The assessment of mentalization: measures for the patient, the therapist and the interaction

Abstract

Purpose: Mentalization has been clearly defined in the literature as a relational concept and yet in surveys and transcript-based measures it is almost universally treated as an individual capacity. That approach has value but may not capture the emergent nature of mentalization, as it is jointly constructed within a relational context.

Methods: We report here on a critical evaluation of measurement approaches commonly used to conceptualize and assess mentalization and argue for the value of conversation analysis (CA) as an alternative approach.

Results: A variety of approaches have been shown to have utility in assessing mentalization as an individual capacity. We illustrate how conversation analysis allows for an in-depth-analysis of mentalization as it is co-created across different contexts in real-life therapy sessions. This method of analysis shifts the focus from content to process.

Conclusion: Conversation analysis is a potentially valuable tool to support training, to assess treatment integrity, and to improve outcomes with mentalization-based interventions.

Keywords

Mentalizing, measures, conversation analysis, psychotherapy, mentalization-based-therapy.

Introduction

The psychoanalytic concept of mentalization emerged in France in the 1960s, referring to a group of mental processes that include representation and symbolization (see Freeman, 2016). It was subsequently defined as the imaginative capacity of an individual to understand and interpret human behaviour in terms of underlying mental states (Bateman & Fonagy, 20~~03~~13).While mentalization is often viewed as an explicit and deliberate process that is evident in conscious and deliberate talk about thoughts, desires and motives, it can also be identified in less conscious and more automatic processes, such as in the tailoring of conversation to be responsive to another (Allen, 2006). The latter has been termed implicit mentalization.

The capacity to mentalize may fluctuate and be linked contextually to the relational situation and affective state of the individual (Bateman & Fonagy, 2013). With regard to the former, Sperry (2013) notes that the ways in which the analyst and patient adapt to one another shape the emergence and maximization of each person's capacity to mentalize. This is highlighted in mentalization-based therapy (MBT), in which the therapeutic relationship and the "interactional moves" of the therapist are intended to enhance the patient's mentalizing capacity (Bateman & Fonagy, 2013). These therapeutic moves include taking a "not-knowing" stance, validating the patient's emotions, and prioritizing the *process* over the *content* of therapy (Bateman & Fonagy, 2013).

Despite the acknowledged influence of the relational field on the meanings that are constructed (Mitchell, S 2000), there has been greater attention in the clinical and research literature to the assessment of mentalization as an individual capacity than to its emergent properties within dyadic and social contexts (Sperry, 2013;. Koster, 2017). With regard to the

latter, not only may a person's ability to mentalize fluctuate with different relationships and attachment figures, but it has been shown more specifically, in the analysis of conversations, to be contingent on the nature and quality of the interaction (see Sperry, 2013). Conversation is the platform through which meaning is both created and shared and through which relationships are realised in the moment to moment unfolding of talk.

The unfolding of mentalization within conversations can be uniquely captured by conversation analysis (CA), a qualitative method used to examine the structure and process of social interactions (see Sidnell, 2012,; Davidsen & Fosgerau, 2015a; Keselman et al., 2016). This approach can elucidate conversational practices and features that most effectively facilitate the emergence of mentalization within a therapy session. This information can help to guide the course and supervision of mentalization- based psychotherapies, to assess treatment integrity and the therapeutic process and outcome in research studies.

The Application of Mentalization to Clinical Practice

The capacity to mentalize is thought to develop in childhood in the context of a secure and responsive relationship with a primary carer (Bateman & Fonagy, 2013). When this is impaired, there may be adverse outcomes, including problematic attachments and deficits in the capacity for mentalization (Bateman & Fonagy, 2013). This may be evident in individuals with borderline personality disorder (BPD), a condition which was the preliminary focus of a formalized mentalization-based treatment (Bateman & Fonagy, 2013). In such individuals, the relative lack of the capacity for mentalization may contribute to their tendency to interpret behaviour and experiences based primarily by their own inner thoughts and experiences (Bateman & Fonagy, 2013).

A diminished capacity to mentalize has been linked to a variety of psychological disorders, including depression (Bressi et al., 2016; Luyton et al., 2012), eating disorders (Robinson et al., 2016) and posttraumatic stress disorders (Palgi, Paligi, Ben-Ezra, Shrira, 2014; Allen, Lemma, Fonagy, 2012). Individuals exposed to overwhelming trauma may suffer from a collapse in their capacity to mentalize, perhaps because their memories are experienced as real when they are associated with emotions that are overwhelming in their intensity (Allen et al. 2012). This loss of the capacity to mentalize may also be evident in severely depressed patients who are unable to reflect on their thoughts and perceptions and who may therefore tend to equate their inner thoughts and feelings with external reality (Luyton et al., 2012). We have suggested that life-threatening disease may also collapse the capacity of individuals to mentalize, as a result of both the experience of trauma and of the dominating and singular reality of the disease (Hales, Lo, Rodin, 2015).

Mentalization-based therapy (MBT) was developed to help individuals with a limited capacity to understand the thinking that underlies problematic thinking and behavior to consider alternative ways of thinking and behaving (Bateman & Fonagy, 2013). MBT has been shown to be effective in patients with BPD (Jorgenson et al., 2013) and some recent evidence suggests that it can also be effective in treating patients with depression (Bressi et al., 2017; Jakobsen et al., 2014) and eating disorders (Robinson et al., 2016; Balestieri et al., 2015). We have also shown that a brief supportive-expressive psychotherapeutic intervention , referred to as Managing Cancer and Living Meaningfully (CALM), that involves mentalization is effective in relieving depression, distress related to death and dying and improves preparation for the end of life in individuals with metastatic and advanced cancer (Rodin et al 2018). This approach supports “double awareness “(Rodin and Zimmermann et al 2008) of the possibilities for living and for

facing the end of life in such individuals, who may otherwise feel dominated by the shadow of their disease.

The centrality of mentalization to the understanding and treatment of a wide range of psychological disorders highlights the need to operationalize this construct and to measure it in both clinical and research contexts. CA could be a valuable tool for this purpose and to support the teaching and supervision of therapists and the quality of mentalization-based psychotherapeutic practice. We review here some of the most common measurement approaches and address the potential value of CA for this purpose.

Measuring the patient's capacity to mentalize

Survey designs. Self-report questionnaires have been used to measure the capacity of patients to mentalize (e.g. Ekeblad, Falkenstrom, & Holmqvist 2016). Such measures are comparatively easy to administer although their validity may be limited by their reliance on the participants' judgment about this capacity in themselves.

The Reflective Functioning Questionnaire (RFQ) is the first self-report measure developed to specifically assess mentalization (Fonagy et al., 2016). It has 8 items with a 7 point Likert scale ranging from 'completely disagree' to 'completely agree.' The measure includes a subscale of 'overcertainty' about mental states, referred to as hypermentalizing, and another of 'high uncertainty' about mental states, and referred to as hypomentalizing. The uncertainty sub-scale, which includes such items as "sometimes I do things without really knowing why," indicates a relative lack of understanding of mental states, and, therefore, of the ability to mentalize. The high certainty or hypermentalizing scale, which includes items such as "Of course I always know why I do what I do", indicates a lack of awareness about the limitations in

the extent to which one can actually be certain of one's own mental state. Internal consistency for the scale was reported as satisfactory to excellent, with excellent test-retest reliability. The validity of the scale has been supported by confirmatory factor analysis, by the distinction that it can make between clinical and non-clinical participants, and through its correlations with scales for empathy, mindfulness, perspective taking and borderline personality disorder (Fonagy et al., 2016: 3-4).

Another measure of mentalization is the Parent Reflective Functioning Questionnaire. This self-report measure requires parents to report on their ability to understand their *child's* behaviour in terms of mental states. An example item is the following: "I always know why my child acts the way he or she does", which measures the tendency of the parent to recognise that mental states are not necessarily transparent and that a degree of uncertainty is expected (Rostad & Whitacker, 2016: 57). Internal consistency for this 7-point likert scale was reported as satisfactory to excellent; with excellent test-retest reliability and good factor structure (see Rostad & Whitacker, 2016).

Questionnaire designs have value, although the interpretation of their scores is limited by the influence of social desirability and by the accuracy with which individuals can evaluate their own mental processes (Gratz and Roemer, 2004). The hypothetical or abstract way in which self-report measures typically assess mentalization (Dziobek et al. 2008) also does not take into account the interactional context in which mentalizing takes place. They may not capture the complexity of mentalization in everyday situations, where individuals have a personal stake and interest in making inferences about behavior, intention and emotions of themselves and others (see Edwards & Potter, 2017). Questionnaire designs may therefore be limited in their ecological validity (Dziobek et al. 2008), assessing mentalization in terms of the individual and isolated

capacity of the patient, rather than as a phenomenon that emerges as part of an unfolding conversation.

Transcript based measures. A number of transcript-based measures have been developed to assess a person's capacity to mentalize. These involve the use of an interview transcript, which is then coded on a scale according to the patient's demonstration of the ability to mentalize. The Reflective Functioning Scale (RFS) (Fonagy et al., 1998) is used in most published transcript-based studies of mentalization. The RFS was designed to be used primarily in conjunction with the Adult Attachment Interview (AAI). The AAI is a semi-structured interview constructed to elicit childhood experiences, particularly concerning the patient's parents. It includes questions about the impact that their parents' behavior has had on them, as well as possible explanations for their parents' behavior. It has been adapted for children (the Child Reflective Functioning Scale) for use with the Child Attachment Interview (see Ensink et al 2015).

The RFS Manual (Fonagy et al., 1998) provides a comprehensive guide to rating interview responses, which is intended to be supported with formal training in making such ratings. The manual includes extensive details on rating individual passages, as well as on how to aggregate the scores to provide an overall rating of reflective functioning. The scale importantly takes in to account the context in which a response appears, by distinguishing two types of questions that precede the response: those that demand a response which demonstrates reflective functioning, and those which more minimally permit a response which demonstrates reflective functioning (Fonagy et al., 1998). Responses to demand questions are instructed to carry more weight, as reflective functioning is being directly elicited. However, spontaneous RF responses

are to be marked and noted. The measure has been found to have high inter-rater reliability, as well as good validity in separate studies (Fonagy et al., 1998). Other transcript-based measures take a more decontextualized approach in that they rate the transcript in terms of the presence or absence of particular items on a measure (e.g. The Mind-mindedness Scale: see Barreto et al., 2016).

Transcript-based measures vary in the extent to which they take into account the context in which responses are produced, although they may do so more than questionnaire designs. In-depth interviews may be more revealing of mentalization than more abstract, decontextualized items that directly assess the person's awareness of how they think. Interviews come closer to a more naturalistic exploration of mentalizing, as it arises in everyday conversations, although their structured nature may create a trajectory of conversation and interactional context that differs from situations in which mentalizing more naturally arises. Deliberate standardization of the interview may aim to clearly identify reflective capacity, but give limited insight into its interactive nature. Although the RFS takes into account whether a mentalizing response follows a 'demand' or 'permit' type question, a dialogical approach is not taken in which the relationship between the interviewer's and interviewee's utterances are closely examined (Davidsen & Fosgerau, 2015a). While aggregating scores allows for an overall rating of reflective functioning, this approach runs the risk of decontextualizing and oversimplifying the mentalization process (Katznelson, 2014), or what is known about *how* mentalization is brought about in conversation, in more or less effective ways.

The RFS has been used to measure transcripts of therapy, getting us closer to examining how it unravels as a dyadic process in everyday talk (Karlsson & Kermott, 2006). RF was measured in patients in brief therapy and in relation to items on the Psychotherapy Process Q-

Sort (PQS). The results suggest that RF scores and outcome are associated with patient characteristics rather than aspects of the interaction. However, as reported by the authors, the study is limited in statistical power and that final therapy sessions were not used where RF levels may have actually shown improvement. Furthermore, the PQS provides only a broad characterization of psychotherapy process e.g. “Therapist actively exerts control over the interaction (e.g. structuring and/or introducing new topics)” (Karlsson & Kermott, 2006: 75), rather than offering detailed accounts of therapeutic actions.

The Metacognition Assessment Scale has also been used to measure metacognition in actual therapy sessions (Vohs & Leonhardt, 2016). The scale was developed to assess cognitive capacities similar to those of mentalizing. Vohs & Leonhardt (2016) used a case study to discuss a patient’s development of metacognitive abilities through Metacognitive Reflection and Insight Therapy (MERIT). In doing so, the patient’s metacognitive abilities, as assessed through the MAS, are contextualized briefly in terms of some reported interventions which were used by the therapist to help elicit stronger metacognitive capacities from the patient. While examining metacognition or mentalizing in actual therapy sessions gets us closer to examining mentalizing as it happens in everyday interactions, closer examination of the real-time unfolding of each person’s utterance would get us closer still.

Measuring the therapist’s capacity

Several measures have been developed to assess the capacity of the therapist to mentalize. The Therapist Mental Activity Scale (TMAS) measures therapist mentalization skills by rating their

responses to clinical vignettes on a 5 point scale (see Einsink et al. 2013). This measure assesses 'reflective' ability (i.e. to mentalize the patient's experience) from responses that are emotional ("reactive") or objective (rational). The TMAS has proven to be both reliable and valid (see Ensink et al. 2013). The Reflective Functioning Scale has also been applied to the Therapist Relationship Interview. This is a semi-structured interview concerning the therapist's experience with his or her patient, conducted in order to elicit reflective responses that can be rated for mentalization capacities (see Safran et al., 2014). This can be combined with other measures, such as the RFQ, to assess the therapist's ability to mentalize.

The ability of a therapist to promote mentalizing in their patients may also be assessed through the use of adherence scales (Karterud et al. 2013). The MBT adherence and competence scale (Karterud et al. 2013) is a 17 item scale using a 1-7 Likert scale to measure the adherence of therapists in MBT sessions. The measure allows an overall assessment of such dimensions as 'exploration, curiosity and a not-knowing stance' and 'stimulating mentalization through the process.' It has been found to be a reliable measure overall (Karterud et al 2013) and has been used to show a relationship between therapist adherence and higher RF scores in patients (Moller et al. 2016)

Transcript-based measures such as the TMAS and TRI (with the RFQ) provide a more naturalistic assessment of mentalization than self-report measures, but are still limited by their use of interviews and vignettes as opposed to actual therapy sessions. Further, approaches that isolate the therapist's mentalization from that of the patient may not elucidate the collaborative nature of mentalization. Whilst adherence scales explore the collaborative nature of mentalization, they still focus on an overall assessment of mentalizing capacity, rather than

considering the specific interactional sequences in which mentalization emerges in the dyadic relationship.

Taking an interactional approach

Diamond et al (2003) used a patient-therapist version of the Adult Attachment Interview in which patient and therapist are assessed separately in terms of how they each mentalized their relationship. Their preliminary analysis showed that the therapist's reflective functioning varied with different patients, consistent with the view that reflective function in therapy is a dyadic process. Studying how mentalization emerges in therapeutic interactions, would be an important next step. This has been elucidated in MBT, but examining diverse approaches of therapists to support mentalization in interactional sequences, would expand our understanding of this process and may facilitate the training of therapists and the building of this capacity in patients, therapists and in therapeutic dyads.

Qualitative approaches have been used to study how reflexivity and the ability to adopt different subject positions or identities, emerges in patients within therapy. Such approaches include narrative analysis (Angus & Kagan, 2013), discourse analysis (Guilfoyle, 2016) and dialogical positioning theory (Georgaca, 2003). They may be regarded as social constructionist in that they treat subject positions or different ways of identifying as jointly achieved by patient and therapist embedded within a social and cultural context.

Angus & Kegan (2013) used a narrative approach in examining the process of emotion-focused therapy for a patient with depression. This involved the use of a Narrative Assessment Inquiry, in which the patient is asked about how she sees herself, how others see her and what

she hopes to change. Analysis of the session transcript and interviews before and after the session, showed how the patient was able to develop a new narrative identity through self-reflection, in which she was able to see her negative emotions as arising from her self-criticism. Using a discourse analytic approach, Guilfoyle (2016) examined the transcript of an existential therapy, identifying the patient's transition from one discursive position to another and the temporary adoption of space in-between discursive positions. Finally, Georgica's (2003) analysis of therapy transcripts using dialogical positioning theory, show how the therapist's interventions facilitate the patient's ability to become increasingly self-reflective, recognising his problematic tendency to regard people who want to help him as merely self-serving. The therapy transcripts are analysed in terms of how the therapist positions himself with regard to the relationship pattern at issue– being the subject of it to begin with, then enquiring about its history, and then moving back into it to challenge and break the pattern.

A dialogical approach in which the relational positioning of the speakers is analysed, provides insight into the implications of the therapist's manoeuvres for the patient's ability to self-reflect or mentalize. This approach takes a specific lens; the dialogical positioning or relational positioning, as opposed to specifying how turns are designed in a way that has direct implications for recipiency, taking into account the way talk is systematically organised and socially produced. Using the method of grounded theory (Dilks et al., 2008), identified activities of the therapist that included 'opening up views', 'negotiating shared understanding', 'doing relationship' and 'managing emotion'; these were reported by client to be linked to 'opening up new possibilities'; 'processing distress'; and 'enhancing agency and self-worth'. A next step would be to specify with more precision, how the therapist actions enable self-reflection or

mentalization to emerge between them and that can be specified more narrowly in terms of the moment to moment unfolding of talk.

Conversation analysis (CA). The method of conversation analysis was developed in the social sciences to systematically explore the ordered way in which talk is produced and the implications of different interactional features for the unfolding conversation (see Sidnell, 2012). Specific emphasis is given in CA to investigating the sequential context in which utterances are produced, and to the collaborative, and unfolding nature of conversational sequences. In that regard, CA is a tool that is used to investigate the socially ordered way in which psychological topics are constituted in talk, rather than treating what is said as a straightforward representation of inner processes (Edwards & Potter, 2017). The focus of CA is on the social practices through which mentalization is constituted within talk. The method underscores the importance of using naturalistic data, in order to explicate the real-time interactional subtleties and difficulties that arise in conversation. Session transcripts are used to represent this real-time production through its minute detail of how and when talk is produced (Hepburn & Bolden, 2017).

In conversation analysis, talk and its embodied interaction are analyzed in terms of the actions that are performed, such as advising, requesting or problem-telling. Such actions make relevant a paired response, for example, an invitation makes relevant acceptance or rejection. These adjacency pairs are considered to form the basic structure of conversation. Because actions are linked in this way, recipients are able to interpret what each other has said according to the normative expectation of an action. The speaker can then evaluate whether the recipient has understood them. It is the linking of actions in this way that provides for the possibility of intersubjectivity and for the continued display of shared understanding (Heritage, 1984, see

XXXX). We argue that considering mentalization to emerge through the intersubjective nature of talk is a powerful demonstration of its relational nature. While the concept of implicit mentalization implies its intersubjective nature (see Allen, 2006), CA is a tool that can be used to specify how it is interactionally achieved (see Davidsen & Fosgerau, 2015).

CA has been used to examine interactions in a range of healthcare and psychotherapy settings. Research using this methodology has shown that small changes in the way talk is designed may shape what follows. For example, Heritage et al. (2007) showed that small changes in the words used to ask primary care patients about other concerns they have, had a significant impact on the number of unmet of the patient (Heritage et al., 2007).

In a small number of studies, CA has been used to examine implicit mentalization in interaction. Davidsen & Fosgerau (2015b) compared interactions of depressed patients with their general practitioners to those with their psychiatrist. They operationalized implicit mentalization, in terms of how the professional shows empathy or understanding of the patients emotions based on acoustic features and body movements. Using the fine grained analysis of CA, they showed that general practitioners tended to make affiliative moves and to display emotional intensity in a way that mirrored the patient's emotions in prosody and gesture, more than did psychiatrists. They suggested that this difference might arise from the greater focus of psychiatrists on psychiatric diagnosis, compared to the focus of general practitioners on understanding the broader context of the person.

Other studies have illuminated the construct of implicit mentalization by examining how patients demonstrate their understanding of what the professional has said. In that regard, analyzing the sequential talk of patients with schizophrenia with a CA lens, McCabe, Leudar, Antaki (2004) showed that these patients implicitly demonstrated a theory of mind (a concept

similar to mentalization) in that they understood the therapist's intended meaning, despite having been considered to be unable to mentalize. Similarly, Keselman et al (2016) showed that patients' apparent 'non-mentalizing' responses to invitations to mentalize in therapy sessions, were actually skillful interactional moves that required implicit mentalization of the perspective of the therapist. For example, a patient's resistance to the therapist's invitation to mentalise can paradoxically be a strategy to keep the conversation on a certain track. By taking the interactional order as the primary method for examining mentalization in talk, a person's ability to mentalise can be demonstrated through the specific conversational context in which their talk is produced.

Mentalization in CALM therapy: an illustrative example. We have used CA to analyse psychotherapy interactions and to identify therapeutic interventions and evidence of mentalization in a supportive-expressive therapy, referred to as Managing Cancer and Living Meaningfully (CALM) (designed for people with advanced cancer (Rodin et al 2018), The ability to mentalize of individuals with advanced cancer may be limited because they feel dominated by the singular and objective reality of their disease (Hales et al., 2015). Preoccupation with their disease and its treatment or with concerns about disease progression, dying and death may render some unable to explore the possibilities for living.

We took a first step to examine how interventions of the therapist might support reflective functioning and mentalization in patients with advanced disease participating in CALM. The method of CA allowed us to explicate how therapists invite patients to talk about death, without making it an unwanted interactional requirement for the patient. The study identified common interactional moves made by the therapist and showed how these actions led

to talk about mortality. It was observed that open-ended questions by the therapist about the patient's experience or understanding of their cancer troubles, regularly elicited talk about the end-of-life (XXXX). Providing the possibility of explicit mentalization about the end of life to take place with the consideration of alternative approaches.

In further research, we have examined how CALM therapists specifically engage patients in the activity of mentalization (see XXXX - submitted), identifying how they may support or inhibit this process. The present research has illuminated how questions that invite patients to expand on the meaning of their assumptions and perspectives may be preliminary moves to exploring alternative perspectives, without explicitly objecting to the patient's perspective or making them accountable for it. This encouragement to consider alternate perspectives, without challenging the perspective put forth by the patient, supports the process of mentalization in a way that is supportive of the therapeutic relationship. Such question designs may communicate to the patients the potential for multiplicity in thinking and the explication of such conversational moves allows them to be incorporated into psychotherapy evaluation and research.

Here we provide a brief extract from a CALM therapy session to exemplify another type of question design that may be used to invite the patient to consider alternative perspectives and its implications for the patient's response. The patient has just been telling the therapist that she had to make a quick decision to enroll on a clinical trial. She has reported how she was concerned that she may be ruining the time she has left. However, she was given reassurance by her husband that it was the right thing to do.

Extract 1: Session 6 – Clinical Trial; 9:07-9:50

1 P: [good fit.]
2 T: [So those are] reasons why it's good for the study to have

3 you participate,
4 (.)
5 P: Yeah.
6 (0.2)
7 T: .hh An' what about, (.) for [you.]
8 P: [We]:ll she, (0.2) she said to
9 me:,'the way I would think about it if I were you i:s tha:t
10 (0.5) there's an opportunity here,[that it] could=
11 T: [((cough cough))]
12 P: work,
13 (0.5)
14 P: Uh:: (0.5) an' (.) that there's not a lot of risk.
15 (0.6)
16 P: Uh: because the adverse effects: (0.2) have s- seem to be f-
17 [quite] manage[able,] [an' fairly] mini[mal.]
18 T: [Right.] [Right.] [Right.] [Right.]
19 (1.0)
20 P: .pt (0.7) Uh: .hh (0.5) and if I were you, I would °do
21 (it)°.'
22 (1.3)
23 P: .hhhhh Uh hhh. (1.7) so (0.2) I'm [>doing it.<]
24 T: [.hh]=
25 T: =hhhh. .hhh=
26 P: =Eh huh with some, (0.5) you know, (0.3) .h[hh] I mean=
27 T: [°No.°]
28 P: =there's a part of me 'okay now it gives me [something] to
29 T: [hh.]
30 P: do again, I've got another job.'

The target question (lines 2-7) comes after the patient has positively evaluated taking part in the clinical trial. This question arises in the context of weighing up a decision, which contributes to it being heard as an implicit invitation for her to consider that decision from another perspective. The therapist first formulates the patient's account as coming from a particular perspective (lines 2-3) and then introduces a new dimension, which is the specific value of the trial for her (line 7). The therapist introduces an additional consideration in the decision to enrol in the trial, which is its impact on her personally, apart from its effect on the cancer. This issue here is that the exclusive focus on anti-cancer treatment, which had thus far been ineffective and associated with considerable morbidity, might actually limit possibilities for

her to live her life meaningfully. The question invites the patient to specify, in an extended way, the reasons why the trial might be beneficial for her.

The open question design, together with the 'and' preface, builds on the patient's reported perspective. An alternative perspective is then introduced without objecting to the previous perspective or making her directly accountable for it. The patient responds by providing evidence for why the study is good for her. However, she then orients to the limitations of her decision. The speeded up 'doing it' (line 23) seems to demonstrate a straightforward decision. This is contrasted with the laughter in post position following a silence and long out and in-breath from the therapist (possibly a signal of something problematic). The laughter seems to soften the claim to a straightforward decision (Potter & Hepburn, 2010), and displays recognition that the decision is not actually clear cut. Indeed, she goes on to indicate she has "some" reservations, without actually articulating them (line 26). She also concedes to a more minor reason to taking part in the trial: 'because it gives her something to do' (lines 28 & 30). The patient's displayed recognition of the trial's limitations provides evidence that she has treated the question as inviting her to consider the limitations of her perspective. However, the therapist's question has notably made an answer relevant next, in which the patient expands on the reasoning for taking part in the trial, rather than responding to the question as a challenge.

What this extract shows is a method by which the therapist implicitly introduces a perspective that is alternative to that put forward by the patient (i.e. that there may be limitations or risks to taking part in the study that should be balanced against potential benefits). More specifically, the therapist uses an 'and' prefaced, open question design that works to build on the patient's reported perspective and introduces a new way of considering the clinical trial; which is from her perspective rather than that of the trial. In designing the talk this way, the therapist

avoids directly objecting to the patient's perspective and requiring a response in which the patient would need to account for the position she has taken. It allows an alternative perspective to be raised without any signs of interactional trouble and which is therefore supportive of the therapeutic relationship. Indeed, the maneuver has evidently been successful in making relevant a response which attends to the limitations of her perspective, without requiring her to more directly defend it. Furthermore, we have identified how a patient might use laughter to subtly display interactional evidence of the ability to mentalize.

Here we have used the tools of CA to look at how a therapist's talk may be designed to facilitate the process of mentalization. More examples would be needed to fully explore the normative dimensions of this maneuver as a specific practice but this single case analysis may illustrate the possibilities provided by the design features adopted and the potential for therapeutic effectiveness.

Conclusion

Mentalization is often defined as a relational concept, but most measures of this construct typically assess it as an individual capacity. Surveys and transcript-based measures provide a useful snapshot of the nature of an individual's mentalization in a particular scenario, but may not capture the fluid and interactional nature of mentalization across different contexts and affective states. Such measures of mentalizing capacity may provide only a limited understanding of how mentalization arises in everyday interactions or in psychotherapy where individuals have a personal stake in the outcome. The way in which mentalization is intersubjectively created may be demonstrated within an interaction by studying the moment-by-moment unfolding of sequences of talk. Identifying this sequence requires systematically

examining and reflecting on the affordances and implications of different ways of engaging patients in mentalization talk. Conversation analysis (CA) is a tool that can be used to explore mentalization in such naturalistic therapy interactions. Applying CA in this way to the study of mentalization shifts the focus from content to process and therefore may be a valuable tool to support training in mentalization and to assess treatment integrity and psychotherapy outcome.

Compliance with ethical standards

Funding. This work was supported by the Global Institute of Psychosocial, Palliative and End-of-Life Care (GIPPEC).

Ethical approval. 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.

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