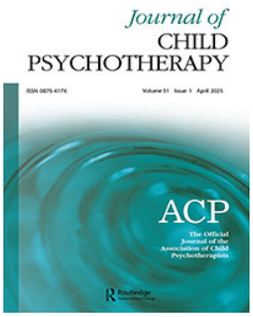

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Therapists' questions in short term psychoanalytic psychotherapy with depressed adolescents

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ABSTRACT

Questions are an integral part of therapeutic exchanges, but little empirical work has been done on how questions are used within psychoanalytic psychotherapy sessions. This study explores how therapists use questions in short term psychoanalytic psychotherapy (STPP) sessions with depressed adolescents. Three STPP cases were selected and questions asked by the therapist were identified, transcribed, and analysed in terms of type and function. A specific type of question (considered as 'performative') was noted as being of interest. These questions and the patients' responses were analysed using Conversation Analysis (CA). A high number of questions were asked across all cases, with type and function generally comparable to findings from non-therapeutic conversational settings. The specific questions identified as 'performative' were used by therapists to verbalise patients' unspoken negative thoughts and feelings towards them. A high proportion of avoidant responses to these questions was found. These results have consequences for refining clinical technique and the training of psychotherapists undertaking STPP with depressed adolescents, with particular reference to addressing the negative transference.

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Depression; adolescence; negative transference; STPP

Introduction

Questions are a universal feature of language (Stivers et al., 2009). It is not straightforward, however, to ascertain what constitutes a question in English. Hayano (2013) notes that questions can be identified in many ways (rising intonation, grammatical structure), but these features on their own are insufficient. Whether a statement can be said to be a question often relies on the speaker's 'epistemic status' (Heritage, 2013, p. 376) – a concept which refers to the degree of knowledge a speaker possesses. Someone with more knowledge may be said to have a higher epistemic status than someone with less, implying an 'epistemic gradient' (Heritage, 2013, p. 378). There have been many studies exploring questions as part of everyday as well as institutional conversations (Curl & Drew, 2008; Heritage & Robinson, 2006; Stivers, 2010; Stivers et al., 2018). These studies show how questions have many

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functions, including setting agendas, revealing presuppositions, seeking information, and revealing the epistemic gradient between conversational participants.

Questions are also an integral part of therapeutic work (McGee et al., 2005), but are utilised in varying ways in different forms of therapy (MacMartin, 2008; Muntigl & Zabala, 2008). Questions may be used by therapists to address therapeutic ruptures (Jager et al., 2016; McGee et al., 2005), to increase the patient's cognitive and affective exploration (Shechtman, 2004), to influence the patient's view of themselves and their relationships (Friedlander et al., 2012), or even to influence their behaviour (Healing & Bavelas, 2011). Research has also been conducted on the impact of questions on immediate and intermediate therapeutic outcomes (Williams, 2023). An assumption persists for some that psychoanalytic psychotherapists should not ask questions (Sousa et al., 2003), but there has nevertheless been an ongoing debate in the psychoanalytic literature regarding their use (Adler & Bachant, 1996; Anvari et al., 2022; Boesky, 1989). Despite recent work on the use of questions by patients (Yadlin et al., 2022), there has, however, been little attempt to theorise and categorise the use of questions by psychoanalytic psychotherapists (Busch, 2013). The current study aims to address this gap in the literature, by exploring how psychoanalytic psychotherapists use questions in the particular context of short-term psychoanalytic psychotherapy (STPP) sessions with adolescents.

The paper has three specific objectives:

(1) To explore how many questions, of what type, and with what function, were asked by therapists in STPP sessions with depressed adolescents;
(2) To explore whether there was something specific about the ways in which psychoanalytic psychotherapists used questions in this therapeutic context;
(3) To explore how patients responded to these specific therapist questions and to examine their impact on the therapeutic interaction.

Method

Setting for the study

The data for this study were existing audio recordings of STPP sessions with adolescents with a DSM-IV diagnosis of major depressive disorder, taken from the STPP arm of the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study (Goodyer et al., 2017). The IMPACT study was a randomised clinical trial which was undertaken at 15 National Health Service (NHS) Child and Adolescent Mental Health Services (CAMHS) in England. The IMPACT study sought to compare STPP, Cognitive Behavioural Therapy (CBT), and specialist clinical care, as treatments for major depressive disorder in adolescents. The Mood and Feelings Questionnaire (MFQ; Daviss et al., 2006) was the main outcome measure, identifying self-reported depression scores at follow up. The results of the IMPACT study showed no statistically significant differences in clinical- or cost-effectiveness between the three treatment modalities (Goodyer et al., 2017).

STPP as used in the IMPACT study is a 28 session treatment model which makes use of the existing principles of psychoanalytic work with children and adolescents, including the focus on putting feelings into words, the relationship between therapist and patient, use of transference and counter-transference feelings, and an emphasis on conflicts, particularly those thought to be of an unconscious nature (Cregeen et al., 2017). Along with other factors such as the maintenance of a 'psychoanalytic frame', working within the transference distinguishes psychoanalytic psychotherapy from other forms of psychotherapy.

This involves recognising the appearance within the patient-therapist relationship of relational elements and expectations belonging to the patient's past relationships, in particular relating to their earliest relationships; by actively paying attention to these, the psychoanalytic therapist 'works' with the transference, including active comments ('transference interpretations') about what is happening between the therapist and patient in the 'here-and-now' (Levy & Scala, 2012), and how this may relate to the issues that brought the patient to seek help. Attention is paid equally to the 'positive' and the 'negative' transference, with the latter including feelings of anger, hostility, or envy.

Therapists offering STPP were CAMHS clinicians with Association of Child Psychotherapy (ACP) recognised training in child and adolescent psychoanalytic psychotherapy (CAPPT).

Sampling and selection of participants

This study was conducted by a research group comprising trainees from the Independent Psychoanalytic Child and Adolescent Psychotherapy Association (IPCAPA) in the UK who were analysing various elements of the STPP process and using Conversation Analysis (CA). Across the research group, STPP cases were selected from an anonymised spreadsheet, on the basis that the adolescent patient had attended the median number of therapy sessions (11 sessions; Goodyer et al., 2017), or as close to the median as possible. This approach aimed to ensure some similarity between selected cases and to avoid outlying cases where only a few or an unusually high number of sessions had been attended. Five cases met this criterion. From these five, three cases were randomly selected as providing a broader view of therapists' questions than a single case study would allow, whilst not preventing the possibility of a detailed analysis of the interactions, as required by CA. The cases were:

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

Case 2: 18-year-old girl, seen by a female therapist. The girl attended therapy sporadically (12 sessions attended) and dropped out before the planned ending. She had previous experience of therapy. The main themes of the psychotherapy were family relationships, her ability to communicate emotions (particularly negative emotions), and her tendency to focus on the difficulties of others, rather than her own.

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

From these three cases, the second, median, and penultimate sessions were identified, giving nine sessions altogether from the three different cases. This was in order to analyse interactions taking place across the course of the therapy. First and final sessions were avoided on the basis that, according to psychoanalytic theory (e.g., Cregeen et al., 2017; Schlesinger, 2014), these are expected to contain specific features in virtue of their position, which was not the main focus of this study. Where the second, median or penultimate session was not available (e.g., had not been recorded), the session immediately following was used.

Data analysis

All sessions were listened to three times, divided into three-minute segments ('chunking'), and important features of the interaction noted, including whether questions were asked. This allowed for an overview of the important themes and features of the sessions.

To address the first aim of this study, each question asked by the therapist was noted, transcribed, and identified with a number. Questions were included in the data if they contained formal indications of being a question, including lexical markers (who, what, why, where, when, how), syntactic markers (question identified by word order, e.g., 'did you go to town?'), or prosodic markers (raised intonation). Questions which did not contain such markers, but which clearly functioned as questions in terms of being designed to elicit a response, were also included. These questions were analysed quantitatively in terms of type. Each question was categorised based on Biber et al.'s (1999) system which identifies three main types of question in English: polar questions (requiring a yes/no answer); content questions (preceded by interrogative words including who/what/where/when/why/how (many)); and alternative questions (proposing two possible answers, such as 'do you want tea or coffee?'; Stivers, 2010). The questions were then analysed by function, using Stivers and Enfield's (2010) categorisation of questions. In this categorisation system, the function of a question is identified from a list which has been shown to capture the main social actions performed by questions in English: 'request for information', 'other initiation of repair', 'request for confirmation', 'assessment', 'suggestion/offer/request', 'rhetorical', 'other' (Stivers & Enfield, 2010).

To address the second aim of this study, a specific type of question was identified as being of interest (see findings below, for justification of this focus). These questions were listed separately and analysed to identify any themes or similarities. To address the third aim of this study, these selected questions and the patient responses (immediate next turns in the interaction) were transcribed. In response to the data, these responses were categorised as:

- *Agreement* – e.g., 'yeah'/'yes'/'I guess so'/'mmm'

- *Disagreement* – e.g., 'no' or a reformulation of the statement to say that it was not the case

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

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

Cases 1 and 2 each contained two 'performative' questions for transcription, whereas Case 3 had 12. Two 'performative' questions from Case 3 were therefore randomly selected to provide the same number of examples from each case for more detailed analysis. Excerpts were analysed using Conversation Analysis (CA; Sacks, 1992) a social science research method which enables the study of naturally occurring and institutional conversation which assumes that conversation follows a set of rules and procedures for interaction and focuses on the way utterances are structured and how they follow on from each other according to conversational 'turns' (Sacks et al., 1974). Researchers employing CA usually use videotaped or audiotaped records of interactions, which are then transcribed in a particular way so as to allow the syntactical and prosodic features of utterances to be identified. Importantly, CA focuses on the turn-by-turn interactions of a conversation, and how one turn responds to the previous turn as well as prompting the turn of the next speaker.

For the current study, transcription utilised selected conventions from the transcription system usually employed in CA (Jefferson, 2004). Interactions from one minute before and one minute after the identified question were transcribed, taking into account natural breaks in the conversation. The aim was to capture enough of the interaction to situate the questions in the context of the session, whilst avoiding an artificial cut off.

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

Ethics

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

Reliability of analysis

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

Results

Research question one: how many questions, of what type, and with what function, were asked by therapists in STPP sessions with depressed adolescents?

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

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

The most common function of the questions was a request for confirmation (45%, n = 278) followed by requests for information (30%, n = 183), and suggestion/offer/request (22%, n = 136). The remaining 3% of questions came under the category of 'other', e.g., other initiations of repair, assessment, and rhetorical questions, and there were no instances of questions that served as 'out-loud'. Table 3 shows the breakdown of questions by function, across all three cases.

Table 1. Number of questions asked per case.

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

Table 2. Types of questions asked by therapists.

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

Table 3. Function performed by questions.

Function of question	Frequency
Request for information	30%, $n = 183$
Other initiation of repair	1%, $n = 4$
Request for confirmation	45%, $n = 278$
Assessment	Less than 1%, $n = 1$
Suggestion/offer/request	22%, $n = 136$
Rhetorical	Less than 1%, $n = 1$
Out-loud	0%, $n = 0$
Other	2%, $n = 15$

Research question two: was there something specific about the ways in which psychoanalytic practitioners use questions in this therapeutic context?

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

From Case 1, session 2:

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

From Case 2, session 11:

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

From Case 3, session 2:

> *and I was thinking maybe (.) you know (.) you thought (.) now has he bothered to remember (.) what I was going on about (.) you know has he really listened (.) has he really paid attention (.) he can't even seem to get the names right I've just said*

Across the nine sessions coded, 46 'performative' questions were identified in total. The need for this new category of 'performative' questions suggested to the researchers that these questions might exemplify a type of questioning that is particular to psychoanalytic discourse, at least as it has been explored here with depressed adolescents. A link between some of these questions was noted, as several were observed to address a specific theme of the patient's unspoken negative feelings towards the therapist. 18 questions addressing this theme were identified.

These questions were posed dubitatively, containing markers of uncertainty, for example 'might' or 'maybe'. They were also posed as statements, and often lacked the formal markers used to identify questions. A range of themes was identified with regard

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

Research question three: how did patients respond to specific therapist question types and what was their impact on the therapeutic interaction

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

Table 4. Type and frequency of patient responses to 'performative' questions.

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

Avoidant responses

Below is a transcribed and analysed example of an avoidant response, taken from Case 1, session 3 (male, 15 years, seen by a female therapist). Therapist and patient are discussing the patient's view that it is 'weird' to consider whether other people keep him in mind:

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

P: *Sort of (.) that I (.) sort of the fact that I've never really actually thought about it (.) and (.) the way (.) that you don't really know if someone (.) if anyone's thinking about you (.) so it's not really a one (.) so that you don't get someone sort of someone coming up to you and going oh I was thinking about you earlier*

T: *mm*

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

T: *°yes° (.) but then (3s) erm (3s) and then it (.) I suppose it just (.) brings me back to the therapy as well because (.) you might be thinking you know (.) does she really care (.) you know when you tell me all these (.) about these messy feelings (.) does she really*

you know (.) the session is going to end (.) after 50 minutes (2s) what's (.) what that a (.) what's the therapy ↑about↑ (3s)

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

T: *[↑mm↑]*

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

T: *yeah=*

P: *=that I wouldn't there's never really been a person when I've sat down >apart from now actually< that I've really sort of told em about my emotions in the sense (.) like I've told em maybe (.) this has happened in my life that sometimes I get a bit upset (.) but I've never sort of sat there and really explained (2s) what how I feel*

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

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

sense: 'I've sort of never let a person in properly', and that this is different with his current therapy, where he is invited to talk about the quality of his experience, not only the content.

Agreement responses

Overall, there were more agreement responses (33%) than disagreement responses (17%), suggesting that although 'performative' questions might be awkward for patients, they are not necessarily rejected. Some of these questions might be awkward for patients precisely because they are experiencing the negative feelings the therapist suggests, or because they are not ordinary topics of conversation, so might feel unfamiliar.

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

T: *>so it sounds like you< you feel like you know like you can have these relationships and you can have quite a (.) °↑powerful↑ response° to these things and (.) it quite worries you*

P: *mm-hmm*

T: *how much you can react*

P: *yeah*

T: *and feel out of control (.) erm (.) and I don't know I was thinking maybe (.) maybe there is something about erm (.) thinking about what's this going to be like coming here (.) and (.) whether you're going to have a bit of a reaction to it*

1P: *°mm hmm°*

T: *↓ maybe you (.) already have (.) I don't know (.) but maybe you've sort of wondered about (.) what's this going to do to you ↓*

P: *°mmm°*

T: *and how are you going to feel*

P: *°mmm°*

T: *and am I gonna upset you*

P: *yeah*

T: *and are you gonna feel vulnerable↓*

P: *°mmm°*

T: *and are you gonna feel all of those things are you gonna feel cross and (.) would you really want to*

P: *yeah (.) yeah like that was kind of the first thing that came into my head when like they suggested erm (.) like >any kind of therapy<*

P: *>just that talking about things brings up a lot (.) and just makes you feel like < more ↑ things ↑ (.) and it does kind of make me feel like (.) icky (laughs/exhales)*

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

In the next turn, the patient follows quickly, acknowledging her agreement with the therapist's suggestions by adding to the exchange, 'like that was the first thing that came into my head'. The patient also creates distance between herself and the therapist through a move to the general 'any kind of therapy'. The therapist offers a quiet 'right', which allows the patient to stay with this general stance. Accordingly, the patient begins her next turn with an utterance about things more generally, 'talking about things', rather than the specifics of the relationship between them. She speaks quickly and repeats the general term 'things', proceeding to shift the pronouns from the general 'makes you feel' to the personal 'makes me feel', followed by a quiet laugh.

Clinically, this appears to be quite an emotional interaction. The therapist's 'performative' question seems to identify a key worry of the patient about whether the therapeutic interaction will be uncomfortable or even upsetting. The quietness with which the patient speaks initially and the speed of her speech later both suggest her heightened emotional state. Through the therapist's 'performative' question, which allows for discussion of the general as well as the specific (the therapeutic transference relationship), the therapist is able to generate agreement, as well as creating room for the patient to speak about her personal experience and fears about coming to therapy. The patient is able to put words to this feeling which she describes as 'icky'. Her laugh or exhalation at the end of her utterance also conveys anxiety. The therapist phrases his question very tentatively, and places the personal element of it 'am

I gonna upset you' in the middle, immediately preceded and followed by more general statements. This seems to make the suggestion manageable for the patient. Although the patient agrees, and talks about her own feelings, she moves away from the personal relationship between patient and therapist, and shifts the worry onto how things will feel more generally in therapy.

Disagreement responses

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

P: *yeah (.) I guess so (1 s) and (.) I don't think she really understood it and I think she like (.) she sort of focussed too much on how my dad (.) never lived with me when (.) that isn't really that (.) big a problem (.) in my life*

T: *mmm*

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

T: *right (1 s)*

P: *erm (2 s) and she used to write things down and that really used to annoy me (.)*

T: *right*

P: *When she was talking to me (3 s)*

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

P: *mmm (5 s) like that's (.) why I don't like (.) the (therapy centre) (12 s)*

T: *and perhaps (.) perhaps you feel that sometimes here too that I don't understand or say (.) don't focus on the right things or (.) don't get the right (.) er end of the stick*

P: *I think you do (.) I think (.) I don't I just (.) that other woman I just didn't (3 s) she'd really come out with the wrong things (.) [I think*

T: *[Right]*

P: *I] felt and if I tried to explain to her that I didn't think it was right (.) she didn't get it*

T: *right=*

P: *=or she wouldn't really understand or (.) yeah (3 s) I dunno (2 s)*

T: *so it felt it made things worse*

P: *yeah*

T: *but I guess talking (.) when it's difficult (.) anyway (.) and you kind of manage to do it but then you feel its not heard (.) it's not a (.) very helpful or (.) it's quite a [painful] experience*

P: [yeah]

P: *mm (.) yeah (.) it wasn't very (.) nice (.) I just remember it as being really cold but that's because it was winter*

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

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

coldness possibly links to the emotional coldness at which the therapist hinted. Later in the session, the therapist suggests the patient's hope that this time, in this therapy, things might be different.

Discussion

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

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

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

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

As well as following many of the rules and procedures of ordinary conversation, psychoanalytic psychotherapists working with depressed adolescents were also shown to use questions in more specific and unusual ways. This study identified the therapists' use of 'performative' questions, which were employed to draw attention to negative thoughts and feelings the patients might have had about them. CA analysis of the selected excerpts' interactions showed that 'performative' questions were one example

of a specialised conversational device used by therapists to challenge their patients, and make room for discussion of difficult feelings pertinent to their depressed presentation.

In psychoanalytic terminology, these 'performative' questions would be described as examples of interpreting the negative transference (Freud, 1912) – addressing the patient's inferred negative feelings about the therapist, in the hope that these can be understood and worked through. The negative transference interpretations phrased as 'performative' questions in this study use something the young person brings about an aspect of their life and pulls this into the arena of the therapy by linking it to the therapist him/herself. These can also be described as examples of analyst-centred interpretations (Steiner, 1994), as they focus on the patient's thoughts and feelings about their therapist. One psychoanalytic understanding of depression is that it is resultant of unexpressed aggression that is turned in on the self (Busch et al., 2016; Freud, 1917). Helping patients to experience and express their negative or aggressive feelings towards others, rather than directing these feelings towards themselves, would thus help them to recover. Addressing the negative transference would be expected to be a key part of the therapy of the depressed young people included in this study, for whom the struggle to put difficult feelings into words was a central feature of their presentation. It has not previously been noted, however, that 'performative' questions may be a way for therapists to address such negative emotions.

When examining how young people responded to therapists' 'performative' questions addressing negative feelings about the therapist, our analysis identified that they were often followed by a high frequency of avoidant responses. Patients broke conversational rules in these responses, as the questions were all formulated as polar questions, which conversational rules dictate should be answered with 'yes' or 'no' (Raymond, 2003). This suggests that these patients often found questions that addressed their negative feelings about the therapist awkward or difficult to answer. The detailed CA of excerpts added to this analysis, illustrating how the young people in this study tended to work hard to keep any negative feelings out of the relationship with the therapist. They found it more palatable to discuss negative feelings if they related to another domain – a previous relationship or another aspect of their life- or if they were otherwise generalised. This supports established advice offered to therapists in the need for tactful handling when approaching the negative transference and making use of interpretations in displacement (Trowell et al., 2010) when working with depressed adolescents, and gives some indication of how this is done in practice. 'Performative' questions addressing negative transference issues were also shown to lead to moments of mutual understanding between patient and therapist. In this way, 'performative' questions were one way in which therapists kept their patients engaged in the process of therapy while difficult subjects were addressed, although at times these 'performative' questions appeared to lead to conversational breakdowns, marked by avoidant responses from the young person.

Posing interpretations as questions, particularly dubitatively posed questions, allows therapists to present their epistemic stance as being lower than their epistemic status (Heritage, 2013). In the case of psychoanalytic psychotherapy, the epistemic gradient between patient and therapist is complicated. The patient's feelings about their therapist could be described as knowledge that the patient has in virtue of it being knowledge about their subjective experience. This would afford the patient a higher epistemic

status than the therapist, who arguably doesn't have knowledge of these things. Within psychoanalytic psychotherapy, however, one of the therapist's aims is to bring alive for the patient factors of which they are not consciously aware. From this perspective, the therapist has the higher epistemic status, even though they are discussing the patient's experience. This has the potential to feel uncomfortable for the patient, which is one reason that therapists might choose to present a lower epistemic stance in phrasing their negative transference interpretations more tentatively, as 'performative' questions.

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

Clinical, theoretical, and methodological implications

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

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

Strengths and limitations

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

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

Although appropriate for CA, this study also had a small sample size of three cases ($n = 3$) (nine sessions), so the extent to which the results can be generalised is limited, and links between process and outcome were not the aim of this study. It would be helpful to look at a larger number of cases, or those with different treatment outcomes, to see whether 'performative' questions were also used by other therapists doing STPP. Links to outcome could be informed through further research which analyses a larger sample of cases and looks for links between the number of 'performative' questions addressing the negative transference and clinical outcomes.

Conclusion

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

Glossary

Conversation analysis – an approach to the study of social interaction that investigates the mechanisms by which humans achieve mutual understanding.

Randomisation – the process by which participants are assigned by chance to treatment.

Randomized controlled trial – a study in which the population receiving the intervention andthe control group are both chosen at random from the eligible population.

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personal capacity and was not carried out by, or on behalf of, the Counselling Service of the University of Oxford.

Patient anonymisation statement

Potentially personally identifying information presented in this article that relates directly or indirectly to an individual, or individuals, has been changed to disguise and safeguard the confidentiality, privacy and data protection rights of those concerned, in accordance with the journal's anonymisation policy.

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