The role of patients' questions in Short Term Psychoanalytic Psychotherapy (STPP) with depressed adolescents

Literature review
Empirical paper
Reflective commentary

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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.

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Acknowledgements

The role of patients' questions in psychoanalytic psychotherapy

Literature review

Abstract

This paper reviews the existing literature on patients' questions in psychoanalytic psychotherapy. It starts by examining questions more generally, discussing the role of questions within a conversation in various settings. Thereafter, it reviews conversation analysis studies on questions in psychotherapy, identifying a gap in the literature. Whilst there is wide research on therapists' questions in solution-focused therapies, patients' questions are under-researched. This paper also discusses the existing psychoanalytic literature on patients' questions, showing that generally this is a neglected topic within psychoanalytic literature. This paper links the overlooked topic of patients' questions to core concepts in psychoanalysis, and to broader issues about the nature of psychotherapy and clinical technique. This paper argues that patients' questions raise technical and theoretical challenges for clinicians, and that these challenges are linked to controversies within the profession. Further research on this topic might be beneficial for the development of psychoanalytic psychotherapy's technique and theory, addressing these central debates.

Introduction

In the 1930s, British psychoanalyst Edward Glover circulated a questionnaire among psychoanalysts with the intention of establishing the actual working practices of psychoanalysts in Britain. Of the sixty-three points raised by the

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questionnaire, analysts reached complete agreement on only six points. One of these points was the abstention from answering questions raised by a patient (Glover, 1954). Sousa, Pinheiro and Silva (2003) claim that this 'strange recommendation' persists: analysts are advised to refrain from answering patients' questions. Whilst this 'taboo' is still alive in most psychoanalytic institutions, there are hardly any written documents about this 'rule'. Following an exhaustive search in electronic databases, Sousa et al. (2003) conclude that questions in psychoanalysis are almost a neglected issue. Lemma (2012) supports Sousa et al.'s conclusion, urging authors to write about this topic.

The topic of patients' questions is not only under-researched by psychoanalytic literature but also neglected by empirical researchers. Conversation analysis (CA) studies have focused on the use of questions in various settings (e.g., medical, legal, educational) (Hayano, 2014), and some have even focused on therapists' questions in solution-focused therapies, but they have neglected to examine the events in which patients ask questions (Peräkylä, 2014). The tendency to focus on therapists' questions rather than patients' questions is also reflected in psychoanalytic treatment manuals. For example, in the manual for Short-Term Psychoanalytic Psychotherapy (STPP) with depressed adolescents (Cregeen, Hughes, Midgley, Rhode, & Rustin, 2017), therapists are advised to use questions, but there is no mention of patients' questions and how therapists should respond to such questions.

This paper offers a review of the relatively sparse existing literature on patients' questions in psychoanalytic psychotherapy. The review does not aim to be

exhaustive but includes the key papers in this area. The first section looks at questions and their function in a conversation in different settings. The second section examines the contribution of CA to the study of patients' questions in psychotherapy. The third section reviews the existing psychoanalytic literature on patients' questions. This section shows how patients' questions raise technical challenges for clinicians, linked to broader theoretical discussions within the profession, suggesting that further research is important to the development of the field.

Questions and their function in a conversation

Linguistic and CA research on questions in ordinary conversations suggest that there are three contributing factors that are extensively used to formulate questions: grammar, prosody and epistemic asymmetry (Hayano, 2014). Many languages have grammatical marking that distinguish questions from assertions. For example, in the question 'Did he come?', the proposition 'did' is crucial in establishing the sentence as a question. However, the word 'did' can also be used in an assertion ('He did come yesterday'), which shows that there are no linguistic criteria that can solely define a question (Bolinger, 1957). Similarly, prosody (usually rising intonation) is often used in questions in different languages, but there is evidence that it is wrong to treat rising intonation as a strong indicative of a question, as questions are not necessarily marked with rising intonation (Geluykens, 1988). There are languages that do not seem to use either grammatical convention or intonation to mark questions, but people are still able to recognise and identify questions (Levinson, 2010). According to Hayano (2014), knowledge plays an important role here. Labov

and Fanshel (1977) report that when a speaker makes a statement about a topic that falls into a recipient's domain of knowledge, it functions as a polar question. In other words, when the utterance addresses information that the speaker does not know but the recipient is likely to know, it is treated and responded to as a question. Epistemic asymmetry is thus a major contributing factor in establishing a question, and in some languages it is the only element that contributes to distinguishing between an assertion and a question (Hayano, 2014).

Heritage (2008) suggests that different question designs are used to convey different 'epistemic stances'. He refers to an 'epistemic gradient', namely that the difference between the questioner's knowledge and the answerer's knowledge may be smaller or greater (in his words, 'steeper' or 'relatively flat'). The design of a question is influenced by the relationship between the speakers and their epistemic stances.

Many studies into questions highlight how questions act as a controlling function in a relationship. Sacks (1995) and Brown and Levinson (1987) emphasise how the person who asks the questions is in control of the conversation, pressuring the answerer for a response. Interestingly, Bolinger (1957) has also identified the 'controlling' aspect of questions but perceives the answerer to be in the stronger position: 'the attitude is characterized by the speaker subordinating himself to the hearer' (p. 4).

The disagreement between the views of Bolinger and Sacks may be settled by Athanasiadou's (1991) study. Athanasiadou (1991) classified four different types of questions (information, rhetorical, examination and indirect), arguing that these different types are characterised by different functions and indicate different relationships between the questioner and answerer. Some types of questions are indicative of relationships in which the questioner has more control (Sacks may have referred to these types of questions) and some are indicative of relationships in which the answerer has more control (Bolinger may have referred to these types of questions). For example, examination questions are asked not because the questioner is in search of information, but because the questioner is testing the knowledge of the respondent. In these cases, the questioner would usually have a higher status and use the questions to test, challenge and control a person with a lower status. In contrast, indirect questions may be requests for actions. For example, 'Can you help me?' is a request for help, or 'Can I open the window?' is a request for permission. In these cases, the dominant role is transferred to the answerer as the questioner is dependent on the answerer's response.

Athanasiadou (1991) argues that examining the relationship between types of questions and the status of the speakers involved shows that different types of questions are not equally available to everyone, that is, some types of questions are only used by a higher status person. Studies on questions in institutional contexts, specifically medical and legal institutions, show that it is the professional participant who usually asks the questions and the lay participants who answer them (Gill & Roberts, 2014; Komter, 2014). One study (Beresford

& Sloper, 2003) explores conversations between adolescent patients and their doctors in a medical setting, demonstrating that adolescents patients are particularly reluctant to ask their doctors questions as they are worried about revealing their poor adherence. According to Shakespeare (1996), children and adolescents are assumed to have 'less-than-full membership' in social interactions (Shakespeare, 1996). Full members 'are those with a shared stock of common-sense knowledge about the social world and a common competence in applying that knowledge' (Payne, 1976, p. 330), and it is assumed by society that children are in the process of learning those social rules and developing these competences, enabling them to become 'full members' in social interactions when they reach adulthood (Shakespeare, 1996). Perhaps, adolescents are even more reluctant to ask questions than adult patients as their 'lower status' derives from their position as the lay participant within a professional relationship, combined with society's perception of them as 'less-than-full members'.

Whilst Beresford and Sloper (2003) claim that adolescents do not tend to ask professionals questions, Athanasiadou (1991) gives an example of an adolescent student asking the professionals a question, but he is doing so cautiously and in an attempt to defend himself. This example is taken from an official academic interview. An adolescent male student is interviewed by two members of faculty (both 40-year-old males). Athanasiadou shows how the interviewers' questions seem to be purely seeking information but are also control oriented. However, there is a moment in which the relationship is inversed by the student asking two rhetorical questions. Based on

Athanasiadou's example, questions by the lay participant directed to a professional in an institutional context may imply an inversion of the power relationship (Athanasiadou, 1991). This could explain why questions by lay participants in institutional contexts are not often asked, and why patients' question in psychotherapy may raise technical challenges for therapists, as explored in the following sections.

Athanasiadou's example may illustrates the 'twin dynamic' at the heart of adult–child relations, described by Hutchby and Moran-Ellis (1998), On the one hand, there are efforts by adults to restrain children's competencies. On the other hand, children are more competent than society might think. The adolescent, in Athanasiadou's example, was using rhetorical questions in a sophisticated and competent manner to fight against adults' constrictions. Similarly, Sacks (1992) discusses a common questions asked by children used to challenge their 'less-than-full members' status. In their interaction with adults, children often ask the question 'You know what?'. According to Sacks, children use this question to 'fight' against their restricted right to gain the floor in order to speak. The question 'You know what?' forces the adult to respond by saying 'What?', giving permission to the child to set the agenda of the conversation.

Hayano (2014) explains that questions can be used to control interactions by imposing various constraints on answerers. One such constraint is a presupposition conveyed in a question. For example, 'Do you want to arrange the meeting now or later?' presupposes that the answerer wants to rearrange the meeting. Any direct answer accepts this presupposition as valid and it takes

'interactional work' to refute this assumption. In this way, the question is used to control and to impose an assumption on the hearer. Another constraint is the setting of agendas. A question is a demand to discuss a certain topic, which therefore controls the conversation. If the respondent resists the topic of the question, he/she may be perceived as evasive and/or confrontational. The respondent cannot neglect the agenda set by the question without interactional consequences.

'Preferences' are another set of constraints. When a question is asked, theoretically there are various ways the answerer may choose to respond. However, questions project a preferred response. According to Hayano (2014), when respondents provide a preferred response, they produce it without delays. However, a non-preferred response would usually be delayed. The basic preferred response that applies to all questions is that the answerer should answer the question (an answer is preferred over a non-answer) (Hayano, 2014). CA is interested in the relationship between two sequentially ordered 'turns' within a conversation. There are certain actions, such as questions or greetings, which force a specific action in the next turn. These actions are referred to as 'adjacency pairs' by conversational analysts as there is an intuitive and reflexive link between the two turns, produced by two different speakers. It is unusual for the second item (an answer) to be missing following the first item (a question) (Stivers, 2014). When an answer is missing, it is treated as an indicator of disengagement rather than a non-answer. Therefore, people usually try to provide an answer even if they do not know the answer or they do not want to answer (Hayano, 2014). This may raise questions pertaining

to the general recommendation in psychoanalysis to refrain from answering patients' questions, avoiding a 'preferred response', and the impact of this clinical decision on the patient–therapist relationship.

CA, psychotherapy and questions

One of the methodologies used to examine psychotherapy is CA (Peräkylä, 2014), which is an important approach to the study of human social interaction across the disciplines of sociology, linguistics, communication and psychology. The sociologists Sacks, Schegloff and Jefferson developed CA in the 1970s, based on the assumption that language use may be organised at a minute level of detail. From this idea, CA strives to identify structures that underlie social interaction by using records of spontaneous conversations. It relies on case-by-case analysis leading to generalisations across cases (Sidnell & Stivers, 2014). CA research on psychotherapy has expanded significantly in the last two decades, although in comparison with CA research into medical interactions, this field remains in its infancy, and further study may expand our understanding of the therapeutic process (Peräkylä, 2014).

From the very beginning, the field of CA was interdisciplinary in nature. Most of the earliest CA journal publications were outside sociology in journals of linguistics and anthropology. Currently, CA research continues to appear in publications in journals across the disciplines of anthropology, communication, linguistics, psychology, and education, amongst others. The interdisciplinary nature of the field is expressed in two different ways: first, the knowledge needed to study social interactions draws on different disciplines; and second,

CA is used to widen our understanding of different disciplines (Sidnell & Stivers, 2014). According to Peräkylä, Antaki, Vehvilaninen and Leudar (2008), the contribution of CA to the study of psychotherapy can be done through the concept of 'sequentiality', that is, the understanding that in a social interaction everything that is being said should be understood in relation to what has been said previously. When a person speaks, they present their understanding of what has been said by their co-participant prior to them (Schegloff, 2007). CA in psychotherapy is interested in examining the way in which therapists and patients respond to each other's talk. Its research reveals changes within the relationship, such as gaps, discontinuities, or tensions as well as moments of mutual understanding (Peräkylä, 2014). It is particularly interested in identifying these processes within turn-by-turn interactions, showing how they occur (Knox and Lepper, 2014).

Drew and Heritage (1992) are interested in the way in which social interactions in certain institutions differ from those in other institutions. They identify 'inferential frameworks' as important to the understanding of a particular institutional interaction. The 'inferential framework' of psychoanalytic psychotherapy is unique in that there is an orientation in the therapist to examine the patient's talk beyond its intended meaning (Peräkylä, 2014). While ordinarily language is understood as means for understanding the speakers' conscious communicative intentions (Grice, 1975), in psychoanalytic psychotherapy the therapist is interested in revealing the patients' unconscious thoughts and feelings. CA examines the interaction taking place in psychotherapy that strives to explore this 'beyond' (Peräkylä, 2014).

CA research on psychotherapy can be organised into two categories. There are studies that focus on the therapist's technique (and the way it works within a sequence of interactions), and those that focus on the relationship between the patient and the therapist. It is important to note that the classification into 'technique' and 'relationship' is not rigid: any technique employed by the therapist influences the relationship and the relationship is influenced by the therapist's technique (Peräkylä, 2014).

Peräkylä (2014) mentions the three most CA-researched aspects of the therapist–patient relationship: resistance (focusing on the patient's resistance to the therapist's technique), affiliation (focusing on moments when therapists and patients collaborate), and emotion (focusing on the way emotions are expressed and dealt with in the consulting room). Peräkylä also mentions three techniques that have been most researched by CA: formulations, interpretations and questions. These 'key techniques' are practices by the therapist that convey the therapist's understanding of the patient's prior talk, inviting patients to reflect on this understanding.

According to Peräkylä (2014), CA in psychotherapy has found that formulations and interpretations are common among many kinds of therapies, including psychoanalytic psychotherapy, while questions are used in some therapies more than others. While therapists' questions appear in all kinds of therapies, some therapies can be described as 'question driven', such as solution-focused therapies, meaning that therapists' work is largely performed through

questions. Other therapies, such as psychoanalytic psychotherapy, can be described as 'response driven', meaning that the therapists' work is largely performed through responding to patients' narratives. These responses direct the topic of discussion. Most CA research on questions in psychotherapy has concentrated on question-driven psychotherapies, such as solution-focused therapies (Peräkylä, 2014), and the use of questions in psychoanalytic psychotherapy is under-researched.

The most significant CA research on questions in solution-focused therapies has been undertaken by MacMartin (2008), claiming that questions in solution-focused therapies are used by therapists to convey their positive understanding of the patient's experiences. The question reorganises patients' prior talk, namely their answer to the prior question, in a way that encourages an optimistic response from the patient, putting them in touch with their capabilities (MacMartin, 2008). Whilst MacMartin's study emphasises how questions can be used optimistically by therapists, Halonen's (2006) research demonstrates the way in which therapists use questions to highlight patients' difficulties, and to put them in touch with their struggle.

The research on questions in 'question-driven' psychotherapies focuses on therapists' questions, neglecting to examine questions asked by patients. However, despite this focus, there are studies that reveal and identify patients' questions in the data. For example, a study undertaken by Hutchby and O'Reilly (2010) examining therapists' questions in a solution-focused family therapy had also identified questions asked by patients. The patients asking questions were

the parents, and these questions came directly after the therapist's questions. The therapist's question has been constructed to address the child and so make the child the relevant next speaker. However, the parent 'intervened' in the interaction, by asking a question. Namely, the parents used the 'answer' slot to propose a different question to that put by the therapist. The parent's 'answer', constructed as a question, is thus interjacent: positioned between the 'therapist's question' and 'child's answer'. In this way, Hutchby and O'Reilly suggest that the child's access to the conversational floor was denied, while the adults were 'fighting' over their right to question and to control the agenda of the conversation. The child, in these interactions, did not get a chance to answer questions, and did not ask any questions. Namely, the child's 'less-than-half membership' status is not simply a feature of their status position within the hierarchical structure of the nuclear family, but is also constructed through the turn-taking and sequence-organisation in discussions between therapists and family members. As family therapy is supposed to involve an ethos of equality with all participants having equal participation rights and an active encouragement of children to engage in the therapeutic process, it seems that further research on the imbalance between adults' and children's questions might be beneficial.

Whilst there is no CA research focusing specifically on questions in psychoanalytic psychotherapy, there are studies that have discovered some ways that questions are used in psychoanalytic psychotherapy. Exploring the way adolescents respond to therapists' interpretations around 'endings' in STPP, Della Rosa and Midgley's (2017) study revealed a patient's question in

one of their transcriptions. Following the therapist's mention of the ending session, the adolescent patient asked the therapist what happens if people still needed therapy after the twenty-eight sessions come to an end. The therapist responded by asking the patient a direct question, wondering whether the question was about 'you' and not about 'other people'. In other words, the therapist understood the patient's question as an expression of her own anxiety rather than a general question about 'other people'. In a different single case study, focusing on ruptures, Knox and Lepper (2014) demonstrate how the therapist's questioning hindered the 'therapeutic alliance' between patient and therapist in one sequence, and in a different sequence assisted in repairing a 'rupture'. Knox and Lepper show that patients also ask questions. Their analysis shows how a patient's question led to a breach in his relationship with the therapist as the question was used to dominate the conversation. Knox and Lepper suggest that additional CA of questions in psychoanalytic psychotherapy (therapists' and patients' questions) may deepen our understanding of psychoanalytic technique.

Patients' questions in psychoanalytic literature

Sousa el al. (2003) draw attention to the 'strange recommendation' in psychoanalysis to refrain from answering patients' question and to the lack of written justifications for this 'rule'. They believe that the few authors that have touched on this issue have done so in a non-systematic and incomplete form. Sousa et al. suggest that the lack of literature indicates that we are dealing with something more akin to a 'taboo', transmitted orally from one generation of psychotherapists to the next. Their conclusion raises a question pertaining to

the roots of this 'taboo'. Sharpe (1930) argues that the roots of this 'taboo' should be credited to Freud, but does not mention a specific Freudian paper. Kelner (2009) wonders whether Sharpe had in mind Freud's response to his patient, known as the Rat Man:

> To this I replied that whenever anyone asked a question like that, he was already prepared with an answer; he needed only to be encouraged to go on talking. He then proceeded. (Freud, 1909, p. 181)

In this example, Freud avoided giving his patient an answer and instead prompted his patient to continue free associating (Freud, 1909). While Freud used this technique on this specific occasion, it seems unlikely that Freud suggested this as a rule. Moreover, Thomä and Kächele (1987) claim that in his analysis of the Rat Man, Freud himself answered many of his patient's questions directly, without making the patient's questioning an object of interpretation. This can be exemplified as follows:

> At the next session the patient showed great interest in what I had said, but ventured, so he told me, to bring forward a few doubts.—How, he asked, could the information that the self-reproach, the sense of guilt, was justified have a therapeutic effect?—I explained that it was not the information that had this effect, but the discovery of the unknown content to which the self-reproach was really attached.—Yes, he said, that was the precise point to which his question had been directed. (Freud, 1909, p. 176)

Due to Freud's tendency to answer his patient's questions, Thomä and Kächele (1987) claim that the 'taboo' should not be attributed to Freud. Instead, they attribute the taboo to Ferenczi, who developed in 1919 his counter-question technique:

> I made it a rule, whenever a patient asks me a question or requests some information, to reply with a counter interrogation of how he came to hit on that question. If I simply answered him, then the impulse from which the question sprang would be satisfied by the reply; by the method indicated, however, the patient's interest is directed to the sources of his curiosity, and when his questions are treated analytically he almost always forgets to repeat the original inquiry, thus showing that as a matter of fact they were unimportant and only significant as a means of expression for the unconscious. (Ferenczi, 1950, p. 183)

Whether we attribute the root of the taboo to Freud or to Ferenczi, the above quotations reveal that both Freud and Ferenczi thought that simply answering their patient's question might limit the option of exploring the patient's unconscious. Freud thought that an answer might interfere with the patient's free associations and the patient should therefore be simply encouraged to proceed, while Ferenczi thought that the answer would deny the possibility of exploring the patient's unconscious motivation in asking the question in the first place.

Thomä and Kächele (1987) mention three possible rationales for the development of the 'taboo'. Each rationale is linked to a core psychoanalytic principle. The first justification derives from the idea that giving an answer is over-gratifying for the patient and may hinder the analytic process. This way of thinking associates questioning with erotic-aggressive drives, implicated in the desire to 'penetrate' and to find satisfaction, as suggested by Sousa et al. (2003). Thomä and Kächele (1987) explain that there's an idea in psychoanalysis that instincts and wishes should not be gratified and satisfied by the analyst as analysis should be carried out 'in a state of frustration' (Freud, 1937, p. 231). Thomä and Kächele (1987) explain that analysts who answer their patient's questions on demand may be compared with mothers who give their children everything they want without setting any boundaries. There is an assumption that if the analyst gives an answer once, the patient will continue to ask more and more questions. Greenberg (1995) reflects on his dilemma whether to gratify a patient and calm things down by answering his question directly, or to remain quiet, forcing the patient to deal with uncertainty and tension. Greenberg argues that in that specific instance with that specific patient, allowing a certain level of frustration enabled a deeper exploration of the transference relationship.

The second justification is that many questions asked by patients in analysis are personal questions. Through these questions, the patient wishes to find out something about the analyst's personal life or their feelings towards the patient. According to Freud (1913), answering such questions by providing personal information may disturb the successful development of the transference.

Freud's views established analytic neutrality as one of the defining characteristics of the analyst's attitude in classic psychoanalytic treatment, according to Laplanche and Pontalis (1973). However, Laplanche and Pontalis emphasise that analytic neutrality is not seen as an absolute rule in classical psychoanalysis, as most analysts would agree that in certain cases, particularly ones dealing with children's anxiety or perversions, the analyst may waive the rule of complete neutrality on the grounds of its being neither beneficial for the treatment nor practical. Thus, whilst answering patients' questions by revealing personal information may interfere with the analytic neutrality, in some cases refraining from answering patients' questions may not be practical or helpful.

Some psychoanalysts do not regard analytic neutrality as an ideal. As described in his clinical diary, written in 1932 and published in 1988, Ferenczi disagreed with Freud's position pertaining to analytic neutrality. He claimed that by believing that analysts can keep themselves hidden from their patients, Freud put psychoanalysis on the wrong track. Ferenczi viewed analytic neutrality as a defensive position, serving analysts who prefer to stay aloof from their patients. According to Ferenczi, patients, particularly very disturbed ones, know their analysts very well, as analysts reveal themselves in everything they say and do. Most relational psychoanalysts follow Ferenczi's lead on this controversial issue. For example, Greenberg (1995), a relational psychoanalyst, lists different ways in which analysts might reveal themselves, from their choice of clothes to the interpretation they choose to make. According to this way of thinking, every technical decision (e.g., answering questions, asking questions, making interpretations) in the course of analysis should be

evaluated in light of what it may reveal about the analyst, and every decision would inevitably reveal something. Choosing to answer a patient's question by 'self-disclosing' is a decision to reveal something in a direct and deliberate way, raising questions pertaining to what 'truth' the analyst chooses to share and what 'truth' they might choose to conceal. Every clinical decision, answering or withholding, reveals something and conceals something else.

The third justification for the development of the 'taboo' on answering patients' questions is that asking questions and providing answers are verbal actions that aim to create a dyadic structure. Classic psychoanalysis aims for a more monologue-like pattern when the patient free associates. When the patient free associates, the analyst may trace the way these associations are linked within the patient's discourse, as explained by Laplanche and Pontalis (1973). According to Thomä and Kächele, the movement towards a dialogue may interfere with the patient's free associations and with the analyst's capacity to analyse links within the patient's mind. Nonetheless, Greenberg (1995) argues that free associating is easier said than done. Many patients, according to Greenberg, insist that it would be easier for them to open up if their analysts would do the same. Similarly, Lanyado (2004) describes unusual clinical events, in which the therapist reveals personal thoughts (viewed by some as breaches of technique), as proving helpful in facilitating a safe and free space for the patient. It seems that, theoretically, the movement towards a dialogue through questions and answers may interfere with the patient's free association, but in practice many patients struggle to free associate and find the movement towards a dialogue helpful in overcoming this task.

The 'strange recommendation' to refrain from answering patient's questions is linked to important concepts in psychoanalysis. However, as discussed previously, some analysts challenge these concepts or consider these concepts as impractical principles. Therefore, it is not surprising that different analysts employ different techniques in their consulting rooms. For example, Sharpe (1930) explains that there are situations in which she would choose to answer her patient directly. Her decision is based on whether she thinks providing an answer at a specific moment for a specific question will assist patients in revealing themselves more or will close something down for patients. She explains that an answer to a question can serve as a full stop for patients, but that it may, in certain situations, expand their thinking. Sharpe states that she will always answer questions such as 'Do you know this play, book, place and etc.?' with 'Yes I do' or 'No, I don't'. She thinks that in this way, the analyst demonstrates that they are not afraid of knowledge or ignorance and this may help the patient feel free and confident. Sharpe also mentions a question asked by an adolescent patient about contraception. Sharpe states that she would directly answer the girl's questions by providing her with the necessary information, but would also analyse the girl's feelings of ignorance and would be careful not to fall into the role of a parent. By focusing on the girl's ignorance, Sharpe emphasised the vast differences in knowledge between adult therapist and her adolescent patient, that is, Sharpe's response highlighted the 'steep' epistemic gradient between them, as explained earlier.

Sharpe mentions that she will never respond to a patient's question with a strong silence. Instead, if she decided not to answer the patient's question directly, she would say 'If I do not answer this, it is because this is not what you really want to know. May we go on and try to find out what it is, and then you will find the answer?' (p. 272). Sharpe emphasises that analysts should always strive to understand what a question means, but there are different ways to explore the unconscious meaning, some involve answering the question directly while others withhold the answer. This, according to Sharpe, can only be judged in the context of each individual analysis.

Interestingly, Sharpe emphasises she would not respond to a question with silence. Instead of staying silent, she will explain to her patients why she is not giving them a direct answer and she will, then, encourage them to proceed, hoping that their free association will reveal the answer to the question.[1] Although Sharpe does not explain why she does not stay silent, her need to provide her patient with an explanation for not answering highlights that it may be quite problematic to refrain from answering patient's questions. The pressure for an answer arises from the fact that the question is a means by which the patient can force the analyst to start a dialogue, and by entering a dialogue they are subject to the rules of discourse. As shown by CA earlier, questions and answers are adjacency pairs, and it is highly unusual for an answer to be missing following a question. Thomä and Kächele (1987) explain that patients' questions urge the analyst to answer and the patient will

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[1] In a way, this is very similar to Freud's response to the Rat Man. Freud too did not remain silent, but explained to his patient why he was not giving him a direct answer.

understand everything the analyst does as a response. Silence, in this sense, is in fact an answer.

Thomä and Kächele (1987) explain that if questions are left unanswered, the patient may take this as a sign that the analyst cannot answer or is not willing to do so. An unintended result of not answering patients' questions is that the patient may experience the absence of an answer as a rejection. Whilst one of the justifications for not answering questions is the influence of the answer on the transference, the patient's feeling of rejection may influence the transference as well (Thomä & Kächele, 1987). Greenson (1967) describes his work with a patient whose previous analysis was unsuccessful. According to Greenson, the previous analysis failed due to the analyst's rigid technique, which included not answering questions and never explaining why. In his analysis with this patient, Greenson emphasised the reason he was refraining from answering his patient's questions. Greenson's view was that perhaps this explanation enabled the patient to talk about his feelings of humiliation in his previous analysis. In this way, the patient's negative feelings, which perhaps led to the failure of the previous analysis, became material for interpretation in his analysis with Greenson.

Thomä and Kächele (1987) argue that the analyst must find the right balance between gratification and frustration. Like the mother who needs to find the right balance between gratification and frustration to promote healthy development for her baby, the analyst must find the right balance between the two. According to this way of thinking, some questions must be answered in a way that gratifies

the patient, enabling the development of a positive working relationship between analyst and patient.

While Sharpe, Greenson, and Thomä and Kächele are opposed to the rigidity of the 'rule' and suggest that explaining the rule's logic may be helpful, Kohut (1971) is more strongly opposed to the 'rule': 'to remain silent when one is asked a question, for example, is not neutral but rude' (p. 87). Kohut explains that he would mostly answer his patient's questions, but, on rare occasions, he would also refrain from answering directly, insisting on thinking about the unconscious meaning of the question. Ogden (1992), on the contrary, states that he does not answer most of his patient's question, nevertheless he would answer some questions such as questions about his training and his fees. Ogden treats most patients' questions as an expression of anxiety about being misunderstood by Ogden. For example, if the patient asks the analyst if he treats more women than men, Ogden will treat it as a communication about the patient's worry of being misunderstood due to his/her gender.

Ogden also refers to patients who ask multiple questions. To these patients, Ogden often says that it must feel too dangerous for them to wait for the relationship between them to unfold, 'that, instead, the patient hopes he will be able to sample the future through the answers to his questions, thereby short-circuiting the tension connected with waiting' (1992, p. 242). Ogden also refers to patients who use questions 'to fill the analytic space because the patient feels that his own internal contents are shameful, dangerous, worthless, in need of protection from the analyst, etc. or that there is nothing at all inside of him with

which to occupy the analytic space' (1992, p. 242). He also mentions patients who fall silent and invite the analyst to fill in the analytic space by asking questions. In those occasions, Ogden will talk to his patients about their anxiety manifested in their overuse of questions or in their wish that the analyst will ask questions. In other words, Ogden analyses the actual act of questioning, which involves the analyst in a different way. Similarly, Parsons (1999) also analyses the act of questioning and how questions may involve the analyst providing an example of a patient who uses questions to elicit a playful interaction between them. Sousa et al. (2003) provide an example of a 3-years-old's question in analysis that had a strong emotional impact on the analyst. The analyst described falling off his 'tower of knowledge', and realising, through the girl's question, how defensive he was in his encounter with this little girl. This realisation enabled the analyst to change his technique. Jones (2000) stresses that questions should be analysed in the frame of an 'interactional' structure. Namely, it is the patient's wish to move into a dialogue structure, and elicit a specific interaction, that should be analysed.

Historically one of the reasons for refraining from answering questions was the wish that the patient will remain in the monologue-like form of communication, but Sousa el al. (2003) argue that the psychoanalytic process may be perceived as a dynamic process that activates monologue and dialogical structures and therefore patients' questions should be welcomed, encouraged, and analysed.

Conclusion

This paper offers a review on the existing psychoanalytic literature on patients' questions, and CA's contribution to the topic, demonstrating that this topic is neglected by both disciplines (psychoanalysis and CA). Whilst this paper identifies the lack of CA studies on patients' questions in psychoanalytic psychotherapy, it identifies a single study suggesting that patients' questions may cause a rupture in the relationship between a patient and a therapist (Knox & Lepper, 2014). This claim tallied with CA research on questions in different settings, arguing that questions can be used to gain control and that a question asked in a professional relationship by the person with a lower status often leads to an inversion of the power relationship. Indeed, in reviewing psychoanalytic literature on questions, it has been found that patients' questions raise technical challenges for psychotherapists as well as broader questions about the nature of therapy and therapeutic actions in general, suggesting that further research on this topic is necessary.

This review suggests that the topic of patients' questions is closely linked with controversies in the field of psychoanalytic psychotherapy, such as self-disclosures, dialogical structures, and power relations. Further research on the topic of patients' questions may provide insight into these debates, and assist therapists with understanding their patients' questions and responding in a helpful way that considers different complexities.

This review also identified that children's questions in psychotherapy may raise particular challenges in psychotherapy. As challenges raised by patients' question are associated with issues of power, control, epistemic gradient, and

hierarchy, children's questions in psychotherapy highlight these issues due to their 'double' inferior position (as the lay participants in a professional relationship as well as their classification as 'less-than-full members' in social interactions). Arguably, considering further research on this topic, children patients' questions in psychotherapy might be a useful starting point.

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The role of patients' questions in Short Term Psychoanalytic Psychotherapy (STPP) with depressed adolescents

How to do things with questions?[2]

Abstract

Whilst patients' questions in psychoanalytic psychotherapy are a 'neglected' topic in psychoanalytic research and literature, some authors recognise its importance. This qualitative study aims to bridge this gap in the literature by exploring the role of patients' questions in short-term psychoanalytic psychotherapy (STPP) with adolescents suffering from moderate-severe depression. This is a single case study, focusing on the interaction between the patient and the therapist when a question was asked by the patient, using conversation analysis (CA) methodology. Data were provided from a random controlled trial (RCT) in which all sessions were audio-recorded. Findings show that 'surprising behaviours' that seemed associated with heightened affect appeared when a patient asked a question. The author reflects on the significance of these findings within the context of the therapeutic relationship and the implication of these findings for treatment technique.

Impact statement

This DPsych dissertation discusses an under-researched topic – patients' question in short-term psychoanalytic psychotherapy (STPP) with depressed

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[2] The title of this study is based on *How to Do Things with Words* (1961) by John Langshaw Austin, a philosopher of language.

adolescents. Although therapists' questions are widely researched using the methodology of conversation analysis (CA), the topic of patients' questions is neglected by empirical researchers and within psychoanalytic literature. This dissertation contributes to the field of child psychotherapy, and psychoanalysis more generally, by bridging this gap in the literature and expanding the field's knowledge. Arguably, the topic of adolescent patients' questions is a narrow subject within the practice of psychotherapy, however, it opens broader queries about the nature of psychotherapy, the therapeutic technique and the characteristics of depressed adolescents. This dissertation addresses these broad issues, contributing to the field's theory and to clinicians' technique. Potentially, it could also influence child psychotherapy training's curriculum. Trainees currently face the issues of patients' questions in the consulting room, but there is no specific theory to guide them. This dissertation may serve as a basis for a seminar for trainees about patients' questions, covering the technical and theoretical issues these questions raise in the course of treatment. This dissertation focuses on adolescents' questions in psychotherapy, yet it may also have implications for the field of adult psychotherapy; the findings of this research may be relevant for adult psychotherapists, contributing to their theory, clinical technique and training.

Introduction

One of the psychological therapies recommended by the NICE guidelines (2019) for adolescents suffering from moderate-severe depression is short-term psychoanalytic psychotherapy (STPP), a manualised time-limited treatment offered for twenty-eight weeks on a weekly basis (Cregeen, Hughes,

Midgley, Rhode, & Rustin, 2017). This recommendation is based primarily on the results of the Improving Mood with Psychoanalytic and Cognitive Behaviour Therapy (IMPACT) trial, demonstrating the effectiveness of STPP both at the end of treatment and at the one-year follow-up (Goodyer et al., 2017). Despite the IMPACT trial showing the effectiveness of STPP, it did not explain *how* it works, that is, what happens in the consulting room. This current study aims to explore the interaction between patient and therapist in STPP using conversation analysis (CA) methodology, which has been widely used in examining the therapeutic process (Peräkylä, 2014). This current research focuses on a specific aspect of the interaction between a patient and their therapist that has been somewhat neglected in previous research – questions asked by the patient.

According to Levinson (2010), there is no single way to identify what makes something a question. Although grammar and prosody (usually rising intonation) cannot alone define a question, 'knowledge' is central in distinguishing questions from assertions. Labov and Fanshel (1977) report that when a speaker makes a statement about a topic that falls into the recipient's domain of knowledge, it functions as a polar question. Heritage refers to an 'epistemic-gradient' (2012), evaluating the difference between the questioner's knowledge and the answerer's knowledge. Heritage (2008) shows that the question 'Who did you talk to?' suggests the speaker has minimal knowledge, whereas 'You talked to Steve?' suggests the speaker has more knowledge. In other words, the question's design is influenced by the relationship between the speakers.

Studies in medical (Gill and Roberts, 2014) and legal (Komter, 2014) settings reached the conclusion that within a professional relationship, it is the professional participant (e.g., a doctor) who asks the questions, whilst the lay participant (e.g., a patient) generally avoids asking question. As an example of this rare occasion in which a question is asked by the person with the lower status, Sacks (1992) discusses a common question asked by children 'You know what?', demonstrating how children use this question in their interaction with adults to 'fight' against their restricted right to speak. This question forces the response 'What?' from the adult, which gives the child permission to set the conversation's agenda. According to Heritage (2003), questions control interactions by imposing certain constraints on the answerers, the most important being setting agendas; a question is a demand to discuss a certain topic and it is impossible to neglect this agenda without interactional consequences. Hayano (2014) explains that questions project a preferred response. The basic preferred response that applies to all questions is that the responder should answer the question (an answer is preferred over a non-answer).

According to Peräkylä (2014), questions in psychotherapy are sometimes researched using CA methodology, focusing on therapists' questions in solution-focused therapies. Despite there being no CA research that aims specifically to focus on the use of patients' questions in psychoanalytic psychotherapy, some studies reveal patients' questions in their transcriptions. For example, in a single case study, Knox and Lepper (2014) show how an

adult patient's question subverted a therapist's intended direction and controlled the conversation's agenda. Although their study was not designed to focus on questions, implicitly Knox and Lepper's analysis suggests that further CA of patients' questions would deepen our understanding of the psychoanalytic process.

Following an extensive search in databases, Sousa et al. (2003) concluded that patients' questions are a neglected topic in psychoanalytic literature. Specifically, they draw attention to the 'strange recommendation' in psychoanalysis to refrain from answering patients' question, and to the lack of written documents about this 'rule'. They suggest that this lack of literature indicates that we are dealing with something akin to a 'taboo', transmitted orally from generation to generation.

Sharpe (1930) attributes the origins of this taboo to Freud. Kelner (2009) suggests that Sharpe based her claim on Freud's response to his patient known as the Rat Man:

> To this I replied that whenever anyone asked a question like
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> that, he was already prepared with an answer; he needed only
>
> to be encouraged to go on talking. (Freud, 1909, p. 181)

In this instance, Freud refrained from giving his patient an answer. While this is a technique that Freud recommended in this case, it is hard to conclude that Freud meant this as a general rule, especially since he himself answered many of his patients' questions, as indicated by Thomä and Kächele (1987). Thomä

and Kächele claim that the origin of the 'rule' should be attributed it to Ferenczi, who in 1919 developed a counter-question technique:

> I made it a rule, whenever a patient asks me a question or requests some information, to reply with a counter interrogation of how he came to hit on that question. If I simply answered him, then the impulse from which the question sprang would be satisfied by the reply; by the method indicated, however, the patient's interest is directed to the sources of his *curiosity*. (Ferenczi, 1950 [1919], p. 183, my italics)

Whether the root of the rule is attributed to Freud or to Ferenczi, these quotations indicate that both Freud and Ferenczi thought that withholding the answer might generate therapeutic insights. Freud focused on the unconscious content of the questions, whilst Ferenczi was preoccupied with the act of questioning, namely the form. According to Ferenczi (1919), questioning is an indication of curiosity and it is this curiosity that should be addressed, rather than the content of the specific question. Similarly, Sousa et al. (2003) associate questioning with curiosity, viewing questioning as a sign of health, linked to erotic-aggressive drives (implicated in the desire to 'penetrate' and to find satisfaction). According to Sousa et al., very disturbed patients do not ask questions; rather, they start asking questions as they heal during the course of analysis.

Thomä and Kächele (1987) are also interested in the act of questioning, arguing that asking questions involves the analyst in a different way. Although classical

psychoanalysis aims for free associations, which is based on a monologue structure, a patient's questions may be understood as an attempt to move into a dialogue. Ogden (1992) suggests that this wish to form a dialogue with the analyst through questioning is typical of patients who feel that their own internal contents are worthless and therefore wish to pass their 'turn' to the therapist. Ogden also speculates that some patients who ask many questions feel it is too dangerous for them to wait to see how the relationship between them and their therapist unfolds, and so they seek immediate answers. Whereas Ogden emphasises the anxiety manifested in the use of questions, Parsons (1999) emphasises the playful aspect of patients' questions, showing how his patient's questions elicited playful interactions between them.

Whilst Ogden and Parsons use the psychoanalytic method to examine the interaction between an adult patient and an analyst when a patient asked a question, this current study uses CA to examine the interaction between a depressed adolescent patient and a therapist in STPP surrounding the patient's questions. Sacks (1992) emphasises how children may use questions to fight against their restricted rights by setting the agenda, but there is no study about the use of questions by children/adolescents in psychoanalytic psychotherapy in which their 'lower status' derives from their age as well as their position as the lay participant within a professional relationship. Therefore, this study focuses specifically on questions that potentially aim to set the agenda of the conversation, as these seem to be associated with issues of power and control. Patients' questions, and specifically adolescent patients' questions, are under-researched by CA (Hayano, 2014) and neglected by psychoanalytic literature

(Sousa et al., 2003). This current study attempts to bridge these gaps in the literature.

Methodology

Setting

This current research is a qualitative single case study, offering a secondary analysis of existing data. The data used in this study were recorded as part of an IMPACT study, a randomised clinical trial (RCT) that compared the effectiveness of STPP with cognitive behaviour therapy (CBT) and a brief psychosocial intervention for adolescents suffering from moderate-severe depression (Goodyer et al., 2017). The study was based in the United Kingdom and involved 465 young people aged 11–17 with a diagnosis of depression. All three treatments were manualised, and sessions were audio-recorded. The RCT found no statistically significant differences in clinical or cost-effectiveness between the three treatments.

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

This current study focuses on STPP, a model comprising twenty-eight sessions described in detail by Cregeen et al. (2017) in the treatment manual. The manual defines three stages within the treatment, each characterised by different ways of working with a young person. Therapists are encouraged to facilitate an exploration of the patient's unconscious conflicts, focusing on issues around mourning and separation. Therapists are advised to establish a good therapeutic alliance with the young person, whilst also working in the transference.

The STPP manual dedicates only two sentences to the topic of questions (see Cregeen et al., 2017, p. 66). These two sentences focus on therapists' use of questions. Therapists are encouraged to use questions to assist their patients in elaborating or clarifying their speech. There is no mention of patients' questions in the manual.

Data used for this study

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

- Demographic and baseline information about the selected case gathered by the IMPACT trial: gender, age, and presenting problems.
- Transcription of interviews with the patient and the therapist at the end of treatment, carried out as part of IMPACT-ME, an IMPACT- sub-study (Midgley et al., 2014).

Selection of the case

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

1. To focus on an adolescent who had been randomised to the STPP arm of the study.

2. To have at least six audio-recorded sessions. This figure is based on the lower bound estimate of the median sessions attended. The median sessions attended by young people participating in the IMPACT trial was six to eleven across all treatments (Goodyer et al., 2017). As this study focused on the interaction between a patient and a therapist, low attendance cases were excluded.

3. To have taken part in the IMPACT-ME sub-study (which only covered cases seen in London).

4. To contain examples of patient asking questions. The question format conformed to criteria described in the *Identification of patient's' questions*.

Ten cases were identified which met criteria 1–3. Thereafter, the author listened randomly to a case, searching for patients' questions (meeting criteria 4). The first case did not include any patients' questions that met the conditions of this research. The second case did include such questions and became the selected case for this study, meeting all four inclusion criteria.

The selected case comprised a female therapist and a 16-year-old adolescent male patient, named Sam (this is pseudonym, assigned for the purpose of this

study). Sam had a diagnosis of depression and at the point of referral reported that he was self-harming and had suicidal ideations. He had an exceptionally good attendance record of twenty-five sessions. When STPP ended, the therapist offered to continue working with Sam, and the case proceeded as open-ended psychotherapy.

Listening to all the sessions, the author identified aggression and sexuality as the main themes. According to the audiotapes, the therapist appeared to understand Sam's 'self-harm' as 'self-punishment', claiming he directed his aggression inwards. Another theme was Sam's exploration of his sexual identity. In the interview, collected by IMPACT-ME, the therapist mentioned that Sam had an intense transference towards her, and commented on Sam's withdrawal, stating that at times he was too depressed to engage in conversation. Listening to the whole case, the author had a similar observation: most of the interactions between the therapist and Sam seemed quiet, flat and 'somewhat' dead. In their IMPACT-ME interviews, neither Sam nor the therapist mentioned the topic of questions.

Identification of patients' questions

The author listened to the twenty-five recorded sessions that comprised the whole treatment and identified questions. To be considered a question, the speech needed to meet the following criteria:

1. The author concluded that the therapist understood the utterance as a question demanding an answer, based on a turn-by-turn interaction.

Rhetorical questions were not considered as questions as they do not demand an answer.

2. The question was either formally a question (grammar) or had rising intonation.

3. The question was not a clarifying question.[3] The rationale for the omission of clarifying questions was based on the research's focus on how patients' questions control the conversation by setting the topic, as explained in the introduction. Although clarifying questions do demand that the answerer discuss a certain topic, it does not set a new topic for discussion, but merely encourages the answerer to elaborate on the topic the answerer chose to discuss in their previous utterance.

4. The questions were checked for reliability by a peer, who listened to the audio-recorded sessions and verified that the questions identified by the author met the above criteria.

Transcriptions

Using a transcription methodology created by Jefferson (2004), constituting the basis of CA, the author transcribed in detail the 3-minute interaction around each of the patient's questions – a few seconds before the question and the interaction that followed, capturing the interaction surrounding the questions. Jefferson's methodology attempts to capture sequences as heard through the audio-recording, including pauses, overlapping speech, or changes in volume,

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

reflecting how the utterances were said (see appendix A for full list of symbols applied to the transcriptions). The credibility of the transcriptions and the CA symbols were checked by a peer who listened to the audio-recordings and verified that these were accurate.

Data analysis

The transcriptions were analysed using CA, an inductive, qualitative method that uses records of spontaneous speech to identify underlying structures of verbal interactions (Sidnell & Stivers, 2014). According to Peräkylä, Antaki, Vehvilaninen and Leudar (2008), the contribution of CA to the study of psychotherapy is through the concept of 'sequentiality', that is, the understanding that in social interactions everything being said should be understood in relation to what has been said previously. When the patients/therapists speak, they present their understanding of what their co-participant has just said to them (Schegloff, 2007). CA is interested in examining the way in which therapists and patients respond to each other's speech, revealing movements within their relationship, such as tensions or moments of understanding (Peräkylä, 2014).

CA understands that social interactions in certain institutions differ from those in other institutions (Drew and Heritage, 1992). The interaction between a patient and a therapist in STPP is influenced by the 'psychoanalytic institution'. While, ordinarily, language is understood as means for displaying the speakers' conscious communicative intentions (Grice, 1975), in psychoanalytic psychotherapy there is an inclination to examine the patient's talk beyond its

intended meaning. The therapist would be interested in revealing the patients' thoughts and feelings that were repressed due to unconscious conflicts. CA examines the interaction taking place in psychotherapy, which attempts to explore this 'beyond' (Peräkylä, 2014).

Procedures

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

Ethics

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

in the study. To protect the confidentiality of the participants in this current study, identifiable details, such as names of people/places, were disguised.

Results

Fifty-three patient's questions were identified across the course of the therapy, but twenty-four of these did not meet the above criteria.[4] Therefore, this study is based on the analysis of the remaining twenty-nine patient questions. None of the twenty-nine questions appeared in the first seven sessions. From the eighth session, the twenty-nine questions appeared in different sessions (see table in appendix B).

The 3-minute interaction surrounding the twenty-nine questions was transcribed. As many of the questions followed sequentially, there were an overall total of twelve transcriptions (and not twenty-nine). Whilst neither the therapist nor the patient mentioned any questions in their IMPACT-ME interview, the therapist did mention her two most memorable interactions from the treatment with this young person. Transcribing the interactions surrounding the patient's questions had revealed that these two 'memorable interactions' contained questions asked by the patient (sequence 6 and sequence 7, as shown below). In the interview, the therapist described the memorable interaction by mentioning the content/theme, without stating that a question was asked by the patient.

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[4] Out of the twenty-four questions omitted from this study, sixteen were categorised as rhetorical and eight were categorised as clarifying. Rhetorical questions were understood as those that do not demand an answer (therefore they did not meet criteria 1, see *Identification of patients' question* in the methodology section) and clarifying questions were understood as questions that do not set a new agenda for the conversation (therefore they did not meet criteria 3, see *Identification of patients' questions* in the methodology section).

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

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

First example: This example, taken from the eighth session, is representative of many of the interactions. Following the patient's question and the therapist's non-preferred response, anger was expressed through the patient's 'surprising behaviours' (swearing, shouting and taking a particularly long turn). These 'surprising behaviours' also reflected a rupture in the patient–therapist interaction, which was repaired within the 3-minute sequence. Ruptures and repairs are recognised as universal features of conversational interactions and

are identified at the level of the turn (Sacks, 1992; Schegloff, 1992, 2006). According to Knox and Lepper (2014), ruptures in a conversation occur when there is a clash in participants' perspectives. When a rupture occurs, the participants would work to restore the turn-taking order to enable the conversation to continue. The methodology of CA may detect conversational micro-ruptures and repairs that the participants may only be vaguely aware of.

1. P: I (.) ah yeah

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

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

4. T: =mmm

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

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

7. P: yeah

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

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

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

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

everyone wearing black trousers (.) so what I'm gonna' do I'm gonna'

(.) basically get a pair of black skinny jeans wear them I don't have

any smart shoes so I'll wear these or something even less smart

something black but but it wouldn't fit with something else, wouldn't

it? And really really brightly colour [shirt

12. T: /(laughs)]

13. P: /and they'll be like well I've got the shirt on (.) I've got black

trousers on so what's the problem? (laughs) (.) see what people think

cause it's like it just pisses me off everyone saying you have to wear

this (.) and if you are not you are obviously an idiot or you are

obviously (xxxxx) not confirming to the stupid <u>rule</u> you just decided to

(xxxxx) (1)

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

maybe you also don't [like

15. P: it's so <u>stupid</u>] just sitting and [waiting

In the above interaction, the patient asked the therapist why he had to wait in

the waiting area (turn 5). The therapist did not answer the patient's question

directly, but instead acknowledged the patient's dissatisfaction, 'you don't like

to have having to sort of register in somewhere' (turn 8). This acknowledgement

is, in fact, an indirect question as the therapist was seeking for more

information. In other words, instead of answering the question directly, the

therapist, indirectly, referred an indirect question to the patient. The patient's

failure to provide an answer created a pause in their interaction (2 seconds of

silence). Following the therapist's refusal to answer a direct question, the patient responded similarly with a non-preferred response. This can be seen as a 'micro-rupture' in their interaction.

After the silence, the therapist rephrased her questions, asking the patient directly 'what don't you like about it?' (turn 8). The patient, then, took a particularly long turn, which included raise of voice and swearing words. Through these 'surprising behaviours', the patient demonstrated the freedom of not meeting the demands of the conversation, expressing the anger that triggered his question about the waiting area initially. The therapist enabled the patient to take this long turn, namely she enabled him to express his angry feelings in this way. However, at some point, she laughed (turn 12), putting a boundary to the patient's long turn, and then the patient also laughed (turn 13). The patient's laughter mirrored the therapist's laughter, indicating a collaboration between them. Their laughter was a micro-repair.

Following this micro-repair, they were back on track, meeting the demands of the conversation: each taking their turn yet also enabling the other to contribute (turn 12–15). The therapist could then return to the initiating topic, namely the patient's question in turn 5, sharing her observation about the patient's underlying feelings about waiting for the session in the waiting area (turn 14), and then getting his agreement (turn 15). Whilst there was an agreement in turn 15, the patient also behaved 'surprisingly' again by interrupting the therapist (turn 15). The sequential order was repaired, but the patient may have needed to let his therapist know that he still felt angry/frustrated.

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

Second example: in the first example, Sam's question and the therapist's response, initiated a micro-rupture in the patient–therapist interaction, allowing angry feelings to erupt. In the following extract, taken from the fifteenth session,

'surprising behaviours' (particularly slow and quiet voice) also appeared after Sam's question, expressing depressive feelings. In this example, it was both the patient and the therapist who were speaking particularly slowly using a quiet voice. The expression of depressive feelings following the patient's question was representative of some sequences, although angry feelings prevailed in most of the interactions. The following extract illuminates how the therapist respondent to many of Sam's questions as 'transference-material', and avoided a direct answer. The therapist's interpretation of the transferential dynamics, and the slow quiet voice she adopted, allowed the expression of Sam's depressive feelings, and an intimate exchange between the two of them. The following sequence took place after Sam shared his worry about not having friends in university.

1. P: °why would you want to be with someone that is just depressed?°

2. T: I think it's hard for you to really really believe that the reason why we have 28 sessions is because that's what the project is (.) when you are in that kind of state and you think no one including me would want to be with you you think that really I just divided it in half as if I can't bear to be with you for the whole (.) someway you must know that's not true (.) but that's what it feels like (2)

3. P: ummm (6)

4. T: <I think you do realise that it is very important to keep coming here>

5. P: yeah (xxxx) (5)

6. T: <well there are still some sessions to go (.) and you can choose to (.) have them>=

7. P: =yeah

8. T: <ok and we had our extra time we need to stop for today>

9. P: all right

In turn 1, the patient, speaking very quietly, asked a question, expressing his worry about his depression pushing people away. His quiet tone of voice tallied with the depressive feelings he was referring to. By using a question, he demanded a response from the therapist. The therapist, then, responded to the patient's question by taking a relatively long turn, which included many silences/pauses, and talking about the patient's fear. The therapist reframed the question about making friends in university as a 'transference question', related to their relationship.

In turn 3, the patient agreed with the therapist ('ummm'), and thereafter there was a particularly long pause (6 seconds). The therapist then took her turn, speaking surprisingly slowly (turn 6), responding to the patient's fear about not being wanted by saying: <I think you do realise that it is very important to keep coming here>. In that way, the therapist showed the patient that he is wanted; she wants him to come. The surprising slow voice added affect to her words, as she sounded warm and soothing. In turn 5, the therapist obtained the patient's agreement, and then there was another long silence. The therapist then responded in turn 6 by speaking particularly slowly, encouraging the patient that there are still sessions to go, addressing his worry about being abandoned. The patient, in turn 7, responded straight away, by saying: 'yeah'. The lack of gaps between their turns conveyed that the patient was attuned to the therapist's speech, enabling the therapist to end the session in turn 8: 'ok

and we had our extra time we need to stop for today'. The therapist employed the same slow soothing voice in that turn, making the ending feel smooth. Without the previous collaboration/agreement between them, the ending of the session might have felt abrupt. In turn 9, the patient responded by saying 'all right'. Perhaps, despite the depressive feelings, there was something 'right' in the interaction between them.

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

Third example: the following sequence, taken from the twenty-third session, provides an example of an interaction in which the patient asked multiple questions, and the therapist responded to all these questions with a non-preferred response. Namely, the therapist did not answer any of his questions directly. The appearance of patient's questions one after the other was typical

of many of the sequences. In the following sequence, the surprising behaviours included overlaps and abrupt changes in volumes.

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

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

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

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

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

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

7. P: /I think]

8. T: /manage my exams

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

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

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

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

13. P: did you?↑

14. T: well I think you might also really be sort of much more interested in what °you know° what have I studied to be able to do what I'm doing now it's not so much understanding Spanish to be the issue but it's understanding can can I understand (.) you and your some of your emotional ups and downs it's a different kind of language

15. P: yeah

16. T: that seems to be much more

17. P: =well I'm guessing it's much more difficult than understanding Spanish but I guess there are things that people do °when something is going on when specific things happened to them° like there are specific behaviours that indicate something

In the above interaction, the patient asked five questions. In turn 1, the patient took a relatively long turn, ending with a question. The patient wanted to know whether the therapist read the book he has been studying at school. In turn 2, the therapist did not provide a direct answer, but referred to other things the patient wanted to know about her, such as whether she passed her GCSEs. The patient then interrupted the therapist's speech in turn 3, rephrasing the topic the therapist raised as a direct question forwarded to the therapist: 'I guess] I guess you did °did you do GCSEs?° ↑Did they have GCSEs?↑ °I don't know if they had GCSEs°'. The 'surprising behaviour' of overlapping the therapist's speech in turn 3 may be linked to his anger towards his therapist for

not providing him with a direct answer. The overlap could be indicative of a 'micro-rupture' in their interaction due to the therapist's failure to provide an answer. In this turn, the patient also lowered the volume of his speech, then raised the volume and lowered it again. The abrupt changes in volume may be the result of his feelings of confusion and anger about the therapist's failure to answer his questions directly. In turn 4, the therapist responded again without answering the question directly. She took a relatively long turn, re-framing his questions as 'transference-material', linking it to his curiosity about their common interests.

In turn 5, despite not getting his preferred response, the patient asked another question pertaining to the therapist's personal life, giving the therapist another chance to 'please' or 'disappoint' him – 'repairing' their interaction or deepening the 'rupture'. The low volume he used may be related to his aggression – pressuring the therapist into answering against her will. By lowering his voice, he softened his aggression. In turn 6, the therapist responded again without providing a direct answer, reflecting on the adolescent's curiosity. The therapist spoke particularly quiet in that turn. This quiet voice may be a reaction to the patient's constant demands. The patient, then, surprisingly, in turn 7, interrupted the therapist's speech, making it clear that he wanted an answer for his question. In turn 8, the therapist finished the point she started in turn 6, letting the patient know that despite his insistence, she refuses to give him what he wants. In turn 9, despite her refusal to answer, the patient asked another question. In turn 10, the therapist did not offer a direct answer, but linked the patient's question to a previous conversation they had. Whilst the patient

wanted to know about his therapist's past, the therapist linked the question to a previous exchange between them. The patient confirmed, in turn 11, that he shared the same memory. This was a moment of micro-repair, in which they both referred to a shared-experience.

Following the micro-repair, in turn 13, the patient again asked a direct question, pushing the therapist into a corner, insisting on getting what he wanted. The therapist then relied on the micro-repair in turns 11 and 12 and offered her understanding of the dynamics between them. According to the therapist, the patient's questions had to do with his worry about being misunderstood. This enabled the patient and the therapist to think about this worry in turns 15–17, and the patient 'dropped' his insistence on a direct answer. It was the therapist's avoidance of preferred responses that enabled them to explore Sam's underlying worry, and when this worry was acknowledged the questioning stopped.

In the above interaction, the patient asked five questions about the therapist's personal life. The therapist did not provide a direct answer to any of these questions. Through the questions, the patient was breaking the rules of the professional encounter, attempting to change the epistemic gradient. In classic psychoanalysis, it is the therapist who learns about her patient's personal life and not the other way around. When the patient did not manage to change the epistemic gradient by receiving information about the therapist, he made another attempt, making it clear that he refuses to conform with the 'rules'. By

refusing to answer the patient's questions, the therapist protected the 'rules' of the professional encounter, but this led to a micro-rupture in their interaction.

Clinical commentary: In this interaction, Sam may have been using questions as a means to engage the therapist in a verbal-intercourse, attempting to 'penetrate' into her mind. Sam's 'intense transference' towards the therapist had a sexual nature. He was using questions to establish his self-assertion and masculinity. Although the therapist refused to answer his questions (refused to be intruded), she did acknowledge his wish to be known (remembered and understood) and it is this acknowledgement that ended his questioning. The questions, in this interaction, had a developmental function, enabling Sam to explore his sexuality and potency.

Discussion

Austin (1961) coined the term 'speech act', suggesting that 'by saying something, we *do* something' (p. 1), referring both to the action taken by the speaker through his utterance and to the utterance's effect on the listener's actions. Whilst the twenty-nine questions identified in this study differed in terms of content, they all elicited similar 'actions' as the participants behaved 'surprisingly', expressing strong anger/depressive feelings. In other words, the questions 'did' something in the interaction, and perhaps the role of the questions was to prompt a certain interaction.

Through the use of CA, this study identified a specific pattern in relation to questions and answers: following the adolescent's questions and the therapist's

non-preferred responses, the patient and the therapist found themselves in a 'lively' interaction in which strong feelings erupted. These interactions were unique within the context of this treatment, as the therapist described Sam as withdrawn. Thus, it can be argued that the function of the questions was to fight the 'deadness', 'livening' up the interaction by eliciting a lively dialogue. The therapist's non-preferred response facilitated/enabled the expression of these feelings and their containment. Through the questions, Sam demanded care and requested special attention, and the therapist's response was maternal. Therefore, it might not be surprising that the therapist offered to continue working with Sam in an open-ended therapy after STPP ended. She had understood his request and responded by offering him the 'special attention' he was fighting for through his questions.

Understanding questions as a request for special attention is interesting in relation to Freud's (1909) response to a question asked by his patient, known as the Rat Man:

> What, in particular, could be done against his idea about the next world, for it could not be refuted by logic?—I told him I did not dispute the gravity of his case nor the significance of his pathological constructions; but at the same time his youth was very much in his favour as well as the intactness of his personality. *In this connection I said a word or two upon the good opinion I had formed of him, and this gave him visible pleasure.* (p. 178, my italics)

In this interaction, Freud answered the Rat Man's question directly, and also added some reassuring compliments. Whilst Freud and the therapist in this

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study responded very differently to their patients' questions (Freud answered this question directly, and the therapist in this study mostly avoided direct answers), the patients' question, in both cases, invited a parental response and an intimate exchange. Whereas Freud offered direct reassurance/comfort to the Rat Man through his preferred response (direct answer) and additional compliments, the therapist in this study offered subtler reassurance/comfort, which might only be detectable through the methodology of CA.

The findings of this research suggest that questions may prompt an emotional interaction and therefore it is not surprising that some of these interactions were the most memorable for the therapist. According to Schacter (1996), 'memories are records of how we have experienced events, not replicas of the events themselves' (p. 6). Whereas the therapist in this study focused on the content of these interactions, as she remembered it, she 'failed' to replicate the presence of a question. This study suggests that it is the form of questioning that plays a significant part in enlivening the interaction, as it involves the therapist in a different way, as suggested by Thomä and Kächele (1987). Whereas Thomä and Kächele emphasise that questions can be used to move into a dialogue, this study demonstrated significance of these dialogues within the treatment.

This research contributes to psychoanalytic exploration of patients' conscious/unconscious motivation in using questions. Although Ogden (1992) speculates that patients ask questions to pass their turn to their therapist in an attempt to avoid feelings of uncertainty and emptiness, this study suggests that

questions may be used as a means to form contact, eliciting a meaningful interaction, which may be facilitated by the therapist's response. Hopefully, this research may encourage therapists to notice whether and when their patients ask questions, and to reflect upon the unconscious motivation of such questions, or lack of questions, considering what questions and responses are doing in their interactions.

This study also suggests that there is a link between the patient's questions and aggression, as many of his questions elicited an angry/aggressive interaction. This link is particularly interesting given the patient's diagnosis of depression. Psychoanalytic formulations of depression associate depression and aggression. According to Freud, the depressed subject directs his aggression towards its own ego (Freud, 1917). According to Parsons (2007), during puberty adolescents are besieged with increasing sexual and aggressive forces as their bodies change. As a result of this abrupt change, they are often scared of their own aggression, specifically its potential to harm their objects, and therefore they may direct their aggression inwards. This deflection prevents the development of healthy aggression, which is essential for psychic growth, enabling the adolescent to separate, individuate and develop their mature sexuality. When healthy aggression does not develop properly, the adolescent may experience depression and might self-harm. According to this study, questions in psychotherapy may be an opportunity to direct one's aggression outwards in a safe space. The therapist's response to the patient's questions is important in enabling this to happen, and for this process to feel safe for the patient. In this study, the therapist's clear boundaries and sensitivity, expressed

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through her tone of voice (soft, slow, quiet, laughter), contributed to feelings of warmth and safety, whilst the non-preferred responses encouraged the expression and exploration of aggression.

The link between healthy aggression, sexuality and questioning supports Sousa, Pinheiro and Silva's (2003) understanding of questioning as a sign of health and as an indication of progress in therapy. Arguably, Sam's questions did not appear in the first few sessions and only appeared later in the course of treatment, as throughout the treatment he was developing his healthy aggression and his capacity for 'questioning'.

In her unpublished DPsych dissertation at UCL, Dehl (2020) found that therapists asked around 200 questions across three sessions of STPP with depressed adolescents. A comparison between Dehl's findings and this research showed that depressed adolescents in STPP ask far fewer questions than therapists, although it is impossible to state this with confidence as both studies used a very small data. This conclusion complements the findings of studies in other institutional settings, showing that the professional participant asks the most questions (Gill & Roberts 2014; Komter, 2014). Considering patients' questions in STPP as a rare event suggests that such questions may have a rebellious quality. Adolescents may 'learn' that they are not expected to ask questions in therapy. According to this idea, when adolescents do ask questions, they liberate themselves from this unwritten rule. In that sense, a patient's question is in itself a 'surprising behaviour', which frees the

participants from the rules of discourse, and it is of little wonder that additional 'surprising behaviours' appear following these questions.

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

It is possible that once adolescents free themselves from the need to 'comply', they are more able to 'play'. Parsons (2007) explains how children channel their aggression into constructive play, and that this capacity for sublimation is a remarkable achievement, opening new horizons for self-enhancement. Whilst younger children might play with toys, adolescents may use developmentally appropriate 'toys' as an outlet for their aggression – words. This research supports Parsons' (1999) observation regarding the playful use of questions, suggesting that patients' questions may be understood as a 'playful move', adding 'spice' to the 'game' by challenging the 'rules'.

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

pretend that they wish to hurt each other. It is interesting to think about the idea of a 'playful battle' in relation to the conversational ruptures and repairs identified by CA. These ruptures and repairs, following the patient's questions, did not lead to a breakdown but were fixed within seconds. According to Safran, Muran and Eubanks-Carter (2011), the presence of rupture–repair episodes is associated with a good therapeutic alliance, whereas failure to resolve ruptures is seen as predictive of dropout. It may be the 'playful' quality of these 'battles' that enables the conversational rupture to be repaired quickly, preventing the rupture from intensifying. In this study, the methodology of CA identified the existence of ruptures, repairs and surprising behaviours, (i.e., what and how it is happening), whilst the psychoanalytic perspective contributed to the understanding of the significance of these behaviours in the context of the treatment, taking into consideration the patient's developmental stage, his diagnosis, the setting and the transference relationship.

This was a single case study selected from within an RCT. In psychotherapy research, particularly psychoanalytic research, there's a fundamental debate between single case studies and RCTs. Psychoanalytic knowledge production originated in the detailed analysis of single cases (Hinshelwood, 2013). For decades, following Freud, psychoanalysts regarded the psychoanalytic single case study as the primary modality for discovery of the unconscious mind. The case study was perceived as able to capture the complexity of the therapeutic process and the individual's internal and external struggles, in a way that an RCT fails to do (Midgley, 2006). Nonetheless, NICE, formed as a tool for assessing evidence-based practice, treat single case studies as the least valid

form of evidence. At the top of the list, NICE put RCTs, regarding them as the 'gold standard' research methodology when assessing effectiveness of treatments (Hinshelwood, 2013).

In defence of the single case study, Hinshelwood (2013) claims that single case studies do not carry such low status in natural science; quite the reverse. In fact, physics, for example, is grounded on single case experiments. Through single case studies, natural scientists observe occurrences. This current study endorses Hinshelwood's claim that psychoanalytic research should be entitled to employ single case studies in a similar way. Despite the data coming from an RCT, this current study was not concerned with treatment outcome, but rather in observing/identifying occurrences, and developing models of understanding, in the context of a relationship between a patient and a therapist.

Whilst there are similarities between psychoanalytic case studies and single case studies used by natural scientists, Hinshelwood mentions a difference. In psychoanalysis, traditionally, the research methodology and treatment method were identical; Freud's theory emerged through his encounter with individual patients and the treatment of these patients was influenced by his theories (Sandler, 2005). In natural science experiments, however, the research methodology is always separated from the studied subject. Hinshelwood, who defends the single case study, views the lack of separation between research and treatment in psychoanalysis as problematic, referring to it as a 'circular argument'. Hinshelwood calls for 'triangulation' in psychoanalytic research. This

study took into consideration Hinshelwood's criticism, and separated between research and treatment, by using the methodology of CA in exploring a single case. In this way, this study enjoyed the benefits of the single case in understanding the patient's questions in the context of a therapeutic relationship, and at the same it aims to avoid the 'circular argument'.

Hinshelwood shows how natural scientists make generalisations based on single cases, but mentions that such generalisations can easily be refuted by a single piece of contradicting evidence. For example, one black swan is sufficient to disprove the generalisation that all swans are white. Whether or not a study is based on a single case or many cases, it may be challenged by a single piece of contradicting evidence. However, one may argue that generalisations based on larger data are more credible and robust, and therefore further work needs to be done before it can be said how much the pattern identified in this study may be more generally characteristic of adolescents in psychotherapy. The author cannot conclude based on this research whether all adolescents ask questions during therapy, and if they do, whether all adolescents use questions in the way demonstrated by this young person. A unique characteristic of the young person was that he was an exceptionally good attender who engaged well in the therapy process. Larger data would enable an examination of whether there is a link between patients' questions and attendance/engagement.

Conclusion

This was a single case study, exploring the role of an adolescent patient's questions in STPP using CA methodology combined with a clinical/psychoanalytic commentary. According to the findings of this study, 'surprising behaviours' that seemed connected with strong emotions appeared when the patient asked a question that potentially aimed at setting the conversation's agenda. These questions, and their responses, elicited a 'lively' interaction between the patient and the therapist, often leading to episodes of conversational rupture and repair. The findings of this study suggest considering what questions 'do' in an interaction in psychoanalytic psychotherapy. Further research on patients' questions may expand our understanding of their role within the unique relationship between patients and therapists.

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Appendix A

Transcription coding symbols (Jefferson, 2004)

° °	between degree signs is quiet
<u>Underline</u>	emphasis
LOUD	capitals
↑	raised upward intonation
↓	lowered downward intonation – where marked
(.)	short silence – second or under
(−)	timed silence, write in the number if over a second, e.g. (2s)
?	question
?,	pitch rise
> word word <	faster speech if noticeable
< word word >	slower if noticeable
[ ]	overlapping utterances
((sound))	something not represented in words/sound vocalisation
[[	simultaneous utterances
=	no interval between adjacent utterances
]]	end of simultaneous utterance
(xxxx)	inaudible – or write in what you think it is

Appendix B

Questions asked by patient

Session no. and timecode	Questions
1) Session 8, 0–3	• °I don't know why ah that work (.) I can always just come here?° ↑
2) Session 8, 33–36	• But actually (.) it's not really a problem (.) is it? Like it is a massive proble • Where CAN I do it? (.) If I can't (.) say what I want to say here where can • WHAT THE FUCK CAN I DO? ↑

3) Session 13, 24–27	• °I was just thinking this why is this?°
	• When you said I'm more alive this week does that mean I was <u>dead</u> last
	  week? ↑
	• Pale? ↑
	• Last week? ↑
	• Last
	  Thursday? ↑

4) Session 14, 0–3	• Do you know it? ↑
5) Session 14, 42–45	• What left? ↑ • 28? ↑ so how long does that last 28 weeks?↑ The whole thing is 28 week we had?↑

6) Session 15, 3–6	• (.) Can you understand Spanish? ↑
7) Session 15, 36–45	• =Well, pretty much (.) well why would you keep talking to me if all I say is anything?↑ • That I'm a waste of time?↑ • Why would you want to be with someone that is just depressed?
8) Session 23, 4:30– 7:30	• Have you read it? ↑ • I guess] I guess you did °did you do GCSE's?↑did they have GCSE's?↑ I GCSE's° • Umm what did you do for A levels? ↑ • I think you already told me but I can't remember did you do [subject A]? ↑ something about [subject A] or maybe that somehow • Did you? ↑
9) Date unknown, 15:30– 18:30	• Do you watch BBC news?↑ • You know the queen she lost on her [horse share? ↑
10) Date unknown, 44–47	• Do they just listen to everything I say? ↑ what do they do? ↑ • Why would you? ↑ °you are listening to me now°

11) Date unknown, 9–12	• Have you seen it? ↑
12) Date unknown, 23–27	• When is it? ↑ • Ummm (2) when is that? ↑ • How many sessions is it? ↑

Reflective Commentary on Child Psychotherapy Research:

Working through resistance towards creativity and meaning

Introduction

In this paper, I will reflect on my research experience as part of my training as a child and adolescent psychoanalytic psychotherapist. I will explore my resistance to the task and the process of overcoming it in light of wider issues regarding research and clinical practice.

Resistance

Four years ago I started my training as a child psychotherapist in a programme that was a collaboration between the Anna Freud Centre (AFC) and the Independent Child and Adolescent Psychotherapy Association (IPCAPA). Although this was one programme, it included two main components: clinical studies held at IPCAPA and the research component held at the AFC.

When I started my training, I had little experience either as a clinician or as a researcher. I remember feeling enthusiastic about gaining experience in both arenas. A year into the training, alongside my work as a trainee in a clinical setting, I joined a research group comprising child psychotherapy trainees. My research group was assigned to analyse audio-recorded sessions of short-term psychoanalytic psychotherapy (STPP) with depressed adolescents, drawn from a large-scale evaluation of psychological therapies, the Improving Mood with Psychoanalytic and Cognitive Behaviour Therapy (IMPACT) study (Goodyer et al., 2017), using the conversation analysis (CA) methodology. My

group was invited to focus on specific aspects of the sessions: 'beginnings', 'endings', 'questions' and 'answers'.

I remember finding the research topic intriguing and relevant to my clinical work. At the time, I worked with a few adolescents and grappled with these exact issues. How should I start my sessions with these young people? How should I end them? Should I ask questions? How should I respond to their questions? I thought the research might provide me with a good opportunity to learn from experienced clinicians. However, despite my initial enthusiasm, I soon found myself feeling a strong resistance to actually doing the research.

In theory, the research seemed interesting, but in practice, I continued to delay starting working on it. I identified very much with some of my adolescent patients, who resist studying for their exams, feeling that they are forced to do something they do not want to do. One of my patients had labelled her lack of motivation as 'laziness'. Psychoanalysis, of course, tends to avoid this judgmental way of thinking and instead reflects on the unconscious meaning of resistance.

Freud discovered the power of resistance in 1893: as he practised his new therapeutic method, namely psychoanalysis, he came across barriers, the main one of which was the resistance of his patients. He realised that whilst he was making accurate interpretations, there was a force that blocked his ideas from reaching the patient's conscious mind: 'by means of my psychical work I had to overcome a psychical force in the patients which was opposed to the

pathogenic ideas becoming conscious' (Freud, 1893, p. 268). Freud suggested that such resistance indicates an unconscious conflict (Sandler, 1976). I wondered why I felt this strong resistance towards the research project despite my apparent curiosity. What was my unconscious conflict about? I soon came to realise that I was not the only one feeling this strong resistance. In fact, this was a shared feeling amongst my research group. Research became something that we just had to do, and it was experienced as extremely difficult. We spent a significant amount of time in our group supervision seminars thinking when to fit this difficult task within our busy timetable. Although I expected our group supervision seminars to focus on the content of our research, in practice our discussions often diverted into practical conversations about logistics (who is doing what and when, internal deadlines, etc.). The practicality of the seminars was intended to help us overcome our resistances, but in practice, for me, it created a split between the clinical seminars, which were a 'thinking-space', and the research seminars, which often seemed solely practical; and I believe this split strengthened my resistance to the research. At the time, I did not have the internal space to notice and become curious about this process that was going on.

I think that the practical conversation about space and time for research within our busy lives as trainees might also have reflected a wider conflict pertaining to the place of research within the profession of child psychotherapy. Perhaps our resistance to the research project reflected a broader struggle within the profession. To convey psychotherapists' resistance to research, Midgley (2004) cites two different studies in his paper. The first is by Morrow-Bradley and Elliott

(1986), who found that most practising psychotherapists do not participate in research and do not find research studies relevant or useful to their clinical practice. Specifically, they found that in comparison with psychotherapists from other theoretical backgrounds, psychodynamic therapists are least likely to find research helpful and are most suspicious of its ability to capture the complexities of their clinical work. The second study, by Darlington and Scott (2002), reports the result of a word-association trial conducted with a group of psychotherapists. Relating to the word 'research', the group came up with words such as 'objective, hard, cold, scientific, measurement, accurate, factual, time-consuming, difficult, prestigious, tedious and expert'. When the same group was asked about the word 'practice', however, they came up with words such as 'subjective, people, busy, messy, difficult, soft, warm, pressured, flexible'. As Midgley (2004) noticed, the only word association common to both sets of data is the word 'difficult'. So, despite both clinical practice and research being experienced by psychotherapists as difficult, interestingly, the latter incites resistance and it is perceived as intimidating.

The resistance of the psychotherapy profession to research is especially startling given Freud's perception of himself as both a clinician and a researcher/scientist, regarding the psychoanalytic theory of the mind as a natural science, as explained by Wallerstein (2003). Freud's theory emerged through his encounter with individual patients and the treatment of these patients was influenced by his theories (Sandler, 2005). Psychoanalysis, both as a treatment and as science, has emerged on the basis of Freud's assumption that there is an 'inseparable bond between cure and research … it

was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficent results. Our analytic procedure is the only one in which this precious conjunction is assured' (Freud, 1926, p. 256). For decades, following Freud, psychoanalysts regarded the psychoanalytic single case study as the primary modality for discovery of the unconscious mind. Namely, a case for treatment served also as a case for research (Midgley, 2006a).

If initially there was no differentiation between clinical practice and research, why do psychotherapists in the twenty-first century feel there is such a vast split between the two? According to Midgley (2004), the explanation could be attributed to the hierarchy of evidence-based methodologies endorsed by natural scientists in the twentieth century in relation to treatment outcome research. This hierarchy places randomised controlled trials (RCT) at the top of the hierarchy and the single case study at the bottom, leading to questioning of the validity of psychoanalytic findings (Midgley, 2004). Fonagy (2003) identifies the inferior position in which child psychotherapy has found itself due to this hierarchy, and argues that the research methodologies employed by child psychotherapists should change dramatically.[5] Even though he acknowledges the importance of the case study in gaining insight into the unconscious, he argues that child psychotherapy should collaborate with other disciplines when evaluating treatment outcomes:

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[5] Whilst Fonagy's claim may be relevant for any psychoanalytic practice, in this paper I am referring to a specific debate within the profession of child psychotherapy regarding research.

rather than fearing that fields adjacent to ours might destroy the unique insights offered by long term intensive individual therapy, we must embrace the rapidly evolving 'knowledge chain', focused at different levels of the study of brain-behaviour relationships … this may be the only route for the preservation of the hard-won insights of our mother discipline, psychoanalysis. (Fonagy, 2003, p. 134).

Nonetheless, within the profession of child psychotherapy, there are those who disagree with Fonagy's call for 'dramatic change'. According to Rustin (2003), the theory and practice of child psychotherapy develops gradually 'in and out' of the consulting room:

in it, in the sense that this is where its facts or data came from, and out of it, in the sense that much reflection and thought took place outside, in the minds of analysts, in discussion with supervisors and colleagues, and in their solitary struggles to formulate ideas for the printed page. (Rustin, 2003, p. 140)

Despite Rustin understanding that researchers outside of the psychoanalytic world do not consider the psychoanalytic methodology as scientific proof for treatment outcome, he argues that a diversion from the psychoanalytic methodology might result in the loss of the field's distinctiveness.

My experience of doing research within this specific 'political' climate reminds me of a short story told by Foster Wallace:

> There are these two young fish swimming along, and they
> happen to meet an older fish swimming the other way, who
> nods at them and says, 'Morning, boys. How's the water?' And
> the two young fish swim on for a bit, and then eventually one of
> them looks over at the other and goes, 'What the hell is water?'
> (Foster Wallace, 2005, in Krajeski, 2008).

As a trainee embarked on a psychoanalytic training, I was a young fish 'swimming' in unknown territory. Initially, I approached my research project without recognising I was swimming in 'water', namely without knowing the 'politics' of research within the profession of child psychotherapy. Whereas the young fish do not see or acknowledge the 'water' around them, they are, of course, affected by its temperature and flow. The water I was swimming in had categorised 'research' as the 'other', that is, as dramatically different from psychoanalysis. My resistance to my research project had to do, perhaps, with a wider (conscious or unconscious) feeling within the profession that research might be potentially threatening to the essence of psychoanalysis. My feeling that I was forced to do something might have been influenced by a general feeling in the profession (again conscious or unconscious) that research must be done for political reasons, nonetheless the 'real' insights are discovered in the consulting room.

Working towards creativity and meaning

Despite my resistance, I did manage to come up with a research question: the role of patients' questions in STPP with depressed adolescents. My interest in patients' questions derived from my clinical work, as I recalled a few incidents

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in which I was asked a question by a patient and had had an intuition that there was something meaningful about the moment in which the question was asked. I also found myself constantly dealing with my research question in the consulting room. For example, a 5-year-old boy asked me about the colour of my car; a 16-year-old boy asked me whether I believed in Jesus; and a 15-year-old girl asked me what I thought of her. Whilst I found the content of their questions fascinating, I also became interested in the meaning of such questions in the context of our relationships. For example, the question of my 15-year-old patient was asked towards the end of our last session before the Christmas break, so that it was impossible for me to respond properly to her question. I told my patient that we could think about her question after the break. Instead of 'wrapping-up' the session before the break, I felt things were left open. I felt guilty about this, and as a psychotherapist, I reflected on my countertransference in clinical supervision: was my patient's question set up in a way that forced me to abandon and reject her? What was played out between the two of us in that moment? My curiosity about my patients led me to realise how relevant my research question was to my clinical work.

At the same time as I was working with patients and trying to find space for my research project, my parents moved out of my childhood home and I went to help them clear out my room. As I did this, I came across a short script I wrote for a script-writing class (as part of my undergraduate studies). The assignment was to write a scene in which X wanted something from Y, but Y refused to give it. Interestingly, the scene I wrote was taking place in a consulting room: the patient was asking the therapist a question – 'Should I break up with my

boyfriend?' – and the therapist refused to answer the question directly; instead, the therapist analysed the patients' dilemma, linking it to her previous dilemmas. This scene became contentious as the therapist withheld a direct answer, despite the patient's insistence and dissatisfaction. I found it remarkable that ten years ago I wrote a script that was essentially an artistic representation of my research question. It turned out that my research question was intrinsically linked to my work as well as to my personal life (otherwise, why would I have written a script about it before I even knew I would embark on a psychotherapy training?!).

Thinking about the linkage between my script and my research question, I am reminded of Bollas' (1993) reflection on his decision to write his PhD about *Moby Dick*. As a PhD student, Bollas assumed he selected this topic simply because he enjoyed the book. It was only years later that he realised that the content of *Moby Dick* reminded him of his repressed childhood memory. By writing about *Moby Dick*, Bollas was unconsciously working through an internal conflict (Bollas, 1993). Similarly, I learnt that the subject of my 'cold', 'tedious', 'scientific' research was derived from my 'soft', 'warm', 'subjective' internal world, and I used my personal analysis to explore this.

As I started listening to the data (having finally managed to overcome my resistance and got some work done), I searched for patients' questions in the data. While I was listening to the material as a researcher, applying the methodology of CA, it was impossible for me to shut down my clinical thinking. For example, in the first case I listened to, the therapist was asking a lot of

questions, and the patient was withdrawn, mostly quiet, and did not ask a single question. I wondered if the therapist's questions were intended to engage the patient in the therapeutic process by enlivening him, and whether depressed patients ask fewer question due to their 'deadly' presentation? I became interested in questions, but also in their absence. I wondered whether the absence of questions could possibly be the topic of my second research? I noted to myself that despite initially feeling forced to do a research project, I was gradually finding myself thinking of the possibility of conducting two different research projects: one on questions and one on their absence. As a further example, in the second case I listened to, I noticed the patient was very engaged with the treatment, and although he did not ask any questions in the first few sessions, his passion led me to believe that he would ask a question at some point in the course of treatment. It turned out that he did indeed ask the therapist several questions during the treatment, and these questions served as the basis for my research project.

These examples demonstrate the subjective aspect of the process of doing research. As I listened to 'real' data, using a 'systematic' methodology, I realised that I was experiencing it in my own individual way, having my own thoughts, feelings and assumptions. I think that, inevitably, the outcome of my research project, namely the empirical paper, is an interplay between this 'objectivity' and my 'subjective' understanding of it. Even though psychotherapists tend to categorise research as 'cold' and 'scientific', throughout the process, I discovered it can actually be human and creative.

Perhaps, clinicians who are not involved in research imagine that it is not, and it is this phantasy that initially effected my resistance.

According to Winnicott (1971), creativity takes places in a 'transitional space', a space that is both 'me' (subjective) and 'not me' (objective). It is this interchange between subjective and objective experiences that enables us to live creatively and it is this creative living that facilitates the growth of any cultural phenomenon, such as the arts, religion or science. Compliance, according to Winnicott, is the opposite of creativity, as it involves the neglect of the subjective experience and requires extreme adaptation to objective reality (Winnicott, 1971). Feeling I had to merely comply and adapt myself to the task had stopped me from working on my research. The process of overcoming my resistance to the research involved finding the relevance of the project for myself, both as a clinician and as a person.

Reflection and conclusion

Swimming as a young fish in the water of 'child psychotherapy research', I slowly grasped the 'politics' around me, namely the tendency within the profession to categorise research as the 'other' due to a common phantasy within the profession that research is about 'absolute-truth'. Throughout my work on my research, I realised the simplistic nature of these labels and categories. Midgley (2004) argues that the phenomenon studied by qualitative research is distinctive in its nature, and the subjective experience of the researcher is always essential. My experience of working on a qualitative study supports Midgley's argument. Although I followed a systematic methodology,

my subjective understanding of the data generated a certain narrative of the therapeutic interaction that I was studying. My empirical paper is thus a specific representation of certain aspects of the case I investigated. I believe that if the therapist of this specific case had written up her own account, she would have created an alternative subjective representation of the same case. Thus, both qualitative research and the psychoanalytic case study offer a construction, a subjective narrative of the treatment.

One may wonder what is the point of conducting qualitative research if it merely offers a subjective representation of the treatment, and in that sense, it is not different from the psychoanalytic methodology. Why not just remain loyal to the 'treatment-research' tradition of psychoanalysis, that is, the narrative case study? Midgley (2004) explains that qualitative researchers suggest several criteria and methods that assess qualitative research, aiming not to confirm that the researcher's explanation is the only definitive report of the data, but only that it is a 'credible' and 'trustworthy' interpretation of the data. These include the use of an independent auditor, who evaluates the credibility of the research by cautiously following the methodology, from the first steps of data collection to the analysis of the data, checking how researchers have reached their conclusions. In addition, Midgley argues that using different methodologies to examine the same topic helps to strengthen one's claim. In other words, the findings of qualitative research may strengthen or shed specific light on conclusions drawn by a psychoanalytic case study, and vice versa. The methodologies may also reach different conclusions, which leads us to look again, re-think and perhaps discover new ways of understanding. Each

methodology has its strengths and its limitations; although CA may focus on the use of language in psychotherapy, the psychoanalytic case study may emphasise the feelings in the consulting room, that is, the countertransference.

Keeping in mind the strengths and limitation of CA, I decided to contrast my findings with the therapist's account of her own countertransference. Happily, this comparison provided further support for my analysis: in an interview for a different qualitative study, the therapist pointed out two moments during the treatment that seemed most meaningful. Despite the patient rarely asking questions, each of the meaningful moments identified by the therapist, based on her countertransference, did contain a patient's question. Notwithstanding that this comparison, between my interpretation of the therapist–patient conversation and the countertransference of the therapist, illuminated the commonality between the two subjective narratives of this treatment, there are studies that highlight differences. For example, Creaser's (2019) study is a comparison between what is learnt from audio-recordings, and what is learnt from therapists' process notes of the same sessions (revealing aspects of the therapist's countertransference), showing significant differences between the two accounts. Whether or not these comparisons reveal similarities or differences, Midgley (2004) claims that these evaluations get us closer to an account of reality that is 'trustworthy, credible, coherent and reflexive' (p. 104), without arguing for 'absolute-truth', which is exactly what psychoanalysis strives to do. Similarly, Wallerstein (2009) argues that it is the interplay between the findings of different studies, qualitative as well as quantitative, that enables the development of psychoanalysis as both a theory and a treatment.

Despite some child psychotherapists finding some research methodologies threatening because it is not 'psychoanalytic', I think its value stems precisely from the fact that it is not psychoanalytic. Any research methodology, qualitative or quantitative, offers a different perspective on similar data. According to the traditional psychoanalytic method invented by Freud, there is no separation between research and treatment. Historically, in psychoanalysis, research and treatment were in an 'enmeshed relationship'. In psychoanalysis, we are very aware of the importance of the 'third', who intervenes between the mother and her baby, facilitating separation and individuation, yet still maintaining a close relationship. When research is done 'in' and 'out' of the consulting room, as Rustin suggests, there is no third; 'in' the consulting room, the therapist is working in a psychoanalytic framework, and 'out' of the consulting room, the therapist explores the data with psychoanalytic trained colleagues, relying on psychoanalytic theory. Alternatively, Zimiles (1993) argues for a process of 'triangulation' in research, relying on multiple sources and methodologies. My research also started in the consulting room with my observation of my patients' questions, but later involved a different methodology – CA – which is not psychoanalytic and therefore functions as a 'third'. Midgley (2006b) asks: when analysing a case, how does one choose between different psychoanalytic theories (Freud, Klein, Lacan or Winnicott?)? Is one theory closer to the truth of the specific case being analysed? Midgley suggests embracing a 'both/and' viewpoint, rather than an 'either/or' viewpoint, when assessing the theoretical input of different psychoanalysts. Theory develops by adding new perspectives, while keeping the old in mind (Midgley, 2006b). Similarly, I think that adding

findings gained through 'non-psychoanalytic' methodologies, whilst retaining psychoanalytic findings, may help our theory move forward.

My research is about questions. I would like to end my reflective commentary with some questions. Why are we, as a profession, so scared of the 'third'? Why do we fear so much that other research methodologies will intrude upon us and ruin our distinctiveness? Is it simply human nature to fear criticism or change? Or are we so insecure that we worry our theories will be invalidated by other methodologies? In a conference I attended recently, intended for a psychoanalytic audience, a paediatrician offered a medical understanding of developmental trauma. The psychoanalytic audience was surprised, but pleased, to notice the extreme similarities between the medical and the psychoanalytic model of developmental trauma. I think that comparing our findings with findings gained through 'non-psychoanalytic' methodologies might be more reassuring for our discipline than we might think. This is, at least, my subjective opinion, based on my personal experience of research.

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