**Title: Inviting end-of-life talk in initial CALM therapy sessions: a conversation analytic study**

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**Abstract**
*Objective:* To examine how end-of-life talk is initiated in CALM therapy sessions with advanced cancer patients.
*Methods:* Conversation analysis was used to systematically examine the sequences where talk about death was raised in the first sessions of ten patients.
*Results:* Open questions about the patients' experiences, feelings or understanding in the context of talk about their troubles, were found to regularly elicit talk concerning end-of-life. These questions were designed in ways that invite patients to discuss troubling aspects of their cancer journey, without making discussion of this topic an interactional requirement. That is, the interactional work required to not engage in such talk is minimised. This choice is provided through the open question design, the degree to which negative feeling descriptors are specified, and the sequential context of the question.
*Conclusion:* The analysis shows that therapists provide patients with the opportunity to talk about end-of-life in a way that is supportive of the therapeutic relationship. The readiness of patients to engage in end-of-life talk displays the salience of this topic, as well as the reflective space provided by CALM therapy.
*Practice Implications:* The results provide important insight into the process of CALM therapy, which can be used to guide training.

**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 work was carried out at UCLH/UCL within the Cancer Theme of the NIHR UCLH/UCL Comprehensive Biomedical Research Centre supported by the UK Department of Health. The funding bodies played no part in the conception, design, analysis or preparation of research outputs.

## 1. Introduction

Patients with advanced cancer are faced with multiple and profound challenges related to their illness. These include the requirement of dependency, fear of suffering and vulnerability, and the anticipated foreshortening of their life.[1] Managing Cancer and Living Meaningfully (CALM) is a therapeutic approach, uniquely designed for individuals and their partners facing advanced cancer, intended to alleviate distress and promote psychological growth.[2] The CALM intervention is an attachment-based supportive-expressive therapy with specific attention to four domains 1) managing symptoms and navigating the health care system; 2) understanding how the disease has changed self and relations with close others; 3) spiritual meaning and purpose; and 4) future, hope and mortality. [2]

CALM therapy is semi-structured: "the sequence and relative emphasis on each domain varies, depending on their urgency and relative importance in each case." [2](P4) Patients are informed at the beginning that these domains will be addressed. Death is typically raised by the therapist indirectly through reference to the future. CALM optimally consists of six sessions, approximately 45-60 minutes long and delivered over three to six months. It is intended for patients with a prognosis of 6-18 months, focusing as much or more on living as on the end of life. [2]

Phase 2 trials have shown promising results, demonstrating the feasibility and effectiveness of CALM in improving depressive symptoms, death anxiety and spiritual well-being. [3] In qualitative interviews, patients report that CALM provides "a safe place for them to explore their fears, to be seen in human terms, and to face the challenges and threats of advancing disease", as well as giving them "the permission to talk about death and dying". [4] However, research is needed to understand in more depth and with more specificity, the process of CALM therapy and the mechanisms by which it may effect change. In particular, research is needed to identify *how* therapists effectively broach the sensitive topic of death. Such insight would provide an important evidence base to guide training and knowledge translation.

Conversation Analysis (CA) is a method used in the social sciences to study the organised ways in which people communicate with one another. It is a rigorous and systematic approach used to explore the conversational practices of health care professionals. [5, 6] CA provides a method for exploring the moment-by-moment unfolding of conversations, capturing the details of how talk is produced, including volume, emphasis, speed, and overlap. [7] As such, the method is particularly fitted to the task of exploring *how* talk about death is introduced and the implications for the unfolding sequence of talk.

A recent systematic review identified the potential utility of CA in exploring communication about disease progression and end of life, but few studies have systematically examined this phenomenon. [8] Lutfey and Maynard (1998) examined how doctors break the news of a terminal diagnosis to cancer patients. They found that doctors did so without using the words 'death' and 'dying', and tailoring their explicitness to the patient's responsiveness. [9] Perakyla (1995) used CA to study AIDS counselling at a time when prognosis was poor. However, the topic of death was not necessarily a therapeutic focus in that intervention. [10] Pino et al (2016) focused specifically on end-of-life conversations between palliative care doctors and patients referred to a hospice for symptom management. [11] Both studies show how therapist questions are designed to invite talk from the patient, and in the latter, specifically about the end of life. This was achieved through questions that invited patients to talk about their thoughts and fears concerning specific described experiences.

Research into interactions where end-of-life talk is clearly initiated as a therapeutic topic is relatively absent from the literature, although such communication with health care providers is often valued by people affected by advanced cancer. [1] CA may have particular utility in understanding the nature and potential benefit of such interactions. [12] Studying how end-of-life talk is initiated in CALM

therapy may shed light on facets that are specific to CALM and on those that have broader applicability to end-of-life conversations.

The method of CA was employed to explore whether and how talk about end of life is initiated in first sessions. This study is part of a wider program of research designed to systematically examine the therapeutic approach of CALM.

## 2. Methods

### *2.1 Participants and procedure*

Data was collected as part of a Phase III randomised controlled trial of CALM at the Princess Margaret Cancer Centre. [13] The trial aims to establish the impact of CALM on distress related to dying, spiritual well-being, quality of life, psychological growth and satisfaction with care.

The therapy is delivered by social workers and psychotherapists. Sessions lasting approximately one hour were captured with a digital audio-recorder. Patients were eligible for the trial if 1) over 18 years; 2) fluent in English; 3) no cognitive impairment and 4) confirmed diagnosis of "wet" stage IIIB (those not treated with curative intent) or stage IV lung cancer, any stage of pancreatic or other stage IV (metastatic) gastro intestinal cancer, stage III or IV ovarian and fallopian tube cancers, or other stage IV gynaecological cancers; and stage IV breast, genitourinary, sarcoma, melanoma or endocrine cancers (all with expected survival of 12-18 months).

First sessions were selected in order to understand how death talk first emerges within the therapeutic relationship. In first sessions, the therapist typically introduces the four domains of CALM and gathers information about the patient. How therapists manage these multiple tasks whilst establishing a therapeutic relationship is of particular interest. Ten patients were purposefully selected who were randomised to receive therapy (147) over usual treatment (148). Sessions were selected to incorporate variation in: gender, age, cancer sites and therapists. A total of four therapists were included in our sample. A summary of patient and therapist demographics can be seen in figure 1.

Our therapeutically relevant starting point for analysis was to identify instances where death talk was first raised and then identify common features of how these instances were initiated. Any reference which we jointly recognized as alluding to the patient's death was counted; **these** included explicit references, such as 'death' and 'dying', but also oblique references such as 'all black'. We used this "loose, to-be-refined notion of the phenomenon" (Edwards, 2005: 7) [14] in order to honour vernacular and often implicit references that make a formal definition particularly problematic both analytically and therapeutically. Instances where death was mentioned by the therapist in the introduction to CALM were not included. The sequences of talk where these first mentions were produced were transcribed using the Jefferson Transcription System, a standard convention used in CA. [7, 15] CA requires that talk be analysed in the sequential context in which it is produced, and in terms of the actions being done and the implications these have for the unfolding conversation. [16, 17]

### *2.2 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.

**Figure 1: Table of patient demographics**

## 3. Results

Patients were aware that taking part in CALM therapy meant that they would be addressing issues related to death. For seven of the patients, the first mention of death occurred in the first 10-15 minutes of the session. The analysis of first mentions revealed that death talk was often topicalized by patients following open questions from the therapist about the patient's experiences, feelings or understanding. The unifying feature of these question designs is that they invite the patient to provide introspective or self-reflective descriptions of troubling aspects of their cancer story, or what Jefferson and Lee have referred to as 'troubles talk'. [18] Analysis shows patients tended to respond to these questions by making reference to their end-of-life.

### a) Inviting end-of-life talk through introspective open questions

In the first extract, the patient is starting to tell her cancer story.

Figure 2: Extract 1, F1064 – 02:08-04.49

The therapist acknowledges the patient's story (line 5 and 7). After a short silence, the therapist asks a 'what' question. This question invites the patient to expand on her cancer story by specifying the quality of her experience (her feelings and thoughts) in an unrestricted way. She is not invited to talk specifically about the troubling aspect of her diagnosis, although no doubt this is relevant, and the extent to which she should focus on the negative aspects is treated as optional. Indeed, the therapist does not presuppose any specific feeling states but instead enquires generally about her feelings.

The patient responds to the question with an extended description following some initial delay (the 'urm', pauses and in breaths in line 11). The question did not limit the patient to confirm or specify particular aspects of her feelings. Instead, she describes her experiences in an open way, engaging in further talk about her troubles. The patient even alludes to death by reporting being 'frightened to ask about some stuff' (lines 41-43), and in giving an optimistic projection: 'things can't be all black' (line 59). Relevant here is that the question has arisen in a context where the patient has been talking about her cancer diagnosis. In this context, prognosis and ultimately death is of relevance to the patient. It is perhaps this relevance that allows an open question to invite the possibility of talk about death.

In the next extract, the patient has just described his cancer history and the medication he is taking. While the medication has been successful in shrinking his tumour, he reports some trouble with the side effects.

Figure 3: Extract 2, M1120 - 06:07 - 07:07

In line 1, the therapist enquires about the length of time the patient has been on Sutent, and then proposes a candidate; an indefinite period. Rather than simply affirming with a 'yes' response, the patient provides further specificity; 'as long as I'm around.' In doing so, he makes reference to his end of life. The therapist responds with a news receipt (line 6), through the emphasis and stretch on 'really.' This displays a view that this would be difficult, in line with the patient's previous talk (not included

here). This and the pauses that follow (lines 7 and 9) provide the patient with space to expand further. After no uptake, the therapist asks an open question about the patient's feelings (line 10).

The 'how' question invites the patient to expand by making relevant a response with feeling descriptors, without specifically limiting the focus to something troubling. Indeed the therapist adds an increment; narrowing the focus of her question by inviting the patient to respond in terms of his side effects. Given the patient's previous reference, the patient's limited life span is still relevant to his feelings about the side effects in terms of the length of time he will have to endure them and ultimately the quality of his life that remains. However, it is not 'conditionally relevant' (see Schegloff, 1968).[19] That is, the question does not expect an answer that addresses his limited life in particular and the absence of this is not accountable or problematic. The open question allows the patient to give an extended and open response. After some initial delay (the 'um' and pause) the patient describes his feelings by making a comparison with what the alternative would be. While viewing being on the medication in a more positive light than alluded to by the therapist, the patient engages in talk about his poor prognosis and more imminent death, in terms of a comparison, should he choose not to take the medication. Again, it is perhaps the relevance of death in the sequence preceding the therapist's question that allows an open question to invite the possibility of talk about death, even when the question is targeted to an apparently less obviously related topic of side effects.

The next extract shows the degree of interactional choice that is provided by this question design, where the patient chooses not to focus on the troubling aspects of his diagnosis. It is a deviant case showing how these open questions provide the *option* of talk about death rather than providing an example of where death talk is raised.

Figure 4: Extract 3, M1104 (12.00-13.45)

The therapist re-formulates the patient's story, [20] focusing on his troubles i.e. that it took a while to diagnose and then acknowledges (line 4 and 6) the patient's confirmation, said in overlap (line 3). The therapist then asks a 'how' question about the patient's experience. This question again does not label any specific feeling descriptors and invites the patient to expand by reporting on his feelings in an open way. The therapist attempts to specify her question, but the patient interrupts the therapist's turn to reformulate the initial question. Again, the confirmed question provides the possibility of extended talk about the patients' troubles, without making this a requirement. We can again note that while death has not been mentioned, a cancer diagnosis was given where prognosis and ultimately death is of relevance to this advanced cancer patient.

The patient orients to the question as difficult to answer; note the delay via the repeat of the question, and silence on line 13. The response in line 14 is also prefaced with a 'well', treating it as non-straightforward to answer; [21] indeed the patient reports difficulty in demarcating the time when things became more serious (14-19). The patient claims to not be troubled by what happened: 'it was fine' (line 21), while, at the same time, flagging a degree of difficulty. This is achieved by marking a straightforward response as difficult (i.e. 'what can I say') and by using the post-completion laughter to modulate the strength of his 'no problem' response. [22, 23]

This example shows how the patient is able to provide a response that claims a non-problematic situation, while still flagging the situation as problematic to some extent. The key point here is that the question has invited an opportunity for talk about the patient's troubles, whilst not making it conditionally relevant. That is, the patient is not interactionally accountable for choosing not to give such a response.

**b) Modulating the interactional constraint of the question**

The following two extracts show how these open questions sit along a gradient of being more to less open. The first extract shows how the *sequential environment* can modulate the function of the question putting more interactional constraint on the response. We join the conversation where the patient has been talking about how her illness has affected her relationship.

Figure 5: Extract 4, F1136 (08.33)

At the end of the patient's complaint, the gist of which is that the husband is not treating her as if she is ill, the therapist questions whether she thinks her partner understands her condition fully. After confirmation that he probably does not, the therapist enquires, in a stepwise fashion, about what the patient herself understands. In line 9, the therapist explicitly refers to his own talk 'actually maybe I should ask you'; enabling him to not ask the question directly, while nevertheless making the question relevant to her. 'Maybe' also (line 9) mitigates the extent to which he is entitled to ask. After a slight pause from the patient (line 11), the therapist, in overlap with the patient, reformulates the patient's version of the question to a more open version: 'what do you understand.'

As in the previous examples, the open question design invites the patient to expand on her understanding of her medical condition. The question pursues the patient's understanding and feelings surrounding her condition, without targeting specific aspects of that understanding. The question, however, implicitly raises the possibility that she has some responsibility in the problem with her husband. This is conveyed through an enquiry which doesn't align with the complaint or treat the partner's problematic behaviour as independent of her. The question instead challenges the patient to consider an alternative understanding of the situation; inviting her to demonstrate the seriousness of her condition in order to head off the proposition that the problem lies with her. Given this sequential context, the question claims more knowledge or understanding of the situation than the questions in the previous extracts and thus puts more constraint on the type of response expected. [24] Again, this focus on the seriousness of the patient's illness makes relevant the patient's prognosis and end-of-life to the interaction.

The patient treats the question as slightly challenging. Her response is delayed with the silence and the 'well' that prefaces her acknowledgment of a serious cancer diagnosis (see Pomerantz, 1984) (line 16). [25] Her response may be regarded as a concessionary structure, [26] in which she displays some awareness of the seriousness of her condition, but then counters this with the positive way she feels. This interactional resistance provides evidence that the patient treats this question as more strongly inviting talk concerning the problematic nature of her illness. At the same time the question is effective in eliciting talk about the patient's troubles, in that the patient demonstrates an awareness of her prognosis and alludes to end of life, even though by a contrast that prioritizes her positive feelings (lines 23-24).

The next extract shows how the *design of the question* can be modulated to put more interactional constraint on the patient's response. In the following extract, the patient has been describing the drug trial he will be starting.

Figure 6: Extract 5, M1126: 35.00-37.35

The patient has described some troubles i.e. that the cancer might have metastasized. This advanced cancer diagnosis again raises the relevance of the patient's prognosis and ultimately his possible shortening of life. The therapist responds by acknowledging this information in a breathy and quiet voice, displaying some symmetry with the seriousness of what the patient has reported. After no response from the patient, the therapist enquires about the patient's feelings.

This question invites the patient to engage in further talk about her troubles. Again, it is not presupposed that the patient has negative feelings, because this is questioned rather than asserted. However, the design of this question more strongly invites confirmation of this. In particular, the therapist specifies a candidate negative emotion – 'feeling nervous' and makes relevant a yes or no response, rather than a description of his feelings in his own terms. [27] Notably, the question is prefaced with a 'so' positioning it as building on the recipient's talk, and therefore may provide the grounds for a more constraining question design.

The patient initially responds by implicitly proposing that the question need not have been asked through the use of 'of course' (line 12), [28] treating the answer to the question as something that should already be known. This nicely demonstrates the potentially constraining nature of this question design, which expects a 'yes' response and, in this case, engagement in talk about his troubles, rather than inviting this as something optional. Still, the design works to elicit talk specifically centered on his end of life, through the (slightly inaudible): 'because I'm feeling it's better to go' (line 14) and 'I know what's straight ahead' (line 18), as well as the audible upset: higher pitched voice and quieter volume on 'feeling' (line 14). Following the 'tut' particle (line 16) and minimal acknowledgments from the therapist (lines 20 and 22), the patient quickly moves out of his 'troubles talk' with an optimistic projection (lines 24-26). Clinically this may signal that the patient did not find a ready enough response to the expression of his deepest fears and consequently moved to 'the positive'.

## 4. Discussion and conclusion

### *4.1 Discussion*

Initiating talk with patients with advanced cancer about end of life can be challenging for therapists, particularly in first therapy sessions where they are also tasked with gathering information about the patient's life history and with establishing a therapeutic relationship, based on trust. The present analysis demonstrates that therapists facilitate such talk through questions which invite talk about the patient's feelings or understanding of their condition. Such questions regularly led to talk about the patient's troubles, particularly about the end of life to varying degrees. However, the design of the question did not make troubles talk conditionally relevant; the interactional work required to give an alternative response was minimised. This unconstrained response slot is provided through the design of the question and the degree to which negative feeling descriptors are specified. It can also be calibrated through the sequential positioning of questions. Although some questions might appear open in their format, in certain sequential positions they can claim more knowledge and therefore have a higher expectation of a certain answer (see extract 4, where the patient's understanding was challenged [24]). These questions are therefore calibrated to sit at different degrees along a continuum of openness.

The question designs observed share features with those identified by Perakyla (2005) and Pino et al. (2016). Perakyla (2005) identified the use of 'open' and 'distress relevant' topic elicitors. These questions invite patients to initiate talk on a new topic; something general or, in the latter case, about their fears and worries. In so doing, they provide patients with the opportunity to raise end-of-life

talk.[10] The questions identified here, in contrast, build on prior talk about patients' troubles and therefore index something problematic, without explicitly stating this. In particular, these questions build on talk from the patient in which death-related matters have been introduced via reference to the patient's diagnosis of metastasized cancer (e.g. extract 5), or limited life span more explicitly (e.g. extract 2). Pino et al. show how doctors provide patients with the opportunity to volunteer talk about death through 'open elaboration solicitations'; questions that elicit patients' thoughts and fears in relation to a topic already raised by the patient. These questions target particular experiences and raise concerns that the patient may have about the future. 'Fishing questions' in particular are the least targeted approach identified e.g. "Do you think that's all around your breathing getting worse or something else?" (p10), (concerning the lowering of the patient's mood). They invite the patient to elaborate on their prior talk in a way that could lead to end-of-life talk. [11] The questions identified in the CALM therapy sessions similarly invite the possibility of talk about the patients' troubles, but do so in a less targeted way, using a more open question design. In other words, through non-specific questions, the link to end-of-life is more tenuous and is not as clearly alluded to by the therapist.

The regularity of end-of-life talk that follows from the open-ended questions in the present analyses highlights the readiness of individuals with advanced cancer to talk about this topic. This can be contrasted to AIDS counselling sessions, where Perakyla (1995: 256) notes: "The variety of patients' responses to all types of topic elicitation shows that the topic elicitation alone may be rather ineffective in invoking descriptions of hostile future worlds" (p256). This difference might, in part, be accounted for by the differing focus of these two therapeutic approaches. The Milan approach focuses on questions that initiate a therapeutic intervention; highlighting a particular system disorder to produce change. [29] By contrast, CALM emphasizes the therapeutic relationship, attachment security and qualities such as empathy and authenticity. It is, perhaps, the unique space provided by CALM therapy sessions where there is mutual expectation that talk about death will arise, and where death-related matters have been introduced albeit often implicitly, that enables these open questions to elicit end-of-life talk. More specifically, we suggest that it is the common sequential context in which prognosis and ultimately death are of relevance, and particularly in this therapeutic context, which enables these open questions to do the subtle work of inviting patients to talk about death. It is also possible that this occurred less often in AIDS counselling because patients were diagnosed recently and the disease was not perceived an imminent threat to their lives.

CA can be used to connect empirical findings with the theoretical perspectives and concerns related to them. [30] In that regard, the findings of the present study allow us to specify how therapists manage the task of engaging in talk of a challenging nature in first sessions. It is impressive that the therapists were able to do so in a way that was nonintrusive and supported the therapeutic relationship. Further analysis is needed to explore how these sequences unfold and the degree to which end-of-life talk becomes of central focus and ~~is~~ emotionally heightened in these first sessions.

*1.2 Conclusion*

The present study demonstrates how end-of-life talk occurs in the first session of CALM therapy, typically in response to open questions by the therapist about the patient's experiences, feelings or understanding. The emergence of these concerns may occur so early in the therapy because of the urgent and felt need of patients to raise such issues, the extent to which these concerns are salient to the interaction and the reflective space created by CALM therapy in these first sessions. We observed that the degree of openness of the invitations to discuss end-of-life concerns was calibrated by the specificity of negative feeling states and the sequential context of the question. Overall, the findings suggest that when a trained therapist provides reflective space for patients with advanced cancer, end-of-life talk emerges early in the sessions, even when it is not specifically elicited by the therapist. This

highlights the felt need for patients to communicate such concerns and for therapists to provide opportunities for them to be discussed. CA was shown to be a powerful means to examine the specific interactional sequences that delicately invite such talk to occur.

*1.3 Practice Implications*

The results have important implications in providing CALM therapists with conversational resources for broaching end-of-life conversations with their patients. In particular, it highlights the subtle ways in which therapists invite, without expecting, talk about death. By treading carefully through their open questions, therapists enable patients to make a real choice in the extent to which they engage in such talk. The nuanced way in which therapists delicately elicit such talk in a way that avoids causing interactional trouble, is of central importance to a wide range of psychotherapy practitioners who are dealing with distressed patients for whom death is a concern.

**Acknowledgments**
We give big thanks to the patients and therapists who willingly shared their particularly personal conversations. We also thank the CALM research team at the Princess Margaret Cancer Centre in Toronto, for their support in providing the data. We are grateful to participants at the International Advanced CALM Workshop, May 2016 for their insightful comments and questions. Finally we would like to thank our anonymous reviewers for their detailed and thoughtful comments on earlier drafts.

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Figure 1 Patient demographics

| | |
|---|---|
| Cancer diagnosis | Stage IV Genitourinary Cancer (Kidney), Stage IV Genitourinary Cancer (prostate) X2, Stage IV lung X2, Stage IV Gastrointestinal (pancreatic), Stage IV Gastrointestinal (hepatobiliary), Stage III Gynecological Cancer (ovarian), Stage IV Gynecological Cancer (ovarian), Stage IV Gynecological Cancer (uterine) |
| Gender | 5 male: 5 female |
| Age | 51 – 77 (mean = 59.1) |
| Education level | high school X2, college/trade school X3, undergraduate X2, postgraduate/professional X3 |
| Family status | Married and living with spouse X7:<br>-3x no children<br>-4x children (2 of whom living with children)<br>Widowed X3:<br>-3x children (2 of whom living with children) |
| Therapist professional background | Social Work X9, Psychiatrist X1 |
| Length of session | 55minutes – 1 hour, 43 minutes<br>(mean = 1 hour, 17 minutes) |

Figure 2 Extract 1

```
1 P:      ..well >you know< a whole series of tests, an the end
          of
2         them they basically told me °that I° had this tumor,
          .hh=
3 Th:     =[°Okay.° ]
4 P:      =[that was] blocking the bile du[ct.]
5 Th:                                     [ .h]h Okay.
6         (0.2)
7 Th:          Okay.
8         (0.3)
9 Th:      .snhhh °What-° what was it like for you when you were
          told.
10 Th:    What was it* (0.3)
11 P:     Ur:m, HH (0.3) .HH (0.8) HH yes it's ↑quite a
          s:trange,<I
12        guess it was a- (0.2) p:eriod of disbelief:,=
13 Th:    =mhm=
14 P:     =>You know< how can this possibly (0.7) be me,
15 Th:    Yeah
16 P:     .hh (0.2) ur:m:, (0.3) >but< (.) I was surprised at
          myself,
17         I took it very calm[ly         ]
18 Th:                        [(°>Right<°)]

((lines 19-38 deleted about son being wildly optimistic and knowing herself
she was in trouble.))

39 P:     =But urm, (0.7) again I mean I'm in the process: I
40        understand what's g- I think I understand
41        [most of] what's going on<I'm frightened to ask about
42 Th:    [ mhm   ]
43 P:     °some stuff° [.hh ] I have to confess. .hh (0.3) ur:m,
hh
44 Th:                 [Yeah]
45        (1.1) tch.hh (0.2) >an then< I'm still feel,<I mean I
have 46        days when (0.8) I feel down.
47        (.)
48 Th:    Yeah
49 P:     You know.
50 P:     Ur >i- i-< I feel kind of scar:ed, what's gonna
51        happ[en,   ] .hh
52 Th:        [ ↑Yeah]
53        (.)
54 P:     An other days when I think 'well okay the chemo appears
          to
55        be working, my doctor 'as says: my liver function is
          goo:d,
56        .hh [my tumor marker is going down]
57 Th:        [°↑Okay : : : .↑°             ]
58 Th:    °↑mm:°=
59 P:     =Things can't be (0.2) all black.
```

Figure 3 Extract 2

```
1 Th:     And so now s:o now it's the Sutent for: (0.9) an
          indefinite
2         ↑period?↑
3         (0.3)
4 P:      As long as I'm around.
5         (.)
6 Th:          R:eally
7         (0.2)
8 Th:               Okay.
9         (1.1)
10 Th:    An how >how do you feel about that<,
11 Th:    With the sym- (.) with the side effects how are you:
     (0.3)
12 P:          Um (1.9) >you know,< °it's° better than: (0.2) the
13        alternative.
14 P:          When I asked (0.2) before I went on the Sutent I
     asked the
15        oncologist, (0.9) >you know< 'what's, (0.7) the
     outlook'=he
16        says well, (0.3) untreated or if it doesn't work ↓six
     months
17        to a year.
18        (0.9)
19 P:          So basically Christmas or (0.3) six months after.↓
20        (0.3)
21 Th:    (°°O:kay°°)
22        (0.3)
23 P:          I was happy to hear that it was working.
24 Th:    Right.
```

Figure 4 Extract 3

```
1 Th:     So you're mentioning it- it took a while for them to-
          to
2         diagnose it [to-  to-  (.) to  figure it   out.   ]
3 P:                  [To figure out exactly what it was (…)]
4 Th:          Okay.
5         (0.8)
6 Th:          °Okay,°
7         (1.1)((inbreath during))
8 Th:     And how was that for you at that tim:e=When they were
          trying
9         to figure things out, were you- were they,=
10 P:          =How was it for me?
11        (0.2)
12 Th:    <Yeah (0.5) yah.
13        (1.6)
14 P:     Well  it's  kinda  difficult  to  define  the  (.)  the
          transition
15        between (1.8) you know it's: (0.2) pneumonia which was
          the
16        first (0.7) [diagn↑o]sis [an ]
17 Th:                [ mhm-  ]    [mhm]
18 P:     an  then  something  more  serious  than  that  so  .hhh
          there's no
19        real clear demarcation point but (0.5)
20 Th:    mhm:
21 P:     (0.2) urm (0.5) °what° can I say, it was fine. huh
huh(it's)
22 Th:    mhm
```

Figure 5 Extract 4

```
1 P:      …but (0.2)°I-° (0.7) I'm n↑ot the- (.) s↑ame as I was:
          (0.4)
2         three years ago.=
3 Th:          =.h Do you believe he understands your
>condition.<
4         (1.7)
5 P:      °mm° I don't- (0.2) not ↓fully.
6         (0.2)
7 P:      I don't think he understands it fully.
8         (0.8)
9 Th:          >A[ctually< may]be I should ask you:
10 P:            [    aha,    ]
11        (0.2) / ((possible inbreath during))
12 P:          [Do ↑I] understand [it fully? ]
13 Th:    [Wh-  ]            [Or or what] do you
     understand °about
14        it.°
15        (0.6)
16 P:          W#ell I know I have s:tage four lung cancer, .hh
     #but I'm:,#
17        (0.9) I feel good. I've gotta tell you.
18        (0.2)
19 P:          I'm not s:ick, I've never been sick a day:, (0.9)
     with this:
20        (0.4) <other than, (.) psychological stuff, (0.6) .HH
     ur:m
21        an I-:# I jus- (.) I'm- (0.2) tryna f↑ight it.
22        (0.5)
23 P:          A:n I know that (.) huh the sta(h)ts ar:e (0.4)
     are
24        terrible, (0.9) but (1.4) I'm tryin ta t↑ell myself,
     (.)
25        unless it's: z↑ero percent or a h↑undred percent, (2.1)
     they
26        don't c↑ount.
```

Figure 6 Extract 5

```
1 P:      =But then there's a problem that (0.2) it might have me
2         metastasised into the soft tissue somewhere.
3         (0.3)
4 P:      So that was the reason for the see tee scan yesterday.
5         (0.2)
6 Th:          °Okahhy.°
7         (0.7)
8 Th:          [So are you] feeling ↑nervous [about] °tha[:t,°
]
9 P:      [So        ]                  [Yeah,]     [°I feel]
     nervous:
10        yeh.°
11        (5.3) ((gulp during))
12 P:          (tch) Of ↑course.
13        (1.2)
14 P:          Because I'm °↑feeling° (0.8) (it's better to go.)
15        (0.7)
16 Th:    tch
17        (3.8)
18 P:          You know I know what's (straight ahead.)
19        (.)
20 Th:    mhm:
21        (0.7)
22 Th:    °°Yeah°°
23        (0.2)
24 P:          But I d↑on't th:ink it's, (0.2) there's any
     problem >I think
25        it would have showed< (0.5) I think it would have gone
     into
26        the bone, (0.5) an both scans clean so °that-° so
     that's
27        good,
Th:  mhm:
```