to do this research. I also feel that learning to use the method of CA with clinical material, requiring a very

detailed and ordered focus on what is being said, when, and how, has been good training in being able to notice in a different way how conversations are taking place in my own clinical work. In this way, completing this empirical research has been able to complement the clinical learning of my training.

It was encouraging to realise at this point that much of what I feel psychoanalytic psychotherapists know, understand, and specialise in was reflected in the material when CA was applied. The importance of how things are phrased, the use of tone, waiting for the right time - all were present in the material I analysed. This raised the question for me of what this research could demonstrate which is new, and I wondered again about the worth and relevance of the project. I have always held the view that psychoanalytic work is, in itself, a kind of research, but I am also aware that to those without a psychoanalytic training, the processes of psychoanalytic work can appear somewhat obscure. On balance, I decided that it is helpful to disseminate knowledge about psychoanalytic practice to a wider audience. I feel this is particularly relevant in promoting conversation and sharing knowledge with practitioners from different fields. The methodology I had chosen allowed me to translate psychoanalytic thinking and practice into a language that could perhaps be more accessible to non-psychoanalytic practitioners. I could see more clearly that completing empirical research of this kind with psychoanalytic material also has political relevance, as it makes clearer the value of psychoanalytic work and thinking, as well as adding ‘depth’ (Green and Thorogood, 2004, p. 46) to the IMPACT study from which the data was

taken. If I were to do a similar project again, I would be interested to adapt the methodology to ascertain links between performative questions addressing the negative transference, and treatment outcomes. This would go beyond a descriptive account of how questions are used in sessions by therapists, to explore how the use of particular types of questions might impact clinical outcomes for young people.

Conclusion - final reflections

Having considered and worked with the resistances I had to completing this project, there are several things I have learned that I feel I can carry over into clinical practice and could even become part of training, if further research was carried out.

I am more aware, when asking questions, of what format I am asking them in, as well as noting how patients respond. This study, as well as the reading I did to complete the literature review, has increased my sensitivity to the importance of phrasing and to the way in which the format in which questions are asked by a therapist can have an impact on creating space for the patient to speak more freely, or alternatively might close down a conversation.

I feel this research also strengthened and gave me more evidence for understanding some elements of clinical practice which I felt intuitively to be right, such as the delicate nature (and yet importance) of addressing

transferential issues with depressed adolescents. I felt encouraged by my findings as it seemed to me that they showed the high levels of sensitivity that are required when working with this particular cohort. Although this was not the topic of my research, my sense is that the findings can be extended to working with any child or adolescent patient who might be very wary of talking or thinking about their relationship to the therapist, particularly with regard to negative feelings. I feel these findings are worth keeping in mind in all work with adolescents, given their developmental stage is one of separation and individuation from parental figures. In this way, if further research was completed in this area, it could, perhaps, become part of clinical teaching.

At the end of this project, I feel something is more integrated between my clinical identity and my researcher identity. I still struggle with the role of researcher – and particularly with the feeling that, although I have completed this piece of work, my experience in completing research is still very limited. Despite this, having completed a piece of research, I feel if I came across another clinical question which I wanted to explore further, I would consider doing research in the future. This is a long way from the position I started this project with, and I hope I will be able to use the research skills I have learned to continue to complement, and even become part of, my clinical thinking.

References

Freud, S. (1925). The Resistances to Psycho-Analysis. *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIX (1923-1925): The Ego and the Id and Other Works*, 211-224

Goodyer, I., Reynolds, S., Barrett, B., Byford, S., Dubicka, B., Hill, J., Holland, F., Kelvin, R., Midgley, N., Roberts, C., Senior, R., Target, M., Widmer, B., Wilkinson, P., & Fonagy, P. (2017). Cognitive behavioural therapy and short-term psychoanalytical psychotherapy versus a brief psychosocial intervention in adolescents with unipolar major depressive disorder (IMPACT): a multicentre, pragmatic, observer-blind randomised controlled superiority trial. *Lancet Psychiatry*, 4(2), 109-119.

Green, J., & Thorogood, N. (2004). *Qualitative Methods for Health Research*. London: Sage Publications.

Midgley, N. (2004). Sailing between Scylla and Charybdis: Incorporating qualitative methods into child psychotherapy research. *Journal of Child Psychotherapy*, 30, 89-112.

Sacks, H, (1992). *Lectures on Conversation*. Oxford: Blackwell.

Stivers, T., & Enfield, N. J. (2010). A coding scheme for question–response sequences in conversation. *Journal of Pragmatics*, 42, 2620–2626.