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Unraveling the role of client-professional communication in adolescent psychosocial care

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Document Version

Publisher's PDF, also known as Version of record

Publication date:

2016

[Link to publication in University of Groningen/UMCG research database](#)

Citation for published version (APA):

Jager, M. (2016). *Unraveling the role of client-professional communication in adolescent psychosocial care*. Rijksuniversiteit Groningen.

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Therapists' continuations following *I don't know* – responses of adolescents in psychotherapy

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ABSTRACT

Objective: In psychotherapy clients' *I don't know* – responses (IDK-responses) to therapists' questions are typically considered to be non-cooperating behaviors. How therapists actually handle these behaviors remains unclear. This study therefore aims to assess client-therapist interactions following IDK-responses.

Methods: Data were collected in a Dutch child and adolescent mental healthcare service by observing Dialectical Behavior Therapy aimed at adolescents with severe emotional distress. Eighteen individual psychotherapy sessions involving two therapists with six clients were video-recorded and transcribed. Stand-alone IDK-responses were selected ($n = 77$) and analyzed using conversation analysis.

Results: IDK-answers by adolescents led to varying responses by therapists. We identified five categories of continuations after IDK-responses: no IDK-related continuation; redoing of the question; proposing a candidate answer; collaborative therapeutic interaction; and meta-talk on the problematic nature of the IDK-response.

Conclusions: Therapists treat IDK-responses not just as non-cooperative behavior on the part of the client; IDK-responses are also used as a therapeutic starting point to work together from a state of *not knowing* to a state of *knowing*.

Practice implications: After IDK-responses therapists can use a variety of continuation strategies with varying therapeutic functions. These strategies can be embedded in training of therapists to deal with potentially non-cooperative behavior.

INTRODUCTION

During psychotherapy and counseling clients may be considered as non-cooperative or even resistant when responding to questions with 'I don't know'.^{1,2} This behavior is then associated with unwillingness of the client to engage in therapy, and is believed to be a potential threat to the achievement of successful treatment. To achieve therapeutic goals therapists and clients should both endorse and be committed to the main principles of therapy.³ *I don't know* – responses (IDK-responses) are considered a risk for the desired active participation of the client and the progress of the therapeutic conversation. For this reason psychotherapeutic handbooks suggest reducing this type of behavior in order to increase the likelihood of successful therapy.^{2,4,5}

Research on IDK-responses in therapeutic and counseling settings has focused on the non-cooperativeness of this behavior. Stivers and Robinson⁶ refer to IDK-responses to questions as 'non-answers' because they only satisfy the 'technical part' of responding to a question, while failing to promote the action sequence initiated by the question. This type of response seems to block the relevant course of action.^{7,8} In child counseling, the repeated use of IDK-responses was described as strategic and non-cooperative behavior on the child's part.¹ The counsellor was left with the dilemma whether to treat the child's utterances either as legitimate no-knowledge claims or as a strategy to avoid a particular line of therapeutic conversation.

Other studies show that not all IDK-responses are treated as a resistance strategy on the part of the client;^{9,10} in these studies IDK-responses were combined with at least an account of not being able to provide the requested information. When IDK-responses were followed by such 'inability accounts', the speaker seemed to demonstrate that he or she was not unwilling to comply with what had been asked, but unable to do so.¹¹

For therapists, IDK-responses that are not followed by further utterances of the client, i.e. stand-alone IDKs, may be challenging. However, how they actually handle these behaviors in practice remains unclear. The aim of this study was therefore to assess client-therapist interactions following stand-alone IDK-responses to gain more insight into how therapists deal with these potentially non-cooperative behaviors.

METHODS

Study design

This study was conducted by observing Dialectical Behavior Therapy (DBT) in a Dutch child and adolescent mental healthcare organization. DBT is a well-established intervention first developed for adult patients with borderline personality disorders (BPD).² In recent years the therapy has been adjusted for adolescents who suffer from severe emotional distress and display symptoms of BPD,ⁱ and/or conduct into suicidal behavior.⁵ These adolescents may have severe problems in interacting with their environment, leading to school drop-out, alcohol and drug abuse, family problems, and a high use of care.¹⁴⁻¹⁶ Various studies found that approximately 10% of BPD patients die prematurely due to suicide or the consequences of reckless and impulsive behavior.¹⁷⁻²⁰ The main goal of DBT is to replace maladaptive coping strategies such as dissociation, drug and alcohol abuse, and (para-) suicidal behavior with adaptive coping strategies such as finding distraction and mindfulness.^{2,4,5} DBT consists of weekly group skills training, weekly individual psychotherapy, and the possibility of contacting the therapist 24 hours a day. For the purpose of this research project, individual therapy sessions were videotaped. Video recordings were conducted between December 2012 and June 2014.

Sample and procedures

Two out of three therapists involved in DBT agreed to participate. They were asked to recruit clients at the start of the DBT program, and record as many psychotherapy sessions as possible. Both therapists recruited three clients, and 34 therapy sessions were recorded (range per client-therapist dyad 3-13). The videos lasted 45-65 minutes, corresponding to normal therapy sessions of approximately one hour.

Both therapists were trained in DBT. Therapist 1 was female, 38 years old, had 13 years working experience as a therapist for children and adolescents, and one year as a DBT therapist. Therapist 2 was female, 50 years old, had 30 years working experience as a therapist for children and adolescents, and one year as a DBT therapist. The clients were female, aged 14 to 19 years. All clients experienced severe emotional distress and conducted into maladaptive behavior to handle their strong emotions. Clients displayed symptoms of borderline personality disorder and some conducted para-suicidal behavior (usually self-mutilation).

Informed consent was obtained from the participating adolescents, and for those below the age of 16, from their parents, after the nature of the study had been fully explained. The camera was positioned so that both the therapist and client were clearly visible.

Data handling

We analyzed three psychotherapy sessions per client-therapist dyad. When more than three sessions were recorded, we randomly selected one session at the beginning, one in the middle, and one at the end of treatment. Video recordings were transcribed according to the conventions of conversation analysis.²¹ All names and points of reference have been changed to protect participants' privacy.

Analysis

The theoretical and analytical framework of conversation analysis (CA) was used to analyze the data. CA studies the order of talk in interaction and the ways in which intersubjectivity between speakers is achieved. One of CA's main principles is that interactants show in their next response how they have understood the other speaker's preceding response.^{22,23}

Analyses concerned clients' IDK-responses that contained the verb '*weten*' (knowing) such as *ik weet het niet* (I don't know), *dat weet ik niet* (that I don't know), *kweenie* (Idunno), and *ik weet het niet meer* (I don't know anymore). We included only the stand-alone IDK-responses, as we were interested in their possible non-cooperative nature. IDKs that functioned only as a hedge and not as an answer as such were excluded: for example "I don't know, I just felt sad". We also excluded IDK-responses that were immediately followed by another utterance of the client such as an inability account, for example "I don't know, I was not there". Next, we analyzed therapists' continuations following the stand-alone IDK-responses.

We first reported background characteristics and frequencies of type of therapeutic response. Second, we categorized responses by type, and analyzed the interactional and therapeutic consequences of the continuations per type.

RESULTS

Participant characteristics and distribution of IDK-responses

Table 1 shows client characteristics and the distribution of IDK-responses in the eighteen psychotherapy sessions. We identified 77 stand-alone IDK-responses, with numbers per session ranging from 0 to 22. Some clients rarely displayed this behavior (clients 3 to 6), while others did so repeatedly (clients 1 and 2). The data-driven analysis resulted in five categories of continuations following IDK-responses: no IDK-related continuation; redoing of the question; proposing a candidate answer; collaborative therapeutic interaction; and meta-talk on the problematic nature of the IDK-response.

Table 1 Participant characteristics and categories of therapist continuations following stand-alone IDK-responses

Categories of therapist continuations following stand-alone IDK-responses											
Th	CI	Age	Living circumstances	Diagnosis	Session	Not IDK-related	Reading question	Candidate answer	Therapeutic interaction	Meta-talk	n (%)
1	1	19	Lives with parents and brother, dropped out of school.	Eating disorder Not Otherwise Specified, depressive feelings. Potential: social phobia and Post-Traumatic Stress Disorder (PTSD), due to bullying in the past.	46 min. 53 min. 34 min.	2 6 1	4 6 3	4 7 3	1 2 2	1 1 1	12 (15.6) 22 (28.6) 10 (13.0)
2	17	Residential, lived in foster homes for 16 years, individual school program.	Anxiety, unsafe attachment, possibly Attention Deficit Disorder (ADD). Personality disorder symptoms.	65 min. 47 min. 22 min.	1 2 0	6 5 0	3 3 1	3 3 1	1 0 0	0 0 0	11 (14.3) 10 (13.0) 1 (1.3)
3	19	Lives with her boyfriend. Good relationship with parents. No work, school or daily routine.	Attention Deficit Hyperactivity Disorder. PTSD, anxiety and mood problems. History of drugs dependency.	37 min. 41 min. 34 min.	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 (0.0) 0 (0.0) 0 (0.0)
2	4	18	Residential.	Personality disorder.	69 min. 55 min. 45 min.	0 0 0	1 0 0	0 0 0	0 0 0	0 0 0	1 (1.3) 0 (0.0) 0 (0.0)
5	14	Parents separated, lives with father, stepmom and stepsiblings.	Depression, eating disorder, parent-child-relationship problems.	60 min. 56 min. 61 min.	1 1 0	2 0 2	1 0 0	1 0 0	0 0 0	0 0 0	4 (5.2) 1 (1.3) 2 (2.6)
6	18	Lives with her boyfriend. No work or school.	Depressive episode recidivated, borderline personality disorder symptoms, parent-child-relationship problems.	53 min. 39 min. 52 min.	1 0 0	0 1 0	0 0 0	0 0 0	0 1 0	0 0 0	1 (1.3) 2 (2.6) 0 (0.0)
Total n (%)						15 (19.5)	30 (39.0)	22 (28.6)	7 (9.1)	3 (3.9)	77 (100.0)

No IDK-related continuation

In this first category, the therapist treated the IDK-responses as unproblematic; the IDK-response was accepted as an answer and the question/answer sequence was closed by a post-sequence. Extract 1 shows an example.

Before the start of Extract 1 client and therapist discussed the client's withdrawn behavior during the past skills training session. The client indicated that she did not like her own withdrawn behavior and the topics that were discussed (how to handle an emotional crisis). Extract 1 starts with the therapist asking what bothered her most. After a rather long pause, the therapist rephrases her question and after an even longer pause the client provides an IDK-response in line 5.ⁱⁱ

(1) Therapist 1 – Client 1 – Session 2

- 1 T: oke •hh en wat het meeste waar voelde je je het meest rot over?
'okay •hh and what was the most what did you feel most awful about?'
- 2 (2.0)
- 3 T: wat had de overhand? waar gingen je gedachten vooral naar uit?
'what prevailed? where were your thoughts especially going to?'
- 4 (7.0)
- 5 C: ja da weet ik niet
'yes tha I don't know'
- 6 (0.4)
- 7 T: •ht nee?
'•ht no?'
- 8 C: ((*head shakes*))
- 9 T: °oke°
"okay"
- 10 (3.4)
- 11 T: •hhh en al die rottige gedachtes, welk gevoel leverde jou dat op?
'•hhh and all those bad thoughts, which feeling did that give you?'
- 12 (3.5)
- 13 C: umhm:h (1.6) schaamte, schuld
'umhm:h (1.6) shame, guilt'

After a short pause, in line 7 the therapist asks for confirmation of the IDK-response, providing another opportunity for the client to answer the question. When the client again (non-verbally) declines to do so, the therapist registers and accepts the IDK-response as a legitimate answer to her question by closing the question/answer sequence with "okay" and starting a new question/answer sequence, unrelated to the IDK-response in line 11 that is taken up by the client in line 13.

Interestingly, even in this most unproblematic case IDK-responses pose problems for the progression of ongoing conversation: in our corpus no IDK-responses are

immediately, i.e. without a post-sequence, accepted as answers as such. This is not surprising as the IDK-response is only a 'technical' response to a question, and fails to promote the action sequence initiated by the question.⁶

Redoing of the question

In the second category, the therapist treated the IDK-response as a result of some kind of problem with the question. In these cases she continued with a redoing – sometimes a modified version – of the question. Extract 2 shows an example.

Before the start of Extract 2 the client spoke of some mathematics exercises she had done to prepare for the educational program she hopes to begin with next year. Extract 2 starts with the therapist asking about the client's experiences with doing these exercises.

(2) Therapist 1 – Client 1 – Session 2

- 1 T: en hoe was dat?
'and how was that?'
- 2 C: weet ik niet
'I don't know'
- 3 T: (en) hoe vond je het om te maken?
'(and) what did you think about making it?'
- 4 (0.6)
- 5 C: ja ik vind het altijd heel moeilijk maar
'yes I always think it is very hard but'
- 6 T: ja?
'yes?'
- 7 C: Ja
'yes'

The IDK-response in line 2 is immediately followed by a redoing of the question by the therapist. She modifies her first – rather unspecific – question (how was that?) into a question which explicitly states what she wants the client to reflect on (her feelings about making it). Now the client does provide an answer (line 5), which the therapist treats as an adequate continuation of the project initiated by the question.

By redoing the question, the therapist provides the client with an additional slot to provide an adequate response, thereby treating the IDK-response as inadequate. In some cases, however, the therapist provides a modified version of the question. In these cases the therapist seems to orient to a possible problem the client may experience in understanding the question. By reformulating the question the therapist again treats the

IDK-response not as an answer, but as an indication of a problem with providing an adequate answer.

Proposing a candidate answer

In the third category, the IDK-response was treated as indicative of a problem with selecting a suitable answer. In these cases the therapist proposed a candidate answer, thereby projecting an agreeing or disagreeing response of the client. Extract 3 shows an example.

Before the start of Extract 3 client and therapist discussed the client's lack of participation during the previous week's skills training session. Extract 3 starts with the therapist asking the client about the consequences of this behavior.

(3) Therapist 1 – Client 1 – Session 2

- 1 T: wat gebeurde er in je omgeving?
'what happened in your surrounding?'
- 2 (0.8)
- 3 C: ja dat weet ik nie
'yeah that I don know'
- 4 (0.9)
- 5 T: lieten ze je me rust? gingen ze je extra lastigvallen?
'did they leave you alone? did they bother you even more?'
- 6 (2.8)
- 7 C: beetje van allebei eigenlijk
'bit of both actually'
- 8 (0.3)
- 9 T: vertel
'tell me'

The therapist does not take the floor immediately after the IDK-response of the client in line 3, but after a pause in which the client fails to expand her response, the therapist provides two opposite candidate answers meant to prompt the client to choose one. Although the client does not make a choice, her reaction in line 7, "bit of both actually", is taken up by the therapist as a starting point toward the provision of information requested in line 1. After the therapist in line 9 invites her to elaborate on her answer, the client indeed continues with a description of what happened.

By providing a candidate answer, the therapist orients herself to a problem in answering the question. In this case the source of the trouble is not in the question as such but in the answer. The therapist orients herself to problems the client may experience in providing an adequate answer to an unproblematic question.

Therapeutic interaction

In the fourth category, the IDK-response triggered an elaborative, collaborative sequence in which both therapist and client engage in therapeutic interaction to come up with an answer. In such cases the IDK-response is treated as an adequate response to the question. The continuation is organized in question/answer sequences in which the therapist helps the client to find possible answers.

Extract 4 shows an example. Prior to this extract therapist and client have been discussing how the client reacts to arguments between relatives at family gatherings. The therapist prompts the client to investigate why these arguments cause her so much distress. After general discussion of the topic, the cause of which the client clearly finds hard to formulate, the therapist asks the client to describe her feelings while listening to these arguments.

(4) Therapist 1 – Client 1 – Session 1

- 1 T: oke en wat is er dan precies zo lastig aan?
'okay and what is so difficult about it exactly?'
- 2 C: ja weeknie
'yes I donno'
- 3 (8.2)
- 4 T: probeer is d- d'r is naar te kijken op een manier zoals je het bij de vaardigheidstraining hebt geleerd,
op een beschrijvende manier
'try t- to look at it in a way that you have learned during skills training, in a descriptive manner'
- 5 (4.1)
- 6 C: hoe bedoel je dat?
'what do you mean by that?'
- 7 T: •h nou bij de vaardigheidstraining zit je volgens mij op dit moment bij: u:hm (0.4) bij de
watvaardigheden klopt dat?
'•h well at skills training I think you are currently at: u:hm (0.4) the whatskills is that right?'
- 8 C: wat?
'what?'
- 9 T: (de) ↑wat↓vaardigheden. dat je beschrijft wat er gebeurt
'(the) ↑what↓skills. that you describe what is happening'
- 10 (5.9)
- 11 ja dat zou maar zo kunnen ((lacht))
'yes that might just be true' ((laughs))

In line 4 the therapist suggests an alternative approach: the client can use previously discussed skills to answer this particular question. The therapist hereby not only links the questions to concrete therapeutic goals, but she also ratifies the client's IDK-response as a possible answer to the question. After this extract comes a short intermezzo in which client and therapist try to establish which skills have (or have not) previously been

discussed. Then the therapist refers to the general skill the client could apply in this particular situation: linking a description of the situation to a description of her own feelings. The therapist then engages in this activity by first asking for a description of the situation followed by an inquiry about its effects on the client.

Rather than working toward an answer to a particular question, the process is geared towards equipping the client with skills applicable to future situations. That is, the IDK-response is not treated as indicative of a problem with the question per se, but as indicative of the client's current stage in therapy. Such focus on usable skills rather than answers to questions is at the heart of the DBT program. By moving through these steps with the client the therapist shows by example how the client can apply these skills in future situations.

Meta-talk on the problematic nature of the IDK-response

In the last category, the IDK-response is followed by meta-talk in which the IDK-response is treated as problematic. In these cases, although the therapist clearly treats the IDK-response as an answer to the preceding question, she explicitly addresses the nature of the IDK-response as problematic.

Extract 5 provides an example. Up to this point, client and therapist have been discussing a particular behavior of the client: during previous skills training sessions the client has often been in a state of dissociation. However, she also stated that she did participate during parts of the training to see whether she could gain any benefit from it. In line 1 the therapist asks the client whether this actually occurred.

(5) Therapist 1 – Client 1 – Session 2

- 1 T: heb je d'r iets voor jezelf uit kunnen halen?
'were you able to get something out of it for yourself?'
2 C: nah dat weeknie
'nah that Idonno'
3 (1.3)
4 T: da(n) zeg je wel hee::l snel
'tha(n) you say ve::ry quickly'
5 C: ((laughs))
6 T: neem je ook niet de tijd om er even over na te denken
'don't you take the time to think about it for a moment'

((lines 7 to 13 were omitted))

14. T: dus: e-e- door dat nu te zeggen hoef ik er ook niet op door te vragen. dat is ook wel weer (.) een handigheidje van jou
 'so: e-e- by saying that now I don't have to ask about it further. that also is again (.) a little trick of yours'

15. C: ((smiles))

((lines 16 to 20 were omitted))

21. T: want ik vraag jou door, (0.5) en dan zeg je gewoon na ja::
 'because I question you, (0.5) and then you just say well yeah::'

22. C: ((laughs))

23. T: ik weet niet eens meer wat je precies zei, moet je nagaan zo slecht luister ik dan ook •hh maak je weer een opmerking waardoor je mij weer gewoon ja da- dan kan ik weer niks:
 'I don't even know exactly what you said anymore, can you imagine that poor do I listen then as well •hh do you make a comment again that makes me again just yes the- then I can't do anything: again'

24. C: ((laughs))

25. (0.4)

26. C: j[a:
 'y[es:'

27. T: [begrijp je?
 [do you understand?

28. C: ((slight head nod))

29. T: •hh het is een beetje jouw kunst he? (0.6) jouw kunde zeg maar
 '•hh it is sort of your trick right? (0.6) your skill so to say'

In line 4, after a pause the therapist challenges the client's IDK-response by engaging in meta-talk. She formulates her reason for not accepting an IDK-response in this particular context: the IDK-response was given too fast. Apparently, although an IDK-response can be an acceptable interactional move in contexts where at least some sort of effort has been displayed to come up with an appropriate answer, here it was not the case. In the following conversation the therapist again instigates meta-talk, calling the behavior of the client a parlor trick (line 14): a recurrent evasive maneuver by the client in situations where the therapist pursues an answer to a difficult question (line 21, 23). In line 29, the therapist again pinpoints the IDK-response and the subsequent answer as a particular recurrent behavior of the client.

In this example the therapist clearly treats the IDK-response as indicative of unwillingness to answer the question. Rather than restating the question or offering a candidate answer, she addresses this presumed unwillingness by moving into an elaborate meta-talk sequence.

DISCUSSION AND CONCLUSION

Discussion

Our study shows that in order to deal with clients' IDK-responses therapists have a wide range of interactional strategies at their disposal. We identified five categories of continuations after IDK-responses: no IDK-related continuation; redoing of the question; proposing a candidate answer; collaborative therapeutic interaction; and meta-talk on the problematic nature of the IDK-response.

These five types of continuations seem to fulfill different interactional and therapeutic functions. We have found empirical evidence of the richness of interactional resources used by therapists in the management of clients' IDK-responses, where the literature and handbooks discuss only the non-cooperative nature of repeated IDK-responses.^{1,2,4,5} This diversity in therapeutic strategies can be related to the therapist's response to the dilemma of whether to treat an IDK-response as a legitimate no-knowledge claim or as a sign of resistance. This dilemma was also described in the context of child counseling.¹ Although IDK-responses can be a risk for the presumed active participation of the client and the progress of the therapeutic conversation, to challenge IDK-responses can have a negative effect on the client-professional relationship. The fact that a good client-professional relationship is essential to achieve successful psychosocial treatment³ may explain why therapists choose not to treat all IDK-responses as signs of non-cooperative behavior.

We found that therapists actually may use IDK-responses as a starting point for therapeutic interaction. We are not aware of any therapeutic handbooks or literature describing this type of strategy. This may have to do with the specific therapeutic context in which we have studied this behavior. In DBT, clients discuss difficult situations during the previous week and are asked to reflect on their behavior, thoughts and emotions during these situations to find out what the problem is, what is causing the problem, what intervenes with solution of the problem, and which resources are available to help the client solve the problem.² This so called 'behavior analysis' must be performed by the therapist and the client working together, but the ultimate goal is for the client to learn how to perform the analysis competently for herself.² As such, the client's not knowing the answer is acceptable, and maybe even expected, at a certain point in therapy. In fact it is exactly this state of *not knowing* that the therapy addresses by providing the client with specific skills to gain more insight into her behavior in difficult situations.^{2,4,5} One goal of these sessions may be to guide clients from a state of *not knowing* to a state of *knowing* with respect to their emotions and responses; in this process the therapist provides the client with skills to recognize specific emotions and to deal with these emotions in future situations. This is quite different from kinds of counseling in which the client is invited to

talk, for example, about traumatic events.^{1,10} In such conversations questions are more about remembering situations, and feelings may be more focused on the present.

In the fifth type of therapist continuations we identified, the therapist does show an orientation to the IDK-response that is in line with the description of IDK-responses in DBT handbooks; these handbooks present such responses as indicative of resistance to the question or an unwillingness to provide the answer.^{2,4,5} The fifth type of continuation challenges the client's commitment to actively participate in the therapy, and seems to be triggered by the client's apparent lack of effort to come up with an appropriate answer. This effort could be displayed for example by a 'thinking pause' preceding the IDK-response, or by adding an explanation for not being able to provide the answer. The latter was shown to be a client strategy in other counseling settings.^{9,10}

We found that this strategy of the therapist to address the problematic nature of the IDK-response does not directly affect the client-professional relationship because the client usually shows signs of agreement with the therapist's challenge. A possible explanation is that in DBT the client's commitment to the therapy is an important factor over the whole course of treatment. In child counseling,¹ but also for example in HIV consultations with (adult) clients,^{24,25} treatment is not always explicitly sought by the clients, a fact which may cause clients to display more resistance to the interaction.

Strengths and limitations

Our findings contribute to the evidence on this type of client behavior in two ways. First, this study provides empirical evidence of the richness of interactional resources brought into play by therapists to manage clients' IDK-responses, whereas literature and handbooks discuss only the non-cooperative nature of such (repeated) responses.^{2,4,5} Second, this study shows how therapists actually handle this type of behavior in practice, whereas handbooks provide no such information.

A limitation of our study is its relatively small sample of just two therapists and six clients. Our analysis showed that IDK-responses are not found in all client-therapist dyads and not in all client-therapist sessions. This led to a further narrowing of our sample, because most IDK-responses came from two client-therapist dyads involving the same therapist.

Conclusion

Handbooks on psychotherapy describe IDK-responses as non-cooperative behavior that must be reduced if therapy is to be successful. However, they provide no clues on how to do this in practice. Although we did find instances where the therapist responded to the IDK-responses of her client as non-cooperative behaviors, we also identified several other ways in which the therapist handled these responses. From a more positive viewpoint,

IDK-responses may even provide opportunities for therapist and client to work together in the therapeutic progress to come from a state of *not knowing* to a state of *knowing*.

Practice implications

Our analysis showed that, in response to IDK-answers, therapists can use a variety of continuation strategies with varying therapeutic functions. Our findings can increase therapists' awareness of this wide variety of possible actions that can be applied.²⁶ These strategies could be embedded in the training of therapists to deal with potentially non-cooperative behavior. Furthermore these findings, based on conversation analytic research, can be used during training for communication skills, providing a useful and fruitful addition to existing methods. The CARM-method could be a useful example.²⁷

Our findings also provide starting points for additional research. First, we have now analyzed one specific type of IDK-responses: stand-alone occurrences of IDK-responses containing the verb *weten* (knowing). Future research could expand on this by including other lexical variants of IDK-responses (e.g., I have no idea) and non-verbal behavior (e.g., shrugs and facial expressions). Second, the types of questions preceding IDK-responses in different psychotherapeutic settings could be explored in more detail to find out whether there is a relationship between the type of information (e.g., knowledge, impressions, feelings) that is requested and the occurrence of an IDK-response. Finally, the effects of different types of strategies on treatment outcomes such as patient satisfaction, participation, and health could be further studied.

NOTES

- i A diagnosis of Borderline Personality Disorder is usually not given to children or adolescents.^{12,13}
- ii Transcription conventions can be found in the appendix.

APPENDIX: TRANSCRIPTION CONVENTIONS

(.)	short silence of less than 0.2 seconds
(1.5)	length of silences between and within turns measured in tenths of seconds
.	falling final pitch contour
,	slightly rising final pitch contour
?	strongly rising final pitch contour
↑↓	onset of noticeable pitch rise or fall
[point at which overlap by another speaker starts
•hh	hearable in-breath
hh	hearable aspiration
–	cut-off marker
:	lengthening of the last sound
(words)	best guess of a stretch of talk that was difficult to hear
()	words spoken were too unclear to transcribe
=	two utterances that follow one another without any perceptible pause
<u>word</u>	salient stress
°word°	quiet talk
(())	descriptions

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