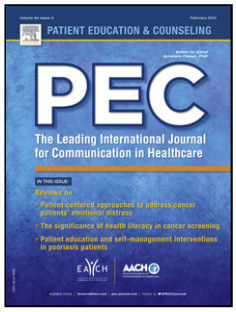

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Authors: Chloe Shaw, Vasiliki Chrysikou, Anne Lanceley, Chris Lo, Sarah Hales, Gary Rodin

PII: S0738-3991(18)30830-9
DOI: https://doi.org/10.1016/j.pec.2018.10.001
Reference: PEC 6084

To appear in: *Patient Education and Counseling*

Received date: 1-11-2017
Revised date: 27-9-2018
Accepted date: 1-10-2018

Please cite this article as: Shaw C, Chrysikou V, Lanceley A, Lo C, Hales S, Rodin G, Mentalization in CALM psychotherapy sessions: Helping patients engage with alternative perspectives at the end of life, *Patient Education and Counseling* (2018), https://doi.org/10.1016/j.pec.2018.10.001

Mentalization in CALM psychotherapy sessions: Helping patients engage with alternative perspectives at the end of life

Shaw, Chloe[a,b*]; Chrysikou, Vasiliki[c,d]; Lanceley, Anne[b]; Lo, Chris[e]; Hales, Sarah[e]; Rodin, Gary[e]

a. Department of Supportive Care, Princess Margaret Cancer Centre, University Health Network, University of Toronto, Toronto, Canada

b. UCL EGA Institute for Women's Health, University College London, UK
E-mail: chloe.shaw@ucl.ac.uk; a.lanceley@ucl.ac.uk

c. Research Department of Primary Care and Population Health, UCL, London, UK
E-mail: v.chrysikou@ucl.ac.uk

d. Central and North West London NHS Foundation Trust (CNWL), London, UK

e. Department of Supportive Care, Princess Margaret Cancer Centre, University Health Network, University of Toronto, Toronto, Canada
E-mail: chrislo@uhnresearch.ca; E-mail: sarah.hales@uhn.ca; E-mail: gary.rodin@uhn.ca

*Corresponding author's address:
UCL EGA Institute for Women's Health, Institute for Women's Health, Rockefeller Building, 21 University Street, London, WC1E 6DE, UK

Highlights

- **Meaning expansion enquiries are used as preliminary moves to challenge a patient's perspective.**
- The therapist avoids explicitly objecting to and invalidating the patient.
- Importance of these implicit moves in the delicate context of end-of-life.
- Reveals the process of mentalization in therapy.

Abstract
Objective: To identify how therapists invite patients with advanced cancer to engage with alternative perspectives about their illness trajectory and their end of life.
Methods: Sequences of talk in which a therapist introduced a patient to alternative perspectives, were transcribed and analysed using the method of conversation analysis.
Results: The analysis identifies one subtle way a patient is invited to consider an alternative perspective relating to their disease progression. Meaning expansion enquiries invite the patient to expand on the meaning of an utterance and in doing so, implicitly problematize the singularity of the patient's assumptions, without directly challenging them. The questions work as preliminary moves, providing the patient with the opportunity to expand on their assumptions. This enables the therapist to subsequently present an alternative perspective in a way that incorporates the patient's expanded perspective.
Conclusion: The analysis reveals a skilful way in which therapists can cautiously and collaboratively introduce a patient to alternative perspectives concerning end-of-life, without invalidating the patient's perspective in this particularly delicate context.
Practice Implications: Whilst mentalization is considered an important therapeutic process, the present study reveals precisely how this phenomenon can be enacted in therapy and within the particularly challenging context of end-of-life.

Key words
Mentalization, Conversation Analysis, End-of-Life, Therapy**, questions, alternative perspectives.**

Introduction

Individuals with advanced cancer face many challenges related to their disease, including the reality of a foreshortened life. Managing Cancer and Living Meaningfully (CALM) is a therapeutic approach designed specifically to help individuals in this circumstance to manage their disease and to remain engaged in life, while also facing impending death. [1] Reflecting upon the end-of-life is a pressing but delicate task in this therapy and more broadly for individuals with advanced and terminal disease. Conversation analytic (CA) research has shown that even subtle allusions by the therapist to the end-of-life can initiate conversations about it.[2, 3] [4] Shaw et al. (2016) showed how therapists elicited talk about the end-of-life in first session of CALM therapy through open questions about the patients' experiences, feelings or understanding, in the context of talk about their troubles. The open question design meant that such talk was not an interactional requirement, such that its frequent and early emergence presumably reflects a pressing need of individuals with advanced disease to share their fears and concerns about mortality. [4]

One context for end-of-life talk with individuals with advanced disease is advance care planning for the end-of-life. [5] Analyzing talk between palliative care specialists and terminally ill patients in a hospice setting, Pino et al (2016) demonstrated that palliative care doctors used elaboration solicits to invite further talk about thoughts and fears, thereby providing patients with the opportunity to volunteer talk about end-of-life. [3] In CALM therapy, patients are already engaged in therapeutic talk in which exploring feelings and perspectives is the main focus of the interaction. CALM therapy encourages patients to reflect on multiple perspectives about treatment plans and choices, in the context of a terminal illness, giving particular attention to key relationships and personal identity. This may allow patients who have focused only on cancer and its treatment, to consider other possibilities for living. Entertaining multiple perspectives that include the risks and benefits of pursuing and declining further treatment, can help patients to make more balanced and informed treatment decisions and plan for the end-of-life. The therapeutic challenge in exploring multiple perspectives with patients is to avoid invalidating their already displayed perspectives, such as about treatment plans and choices. There is the risk that introducing an alternative perspective in this context could trigger distress related to the implied shortness of their life.

Sustaining multiplicity in perspective-taking is a core feature of CALM therapy, through a process that has been referred to as mentalization. Mentalization has been defined as "the capacity to understand and interpret human behaviour in terms of underlying mental states" [6] and thereby to be able to distinguish feelings from facts and appreciate the possibility of multiple perspectives.[1] The capacity to mentalize can be diminished in individuals with advanced cancer who feel dominated by the singular objective reality of their progressive disease.[1]. This unavoidable reality may obscure from them the understanding that their assumptions and expectations are personal constructions or ways of thinking about the disease and that alternative perspectives may allow them to find satisfaction in their lives and to even experience psychological growth.[1]

Mentalization has received a great deal of recent attention, although published research has overwhelmingly focused on measuring the capacity to mentalize, rather than on the process by which it occurs in conversation. [7] Conversation analytic studies have more recently begun to examine mentalization from an interactional perspective, viewing it as an enactment in conversation. [8, 9] **Davidsen and Fosgerau (2015) and Keselman et al., (2016) used conversation analysis to study** implicit mentalization **in particular**, which refers to an unconscious and automatic process that is evident in the tailoring of talk to be responsive to a conversational participant.[10] In CA, this can be understood in terms of the architecture of intersubjectivity, whereby participants in conversation constantly display an implicit interpretation of the meaning of their recipient's utterance in their specific response types in subsequent conversational turns. [11, 12] For example, a response to the query "why don't you come and see me sometime" reveals whether this has been interpreted as an invitation or a

complaint, revealing the recipient's displayed understanding of the speaker's utterance. [11] **In CA, this mutual interpretation and responsiveness is similarly not treated as something speakers are necessarily consciously aware of** [11].

In the present study, we focused on what has been referred to as explicit mentalization, in which talk about thoughts, desires and motives becomes the focus of the conversation [10]. In doing so, we aimed to explicate how such talk is initiated by the therapist, rather than attempting to discover what it reveals about underlying beliefs or perspectives. More specifically, the present study aimed to identify how therapists invite patients with advanced cancer to consider alternative perspectives concerning their illness trajectory and their end-of-life.

Method

Participants and procedure

Data were collected as part of a Phase III randomised controlled trial of CALM at the Princess Margaret Cancer Centre.[13, 14] The trial aimed to establish the impact of CALM on death related distress, spiritual well-being, quality of life, psychological growth and satisfaction with care. The therapy in this study is delivered by social workers and psychiatrists. Audio recordings of one patient's complete therapy (7 sessions in total) with one therapist, that was considered exemplary by the therapeutic team in terms of the mentalization sequences within it, were selected for analysis. This has allowed for an in-depth analysis across one therapy session (see also [15] [16]). The identification and explication of methods for communicating is recognised as an important first step in analysis.[17] This paper takes that first step with the aim of exploring the regularity of that method across therapists and patients in future research. Indeed, a single case analysis is considered a useful approach to analysis in its own right.[18]

Sequences were identified in which the therapist introduced perspectives that were alternatives to the assumptions and expectations of the future conveyed by the patient in the context of terminal illness. These sequences were transcribed using the Jefferson Transcription System. This is a standard convention used in CA to capture exactly how and when something is said. The method of CA was used to analyse these therapeutic actions within their sequential context, focusing in particular on the implications for the patient's next turn. [19, 20] This paper focuses specifically on the more subtle moves of the therapist because their subtlety in these delicate therapeutic interactions is considered important clinically.

Ethics

The CALM study received approval from University Health Network Research Ethics Board #09-0855-C. Patients and therapists gave written informed consent for their conversations to be recorded for research purposes. All identifying details have been replaced with pseudonyms.

Results

Meaning expansion enquiries

From a total of 7 therapy sessions and 5 hours, 24 minutes of data, instances were identified where the therapist used questions; either on their own, or as part of a sequence, to invite the patient to consider alternative perspectives. A very small collection of 6 questions were found in which the therapist invited the patient to expand on something the patient said before subsequently going on to more explicitly put forward an alternative perspective.

These 'meaning expansion enquiries' relate to the patient's understanding and expectations regarding their treatment choices in the context of a terminal diagnosis. Meaning expansion enquiries function to invite the patient to explore an alternative perspective. We show how the question design

works to introduce ambiguity with regards the perspective presented by the patient, implicitly proposing the possibility of more than one perspective. In doing so, they invite the patient to mentalize in that her perspective is not treated as a fact but as one possible way of thinking. The questions work as preliminary moves, providing an interactional slot for patients to volunteer an alternative perspective before an alternative perspective is more explicitly stated by the therapist. The action of inviting the patient to explore an alternative perspective is achieved by the following main components, which will be **examined in** each extract:

a. Recycling of the patient's talk. This can be **done** as a repeat, **as** reported speech, or **as an utterance which the** therapist portrays as having been made inferentially available from the **patient's** prior talk.

b. **Invitation to expand on** meaning. The patient is either invited to **articulate** their meaning in an open way or **to articulate their meaning by confirming (or not) the therapist's formulation of what the client meant. The latter more strongly encourages the patient to articulate alternative perspectives.**

We will provide two possible sources of evidence that 'meaning expansion enquiries' invite the patient to explore an alternative perspective:

a. The patient treats the meaning expansion enquiry as proposing some possible problem with the assumptions concerning the patient's conveyed perspective.
b. The therapist subsequently asserts an alternative perspective in third position.

The first extract provides an example of how meaning expansion enquiries can be responded to as: 1) inviting mere expansion, or 2) in a way that treats them as problematizing the patient's perspective. The patient begins the therapy session with the news that she has new lesions on her liver and how she takes this to mean she is "dying".

Figure 1 (Session 5: Extract 4 - Bad News; 6:45- 8:55)

The patient is reporting her troubling news and her perspective that she feels that she now must 'give in', and let the cancer take its course given the limited treatment options now **(lines 1-7)**. The alternative perspective put forward by the therapist in lines 59-62 is that 'giving in' is a "psychological thing" and that the "challenge" is "shifting the project to you…an helping you be as well as you can." (lines 59-62). The patient's perspective is said with hearable sounds of upset; the wobbly voice in lines 1-2 and long out and in-breaths in line 7. The therapist's question **(line 9)** therefore comes at a point where, in ordinary conversation, a response that attends to the trouble in some way would be relevant.[21] The therapist's question specifically invites the patient to **articulate** the meaning of her utterance, using an open question format which recycles part of what the patient has said: "give in". Because the patient's interpretation that not receiving treatment means that she is 'giving in' is not treated as a self-evident response to her problem, this question can be seen as conveying curiosity about the patient's assumptions about the future.

The patient demonstrates some initial difficulty answering, shown by the delayed response **(lines 10-15)**. She follows by expanding on what "giving in" means **(lines 15-32)**. She takes this as a straightforward enquiry specifying what it means, rather than treating the question as problematizing her perspective. She treats the notion of "giving in" as a self-evident response to not receiving treatment; that she can no longer work at treatment and therefore she no longer has a project.

The therapist responds with a subsequent question **(lines 33-35)**, in which he recycles part of the patient's utterance, formulating what the patient has just said (see Antaki, 2008)[22]. The rising

intonation raises curiosity about the patient's proposition, making relevant further expansion of the meaning of her utterance, as opposed to just confirmation. By coming back to the patient's reasoning, and in the context of her troubles telling, the therapist is treating the patient's perspective as not an obvious or inevitable view of the situation. The therapist's formulation of the patient's reasoning, together with marked curiosity, makes the question slightly challenging. This time the therapist is in a more knowledgeable position about what the answer is, proposing a candidate meaning and yet still querying it.

After some initial delay, the patient provides a confirmation response, which also edits the formulation slightly (lines 37-40). The patient then goes on to re-emphasize how she feels that she is going to die, said with hearable upset (line 41: wobbly voice, line 44: wet sniff)[23]. This culminates with a challenge to the therapist (lines, 50-51), in which she proposes, through the negatively polarized question, that her view does not make sense to him. She even upgrades her challenge from a yes/no interrogative about understanding to a declarative in which she claims he doesn't understand (lines 50-51).

The patient's challenge provides evidence that the meaning expansion enquiry has invited the patient to consider an alternative perspective concerning her illness trajectory and end-of-life. This is in the form of evidence source A, outlined above: the patient is explicitly orienting to the therapist as problematizing her perspective by not understanding her negative feelings. We also see evidence source B: the alternative perspective is subsequently asserted by the therapist in third position (lines 59-62).

The questions can be seen as preliminary moves, providing the patient with the opportunity to expand on the assumptions underlying her perspective that no treatment is equated to giving in. In doing so, they provide an opportunity for the patient to consider her explanation differently, rather than the therapist explicitly proposing the alternative perspective first. By eliciting the patient's assumptions, the therapist is also able to more effectively problematize her perspective subsequently. Since she has equated not receiving treatment with giving in, he is then able to separate these two possibilities as not directly related. In doing so the therapist fosters the possibility of alignment with the patient; one of the affordances of the perspective display sequence, where the recipient's perspective is elicited prior to the delivery of news. [24]

In the next extract, we see further evidence that the meaning expansion enquiries can be treated by the patient as both: 1) simply seeking expansion, and 2) problematizing the patient's perspective. The patient has been describing how she went to see the palliative care team with her family and that it was very reassuring. The patient goes on to report one big difference she found compared to her oncology care, was the orientation towards health and functioning as opposed to disease progression.

Figure 2 (Session 7: Palliative care services; 12:04-14:23)

Here, the patient expresses the perspective that "everything depended on the…scans" (line 10), which is subsequently contrasted with the perspective put forward by the therapist (lines 77-79), that "paying attention to your body….would determine what you would be doing now?" In lines 1-2, the therapist invites the patient to expand on the difference the patient had noticed between palliative care and her normal oncology care. The patient goes on to report how she came to realize how palliative care focused on health, functioning and listening to your body, rather than relying on scans to focus on disease progression **(lines 4-38)**.

At this point, the therapist delivers a meaning expansion enquiry (lines 40-43), seeking expansion of what the patient had meant about the scan results. Again, the patient's talk is recycled, although note that the reported speech has actually been edited from "everything depended on the…scans" (line 10) to "I have to wait until the scans" (line 40). In doing so, the therapist addresses a

specific aspect of depending on the scans which hasn't yet been elucidated; the implications of the scans for how the patient lives her life now, as opposed to just interpreting disease progression. The patient has specifically been invited to **articulate** the meaning of her utterance by specifying 'what' she meant. The therapist's question raises curiosity with the patient's reported concern with waiting for scan results. In doing so, it invites the patient to consider the assumptions in this perspective, implicitly introducing the possibility of additional ways in which the situation might be viewed; of not relying on scan results.

A candidate is offered **in line 43** but is then cut off, **as it is said in overlap: "I** have to wait until s-.". The patient responds by specifying the 'what' in the question **(lines 44-45)**. The therapist then continues his questioning of the patient's meaning, seeking further expansion on the implications of the scans for her conduct (lines 47 and 50). The question in line 47 is responded to again as a mere question; the 'what' is specified **(line 49)**. The question in line 50, however, is responded to quite differently, and again we see evidence that these meaning expansion enquiries invite the patient to explore an alternative perspective.

First, we see evidence source A for the function of the meaning expansion enquiry: the patient expands on the implications for her conduct in a way that justifies relying on scans**, therefore heading off any implied problems with relying on scans. She does this by emphasizing** the extent to which the scans matter, rather than just specifying in what way they matter: "We:ll one thing that< (0.2) it matters a lot to…" **(line 53).** This justification work seems to orient to the question(s) as raising a potential problem in her basis for relying on the scans. Indeed, the close succession of the questions; latched on to the patient's talk, seem to build them as potentially challenging. After the patient has expanded on the perspective of waiting for the scan results more fully, the therapist goes on to more explicitly problematize her perspective, providing evidence source B for the function of the meaning expansion enquiry. In doing so, he incorporates her expanded perspective, affiliating with that approach first (**lines** 68-75), before emphasizing an alternative approach of paying attention to her body to determine her present conduct (**lines** 75-79).

The meaning expansions worked here as preliminary moves, providing the patient with the opportunity to expand on the implications of the scans for her conduct, before the therapist more explicitly proposes something different; that her current functioning rather than the scans should determine what she does. In this case, the patient's expanded perspective was utilized by the therapist through his validation of her perspective that scans are important for making decisions about further treatment (line 72). Again, this enables the possibility of alignment with the patient; one of the affordances of the perspective display sequence. [24]

The next extract shows how a meaning expansion enquiry can again be treated as problematizing the patient's perspective, this time through an orientation to the implications for future conduct. The therapist has been emphasizing the importance for the patient of prioritizing the potential loss of her well state, when making decisions about clinical trials. This is consistent with a previously expressed view of the patient, who **previously emphasized** that she wants to do things now while she can.

Figure 3 (Session 6: Extract 8 – Clinical Trials; 26:00-26:52)

Here, the patient's expressed perspective is that she won't be able to "hop off" (from the trial) "at any point" (line 16). The therapist subsequently introduces a contrasting perspective, that she should be able to make decisions about whether she should commit to trials more broadly (**lines** 35-54). **We join the sequence where** the patient raises a problem that the trial will soon prevent her from doing the things she would like to do **(lines 1-8)**. The patient's objection that follows (note the 'but' in line 11), seems to make a contrast with the concerns that she and the therapist have raised about how she is

spending her time. She proposes (metaphorically) that she feels unable to bring a halt to the clinical trial now that she has committed to it **(lines 13-18)**.

The therapist's question in line 19 seeks clarification of the meaning of what she has just said regarding the extent to which she can "hop off" the treatment. Again, the therapist recycles parts of the client's talk: 'any' **and** adds "whole trajectory". This editing work, like in the last extract enables the therapist to bring attention to the extent of **the** patient's perspective for matters beyond the immediate trial commitment. The extreme case formulation "whole trajectory" together with the rising intonation, makes the question hearable as potentially problematizing her claim. By not treating the patient's claim as self-evident, the therapist's meaning enquiry invites the patient to expand on her assumptions that she is unable to stop the clinical trial at any time, implicitly proposing the alternative; that she can. In this case, the therapist invites the patient to confirm the proposed meaning. The question is negatively polarized to prefer a 'no' response, putting constraint on what the answer should be. As such, it problematizes the patient's perspective in a stronger way **than in previous extracts**.

What follows provides evidence that the meaning expansion enquiry invites the patient to explore an alternative perspective. The patient responds with a "no", but she claims agency with "I wouldn't say that", as opposed to a straight forward 'no' **(line 21).** She treats the question as more than a straight forward enquiry and one that is implicitly problematising her assumptions about the future, by making relevant her continued commitment to the trial, rather than just providing confirmation or disconfirmation (lines 23-24). This provides evidence source A. Furthermore, the third position accountability work of the therapist, in which he demarcates the parameters of decision-making he was referring to, retrospectively treats the question as indeed problematizing her assumptions (lines 25-49), providing evidence source B.

The questioning format nevertheless invites the patient to consider the limitations of her assumptions about the future, without making her directly accountable for them. That is, the patient is invited to clarify what she means by providing an answer to the question, as opposed to more explicitly resisting or accepting an explicit challenge. In this way, the question can be seen as a preliminary move in which the patient has the opportunity to consider the underlying assumptions to her perspective, before the therapist more explicitly problematizes the broader assumption that she can't make decisions to stop treatment.

The final extract provides a more subtle type of evidence that the therapist has invited the patient to explore alternative perspectives. The extract comes later on in session 5, following extract 1 above. The patient has been describing to the therapist how she feels she should "give in" and accept that she is dying because she has limited options now for managing her illness. They have just been discussing the possibility of a clinical trial and the need to carefully weigh up the potential benefits and risks of doing it.

Figure 4 (Session 5 – communication with my network; 16:45 – 19:17)

Here, the patient reports her wish to tell her loved ones positive news, despite the bad news she has been given about her cancer. The perspective introduced by the therapist is that she "almost…worry(s) more about other people" (lines 90-91) – the implication being that this might be problematic. The therapist initially responds to the patient's expressed concern by seeking clarification for the reasoning behind her desire to offer positive news (lines 27-29). Again, there is recycling of the patient's turn: "you want it" (line 27), which resembles "I'd like to" (line 21). Theimplicit contrast with reasoning that is marked as "obvious" (line 28) and the rising intonation at the end of his turn, underscores the

perspective as novel rather than inevitable. After minimal uptake from the patient, the therapist offers a candidate reasoning, seeking further clarification (lines 32-33). In questioning the patient's reasoning again, and using rising intonation, the therapist is treating the patient's perspective as not an obvious or inevitable view of the situation. Furthermore, the emphasis on "them" builds an implicit contrast with "her". As was the case with the previous extract, the therapist is seeking clarification of the patient's meaning which is framed as dubious. This again therefore puts interactional constraint on a 'no' type response.

The patient responds by reporting on her strong negative feelings regarding her friends and family being discouraged (line 35). In doing so, she confirms the therapist's proposed meaning while providing a rational for it that justifies her concern. She then continues to emphasize how she hates discouraging them, and following a number of pauses and inbreaths, she self-repairs and goes on to describe the extent of the problem; it's "a lot of people" who are going to feel discouraged **(lines 35-39)**. The smiley voice, interpolated laughter in "people" and post-position laughter "eh hnh hnh" (line 39), all do work do modulate this claim. [25, 26] In doing so, the patient demonstrates an awareness of a potentially problematic perspective, justifying her concern whilst also downplaying the extent to which she sees her loved ones' discouragement as a real concern. This provides evidence source A for the claim that the question is inviting the patient to consider an alternative perspective.

The patient then reports on evidence of how a close friend had actually demonstrated the opposite; she wasn't discouraged by the bad news **(lines 41-82)**. The focus becomes on how the patient is able to cope rather than on how she does not want to discourage her friends. The therapist agrees with the patient, before going on to more explicitly challenge the patient's assumptions for communicating with her friends and family (evidence source B), by making an observation that casts it in a negative light (89-91). Worrying about other people, whilst being an altruistic action, is nevertheless also presumably problematic when you are the one needing help. So, by using a question which invites the patient to expand on her meaning, the patient is given the opportunity to expand on the assumptions underlying her concern for other people first and is only subsequently made accountable for that perspective.

In summary, we have shown how the therapist uses questions that enquire about the meaning of a patient's utterance, to introduce an alternative perspective by implicitly problematizing or casting into doubt the premise that the assumptions being made about the future, are the only ones available. As such, the patient is invited to mentalize in that her perspective is not treated as a fact but as one possible way of thinking. The patient's perspective is not invalidated or discounted explicitly. Instead, an answer to the question is made relevant next, with an opportunity to expand on and consider differently, the assumptions being made about the future rather than either resisting or accepting a challenge. The questions can be seen as preliminary moves, providing the patient with the opportunity to expand on their view, before the therapist more explicitly proposes something different. The alternative perspective, when explicitly presented, can then be tailored in a way that incorporate the patient's expanded perspective (as in extracts 1 and 2). That the patient can and does treat the meaning expansion enquiry as either problematizing her perspective, or **as** just a mere enquiry about meaning, highlights the affordance of these questions as being viewed on the surface as neutral, whilst also having the potential to very subtly challenge the patients' singular assumptions about the future.

Discussion and conclusions

Discussion

Inviting patients with advanced cancer to reconsider their understanding and assumptions concerning their illness trajectory and relating to their end-of-life, in particular, can be challenging. The analysis reported here shows some of the subtle moves made by one therapist to explore such alternative perspectives with a patient. The sequences in which the meaning expansions arise can be considered as perspective display sequences, [24] through which the therapist elicits the patient's perspective (their assumptions about the future) before delivering**, in this case,** an alternative perspective (rather than news). The affordance of the perspective display sequence is that the alternative perspective, when explicitly presented, can then be tailored in a way that incorporates the patient's expanded perspective (as in extracts 1 and 2). This device is especially useful in contexts where caution might be needed, as in the case of delivering diagnostic news about a child's developmental disability. [24] Here they provide the therapist with a way of exploring the patient's understanding and assumptions about a future that is relatively unknown and limited, allowing for different perspectives to be arrived at slowly and collaboratively. They can be viewed as preliminary and subtle moves that in themselves implicitly problematize the patient's narrowly constructed assumptions about the future. The premise that meanings are personally constructed rather than inevitably determined by objective events, opens up the possibility of other perspectives. Such questions can be designed to be more or less neutral in this regard, whilst still only making an answer relevant next as opposed to having to deal with an explicit challenge.

Similarities can be identified here with Butler et al's (2009[27] (see also Shaw et al., 2015 [28]) study of advice-giving on a children's helpline. They showed how advice was given implicitly, through the use of questions that made an answer relevant next, as opposed to requiring acceptance or rejection of explicit advice. Questions in themselves can more explicitly challenge the recipient, as has been shown with yes/no interrogatives[29] and 'wh' questions,[30] when the questions are treated as unanswerable challenges. In such cases, the answer is deducible from the prior talk, and so the questions are treated as assertions. The questions here, by contrast, display less knowledge about what the answer is, and, although they may be calibrated to display more knowledge, they are still not treated as unanswerable challenges.

The affordance of these implicit moves is illuminated when compared to explicit therapeutic challenges. Weiste (2015) looked at therapists' disagreeing turns in audio-recorded psychotherapy sessions .[31] The disagreements were regarded as supportive when the patient's personal experience was validated and unsupportive when the therapist discounted the patient's perspective and maintained a divergent one. Patients tended to respond to the latter with irritation and anger. Such interactionally problematic responses highlight the risk entailed in explicit challenges. Studies have shown that validating or empathising with the patient may ameliorate such potential problems (see [31] [32]). The alternative risk, is that the subtler question forms (e.g. **Figures 1 and 2**), may become missed therapeutic opportunities. However, even when the patient does not treat a question as inviting exploration of an alternative perspective, **the question** may still invite expansion and therefore encourage patients to explore their perspectives more fully. Indeed, in exploring their assumptions more fully, the therapist may then be able to more effectively problematize the patient's perspective, as in extract 1.

In CALM therapy, the therapist aims to help patients become aware of multiple perspectives, and to sustain multiplicity or so-called double awareness.[1] The 'not knowing stance' in which the therapist does not claim a greater position of knowledge about the patient's experiences or about the optimal course of action, is a position taken by mentalization-based therapies more broadly.[33, 34] In such therapies, the therapists use the approach of active questioning to explore the patient's perspectives, ensuring not to invalidate their experiences. [33, 34] The questions in the present study are comparable to those in the early stages of therapy, where the therapist first attempts to be supportive and seek clarification and elaboration of the patient's perspective.[33] By using CA, we have

shown how these preliminary questions can implicitly introduce an alternative perspective, inviting the patient to mentalize; an intervention that has typically been considered to be appropriate only at a later step in the therapeutic process [33].

Limitations

The analysis is based on a limited collection of data, although it provides evidence of a robust pattern. The identification of a method and how it works, as in the present study, is a recognised first step in analysis, and the regularity of that practice would be a next step in continuing research. [17] The data is based on analysis of just one therapeutic dyad, which raises questions about the generalizability of the findings. However, the data are considered by the therapeutic team to be exemplary in terms of the mentalization sequences within **them**. The practice identified is also comparable to that which has been found in paediatric consultations,[24] providing support for its applicability to practices across different settings. [35] Although many of the major ideas and theories associated with counselling and psychotherapy have been created and empirically demonstrated through case study research (e.g. [36]), future research should investigate this practice more broadly, identifying further dimensions that may be pertinent.

Conclusion

This study demonstrates that CA can be used to elucidate the way in which mentalization can be elicited and supported in therapy at the end-of-life. The findings illuminate the subtle ways in which one CALM therapist was able to introduce a patient to alternative perspectives relating to their disease progression, by inviting the patient to expand on the meaning of **their** utterance**s**. **Through meaning expansion enquiries, the therapist was able to** raise alternative perspectives without explicitly objecting to the patient's understanding and assumptions about the future and making her explicitly accountable for them. Furthermore, by inviting the patient to expand on and weigh up her understandings and assumptions without imposing an explicit challenge to them, the therapist was able to facilitate the patient's consideration of alternative perspectives about an unknown and limited future. The skillful work of these questions is evident in view of the particularly delicate arenas that they are navigating. There is risk, on one hand, that such maneuvers will invalidate the patient's perspective through a challenge, and on the other of missing a therapeutic opportunity by not making alternative perspectives available to the patient for consideration. That these sequences were brought off with minimal interactional trouble in the particularly delicate context of end-of-life talk, is testament to the success of this titration.

Practice implications

For professionals communicating with patients at the end-of-life, these findings provide important and novel insight into a challenging but rewarding therapeutic conversational maneuver of inviting patients to consider their treatment options and end-of-life from alternative perspectives. This paper identifies how this can be done in a subtle and collaborative way without **invalidating the patient's perspective** The paper also provides important insight into how the process of mentalization is facilitated in therapy, with broad relevance across diverse clinical settings.

Role of funding

The research was supported by the University Health Network Department of Psychiatry (G.R.) and partly funded by the Canadian Institutes of Health Research (CIHR #MOP 106473). It was also supported by the Princess Margaret Cancer Foundation Hertz Centre Fund, the Campbell Family Cancer Research Institute and the Ontario Cancer Institute at Princess Margaret Cancer Centre, and by the Ontario

Ministry of Health and Long Term Care (OMOHLTC). The first author was supported by a research fellowship within the Global Institute of Psychosocial, Palliative and End-of-Life care (GIPPEC). The funding bodies played no part in the conception, design, analysis or preparation of research outputs.

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Figure 1

```
1 P:    >It feels like< I just have to give in: (0.2) an' l:~et
2       (0.3) things take their cou:~rse.
3       (1.2)
4 P:    <Unless, (0.2) >I mean-< (.) I- ↑I mean I don't↑ (0.2) know
5       why: (.) °I don't, [hm°]
6 T:                        [ hh]h.=
7 P:    =.hhhhh HHhh.
8       (1.3)
9 T:    What does that mean?=Giving in.=What does that mean.
10      (.)
11 T:   .hh[hh ]
12 P:      [tch]
13      (0.6)
14 T:   h[h. ]
15 P:    [I c]an't, (0.9) .pt work a:t (0.9) treatment. hh.
16      (0.3)
17 P:   An'- (.) an fixing i~t, (.) an' making it (0.7) it better.
18      (1.7)
19 P:   This .hh you know I had, (0.2) because- (0.4) you know,
20      (0.5) that (1.4) clinical trial (0.3) .hh was~: (0.3) a part
21      tim~e, jo:b, in which my jo:b (0.3) .hh was: to do
22      everything I (0.3) could, (0.2) .hh to (.) kind of (0.5) urm
23      (1.0) impr↑o:ve (0.2) .hhhhh what otherwise would have
24      happened °to us kin' of° (0.5)
25 T:   .hh=
26 P:   =°the [.hhhhh°] quality improvement °project.° hh.
27 T:         [ hhhhh.]
28 P:   °(if) you like, [.HH[ .snff]
29 T:                    [.pt[  S-  ] (0.3) [mm ]=
30 P:                                       [But]
31 T:   =hhhh.=
32 P:   But I don't have a project °now.°
33 T:   .HH So having chemotherapy, means not giving in:, (0.6)
34      °#hn#° and .HH n:ot having chemotherapy means you're giving
35      in?
36      (4.4)
37 P:   Uh:: (0.5) yeah.=I make a distinction between: (1.3) clinical
38      trials an' chemo' °yeah.°
39      (0.2)
40 P:   But that's >probably< (0.5) °u° splitting hairs.=Yeah, it is
41      how it °feels.° .hhh But- (0.5) °u-° (we~ll) hh. (0.9) .PThh
42      (3.5) yeh.
43      (0.6)
44 P:   °snff°
45 P:   But then:, (4.6) I can't.
46      (1.6)
47 P:   I have to, come to terms with, an' accept (0.8) that (1.0)
48      °I'm (0.3) gonna °die.°°
49      (0.2)
50 P:   That I'm ↑dying.=Yeah.=↑That's what it feels like  I- (.) does
51      it- (.) it doesn't make s↑ense to you?  eh hih [.iHH]
52 T:                                                  [ .HH]
```

```
53 T:     Well it [d↑oes] an' it doesn't.=I- I understand that it=
54 P:             [ .HH ]
55 T:     = would feel better obviously, you'd feel better an' (.) be
56        more encouraged, .hhh if the treatment was having (0.2) an
57        effect.
58 T:     .hh Or better effect.=°I- I understand that.° .hh (0.2) but
59        °u-° u-urm:: (3.2) you know whether a drug is a good idea or
60        whether it helps, .hh is sort of an empirical thing, (.) I-
61        I think when you .hh (0.2) talk about giving i:n (0.2) ur:
62        .hh (0.2) that's a psychological thing. hm.
63        (0.2)
64 T:     .hhh .pt An I think the challenge now is to shift the idea
65        of a project.=A >part of me as I say< doctor James will .HH
66        (0.2) °an will° advise about the chemoth↑erapy but I- I
67        think it means .HH sh- (0.3) shifting the project (0.2) to:
68        .hh you. hm
69 T:     An' helping you be as well as you can, .hhh .pt whether or
70        not you're receiving °chemotherapy.°
```

Figure 2

```
1 T:  =.hh Explain to me how you noticed the difference.
2     [What are you-] what you're spe[cifically] referring to.=
3 P:  [  >Okay.<    ]                [ So:     ]
4 P:  =I think (0.4)
5 T:  ((cough cough))=
6 P:  =A:t one, (0.6) one (0.2) at one point, (0.2) ur:: (0.4) I- (0.7)
7     was telling her that [(0.8)] I was (.) uncertain about my future.
8 T:                       [.hhhh]
9     (0.5)
10 P: An' that everything depended on the: °ur::° (.) scans which I
11    [won't have [until for a [few wee]ks, an' .h[hh   ] and (0.6)
12 T:[   Mm:     [   right    [ right ]          [right]
13 P: she said to me< (0.2) 'but how are you f:eeling.'
14    (1.0)
15 T: [Right. ]
16 P: ['I fee-] feel grea:t.=I have no symptoms.'=She said, .hhh '>well<
17    (1.4) you have to pay attention to your (0.2) body.
18    (0.5)
19 P: Too.'
20    (.)
21 T: R:i[ght.      ]
22 P:    [>You know<] it's telling you something.
23    (0.6)
24 P: About, (0.4) the extent to which (.) if things are progressing,
25    how far they're progressing or how fast they're [progressing,]
26 T:                                                [    Yes,    ]
27 P: because there hasn't been any ch↑ange.
28    (.)
29 T: Right.
30    (0.4)
31 P: Ur:: (0.5) [a:n']
32 T:            [.hhh] hhh.=
33 P: =it- (0.4) i- (0.3) it's she feels it's not like the scans are not
34    important >but< (.) the scans are really important if you're
35    focused on the disease progression.
36    (.)
37 P: But (0.4) w:e don't pay as much attention to the scans, what we're
38    interested in is your functioning.
39    (0.3)
40 T: .HHH So wai- when you said to her 'I have to wait until the scans,'
41    (.)
42 P: (Yeah)
43 T: You meant I have to wait (.) for wha- <'I have to [wait until s-']
44 P:                                                  [   To   kn↑ow]:
45 P: what my future i:s.=[An' where I'm at.]
46 T:                     [An'   the-    eu-]=
```

T: **=An' what would you be basing on the scans.**
(0.4)
P: Whether the disease is progressing or not.=
T: **=.hh An' therefore what.**
[(0.4)]
T: [hhh.]
P: We:ll one thing that< (0.2) it matters a lot to is whether I go onto the second course (.) of the: (0.2) trial.
(0.3)
P: So there's a s:econd cour↑:se (.) that they: recommend, if it's working, (0.6) uh: (0.2) that (0.4) I'd go <I'd have two more infusions .hhh uh: (0.5) maybe a third course I mean they continue that treatment depending o:n the: (0.8)
[the: (0.3) the results] of it.
{ movement during }
(0.8)
P: Um (0.3) and if: (0.5) if it's progressing: (0.3) we'll forget tha:t an' we'll (0.2) you know (0.7) probably (0.4) um (0.2) then (0.3) not have another option.
(0.8)
P: Um (1.0)
T: .HH[H [So it's] kin' a interesting there's these two different
P: [So [that's:]
T: ways, .hh (0.2) that- >that are both important.<=They need to know the scans, to know what is the effect of the: .hh treatment, an' to decide about the next treatment, .hhhh °a-° which uh- I [unders-] (0.2) [influ-]
P: [Which] (0.2) [affects] me.=
T: =Of course it does. .hh (0.3) an' that's important, °uh° but uh:: .hh (0.5) I th↑ought you were gonna say something slightly different which i:s tha:t .hh °u::° uhm (0.3) about paying attention to your b↑ody .hh (0.6) that's (0.6) isn't that how you would determine .hh (0.5) what you would (.) be doing now?
P: Yes.=
T: =Terms of your life?

Figure 3

```
1 P:    .pt And .hh (.) there will be (.) a period of at least a
2       week an' maybe two (.) where [I'm not] gonna feel [well]=
3 T:                                 [   mm  ]            [ mm ]
4 P:    =from this treatment I'm pretty [sure. .H]H (.) you know=
5 T:                                    [   mm:  ]
6 P:    =jus'the way=they describe it an' [I- <I] would (0.2) doubt=
7 T:                                      [  mm ]
8 P:    =(0.2) that I'm= gonna be able °ta° (0.3) .hhh so hhh.
9       (8.2)
10 T:   .HH [.pt ]
11 P:       [ But] .mhhh=
12 T:   =<So #I- I- I-# [(0.3)[ I thi-]
13 P:                   [ .HH [It's a ]trai:n: (.) Simon it feels
14      like a train that ha' left the station.
15 P:   An' it feels- (.) that's what it feels like for me '>I's I's
16      like<' I'm not gonna be able to hop off at any point.
17      (.)
18 P:   An'- (0.9) °I-° (0.7)
19 T:   At any point in the whole traj↑ectory you mean?
20      (.)
21 P:   .hh Well no I wouldn't say tha:t.
22      (.)
23 P:   But (0.7) you know I probably, (0.4) I- I- I will (.) I'll go
24      through with this:[:  ] [(              ) [Yeh.]
25 T:                      [.HH] [No I- I understand [that]
26 T:   an' I'm [not ] really talking a[bout this] trial.
27 P:           [Yeh.]               [   Yeh.  ]
28 T:   [.hh]
29 P:   [.hh] (0.2) Okay.=
30 T:   =°#Uh:# uh because I- I underst↑and you [made a] decision.=
31 P:                                          [ Yeh. ]
32 P:   =Yeh.=
33 T:   =Uh:[:   ]
34 P:       [°Yeh.°]
35 T:   .hh (.) An' that- [there's] no perfect decision you're=
36 P:                     [ But-  ]
37 T:   =having to- [there's] tradeoff's [either ] way, I'm- I'm=
38 P:               [  Yeah.]           [°Yeh.° ]
39 T:   =just w- I'm= thinking, .hh (0.2) ahead and more
40      broadly:.=[>A< just] about=
41 P:             [  Yeh.  ]
42 T:   =the whole question I- .HH ↑just that I:: (.) I: uhm: (0.2)
43      .hhh 0.3) I- my view is that it ↑is a decision.
44 T:   That you should make.=I'm not (0.2) argu[ing ] as to wha-=
45 P:                                          [Yeh.]
46 T:   =which de[cision] it should [be,  ] but that, =.hhh °uh:°=
47 P:            [ Yeh. ]           [Yeh.]
48 T:   =the idea that there's nothing to think about is- may not be
49      the case uh=
50 P:   =Yeah.=
```

```
51 T:      =.hh [That ] it's a decision that you should make, an' .hh
52 P:           [Yeah.]
53 T:      (0.4) taking the kinds of things we're talking about into
54         accou:nt [>°you know.°<]
55 P:               [   °Yeah.°   ]
```

Figure 4 NEW

```
1 P:    .HHH See the ↑other thing that °I° have to manage (0.2) is:
2       (1.0) uh: hh. (0.6) communicati(h)on with .hhhhh my network
3       an' °my loved ones so that was° going o:n, (0.8) I
4       [had (0.3) <dec↑i[ded yesterday I had this] pla:n, .HHH uh:
5 T:    [ .H  H  H   H  H[    H   H   H    H    H.]
6 P:    I'm just gonna tell the people, (0.3) closest to me:, (0.3)
7       and others I'll w↑ai:t (.) until I can tell the:m, (0.3)
8       .hhhh what< (1.0) the future m: (.) might bring.=What the
9       options °might be. h[h.° ]
10 T:                        [tcha] What is it that you would tell
11      them then.
12      (0.2)
13 P:   .HHhh I- (.) °↑I'd like to give them↑° (0.4) something:
14      (3.8) °hopefu- hopeful.°
15      [(1.1)              ]
16      {tap on table during}
17 P:   About, [    (0.7)    .hh     ] a treatment, (0.3) that
18             {squeaky/leather noise}
19 P:   mi:ght, (1.8) give m~e m~ore °t↑i:~me.°
20      (0.3)
21 P:   That's what I'd like to be able to say to people.
22      [(.) ]
23 T:   [.hh ]
24 P:   >'Cause I thi-< <guess that's what I wanna know.
25      (0.2)
26 P:   .hh hh. (0.2) Uh (0.5)
27 T:   .HH But this is out of cons- I mean I know that you want it
28      obviously but this is out of consideration for them, as
29      well? .hh/(0.3)
30 P:   >mhm<
31      (0.4)
32 T:   You don't want them to get (.) discouraged. °Is that what
33      you mean?°
34 T:   .hhh hh. mm hh. HH. .hhhh=
35 P:   =tcha I h↑ate that*.
36      (0.3)
37 P:   .HHH (0.3) I h↑ate- (1.5) .hhh (2.3) tcha shhhh. (1.2) HHhh.
38      (7.3) there's a lot of £peop(h)le >who are< (0.2) gonna feel
39      discouraged.£ eh hnh [hnh >it's a<] (1.4)=
40 T:                                [    mm:    ]
41 P:   =.sHHH (0.2)/{click noise} although, (2.2)/ {some mouth
42      noise during} one of my (0.3) dear friends (.) called me
43      this morning (0.6) 'cause she knew I- (0.2) >got
44      [an appointment °yesterday.°< ]
45 T:   [    .H    H    H    H    H   ]HH  HHHHH. mm,
46      (0.4)
```

```
47 P:    tcha .hh (0.3) An' she said to me tha~t .hh (1.0) she
48       didn't- (0.2) she was (0.8) °she was° really (0.5)
49       dis'ppoin'ed (.) an' she was~: (0.2) s:ad for me: but that
50       she [w↑asn't]
51 T:        [  mm   ]
52 P:    (0.3) .hhhh (0.3) °distressed° (0.6) ['cause she] kn↑e↓::w,
53 T:                                          [   mm    ]
54 P:    (0.8) that we (w)- (0.2) would be able to (0.3) deal with
55       whatever: (0.7) we have to.
56       (0.8)
57 P:    An' that we've proven that in the past, (0.5) my family has,
58       I have,
59       (0.2)
60 T:    That you can cope.=Is that what you [mean?    ]
61 P:                                        [>That we<] can cope.
62       (.)
63 P:    Yeah.
64 T:    [An' that] we will cope, an:' sh[e said] (0.2) .hhh
65 T:    [  Yeah  ]                      [Yeah  ]
66 P:    you've (0.5) you~'ve do~ne s↑uch (0.3) an amazing job of:
67       (0.4)
68 T:    Right
69       (0.5)
70 P:    Of: (0.7) finding[:     ]
71 T:                     [((cough] cough))=
72 P:    =the (0.7) good. ih a~n' uh~ (0.2) a~nd l↑ivi~ng (0.9) as
73       best you ca:n,=
74 T:    =mm:
75 P:    Even despite °everything.°
76       (0.2)
77 T:    mm
78       (0.3)
79 P:    An' you'll keep doing °that.°
80 P:    >An' it-< (0.4) °I° [↑↑kina] hh. (.) °I° kina ~know that's
81 T:                        [  mm  ]
82 P:    probably [↑true.]~
83 T:             [  mm  ]
84       (.)
85 T:    mm
86       (1.3)
87 P:    HHhh.
88       (0.3)
89 T:    .HHH Since your- I agree with that (.) observation but .HH
90       >it's also< interesting to me that and a- that ↑almost you
91       worry more about other people than your[se(hh)lf.].hh]hh
92 P:                                           [     .H H] hh]
```