Negative stance towards treatment in psychosocial assessments: the role of personalised recommendations in promoting acceptance

Abstract

People presenting to the emergency department with self-harm or thoughts of suicide undergo a psychosocial assessment involving recommendations for e.g., contact with other practitioners, charity helplines or coping strategies. In these assessments, patients frequently adopt a negative stance towards potential recommendations. Analysing 35 video-recorded liaison psychiatry psychosocial assessments from an emergency department in England (2018-2019), we ask how these practitioners transform this negative stance into acceptance. We show that practitioners use three steps to anticipate and address negative stance (1) asking questions about the patient's experience/understanding that help the patient to articulate a negative stance (e.g., "what do you think about that"); (2) accepting or validating the reasons underlying the negative stance (e.g., "that's a very real fear and thought to have"); and (3) showing the patient that their reasons were incorporated in the recommendation (e.g., "it's telephone support if you're a bit more uncomfortable with face to face"). These steps personalise the recommendation based on the patient's specific experiences and understanding. When practitioners followed all three of these steps, the patient moved from a negative stance to acceptance in 84% of cases. When practitioners made a recommendation but did not follow all three steps, the patient moved from a negative stance to acceptance in only 14% of cases. It is not the case that each communication practice works on its own to promote patient acceptance, rather Steps 1 and 2 build on each other sequentially to develop and demonstrate shared understanding of the patient's negative stance. In this way, acceptance and validation play an indispensable role in addressing a patient's concerns about treatment.

Keywords

advice, treatment, communication, conversation analysis, self-harm, suicide, emergency department

Highlights

- Conversation Analysis of video-recorded assessments for self-harm and suicidality
- Patients often take a negative stance towards treatment options and advice
- Avoiding or countering negative stance does not promote a more positive stance
- Asking about, accepting, and incorporating negative stance promote positive stance
- Three-step approach to addressing treatment hesitancy in mental health encounter

Introduction

In England, it is estimated 11.18 million adults have thought of taking their own life and 3.47 million have self-harmed during their lifetime (McManus et al 2014). National Institute for Health and Clinical Excellence (NICE) guidance states that "the emergency department provides the main services for people who self-harm" in England (NCCMH 2004) and psychiatric liaison teams support people experiencing a suicidal or self-harm crisis. It's estimated 220 thousand episodes of self-harm are managed by emergency departments (EDs) in England annually (Hawton et al 2007).

A range of treatments, community support options and coping strategies have been shown to mitigate risk of suicide and improve life satisfaction for people at risk of suicide or who self-harm (Turner et al 2014; Iyengar et al 2018). Hence, connecting people to treatment and discussing practical next steps when they present to the ED in crisis is critical. However, many patients leave the ED feeling the recommendations they received were ill-fitted or problematic (O'Keefe et al in prep; Xanthopoulou et al 2021; Storey et al 2005). Rates of engagement with follow-up care after leaving ED assessments for self-harm are notoriously low (Schmutte et al 2020; Bridge et al 2012).

Research on patient-practitioner communication shows that how a practitioner talks about treatment can promote patient acceptance (Stivers 2005; Bergen 2020; Opel et al 2013) and significantly improve treatment adherence (Zolneirek & DiMatteo 2009; Thompson & McCabe 2012). However, Psychiatric Liaison Practioners (PLPs) are given little guidance on how to talk about treatment options with patients that may be hesitant to pursue these treatments. People with experience of attending the ED in crisis say that they often do not find management plans helpful and would like to be more involved in treatment discussions (O'Keeffe et al in prep; Storey et al 2005). People report that the most helpful aspects of a psychosocial assessment include listening and acknowledging distress, acceptance and nonjudgement, and a co-produced management plan (Xanthopoulou et al 2021). However, research on psychiatric liaison practice in the ED has overwhelmingly drawn on interview and survey data and retrospective chart review (Zarska et al in prep; Cooper et al 2013). To date, no prior studies have used video-recorded psychiatric liaison assessments to study real treatment conversations between practitioners and patients. This makes it difficult to identify what exactly practitioners can say to encourage patient acceptance of a treatment recommendation, or what a co-produced management plan looks like in practice.

In this study, we examine video-recorded mental health assessments with emergency department psychiatric liaison practitioners and people who have presented to the ED with self-harm or thoughts of suicide. We ask how communication practices impact patient uptake of medical advice with a focus on assessments in which the patient has taken a negative stance towards the treatment option.

Background

Giving medical advice

There are many ways to give medical advice. Treatment recommendations can be delivered as pronouncements, suggestions, proposals, offers or assertions, with each having a different impact on the trajectory of the conversation (Stivers et al 2018; Thompson & McCabe 2018; Ford et al 2019). Healthcare practitioners can communicate varying levels of endorsement (e.g., 'I think X will help you.' v. 'Trying X won't hurt.') (Stivers et al 2018; Stivers & Barnes 2018), levels of patient choice (e.g., 'We'll go with X.' v. 'Would you rather go with X or Y?') (Toerien et al., 2013; Tate & Rimel 2020), and rights to dictate the patient's actions (e.g., 'You'll start on X.' v. 'Are you open to starting on X?') (Dalby Landmark et al 2015; Stivers et al 2018). Medical advice can be explicitly linked to symptoms (e.g. 'Daily walks will improve the pain in your legs.') (Bergen 2020), tailored to the patient's narrative (e.g., 'You said you have less pain in the mornings, so I'd advise exercising then.') (Connabeer 2019), or presented cautiously as a declarative evaluation (e.g. 'It might be better to exercise more') (Kushida & Yamakawa 2015).

Treatment recommendations take place within broader treatment discussions (Robinson 2003). In the psychiatric setting, recommending treatment is a complex course of action that typically involves building a case for the treatment recommendation (Bolden & Angell 2017). Across healthcare settings, treatment discussions may include talk about treatments the patient has already tried (Barnes 2018; McCabe & Barnes 2021) or what support the patient believes would help them (Reuber et al 2015). If a patient does not immediately accept the treatment recommendation, practitioners may go on to make concessions, endorse the treatment further, or give the patient more information (Stivers 2002).

These communication practices shape patents' responses to treatment recommendations. For example, in primary care, preparatory questions about the patient's past experience with a treatment (e.g., *Have you tried X before?*) play an important role in securing patient acceptance. These "preliminary recommendations" (Barnes 2018) allow a practitioner to determine if their potential recommendation might be ill-fitted and adjust the treatment plan accordingly. McCabe (this issue) shows that patients may accept recommendations for mental health treatments (e.g., talking therapies) more frequently when primary care practitioners use language that matches the patient's description of their problem. In routine psychiatric visits, patients are more likely to actively resist proposals and offers for treatment versus pronouncements and suggestions (Thompson & McCabe 2018).

Patient stance towards medical advice

Studies on treatment decisions in primary and secondary care settings reveal that patients play an active role in the decision-making process both overtly (Stivers 2005b; Lindström & Weatherall 2015; Bergen et al 2018) and more covertly (Bergen & Stivers 2013; Stivers & Timmermans this issue). Securing a verbal commitment to follow the recommendation is a first step towards treatment adherence. When a patient does not initially accept a recommendation, practitioners treat this as 'passive resistance' indicative of a reluctance to accept the recommendation and foreshadowing stronger active

resistance (Stivers 2005b). One way that clinicians handle this is to pursue a patient's verbal commitment before moving to another topic (Stivers 2005b). When patients reveal the grounds for their resistance, clinicians may meet these grounds by pressuring, coaxing or accommodating the patient (Stivers & Timmermans 2020). Across healthcare settings, patient resistance shapes, and is shaped by, broader clinical trends such as inappropriate prescribing (Stivers & Timmermans this issue) and social acceptability of taking prescription medication (Bergen et al 2018). Beyond resistance, patients can influence treatment decisions earlier in the assessment, before treatment options are put on the table (Stivers & Timmermans this issue). For example, by presenting a health concern in a way that indicates the relevance of antibiotic treatment or answering an assessment question in a way that indicates the relevance of prescription pain relief. This can impact what recommendation practitioners ultimately make (Stivers & Timmermans this issue).

Across medical settings, conversation analytic research on treatment negotiation has focused primarily on the treatment recommendation sequence (Stivers & Barnes 2018; Stivers 2005, 2005b; Toerien et al 2013; Wang 2020; Thompson & McCabe 2018; Costello & Roberts 2001), in which a practitioner recommends a course of action (e.g., taking medication), a patient responds to this recommendation, and any subsequent pursuit of a treatment acceptance. This paper takes a different and broader approach to study patient stance towards treatment (see Dalby Landmark, Svennevig & Gulbrandsen 2016), focusing on all instances in which a patient took an explicitly negative stance cited a reason for that stance, at any stage of the visit. We define explicit negative stance as any talk that overtly orients to a treatment as difficult, unrealistic, problematic, disliked or inferior. For example, describing a negative experience with medication, difficulties attending talking therapy, or fears that coping strategies would be ineffective. Citing a reason for the stance involved providing any account or basis for that stance. All three of the examples above involve citing a reason for the negative stance (negative experiences, past difficulties, concerns), whereas simply rejecting a recommendation without an account is not recognizable as 'citing a reason' for the negative stance.

Medical Advice in Crisis Care

It is challenging for any healthcare practitioner to address a patient's negative stance towards treatment, but ED liaison psychiatry is a particularly high stakes environment. Many patients are experiencing acute distress and are at higher risk of self-harm. At the same time, there are often not enough inpatient beds available to offer hospitalisation. Psychiatric liaison teams must meet 4-hour targets to assess patients regardless of patient load (NCCMH 2004). There is significant institutional pressure to rapidly assess risk to self and others, then discharge the patient and signpost back to community services, which are often the same services patients have used in the past. There is also no follow-up care provided by the service. These limitations impact treatment recommendations and many patients feel they are receiving generic recommendations, not suited to their needs (O'Keeffe et al in prep;). Lack of acceptable follow-up care provided in the liaison psychiatry setting has been shown to promote future disengagement from mental health services (Hunter et al 2013). Over half of people

attending hospital for self-harm or suicidal thoughts will re-attend within one year (Griffin et al 2019). The current study situates the treatment discussion within these real institutional constraints and social outcomes.

Data and Methods

This paper draws on data collected as part of a larger mixed methods study on liaison psychiatry (LP) psychosocial assessments for self-harm and suicidality (Lomas et al, in prep). The study involved the video recording of LP psychosocial assessments in an Emergency Department (ED) in England. Upon arriving to the Emergency Department, people seeking care for self-harm and/or suicidal thoughts meet with ED triage to assess clinical urgency and undergo necessary physical treatments. NICE states that these patients should then be referred for psychosocial assessment with the ED's liaison psychiatry service (NCCMH 2004). Psychiatric liaison practitioners are nurses, social workers, psychologists and other healthcare professionals. This paper adopts the NICE definition of self-harm as "self-poisoning or self-injury, irrespective of the purpose of the act" (NCCMH 2004).

The psychosocial assessment involves an assessment of needs and risks, which lead to a management plan (NCCMH 2004). The management plan tends to include discussion of next steps to manage the crisis after the ED, for example coping strategies, advice on behaviour change (e.g., alcohol, social contacts), contacting helplines/crisis lines and referrals to services in the community (e.g., psychological therapy). This paper uses the term 'treatment' inclusively to refer to these next steps and 'treatment recommendation' to refer to any recommendation for one of these next steps.

This paper involved analysis of 35 video-recorded LP psychosocial assessments with 34 patients and 16 practitioners, collected between September 2018 and February 2019. Additional recordings were collected between February 2019 and April 2019 as part of the larger mixed-methods study (Lomas et al, in prep) but were not included in this analysis. In these data, the most common reason for referral was suicidal ideation (N=18/35) or self-harm by overdose (N=14/35). Caregivers, typically parents, were present in 5 assessments. Two GoPro Hero3 or Hero5 cameras were set up in the assessment room and the assessment was recorded with no researcher present. The study obtained ethical approval from London Central Research Ethics Committee. Study design, materials and recruitment processes were developed in collaboration with a lived experience group made up of one carer, one mental health nurse and six people who had presented to the ED for self-harm more than once in their lifetime.

Patients were invited to reflect on the assessment and management plan with the researcher within ten days of the assessment and again three months later. Where patients discussed specific aspects of the management plan, this was included as supplementary data and referenced in the qualitative analysis (N=9). Due to small sample size, patients' post-assessment reflections were not analysed systematically.

Practitioners were mental health nurses (N=8), doctors (N=3), social workers (N=2), occupational therapists (N=2) and other mental health practitioner (N=1). They ranged in age from 24 to 58 with a mean age of 43 (SD=11) years and were mostly female (N=10/16) and white British (N=15/16). Patients ranged in age from 18 to 76 with a mean age of 35 (SD=15) years and were mostly female (N=24/34) and white British (N=32/34). Over two-thirds had used mental health services in the past (N=23/34) and over one-third had used hospital services during a mental health crisis in the past (N=13/34).

All PLPs who conducted assessments were invited to participate in the larger mixed-methods study (76.7% consent rate, N=33 consented) (Lomas et al, in prep). Patients referred for suicidal ideation or self-harm were approached by a practitioner who assessed capacity to give informed consent. Patients under 16 and those with cognitive difficulties or active psychosis were excluded, as well as patients who required an interpreter or were subject to a restriction order. Eligible patients were then asked for consent for a researcher to tell them about the study. A three-step informed consent process was developed with the lived experience group. This involved written informed consent obtained by a researcher pre-assessment, re-affirmation of consent by the practitioner during the assessment, and post-assessment re-affirmation of consent by the researcher (59.2% consent rate, N=48 consented).

Transcripts shown in this paper are anonymised (e.g., names and locations changed) and use the Jefferson transcription system for conversation analysis (see Hepburn & Bolden 2013).

Data Analysis

Across 35 psychosocial assessments, we identified 53 instances in which the patient took an explicitly negative stance towards a treatment and gave a reason for that stance. The practitioner dropped the potential recommendation in 18 of these conversations and ultimately made a recommendation for the treatment or another option in the same treatment category in 33 of these conversations. Examples include a negative stance towards call-based crisis lines and recommendation for a text-based crisis line (both telephone crisis support), and a negative stance towards bereavement therapy and a recommendation for cognitive behavioural therapy (both talking therapies). All recommendations (e.g., from medication adherence to coping strategies) were included to determine what communication practices might be effective across a wide range of treatments. We did not examine instances in which a patient takes an implicit negative stance, for example by responding only with silence or minimal acknowledgement of the treatment discussion (i.e., passive resistance) (see Stivers 2005b).

Next, all other talk about that treatment was identified across the assessment, both before and after the negative stance was expressed. This included preparatory discussions about a potential recommendation, the actual recommendation and later return to the topic. For example, if a patient said they don't use the Samaritans crisis line because they find it unhelpful, all earlier and later questions about crisis helplines, recommendations for helplines, or pursuit of a commitment to use a crisis helpline

would be included. Some patients expressed a negative stance early in the assessment, often in response to preparatory practitioner questions about past experiences with treatment. In other cases, particularly where practitioners' preparatory questions were minimal, patients only expressed a negative stance late in the assessment, in response to an initial treatment recommendation.

Conversation analytic methods were used to analyse the trajectory of these conversations. Conversation analysis has been growing in popularity for systematic analysis of practitioner-patient interactions (Sidnell & Stivers 2013). The methodology involves inductive micro-analysis drawing on evidence from observable features of naturally occurring conversations between doctor and patient and has been used to analyse treatment recommendations across a range of settings, including mental health care (Peräkylä et al 2008; Bloch & Leydon 2019). Particular focus was placed on practitioner-patient talk that led to a patient moving from a negative stance to ultimate acceptance of a recommendation. For example, a patient initially recounting negative experiences with talk therapy, but ultimately accepting a recommendation for cognitive behavioural therapy. This paper uses Stivers' (2005b) definition of patient acceptance as a verbal commitment (e.g., *okay, alright, I will*). Following a treatment recommendation, anything less than acceptance, i.e. a verbal commitment, is heard as passive resistance, indicating a lack of patient buy-in (Stivers 2005b).

This inductive analysis identified three steps (described in detail below) that practitioners often use to work with possible negative patient stance; (1) asking preparatory questions about the treatment option, (2) accepting or validating the reasons for the patient's negative stance, and (3) showing the patient that their reasons were incorporated into the recommendation. See Table 1. Detailed analysis revealed evidence that these three steps created unique social-interactional affordances for patient disclosure of the reasons underlying negative stance, personalised recommendations involving these reasons, and ultimate patient acceptance.

Coding

All cases were then coded for these three steps and whether the patient ultimately accepted the recommendation.

(1) Preparatory questions about the treatment option included questions about a patient's previous attempts to address a symptom or health issue, a patient's past experience with a treatment or course of action, or their stance or reasons for their stance on that treatment option.

(2) Accepting or validating the reasons for the patient's negative stance included displays of mutual understanding, treating the patient's views as reasonable, agreement and other forms of validation, as well as accepting or summarising the patient's reasons. Minimal acknowledgement (e.g., "Mm." "Ah."), countering the patient's reasons or otherwise working to change their mind were all coded as not accepting or validating. Nonverbal behaviours such as nodding and vocal intonation were taken into account. Nodding in particular implicitly claims affiliation and understanding in storytelling (Stivers 2008).

(3) Incorporating the patient's reasons into the recommendation involved the practitioner referencing or addressing the patient's reason for the negative stance, or adapting the recommendation to address the reason either during the recommendation sequence itself or in pursuit of patient acceptance.

(4) Patient acceptance of the recommendation either immediately after the recommendation or after further discussion was indicated by a verbal commitment (e.g., *okay, alright, I will*) to follow the recommended treatment. Studies have shown that this verbal commitment is distinct from agreement, acknowledgement, and displays of prior knowledge (Stivers 2005b). Practitioners and patients orient to anything less than acceptance as problematic in healthcare assessments.

While inquiry and acceptance of the patient's negative stance tend to occur in quick succession, there is often some space between acceptance and incorporation into the recommendation. Regardless, practitioners were easily able to show patients that their personalised recommendations stemmed from the patient's earlier stated treatment preferences (e.g., *you said…*).

	Recommendation	**Example**
Preparatory Questions	Alcohol Support	Have you ever had periods of trying to cut down or reduce?
	Talking Therapy	What did you think about that?
	Online Resources	You struggle to put things into practice yourself?
Accepting or Validating	Medication Review	That's [addiction] a very real fear and thought to have.
	Medication Review	There is a chance that that [side effect] might still happen again.
	Charity Crisis Service	Okay. (nods)
Incorporating Reasons	Charity Crisis Service	It's telephone support if you're a bit more uncomfortable speaking face to face.
	Alcohol Support	They have kind of modified it so it's inclusive.
	Medication Review	We've got those that can come and support you during that time.

Table 1. Examples of preparatory questions, acceptance and validation, and incorporating the reasons for the negative stance (normalised transcripts.)

Results

Patients in these data frequently adopted a negative stance towards potential treatment options. A negative stance was adopted towards 53 potential treatments across 35 assessments. Patients took a negative stance towards all forms of recommendations for talk therapy (N=7), attending GPs for medication review (N=7), treatment adherence (N=7), asking family or friends for support (N=7), coping strategies (N=6), signposting for alcohol use (N=5), signposting for practical support (N=4), helplines (N=2), support from the crisis team (N=2), getting a new GP (N=2), behaviour change (N=2) and even changes in living situation (N=2). Treatment discussions in which a patient adopted a negative stance involved preparatory questions and/or a treatment recommendation. The majority (N=28/53) involved both, while 22 involved preliminary questions only and 3 involved a treatment recommendation only.

We begin with a case analysis examining the role preparatory questions, acceptance/validation, and personalization play in achieving patient acceptance. We then compare two cases as evidence for the inefficacy of other common approaches. Finally, we compare rates of patient acceptance of treatment recommendations across the dataset.

A Case Leading to Personalised Recommendation and Acceptance

In this section, we show how the two initial steps create affordances later in the visit, when the management plan is discussed. Pam is a woman in her 50's with a long history of suicidal ideation, suicide attempts, and a recent diagnosis of personality disorder with recurrent depression. She is on a waiting list to be assigned a community mental health worker. She presented to the ED with thoughts of suicide. In this conversation, Pam and her practitioner discuss the Samaritans, a well-known suicide helpline and mental health charity in the UK. Patients are advised to contact Samaritans in almost every assessment in these data.

Case 1A

1	L1:	**U:m have you: ever spoken to**
2		**the Samaritans.**
3		(2.0)
4	PT:	No- Uh yes. In the past.
5		Never really:_
6		(3.0)
7	PT:	>Dunno.<
8		(2.0)
9	L1:	**You didn't find that**
10		**help[ful.**
11	PT:	[I think- I think I think
12		you know talking to people
13		over the phone it's just,
14		((sigh, head shake))
15	L1:	**Oka:y.**
16	PT:	You know a lot of the time
17		you just need someone to sit
18		you do:wn have a cup of tea:
19		and just talk about n<u>o</u>rmal
20		things.
21	L2:	M[m::.
22	L1:	**[<u>O</u>kay?**

Asking questions that help Pam articulate her negative stance. How a practitioner asks questions can have a big impact on what a patient is willing to share. In Case 1A, the practitioner begins by asking about Pam's past experience with the Samaritans (lines 1-2). Pam does not give a straightforward answer (lines 4-5) and her delay and repair indicate trouble responding. The practitioner picks up on the patient's difficulty in responding, implying the experience was not positive. She puts forward a possible understanding that Pam didn't find the service helpful (lines 9-10), effectively facilitating Pam in recounting her negative experience. Instead of placing social-interactional pressure on Pam to take a positive stance towards the Samaritans, the format of the question invites Pam to confirm that she does not find the Samaritans helpful. It anticipates a negative stance and does not

embed any assumption that this is the right treatment option. Initially, Pam does not overtly reveal her negative stance, instead responding with non-answers (lines 4-5, 7) and long silences (lines 3, 6). She overtly reveals her negative stance, and the basis of that stance, only after the practitioner invites her to confirm that she does not find the service helpful.

Accepting the reasons for Pam's negative stance. At lines 11-14, Pam describes her perspective, taking a negative stance towards helplines generally. The practitioner comes in at the first opportunity (line 15) with unqualified acceptance ("Oka:y."). In response, Pam continues to describe her perspective, naming an alternative type of support she feels she needs (lines 16-20). The practitioner again accepts Pam's perspective and Pam goes on to explain one of the reasons for her negative stance – that talking about her suicidal thoughts sometimes makes them worse (transcript not shown.)

Accepting the reasons for a patient's negative stance establishes a shared understanding of these reasons without endorsing or agreeing with that way of thinking. Communicating shared understanding sets the groundwork for future talk that implicitly *claims* a shared understanding (see Voutilainen, Peräkylä & Rusuvuori 2010; Weiste, Voutilainen & Peräkylä 2016). In this example, the practitioner establishes shared understanding of Pam's perspective when she accepts the reasons for her negative stance rather than immediately working to change her mind. This creates affordances for later in the visit, when the practitioner makes a recommendation that incorporates these reasons, thereby implicitly claiming as common ground, the reasons for Pam's negative stance towards the Samaritans.

In the next example, we show how the practitioner builds on this shared understanding to create a personalised recommendation that the patient accepts and follows. In transcript 1B, the practitioner discusses a management plan with Pam.

```
Case 1B
1  LP: .hhh Did you know that the:
2      Samaritans have a drop-in
3  PT: ((meets gaze, head shake))
4  LP: in: Newton.
5  PT: N:o. ((nod))
6  LP: No.
7     (3.0)
8  LP: You said about sometimes you
9      just want to sit do:wn and
10     talk to someone [and have a
11 PT:                 [((nodding))
12 LP: cup of tea.
13 PT: ((nod))
14 LP: A:nd that's exactly: the kind
15     of thing that they do.
16 PT: ((big nod, holding gaze))
```

Showing Pam that her reasons were incorporated in the recommendation. The practitioner introduces the Samaritans drop-in service at lines 1-4. She explicitly frames the service as the type of support Pam introduced in Case 1A (lines 16-20), partially repeating Pam's earlier statement and attributing it back to her ("you said" line 8), stating that this is "exactly: the kind of" service the drop-in centre provides. In this way, the practitioner clearly demonstrates that her recommendation is

responsive to Pam's experience and reasons for her negative stance. Importantly, she is able to build this recommendation as responsive because of her earlier work to seek out and accept Pam's perspective on these services. Pam holds eye contact, nodding and nonverbally engaging with the recommendation (line 16). After this, the practitioner expands on the service and Pam ultimately accepts the recommendation (transcript not shown), with the caveat that the centre is not near her home. Three months later, Pam tells the researcher she has visited the drop-in centre as well as a similar drop-in centre she found closer to her home. In contrast with other visits lacking this personalised approach, here the PLP converts Pam's unequivocally negative stance into an acceptance that actually translates into adherence following the visit.

Two Cases that do not Lead to a Personalised Recommendation and are Rejected

Our second prong of evidence that these three-step personalised recommendations promote acceptance comes from the contrast cases. When practitioners do not use the three practices discussed (preparatory questions, accepting or validating, and incorporating reasons underlying negative stance into the recommendation), they are more likely to encounter an upgraded or sustained negative stance. As an illustration, consider Case 2, in which the practitioner does not demonstrate acceptance or validation of the patient's perspective. In these data, it is not uncommon for practitioners to work to change the patient's negative stance upfront, rather than accepting or validating the negative stance upfront.

Paul is a man in his 50s with a long history of alcohol dependence and self-harm while under the influence of alcohol. He attended the ED with thoughts of suicide following an alcohol binge. He is currently supported by an alcohol service keyworker and had been regularly attending group sessions for alcohol use. He stopped attending these sessions about a month ago and the practitioner asks if he feels ready to start attending again in transcript 2A.

Case 2A
4 LP: **Is that something tha:t you**
5 **feel tha:t you're ready**
6 **[to go back along to?**
7 PT: [No. No.
8 LP: **What's going to stop you from**
9 **doing that.**
10 PT: Not in this frame of mind.
11 Not in this frame of mind.
12 (4.0)
13 LP: What about last [week. Do
14 PT: [You you
15 LP: [you think that-
16 PT: [you- When you go to groups
17 you have to be of a certain
18 standard within yourself. By
19 abstinence and what have you.
20 LP: Mm.

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21 PT: You know I don't wanna go in
22     there and say guys I was in
23     the hospital last week and I
24     fucking sliced myself up a
25     bit. Like you know? You don't
26     do that,
       ... [lines 27-40 not shown]
41 LP: But Paul there is a way of
42     managing that and saying
43     actually last week I was
44     struggling [and I was- you
45 PT:            [Don't make it
46     [simplistic. You can't make
47 LP: [don't have go into all the
48     [details,
49 PT: [it simplistic. You can wake
50     up in the morning and you can
51     feel like a bag of shit and
52     it's like I do not want to
53     go into a group with six
54     other people and sit there
55     and share my grief and and
56     my hurt.
```

Asking questions that pressure Paul to take a positive stance. Paul has just disclosed that he has stopped attending group therapy. The practitioner's first question at lines 4-5 embeds an assumption that Paul feels ready to return and anticipates agreement with this (Sacks 1987). It is not an open question (as we saw in Case 2) or a closed question that anticipates a negative stance (as we saw in Case 1). Paul responds with a strong, unqualified rejection (line 7). The practitioner requests an account for his not returning to group therapy (lines 8-9), treating the decision to stop group therapy as something Paul needs to justify, adding to the interactional pressure for Paul to take a positive stance towards group therapy. Paul cites his current state of mind (lines 10-11), and does not expand when the practitioner gives him an opportunity to do so (line 12).

Countering the reasons for Paul's negative stance. When the practitioner begins to ask a follow-up question (lines 13/15), Paul speaks in overlap (lines 14/16), describing what is underlying his negative stance towards attending therapy (lines 17-19). The practitioner minimally acknowledges Paul's perspective ("Mm." at line 20) rather than accepting his perspective (e.g., "Oka:y." in Case 1A, "It is." in Case 2A). Here, Paul becomes visibly angry (lines 21-26), loudly swearing and gesturing as he seeks to explain the reasons for his negative stance.

Paul continues (transcript not shown) until the practitioner presents an alternative view (lines 41-44, 47-48). By not accepting Paul's reasons, and instead presenting an alternative view, the practitioner undermines Paul's right to know his own reasons. Paul raises his voice, demanding "Don't make it simplistic." (lines 45-46). He begins speaking over the practitioner and again working to explain how he feels (lines 49-56). Across these data, when practitioners present an alternative view without first accepting or validating the patient's stance, patients overwhelmingly respond by upgrading and

working to justify their negative stance (as we see here) or disengaging from the conversation. Case 2B picks up less than one minute later in the conversation.

```
Case 2B
73 PT: ((crying)) People make it
74     too simplistic. They think
75     we can all go
76     ((releasing gesture))
77 LP: Not at a:ll. Not at all.
78     (2.0)
79 LP: So you don't feel ready to go
80     back to the group at the
81     moment,
82 PT: No. Not at all.
```

Final rejection of the potential recommendation. Paul continues to explain his stance as the practitioner acknowledges, but does not demonstrate understanding or acceptance of, his perspective (transcript not shown). At lines 73-76, Paul begins to cry, citing people's "simplistic" assumptions about attending group therapy. Though the practitioner has subtly put pressure on Paul to take a positive stance towards group therapy throughout this conversation, she denies Paul's claim (line 77). This is followed by a long silence (line 78). At line 79, the practitioner requests confirmation that Paul doesn't feel ready to return to group therapy. Paul responds with an emphatic no (line 82). Ultimately, Paul refuses to sign the management plan or speak with the researcher about his experience in the assessment.

In Cases 1 and 2, we can see how small differences in the practitioner's approach impact the trajectory of the conversation. In Case 2, the way in which the practitioner solicits and responds to the patient's perspective results in a rejection of the potential treatment during preliminary questioning, so the practitioner never has the opportunity to incorporate the patient's negative stance into a personalised recommendation.

We might wonder whether it would be sufficient to simply accept or validate the patient's negative stance rather than additionally incorporating the reasons for the patient's stance into the recommendation. Case 3 suggests that this is not sufficient. Peter is a young man in his early 20's with no previous interaction with mental health services. He has experienced suicidal ideation in the past but has not harmed himself. He considers himself to have social anxiety though he has never been formally diagnosed. He was brought to the emergency department by university counselling services after he told a friend that he wanted to end his life.

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Case 3A
1  PT: My social anxiety obviously
2      started as a child, and I
3      still have um- I'm still
4      carrying that.
       ... [lines 5-49 not shown]
50 PT: I- I am quite prone to
51     loneliness at this point
52     in time,
```

53 LP: Okay.
54 PT: Yeah.
55 LP: Okay. **So at college and**
56 **things what did you do to**
57 **manage that?**
56 PT: U[m,
57 LP: **[Were you involved in any**
58 **spo:rts o:r any:**
59 **[discussion group, No,**
60 PT: [No:.
61 LP: Mm.
62 PT: No I mean it probably would
63 have been helpful in
64 retrospect but um=
65 LP: **=I mean if you're not into**
66 **it you're not into it**
67 **[are you.**
68 PT: [Yeah.
69 LP: **It's got to be something**
70 **which is of- of value to you**
71 **[to get something fro:m it.**
72 PT: [Mhm.
73 PT: Yeah.

Not providing space for Peter to articulate his negative stance. The practitioner first asks Peter what he did in college to manage his loneliness (lines 55-57). In overlap with the start of Peter's answer, she asks if he was involved in any social groups (lines 57-59). Peter responds that he was not and begins to provide what looks like an account, "would have been helpful in retrospect but um" (lines 62-64). The practitioner quickly comes in and provides her own account (lines 65-67). Though this validates Peter's difficulties joining social groups in the past, it does not give him an opportunity to describe his own reasons for not joining social groups.

Validating Peter's stance, but not the reasons for his stance. At lines 65-67, the practitioner validates Peter's difficulties in joining social groups by citing a possible reason for those difficulties. However, this is not the same as accepting or validating the *actual reasons* for Peter's difficulties joining social groups, as Peter has not yet had the chance to reveal this. Because Peter does not state the reasons for his negative stance, the practitioner will not have the option to incorporate those reasons into her recommendation (Case 3B lines 1-2, 4-10).

Case 3B
1 LP: **And to look at increasing**
2 **your social conta:cts?**
3 PT: Mhm,
4 LP: So whether it's joining s-
5 any of the societies up at
6 the university:, .hh and
7 there's lots going on,
8 there's prob'ly mindfulness
9 groups and things like
10 [that,
11 PT: [Mm. Yeah.
... [lines 12-28 not shown]

29 LP: You'll mix with people
30 who've got simila:r sort
31 of values as well.
32 PT: I feel like the only real
33 barrier to that is my
34 social anxiety,
35 LP: **Yeah?**
36 PT: I do find it kind of ha:rd
37 um (.) yeah to [um,
38 LP: **[Yeah.**
39 PT: Ye[ah.
40 LP: **[What about your house**
41 **mate. What sort of things**
42 **do they do.**
43 PT: Um,
44 LP: **Or would they go with you**
45 **for the first time to**
46 **something.**
47 PT: They prob'ly would if I
48 asked. Yeah.
49 LP: I have to say hand on
50 heart when you try
51 something for the first
52 time it will feel weird.
53 PT: ((nod)) Mm.
54 LP: It's people you don't know,
55 PT: Yeah.
56 LP: **Give it a fe:w (.)**
57 **sessions, [and I promise**
58 PT: [Yeah.
59 LP: **you they will know you**
60 **a:nd [you will be fine.**
61 PT: [Mhm.

Providing a recommendation. At lines 4-10, the practitioner suggests (Stivers & Barnes 2018) that Peter join a social organization such as a mindfulness group. At line 11 Peter agrees with but does not accept the recommendation. Accepting with a recommendation (i.e., making a verbal commitment such as *okay, alright,* or *I will*), is distinct from agreement (*yeah, mhm*), acknowledgement (*mm, ah*), and displays of prior knowledge (*I know*) (Stivers 2005b). Practitioners frequently respond with pursuit of acceptance when patients only agree with or acknowledge a recommendation (Stivers 2005b). Here as well, the practitioner pursues acceptance, emphasizing the importance of joining groups based on shared interests (transcript not shown) so that he can find people with shared values (lines 29-31). Notably, she incorporates the reason *she* offered for Peter's difficulties joining social groups (Case 4A).

In response, Peter cites his own reason for not joining social groups, social anxiety. The practitioner did not provide Peter with an opportunity to express his own reason for not joining social groups earlier in the visit. As we see in other cases, this often results in the patient only revealing the reasons underlying their negative stance after the recommendation. Once Peter reveals his reasons, the practitioner encourages expansion at line 35 (Schegloff 1982) and briefly agrees at line 38.

Here, the practitioner could ask questions about his experience of social anxiety (e.g., 'What do you usually do when you start experiencing social anxiety?'), further work to accept or validate his perspective (e.g., 'That's understandable.') and make a recommendation for socialising that clearly incorporates his social anxiety (e.g., 'With social anxiety, it can be helpful to set specific, realistic goals based on your anxiety triggers.'). The practitioner does begin by asking preliminary questions (lines 40-42, 44-46), but then abandons this line of talk and instead works to convince Peter that he will "be fine" (lines 49-52, 54, 56-57, 59-60). Instead of addressing Peter's social anxiety, the recommendation minimises that Peter will experience difficulties by suggesting he should "give it a few sessions" (lines 56-60).

Although Peter acknowledges and agrees with some of the practitioner's statements, he never accepts the recommendation, again indicating that he is not fully on board (Stivers 2005b). One week after the assessment, Peter told the researcher that he felt the practitioner was empathetic, but the advice he received was unhelpful and the type of advice "a friend could have given me". He returned to the emergency department a few weeks later following a suicide attempt.

Taken together, these cases support our claim that the reason that the three prongs of preparatory questions, acceptance/validation, and incorporating reasons underlying negative stance into the recommendation work is because the last step demonstrates to the patient that she has been heard and her issues have been taken into account. Asking questions alone is insufficient.

Rates of Patient Acceptance

Across these cases, how practitioners approached the treatment made a critical difference. There was a marked contrast in the way patients responded to non-personalised versus personalised recommendations, involving (1) preparatory questions that supported disclosure, (2) acceptance or validation of reasons underlying negative stance, and (3) a responsive recommendation incorporating these reasons (see Table 1).

Of the 17 cases in which the practitioner took the three-step approach to a personalised recommendation, the patient moved from negative stance to acceptance in 14 instances (82% acceptance). Of the 14 cases in which the practitioner made a recommendation but did not take all three steps, the patient accepted the recommendation in only 2 instances (14% acceptance, p=.0002 fisher's exact test two-tailed) (see Table 2).

	Rate of Acceptance
3-Step Personalised Recommendation	**82%** (N=14/17)
Non-Personalised Recommendation	**14%** (N=2/14)

Table 2.

There are 5 instances in which the practitioner gives a recommendation that incorporates the patient's negative stance (Step 3) but either does not ask preparatory questions (Step 1) or does not accept/validate the reasons for the patient's negative stance (Step 2). Of these five instances, there is only one case in which the patient moves from a negative stance to acceptance. This provides further evidence that it is not only one communication practice driving patient acceptance, but the three steps together that promote acceptance.

In these data, there are three deviant cases in which the practitioner takes the three-step approach to a personalised recommendation and the patient does not accept the recommendation. In each case, the patient responds to the practitioner's personalised recommendation by citing additional reasons underlying their negative stance towards treatment and the practitioner later drops the recommendation. There is no indication that patients are resistant towards practitioners carrying out the three steps; rather disclosure of additional reasons underlying their negative stance shows continued engagement in the treatment discussion.

There are two further deviant cases in which the practitioner does not take the three-step approach to a personalised recommendation, but the patient nonetheless moves from an overt negative stance to confirmation. Both cases involve the practitioner explicitly asking the patient to commit to the recommendation (e.g., LP: "You need to go to your provider and get back on your medication… *Will you go?*" PT: "((crying)) Yeah."). These cases contrast with the three-step personalised recommendations shown here insofar as they place significant social-interactional pressure on the patient to accept the recommendation, regardless of their actual willingness to commit.

Across these data, the personalized recommendation approach is critical to improving the chances that the patient will accept a recommendation, if they have taken a negative stance towards the treatment option.

Discussion

This is the first study to analyse video-recorded ED psychosocial assessments with people who have self-harmed or are experiencing suicidal thoughts. This is a high-stakes environment in which patients frequently adopt a negative stance towards medical advice. A successful encounter therefore hinges on whether a practitioner can transform this negative stance into acceptance. By carrying out inductive observational analysis of practitioner and patient behaviour, we deepen our understanding not only of what it looks like to address a patient's treatment hesitancy, but also of what social-interactional building blocks must be in place (communication of shared understanding, acceptance, validation) to address treatment hesitancy in a way that is acceptable to the patient. Self-report data has shown that service users value when practitioners show understanding and acceptance of their perspectives (Xanthopoulou et al 2021). Grounding these concepts in patient and practitioner behaviour through

video analysis reveals further nuance in the relationships between these concepts and the critical role they play in addressing treatment hesitancy.

Specifically, we show that seeking out, accepting and incorporating a patient's negative stance into the treatment recommendation is far more effective than e.g., countering the patient's negative stance. Moreover, we demonstrate how this approach is achieved within the constraints of pressurised routine practice through (1) asking the patient about their experience/understanding of the treatment and helping the patient to articulate their negative stance, (2) accepting or validating the reasons for the patient's negative stance, and (3) showing the patient that these reasons were incorporated in the recommendation.

Patients' negative stances towards treatment are typically grounded in their understanding of their mental health concern or past experiences of seeking help. Conversation analytic research in other settings (e.g., social work, talk therapy) show how communication practices that may discredit or marginalize service users' experiences (see Lee, Herschman & Johnstone 2018) can negatively impact the trajectory of talk and even undermine treatment discussions (Voutilainen, Peräkylä & Rusuvuori 2010; Weiste, Voutilainen & Peräkylä 2016). The current paper provides evidence of increased treatment resistance where practitioners do not show acceptance of the patient's negative stance or show the patient that their perspective was considered in the treatment recommendation. Moreover, we observe cases where patients escalate their negative stance towards treatment in response to their concerns being countered or otherwise discredited.

Conversation analytic studies of healthcare settings often focus on specific sequences of talk (e.g., question and answer) or specific communicative actions (e.g., giving a diagnosis) (Barnes 2019) and how these impact on visit outcomes such as treatment acceptance (Stivers et al 2018; Ford et al 2019; Bergen 2020). Less attention has been paid to the complex relationships *between* communicative actions (e.g., how earlier talk may lay the groundwork for later communicative actions) and how these may impact on visit outcomes (see Voutilainen et al 2010; Barnes 2018). The present study is unique in that it explores an extensive trajectory of talk, from elicitation of the patient's stance to the ultimate treatment recommendation. It shows the powerful analytic footing that can be gained by studying not only how specific communicative actions impact on visit outcomes, but what groundwork must be established for these communicative actions to have effect. When studied in isolation, the three steps of inquiry, acceptance and incorporation do not individually promote treatment acceptance. Rather, inquiry and acceptance lay the groundwork for incorporation and a successful personalised recommendation. These findings point to the benefits of analysing longer stretches of talk relating to the communication practice of interest (in this case, the treatment recommendation).

This study demonstrates that (1) inquiring about and (2) accepting the reasons for a patient's treatment hesitancy lay important groundwork for later personalised treatment recommendations. These communication practices provide evidence of shared understanding of the patient's treatment hesitancy, without going so far as endorsing or agreeing with the patient's perspective. The importance of shared

understanding between patients and practitioners regarding treatment has been discussed in both social science and clinical literature (Collins & Street 2009; Epstein et al 2005; Booker 2005; Lovell 2010). However, in the clinical literature, "establishing shared understanding" is often used to describe the process of educating or informing the patient so they may share the practitioner's understanding of their diagnosis or treatment (e.g., Maskrey & Gordon 2017). The current study contributes to a wider sociological evidence base demonstrating why *establishing shared understanding* must not only involve patient education, but also centrally involve practitioner understanding of the patient's perspective on treatment (Collins & Street 2009).

In both the clinical and social science literature, shared understanding of treatment options is inextricably tied to shared decision-making. Definitions of shared decision making vary widely in the literature but often include a focus on patient values/preferences, patient participation, partnership and options (Makoul & Clayman 2006). Shared decision-making practices include discussing both positives and negatives of treatment, taking an individualized approach, checking understanding (Charles, Gafni & Whelan 1997), incorporating the patient's values, ideas, concerns and outcome expectations (Makoul & Clayman 2006) and supporting patients in deliberating their options and considering their own preferences (Elwyn et al 2012). Conversation analytic studies have contributed to recent efforts to more clearly define what shared decision-making looks like in practice (see Land, Parry & Seymour 2017).

Eliciting patients' treatment preferences is an essential element of shared decision making (Makoul & Clayman 2006). However, conversation analytic research has shown how in practice, this can lead to the patient's stance being delegitimized in favour of the physician's stance (Dalby Landmark, Svennevig & Gulbrandsen 2016). The current study shows that practitioners need not agree nor disagree with the patient's stated stance. Rather, they are most successful when they simply accept or validate the patient's stance (e.g., *that's a very real fear*) and demonstrate that the grounds for the patient's negative stance were taken into account when making the recommendation (e.g., *with the insight that you've got now you might actually stand a better chance*). These personalised recommendations show the patient that their perspective and experiences were not discounted. They provide evidence to the patient that the practitioner took an individualized approach to treatment that placed value on the patient's perspective in the decision-making process.

Declaration of Interests

We declare no competing interests.

Data Sharing

Data cannot be shared due to ethical restrictions.

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